

AN INTRODUCTION TO
**YOUNG
CHILDREN
WITH
SPECIAL
NEEDS**

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3rd
Edition

AN INTRODUCTION TO
**YOUNG
CHILDREN**
WITH
**SPECIAL
NEEDS**

Birth Through Age 8

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This book is dedicated with all my love to Emma. May your life be one of joy filled with boundless dreams and the courage to follow them.

I also dedicate this book to all of the teachers and service providers who steadfastly work to improve the lives of young children with special needs and their families.

I respect and applaud your devotion.

RMG

August, 2009

This is dedicated to the following people:

**Drs. Linda McCormick, Loretta Holder, Judy Wood, David Sexton,
and Jerry Aldridge.**

These individuals, each in their own unique way, have made significant contributions to my professional and personal development, and have enriched my life in countless ways. It was by chance that I met them professionally; it was my great fortune to have developed enduring relationships with each of them. The influence of these mentors, colleagues, and friends will be felt for the balance of my career and they will remain in my heart forever.

JK

August, 2009

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Perspectives, Policies, and Practices of Early Childhood Special Education

Part 1



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Chapter 1

Foundations of Early Childhood Special Education

Chapter 2

The Context of Early Childhood Special Education

Chapter 3

Family-Based Early Childhood Services



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Foundations of Early Childhood Special Education

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Early intervention

Early childhood special education

Tabula rasa

Gifts

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Progressivism

Didactic materials

Sensitive periods

Prepared environment

Auto-education

Schema

Assimilation

Accommodation

Equilibration

Zone of proximal development (ZPD)

Scaffolding

Compensatory education

Project Head Start

Project Follow-Through

Home Start

Early Head Start

Learning Outcomes

After reading this chapter you will be able to:

- Describe the contributions of historical figures to the development of the field of early childhood general education.
- Discuss the evolution of educational opportunities for children with disabilities.
- Explain the concept of compensatory education.
- Describe the purpose of Head Start and related compensatory programs.
- List four long-term benefits of compensatory education.

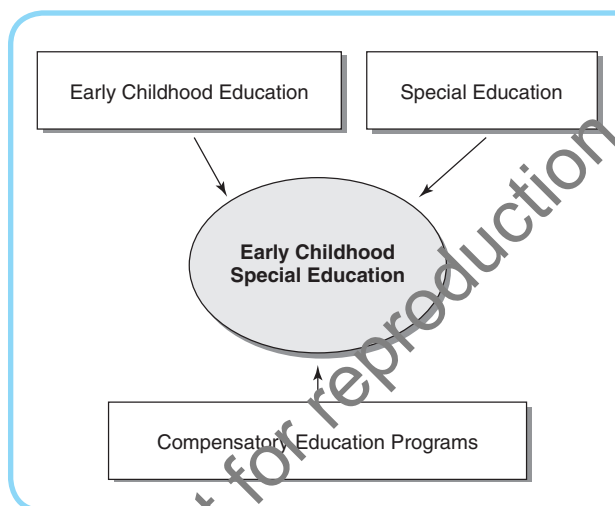
Introduction

Before examining the origins of our field, it is perhaps best to define who is the focus of our attention. When we talk about **early intervention** and **early childhood special education**, we are referring to the period from birth to age eight. In educational terms, this includes early intervention, early childhood special education, and early primary special education. The individuals who require these services represent an especially heterogeneous group of children. The students you serve will vary in their chronological age, cultural, linguistic, ethnic, and socioeconomic backgrounds, as well as in the types and severity of their delays and disabilities. As early childhood special educators, you will encounter pupils with a wide range of physical, cognitive, communication, health, and social limitations (Kilgo, 2006). This textbook is designed to help you deliver an effective educational program to infants and young children with delays and/or disabilities who are receiving services in a variety of educational settings.

The Origins of Early Childhood Special Education

The last thirty-five years have witnessed a dramatic increase in awareness, services, and opportunities for young children with special needs. Legislative initiatives, litigation, public policy, and the efforts of advocacy groups are some of the factors that have helped to focus attention on this group of children. As a distinct field, early childhood special education is relatively young but rapidly emerging. The foundation for constructing developmentally and educationally appropriate experiences for young children with special needs is built upon three related fields. The origins of early childhood special education can be traced to trends and developments in early childhood general education, special education for school-age students, and compensatory programs like Head Start (Hanson & Lynch, 1995). In their own unique way, all the movements have played vital roles in the evolution of early childhood special education. Perhaps it is best to consider the field of early childhood special education as a hybrid built

FIGURE 1-1 The Foundations of Early Childhood Special Education



upon the evolving recommended practices of early childhood and special education, plus the research evidence from empirical investigations documenting the effectiveness of early intervention. Figure 1-1 illustrates this three-fold foundation of the field.

The Development of Early Childhood General Education

Early childhood education has a long history rich with tradition. The efforts of past religious leaders, reformers, educational theorists, and philosophers have helped to shape contemporary thinking about young children. The work of these individuals has also paved the way for many of the concepts and practices utilized with young children with disabilities and students who are at risk for future developmental delays or disabilities. It is important to note, however, that the value of children and their education reflects the social, political, and economic conditions of particular time periods.

Early Contributors

Although a significant historical religious leader, Martin Luther (1483–1546) is also remembered for advocating the importance of literacy and universal, compulsory education. He also was a firm believer in

publicly supported schools for all children, including girls. Luther's legacy includes his visionary idea that family participation is a critical component of a child's education.

Another early religious leader and educational theorist was Jan Ámos Comenius (1592–1670). He was a strong believer in universal education, which ideally should begin in the early years due to the plasticity or malleability of the child's behavior. In *The Great Didactic* (1657), Comenius outlines his view that young children are like soft wax, capable of easily being molded and shaped. Schooling in the first six years of life should begin at home at the mother's knee ("School of the Mother's Knee") and progress throughout an individual's lifetime. Comenius also advocated that all children, including those with disabilities, should be educated (Gargiulo & Černá, 1992).

Many contemporary practices, as well as the thinking of later theorists such as Montessori and Piaget, can be found in Comenius's early ideas about children's learning and development. As an example, Comenius realized the importance of a child's readiness for an activity. He also stressed that students learn best by being actively involved in the learning process. Additionally, Comenius placed great emphasis on sensory experiences and the utilization of concrete examples.

John Locke (1632–1704) was a seventeenth-century English philosopher and physician who also influenced thinking about young children. Locke is

credited with introducing the notion that children are born very much like a blank slate (*tabula rasa*). All that children learn, therefore, is a direct result of experiences, activities, and sensations rather than innate characteristics. Locke was a strong advocate of an environmental point of view. What a person becomes is a consequence or product of the type and quality of experiences to which they are exposed.

Locke's belief in the domination of the environment is reflected in the behavioral theories of B. F. Skinner and other contemporary theorists as well as today's compensatory education programs aimed at remedying the consequences of a disadvantaged environment. Early school experience for children at risk, such as the popular Head Start program, is a prime example. Because Locke also stressed the importance of sensory experiences, his theorizing influenced Montessori's thinking about the significance of sensory training in early education.

One social theorist and philosopher who had a significant impact on education was Jean-Jacques Rousseau (1712–1778). Through his writings, in particular, *Emile* (1762), Rousseau described his views on child rearing and education. His ideas, radical for their time, included a natural approach to the education of young children. Rousseau urged a laissez-faire approach, one void of restrictions and interference, that would thus allow the natural unfolding of a child's abilities. Childhood was viewed as a distinct and special time wherein children developed or "flowered" according to innate timetables. Rousseau emphasized the importance of early education. He also believed that schools should be based on the interests of the child (Graves, Gargiulo, & Schertz, 1996).

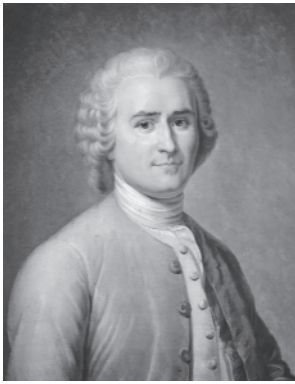
Educational historians typically regard Rousseau as the dividing line between the historical and modern periods of education. He significantly influenced future reformers and thinkers such as Pestalozzi, Froebel, and Montessori, all of whom have contributed to modern early childhood practices.

Pioneers in Early Childhood Education

Johann Heinrich Pestalozzi (1746–1827), a Swiss educator, is credited with establishing early childhood education as a distinct discipline. Like Rousseau, Pestalozzi believed in the importance of education through nature and following the child's natural development. He also advocated developing school



Comenius believed that young children learn best by being actively involved in the learning process.



According to Rousseau, children develop according to innate timetables.

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experiences centered on the interests of the student. Pestalozzi realized, however, that learning does not occur simply through a child's initiative and exploratory behavior; adult guidance is required. Teachers, therefore, need to construct "object" lessons to balance the pupil's self-guided experiences. Due to Pestalozzi's belief in the importance of sensory experiences, instructional lessons incorporated manipulative activities like counting, measuring, feeling, and touching concrete objects (Lawton, 1988).

Three additional ideas distinguish Pestalozzi's contributions to the field of early childhood education. First, Pestalozzi stressed the education of the whole child; second, he was a strong believer in involving parents in a child's early education; and, finally, he saw the merit of multiage grouping whereby older students could assist in teaching younger pupils.

Social reformer and entrepreneur Robert Owen (1771–1858) is recognized for establishing an Infant School in 1816. Influenced by the theorizing of Rousseau and Pestalozzi, Owen was concerned about the living and working conditions of the children and their parents who worked in textile mills. As the manager of a mill in New Lanark, Scotland, Owen was able to initiate his reform ideas. Very young children were prohibited from working at all and the working hours of older children were limited. Perhaps more important, however, was the establishment of a school for children between the ages of three and ten. He believed early education was critical to the

development of a child's character and behavior. The early years were the best time to influence a young child's development. By controlling and manipulating environmental conditions, Owen, like other Utopians, sought to construct a better society (Graves et al., 1996). Education was seen as a vehicle for social change.

Owen's Infant School was noted for its emphasis on the development of basic academics as well as creative experiences such as dance and music. This pioneer of early childhood education did not believe in forcing children to learn and was opposed to punishment, stressing mutual respect between teacher and learner. His ideas were immensely popular, and more than 50 Infant Schools were established by the late 1820s throughout Scotland, Ireland, and England. Several schools flourished in urban areas of the United States; yet, their influence diminished by the mid-1830s.

Owen's Infant Schools served as a forerunner of kindergartens. They were also seen as a way of immunizing children living in poverty from the evils of nineteenth-century urban living. This social reformer was visionary; he realized the important relationship between education and societal improvements. Owen believed, as did other reformers of that time, that poverty could be permanently eliminated by educating and socializing young children from poor families.

Graves and his colleagues (Graves et al., 1996) describe Friedrich Wilhelm Froebel¹ (1782–1852) as the one individual who perhaps had the greatest impact on the field of early childhood education. A student of Pestalozzi and a teacher in one of his schools, Froebel was a strong believer in the education of young children. He translated his beliefs into a system for teaching young children in addition to developing a curriculum, complete with methodology. His efforts have earned him the well-deserved title "Father of the Kindergarten."

Also influenced by the writings of Rousseau and Comenius, Froebel conceived an educational theory ("Law of Universal Unity") partly based on their thoughts as well as his own personal experiences and

¹ Information on Friedrich Froebel, John Dewey, Maria Montessori, and Jean Piaget is adapted from *Young Children: An Introduction to Early Childhood* by S. Graves, R. Gargiulo, and L. Sluder. St. Paul, MN: West Publishing, 1996.

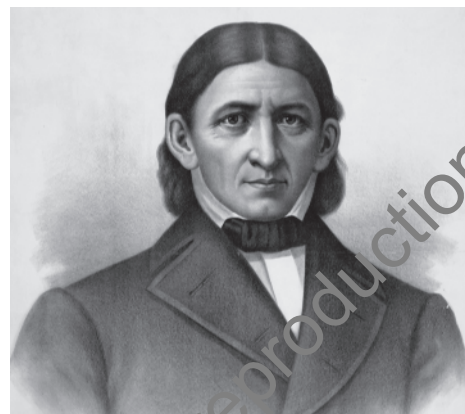
religious views. His basic idea was essentially religious in nature and emphasized a unity of all living things—a oneness of humans, nature, and God. His notion of unity led Froebel to advocate that education should be based on cooperation rather than competition. Like Comenius and Pestalozzi, he also considered development as a process of unfolding. Children's learning should, therefore, follow this natural development. The role of the teacher (and parent) was to recognize this process and to provide activities to help the child learn whenever he or she was ready to learn (Graves, 1990).

Froebel used the garden to symbolize childhood education. Like a flower blooming from a bud, children would grow naturally according to their own laws of development. A kindergarten education, therefore, should follow the nature of the child. Play, a child's natural activity, was a basis for learning (Spodek, Saracho, & Davis, 1991).

Froebel established the first kindergarten (German for “children’s garden”) in 1837 near Blankenburg, Germany. This early program enrolled young children between the ages of one and seven. Structured play was an important component of the curriculum. Unlike many of his contemporaries, Froebel saw educational value and benefit in play. Play is the work of the child. Because he believed that education was knowledge being transmitted by symbols, Froebel devised a set of materials and activities that would aid the children in their play activities as well as teach the concept of unity among nature, God, and humankind. Education was to begin with the concrete and move to the abstract.

Froebel presented his students with “gifts” and “occupations” rich in symbolism. In his curriculum, **gifts** were manipulative activities to assist in learning color, shape, size, counting, and other educational tasks. Wooden blocks, cylinders, and cubes; balls of colored yarn; geometric shapes; and natural objects, such as beans and pebbles, are all examples of some of the learning tools used.

Occupations were arts-and-craft-type activities designed to develop eye-hand coordination and fine motor skills. Illustrations of these activities include bead-stringing, embroidering, paper folding, cutting with scissors, and weaving. Froebel’s curriculum also used games, songs, dance, rhymes, and finger play. Other components of his curriculum were nature study, language, and arithmetic in addition to developing the habits of cleanliness, courtesy, and punctuality.



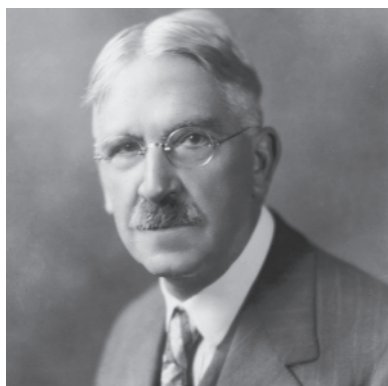
Froebel is considered to be the “Father of the Kindergarten.”

According to Froebel, teachers were to be designers of activities and experiences utilizing the child’s natural curiosity. They were also responsible for directing and guiding their students toward becoming contributing members of society (Graves, 1990). This role of the teacher as a facilitator of children’s learning would later be echoed in the work of Montessori and Piaget.

Influential Leaders of the Twentieth Century

We believe that the thinking and educational ideas espoused by John Dewey, Maria Montessori, and Jean Piaget, along with his contemporary, Russian theorist Lev Vygotsky, have significantly influenced the field of early childhood general education. Many of the practices that are common in today’s classrooms can trace their origins to the work of these four individuals.

John Dewey. The influence of John Dewey (1859–1952) can be traced to the early days of the twentieth century when conflicting points of view about young children and kindergarten experiences began to emerge. Some individuals professed a strong allegiance to Froebel’s principles and practices. Other professionals, known as progressives, saw little value in adhering to Froebel’s symbolism. Instead, they embraced the developing



Hulton Archive/Getty Images

Dewey founded a school of thought known as Progressivism.

child study movement with its focus on empirical study. Because of the work of G. Stanley Hall, the father of the child study movement, formal observations and a scientific basis for understanding young children replaced speculation, philosophic idealism, and religious and social values as a means for guiding the education of young children. Observations of young children led to new ideas about kindergarten practices and what should be considered of educational value for children.

Dewey, a student of Hall, was one of the first Americans to significantly impact educational theory as well as practice. He is generally regarded as the founder of a school of thought known as **Progressivism**. This approach, with its emphasis on the child and his or her interests, was counter to the then prevalent theme of teacher-directed, subject-oriented curriculum. According to Dewey, learning flowed from the interests of the child instead of from activities chosen by the instructor. Dewey who taught at both the University of Chicago and Teachers College, Columbia University, coined the terms “child-centered curriculum” and “child-centered schools” (Graves, 1990). Consistent with Dewey’s beliefs, the purpose of schools was to prepare the student for the realities of today’s world, not just to prepare for the future. In his famous work, *My Pedagogic Creed*, this philosopher emphasized that learning occurs through real-life experiences and that education is best described as a process for living. He also stressed the concept of social responsibility. Basic

to his philosophy was the idea that children should be equipped to function effectively as citizens in a democratic society.

Traditionally, children learned predetermined subject matter via rote memory under the strict guidance of the teacher, who was in complete control of the learning environment. In Dewey’s classroom, however, children were socially active, engaged in physical activities and discovering how objects worked. They were to be continually afforded opportunities for inquiry, discovery, and experimentation. Daily living activities such as carpentry and cooking could also be found in a Dewey-designed classroom (Graves, 1990).

Dewey (1916) advocated the child’s interaction with the total environment. He believed that intellectual skills emerged from a child’s own activity and play. He further rejected Froebel’s approach to symbolic education.

Some have unfairly criticized Dewey as only responding to the whims of the child; this was a false accusation. Dewey did not abandon the teaching of subject matter or basic skills. He was merely opposed to imposing knowledge on children. Instead, he favored using the student’s interest as the origin of subject matter instruction. Thus, curriculum cannot be fixed or established in advance. Educators are to guide learning activities, observe and monitor, and offer encouragement and assistance as needed. They are not to control their students.

Although Dewey’s impact has diminished, his contributions to early childhood education in America and other countries are still evident. Many so-called traditional early childhood programs today have their philosophical roots in Dewey’s progressive education movement.

Maria Montessori. As we examine the roots of modern early childhood special education, the work of Maria Montessori (1870–1952) stands out. Her contributions to the field of early childhood general education are significant. A feminist, she became the first female to earn a medical degree in Italy. (Montessori also held a Ph.D. in anthropology.) She began working as a physician in a psychiatric clinic at the University of Rome. It was in this hospital setting that she came into frequent contact with “idiot children,” or individuals thought to be mentally retarded. At the turn of the century, mental retardation was, unfortunately, viewed as indistinguishable from



AP Photo

Montessori believed that children learn best by direct sensory experiences.

mental illness. A careful observation of these youngsters led her to conclude that educational intervention rather than medical treatment would be a more effective strategy. She began to develop her theories for working with these children. In doing so, she was following an historical tradition upon which the early foundation of special education is built—the physician turned educator. Dr. Montessori was influenced by the writings of Pestalozzi, Rousseau, Froebel, and the work of Edouard Seguin, a French physician who pioneered an effective educational approach for children with intellectual disabilities. She concluded that intelligence was not static or fixed, but could be influenced by the child's experiences. Montessori developed an innovative, activity-based sensory education model involving teaching of **didactic materials**. She was eminently successful. Young children who were originally believed to be incapable of learning successfully performed on school achievement tests.

Montessori believed that children learn best by direct sensory experience. She was further convinced that children had a natural tendency to explore and understand their world. Like Froebel, she envisioned child development as a process of unfolding; however, environmental influences also had a critical role. Education in the early years is crucial to the child's later development. Montessori also thought children passed through **sensitive periods**, or stages of development early in life where they are especially able, due to their curiosity, to more easily learn particular skills or behaviors. This concept is very similar to the idea of a child's readiness for an activity.

To promote the children's learning, Montessori constructed an orderly or **prepared environment** with specially designed tasks and materials. Much like Froebel's gifts, these materials included items such as wooden rods, cylinders, and cubes of varying sizes; sets of sandpaper tablets arranged according to the degree of smoothness; and musical bells of different pitches (see Table 1–1). Dr. Montessori's program also emphasized three growth periods—practical life experiences, sensory education, and academic education. Each of these components was considered to be of importance in developing the child's independence, responsibility, and productivity.

Practical life experiences focused on personal hygiene, self-care, physical education, and responsibility for the environment. Examples of this last activity include tasks such as sweeping, dusting, or raking leaves utilizing child-size equipment. Sensory education was very important in Montessori's education scheme. She designed a wide variety of teaching materials aimed at developing the student's various senses. Her didactic materials are noteworthy for two reasons. They were self-correcting, that is, there was only one correct way to use them. Thus the materials could be used independently by the children and help them become self-motivated students. The sensory training equipment was also graded in difficulty—from easiest to the most difficult and from concrete to abstract. Her sensory training materials and procedures reflected her educational belief that cognitive ability results from sensory development. The final stage, academic instruction, introduced the child to reading, writing, and arithmetic in the sensitive period, ages two to six. Various concrete and sensory teaching materials were used in the lessons of this last stage (Montessori, 1965).

Montessori's classrooms were distinguished by their attractive and child-size materials and equipment. The furniture was moveable and the beautifully crafted materials were very attractive—appealing to the child's senses. Teaching materials were displayed on low shelves in an organized manner to encourage the pupil's independent use. Children worked at their own pace, selecting learning materials of their choice. They must, however, complete one assignment before starting another. Dr. Montessori fully believed in allowing children to do things for themselves. She was convinced that children are capable of teaching themselves through interaction with a carefully planned learning environment. She identified this concept as **auto-education**.

TABLE 1–1 Examples of Montessori’s Sensory Materials

Material	Purpose	How It Is Used by Children
Wooden cylinders	Visual discrimination (Size)	Ten wooden cylinders varying in diameter, height, or variations of both dimensions. Child removes cylinders from wooden holder, mixes them up, and replaces in correct location.
Pink tower	Visual discrimination (Dimension)	Ten wooden cubes painted pink. Child is required to build a tower. Each cube is succeedinglly smaller, varying from ten to one centimeter. Repeats activity.
Green rods	Visual discrimination (Length)	Ten wooden pieces identical in size and color but varying in length. After scattering rods, youngster arranges them according to gradations in length—largest to smallest.
Material swatches	Sense of feel	Matches identical pieces of brightly colored fabric (e.g., fine vs. coarse linen, cottons, and woolens). Initially performs task without blindfold.
Sound cylinders	Auditory discrimination	Double set of cylinders containing natural materials such as pebbles or rice. Child shakes cylinder and matches first according to similarity of sound and then according to loudness.
Tonal bells	Auditory discrimination	Two sets of eight metal bells, alike in appearance but varying in tone. Youngster strikes the bells with a wooden hammer and matches the bell on the basis of their sound; first according to corresponding sounds and then according to the musical scale.

SOURCE: Adapted from R. Orem (Ed.), *A Montessori Handbook: Dr. Montessori’s Own Handbook* (New York: Putnam’s Sons, 1965).

Teachers in Montessori classrooms are facilitators and observers of children’s activities. By using skillfully crafted lessons, the teacher (or *directress* in Montessori terminology) slowly and carefully demonstrates concepts to the children. Ideas are presented to the student in small, sequential steps and build on previous experiences that form the basis for the next level of skill development. Teachers foster the development of independence in their students. A Montessori-designed classroom is typically focused on individual student activities rather than group work.

Many of Montessori’s beliefs and concepts are directly applicable to young children with disabilities. Morrison (2009), based on the Circle of Inclusion Project at the University of Kansas, identified ten elements of Montessori’s work that are relevant to teaching youngsters with special needs.

- *The use of mixed-age groupings.* The mixed-age groupings found within a Montessori classroom are conducive to a successful inclusion experience. Mixed-age groupings necessitate a wide range of materials within each classroom to meet the individual needs of children rather than the average need of the group.
- *Individualization within the context of a supportive classroom community.* The individualized curriculum in Montessori classrooms is compatible with the individualization required for children with disabilities. Work in a Montessori classroom is introduced to children according to individual readiness rather than chronological age.
- *An emphasis on functionality within the Montessori environment.* Real objects are used rather than toy replications whenever possible (e.g., children cut bread with a real knife, sweep up crumbs on the



Montessori classrooms are characterized by their attractive learning materials and equipment.

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floor with a real broom, and dry wet tables with cloths.) In a Montessori classroom, the primary goal is to prepare children for life. Special education also focuses on the development of functional skills.

- *The development of independence and the ability to make choices.* Montessori classrooms help all children make choices and become independent learners in many ways; for example, children may choose any material for which they have had a lesson given by the teacher. This development of independence is especially appropriate for children with disabilities.
- *The development of organized work patterns in children.* One objective of the practical life area and the beginning point for every young child is the development of organized work habits. Children with disabilities who need to learn to be organized in their work habits and their use of time benefit from this emphasis.
- *The classic Montessori demonstration.* Demonstrations themselves have value for learners who experience disabilities. A demonstration uses a minimum of language selected specifically for its relevance to the activity and emphasizes an orderly progression from the beginning to the end of the task.
- *An emphasis on repetition.* Children with special needs typically require lots of practice and make progress in small increments.

- *Materials with a built-in control of error.* Materials that have a built-in control of error benefit all children. Because errors are obvious, children notice and correct them without the help of a teacher.
- *Academic materials that provide a concrete representation of the abstract.* Montessori classrooms offer a wide range of concrete materials that children can learn from as a regular part of the curriculum. For children with disabilities, the use of concrete materials is critical to promote real learning.
- *Sensory materials that develop and organize incoming sensory perceptions.* Sensory materials can develop and refine each sense in isolation. A child who cannot see will benefit enormously from materials that train and refine the sense of touch, hearing, and smell, for example (Morrison, 2009, p. 148).

Jean Piaget. Jean Piaget (1896–1980) is one of the major contributors to our understanding of how children think. He is considered by many to be the premiere expert on the development of knowledge in children and young adults.

Piaget studied in Paris, where he had the opportunity to work with Theodore Simon, who in conjunction with Alfred Binet was constructing the first test for assessing children's intelligence. While standardizing the children's responses to test questions, Piaget became extremely interested in the incorrect answers given by the youngsters. His careful observations led him to notice that they gave similar wrong answers. He also discovered that the children made different types of errors at different ages. This paved the way for Piaget to investigate the thinking process that led to incorrect responses.

According to Piaget's (1963, 1970) point of view, children's mode of thinking is qualitatively and fundamentally different from that of adults. He also believed that children's thought processes are modified as they grow and mature. Because Piaget's ideas about intellectual development are complex, only his basic concepts will be presented.

First, it is important to understand Piaget's (1963, 1970) view of intelligence. He was concerned with *how* knowledge is acquired. Piaget avoids stating a precise definition of intelligence; instead, he attempts to describe it in general terms. Piaget speaks of intelligence as an instance of biological adaptation. He also looks at intelligence as a balance or equilibrium between an individual's cognitive structures and the



Bettmann/Corbis

Piaget is widely recognized for his ideas on the development of the intellect.

environment. His focus is on what people *do* as they interact with their environment. Knowledge of reality must be discovered and constructed—it results from a child's actions within, and reactions to, their world. It is also important to note that Piaget is not concerned with individual differences in intelligence (Ginsburg & Oppen, 1969).

Piaget's (1970) theory rests on the contributions of maturational and environmental influences. Maturation establishes a sequence of cognitive stages controlled by heredity. The environment contributes the child's experiences, which dictate how they develop. Thinking is a process of interaction between the child and the environment. Graves (1990) describes children as "active agents who interact with the social and physical world" (p. 198). Youngsters are self-motivated in the construction of their own knowledge, which occurs through activity.

One consequence of interaction with the environment is that the person soon develops organizing

structures or **schema**. These schema, or mental concepts, become a basis from which later cognitive structures are established. Piaget developed three concepts that he believes individuals use to organize their personal experiences into a blueprint for thinking. He called these adaptive processes assimilation, accommodation, and equilibration.

Assimilation occurs when the child is able to integrate new experiences and information into existing schemes, that is, what the child already knows. Children will view new situations in light of previous experiences in their world. As an illustration, when a toddler first encounters a pony, she will most likely call it a dog, something the youngster is already familiar with.

Accommodation is Piaget's second process. It involves modifying existing cognitive structures so that new data can be effectively utilized. Current thought patterns and behavior are changed to fit new situations. Accommodation involves a change in understanding. For example, two-year-old Victoria visits Santa Claus at the mall. Later that day she is shopping with her mother and sees an elderly gentleman with a long white beard whom she calls Santa Claus. Victoria's mother corrects her daughter's mistake by saying that the man is old. When Victoria next meets a man with a white beard, she asks, "Are you Santa Claus or are you just old?" Victoria has demonstrated accommodation—she changed her knowledge base.

Assimilation and accommodation are involved in the final process of equilibration. Here an attempt is made to achieve a balance or equilibrium between assimilation and accommodation. Piaget believed that all activity involves both processes. The interaction between assimilation and accommodation leads to adaptation, a process of adjusting

TeachSource Video

Piaget's Preoperational Stage

Watch "Piaget's Preoperational Stage, available on the premium website for this text." After watching the video, answer the following questions:

1. What types of materials would you include in an activity center to help develop symbolic reasoning?
2. Why do preoperational children have difficulty with conversation tasks?

TABLE 1–2 Piaget’s Stages of Cognitive Development

Approximate Age	Stage	Distinguishing Characteristics
Birth — 1½ – 2 years of age	Sensorimotor	- Knowledge constructed through sensory perception and motor activity. - Thought limited to action schemes. - Beginning to develop object permanence.
2 – 7 years of age	Preoperational	- Emergence of language and symbolic thinking. - Intuitive rather than logical schemes. - Egocentric in thought and action.
7 – 11 years of age	Concrete operations	- Beginning of logical, systematic thinking; limited however, to concrete operations. - Diminished egocentrism. - Understands reversibility and laws of conservation.
12 years of age – adulthood	Formal operations	- Abstract and logical thought present. - Capable of solving hypothetical problems. - Deductive thinking and scientific reasoning is possible. - Evidences concern about social issues, political causes.

to new situations. **Equilibration** is the tendency to reach a balance, which accounts for the formation of knowledge. Intellectual growth, according to Piaget, is achieved through the interplay of these three processes.

Four stages of cognitive development were identified by Piaget. Children pass through these stages in an orderly, sequential fashion. Each stage is a prerequisite for the next one. The ages identified in Table 1–2 are only rough estimates of when a youngster enters each stage. Children progress at their own rate, which is influenced by their experiences and existing cognitive structures, in addition to their maturation.

Lev Vygotsky. Russian psychologist Lev Semenovich Vygotsky (1896–1934) was a contemporary of Piaget and another influential contributor to present understanding of how children learn and develop.

A brilliant young man (he was literate in eight languages), Vygotsky entered Moscow University in 1914, where he studied law, one of the few vocations open to a Jew in tsarist Russia. Upon graduation in

1917, he returned to the city of Gomel, where he had spent most of his youth, and taught in several local institutions. The massive changes brought about by the Russian Revolution provided Vygotsky with the opportunity to teach at Gomel’s Teacher’s College. It was here that he became attracted to the fields of psychology and education, where his lack of formal training as a psychologist proved a distinct advantage. It allowed Vygotsky to look at the field of psychology as an outsider, someone with fresh perspectives and creative ideas about child development (Berk & Winsler, 1995). A visionary thinker, Vygotsky’s theories and beliefs significantly shaped contemporary thinking about children’s language, play, cognition, and social development.

In his book, *Mind in Society*, Vygotsky (1978) argues that people—children in particular—are the products of their social and cultural environments. Children’s development is significantly influenced by their social and cultural worlds and the individuals they come into contact with such as parents, teachers, and peers. Social experiences were very important to Vygotsky because he believed that higher-order cognitive processes, such



Vygotsky emphasized the importance of social interaction.

RIA Novosti/Alamy

as language and cognition, necessitate social interaction. What begins in a social context is eventually internalized psychologically. In his writings, Vygotsky emphasized the link between the social and psychological worlds of the youngster. Learning and development occur via social interaction and engagement.

Learning awakens a variety of developmental processes that are able to operate only when the child is interacting with people in his environment and in collaboration with his peers. Once these processes are internalized, they become part of the child's independent developmental achievement (VYGOTSKY, 1978, p. 90)

Vygotsky (1978, 1986) believed that social interaction not only fosters intellectual development, but also is vital to the development of social competence. Vygotsky's emphasis on the reciprocity of social

relationships, however, is contrary to the theorizing of Piaget. Recall that Piaget saw children as active yet solitary and independent discoverers of knowledge.

Perhaps the best-known Vygotskian concept is the **zone of proximal development (ZPD)**. Simply described, it is a hypothetical region defined by Vygotsky (1978) as "the distance between the actual developmental level as determined by independent problem solving and the level of potential development as determined through problem solving under adult guidance or in collaboration with more capable peers" (p. 86). The ZPD exists between what a youngster can presently accomplish independently and what the child is capable of doing within a supportive environment. Support is typically viewed as coming from more mature thinkers like adults and competent peers, although, according to Hills (1992), it may be derived from materials and equipment. The ZPD is actually created. Judge (1992) writes, through social interaction. It is the arena or "magic middle" (Berger, 2007) in which learning and cognitive development takes place. Figure 1–2 portrays Vygotsky's concept of ZPD.

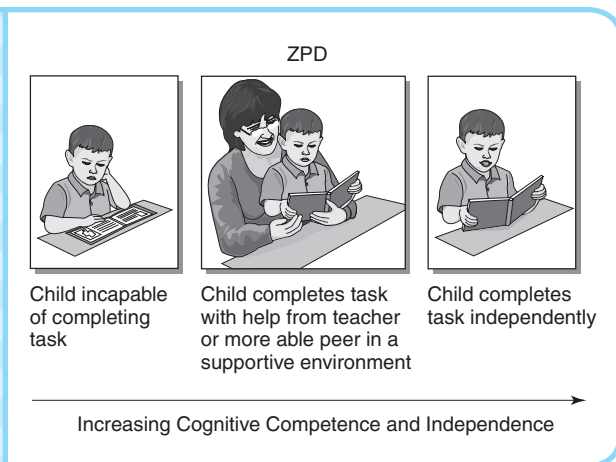
Scaffolding is an idea related to Vygotsky's notion of a ZPD. It refers to the assistance given to a child by adults and peers that allows the individual to function independently and construct new concepts. Social interaction and collaboration with others typically provide youngsters with opportunities for scaffolding. One of the primary goals of scaffolding is to keep children working on tasks that are in their ZPD. This goal is generally obtained by providing the minimum amount of assistance necessary and then further reducing this aid as the child's own competence grows (Berk & Winsler, 1995). Within this context, the teacher's role is one of promoting and facilitating pupils' learning.

TeachSource Video

Lev Vygotsky, the Zone of Proximal Development, and Scaffolding

Watch "Lev Vygotsky, the Zone of Proximal Development, and Scaffolding, available on the premium website for this text." After watching the video, answer the following questions:

1. How can an inclusive learning environment help develop the cognitive competence of a young child with a developmental delay or a disability?
2. What learning strategies would you use to enhance children's learning?

FIGURE 1–2 Vygotsky’s Zone of Proximal Development

As we have just seen, collaboration and social interaction are key tenets in Vygotsky’s sociocultural approach to understanding children’s learning and development. For Vygotsky, learning leads to development rather than following it. Learning is not itself development; rather, structured learning experiences play a major role giving impetus to developmental processes that would be difficult to separate from learning (Tudge, 1992). According to Vygotsky, development and learning are neither identical nor separate processes; instead, they are interrelated and integrative functions. This perspective sees developmental change as arising from a child’s active engagement in a social environment with a mature partner. Growth occurs, therefore, within this ZPD. His approach to education could accurately be described as one of assisted discovery, also known as guided practice or assisted performance (Berk & Winsler, 1995).

Vygotsky also spoke to the issue of children with disabilities. In fact, he enjoyed the title “Father of Soviet Defectology,” which loosely translates to mean special education. Vygotsky (1993) was of the opinion that the principles that govern the learning and development of typical youngsters also apply to children with disabilities. He was firmly convinced that the optimal development of young children with special needs rested on fully integrating them into their social environment while ensuring that instruction occurs within their ZPD (Berk & Winsler, 1995). Children with learning problems should be educated, according

to Vygotsky, in the same fashion as their peers without disabilities.

One of the major difficulties encountered by children with disabilities is how the impairment modifies their interaction with, and participation in, their social environment and not the disability itself. A child’s disability results in restricted interactions with adults and peers and this contributes to the creation of a secondary—yet more debilitating—social deficit. Potentially more harmful than the primary disability, Vygotsky believed that these cultural deficits are more amenable to intervention than the original disorder is.

Several contemporary practices in early childhood special education can be traced to Vygotsky’s thinking. His conceptualizations suggest that young children with special needs should be included as much as possible in environments designed for typically developing learners. As an early advocate of integration, Vygotsky believed that a segregated placement results in a different social climate, thus restricting students’ interactions and collaborative opportunities and thereby limiting cognitive development. Furthermore, educators should focus on students’ strengths and abilities rather than their weaknesses. What a student can do (with or without assistance) is more important than what he or she cannot do. Finally, a student’s learning (social) environment should be rich with opportunities for scaffolding, which is seen as assisting in development of higher-order cognitive processes.

Vygotsky’s contributions to children’s learning and development were not limited to children with disabilities. Many well-known instructional strategies are grounded in his theories. Teachers who engage in cooperative learning activities, peer tutoring, guided practice, reciprocal teaching, and incorporate mixed-age groupings or a whole-language approach can thank Vygotsky.

A Concluding Thought. Our brief examination of the historical roots of early childhood general education suggests two conclusions. First, efforts on behalf of young children were and are frequently constrained by the political and social realities of the times. Second, much of what we often consider new or innovative has been written about and tried before. Present services for young children with disabilities have been influenced significantly by the history of education for young children. As an illustration, many contemporary programs for young children with special needs emphasize parent involvement, a child-centered

curriculum, and interventions based on practical applications of child development theory. These programs also recognize that early experiences impact later social, emotional, and intellectual competency (Meisels & Shonkoff, 2000).

Table 1–3 presents a brief summary of the contributions of key individuals to the development of the field of early childhood education. We now turn our attention to the contributions emerging from our second parent field—special education.

TABLE 1–3 Key Contributors to the Development of Early Childhood Education

Sixteenth Century	
Martin Luther	Strong believer in publicly supported schools. Advocate of universal, compulsory education.
Seventeenth and Eighteenth Century	
Jan Ámos Comenius	Advanced the notion of lifelong education, beginning in the early years. Realized the importance of a child’s readiness for an activity. Stressed student’s active participation in the learning process.
John Locke	Believed that children are similar to a blank tablet (tabula rasa). Environmental influences strongly impact a child’s development. Sensory training is a critical aspect of learning.
Jean-Jacques Rousseau	Emphasized the importance of early education, which should be natural and allow for the unfolding of a child’s abilities. School should focus on the interests of children.
Johann Heinrich Pestalozzi	Advocated education through nature and following the child’s natural development. Early champion of the whole child and involving parents in the education process. Promoter of sensory education.
Nineteenth Century	
Robert Owen	Theorized that the early years were important in developing a youngster’s character and behavior. Linked social change and education. His Infant Schools served as a forerunner of kindergartens.
Friedrich Wilhelm Froebel	Established first kindergarten. Believed in the educational value and benefit of play. Considered development as a natural process of unfolding that provides the foundation for children’s learning.
Twentieth Century	
John Dewey	Founder of the school of thought known as Progressivism. Argued that learning flows from the interests of the child rather than from activities chosen by the teacher. Coined the phrases “child-centered curriculum” and “child-centered schools.” Saw education as a process for living; stressed social responsibility.
Maria Montessori	Believed that children learn best by direct sensory experience; was also convinced that there are sensitive periods for learning. Designed learning materials that were self-correcting, graded in difficulty, and allowed for independent use. Classroom experiences were individualized to meet the needs of each pupil.
Jean Piaget	Developed a stage theory of cognitive development. Cognitive growth emerges from a child’s interaction with and adaptation to his physical environment. Youngsters are self-motivated in the construction of their own knowledge, which occurs through activity and discovery.
Lev Semenovich Vygotsky	Russian psychologist who theorized that children’s development is significantly influenced by their social and cultural environments and the youngster’s interactions with individuals therein. Saw learning and development as interrelated and integrative functions. Originator of the concept of a zone of proximal development (ZPD).

The Development of Special Education: Historical Perspectives on Children with Disabilities

The history of special education provides a second point of departure for examining the evolution of early childhood special education. Society has chosen to deal with such individuals in a variety of ways. Oftentimes, programs and practices for individuals with special needs are a reflection of the prevailing social climate, in addition to people's ideas and attitudes about exceptionality. A change in attitude is often a precursor to a change in the delivery of services. The foundation of societal attitude in the United States can be traced to the efforts and philosophies of various Europeans. We now turn our attention to the historical contributions of these individuals with vision and courage.

People and Ideas

Present educational theories, principles, and practices are the product of pioneering thinkers, advocates, and humanitarians. These dedicated reformers were catalysts for change. Historians typically trace the roots of special education to the late 1700s and early 1800s. It is here that we begin our brief examination of early leaders in the field.

One of the earliest documented attempts at providing special education were the efforts of Jean Marc Gaspard Itard (1775–1838) to educate Victor, the so-called “wild boy of Aveyron.” A French physician and expert on hearing impairment, Itard endeavored in 1799 to “civilize” and teach Victor through a sensory training program and what today would be known as operant procedures. Because this adolescent failed to fully develop language after years of instruction and only mastered basic social and self-help skills, Itard considered his efforts a failure. Yet Itard demonstrated that learning was possible even for an individual described by other professionals as a hopeless and incurable idiot. The title Father of Special Education is bestowed on Itard because of his groundbreaking work more than 200 years ago.

Another important pioneer was Itard's student, Edouard Seguin (1812–1880), who designed instructional programs for children his contemporaries

thought to be incapable of learning. He believed in the importance of sensorimotor activities as an aid to learning. Seguin's methodology was based on a comprehensive assessment of a youngster's strengths and weaknesses coupled with an intervention plan of sensorimotor exercises prescribed to remediate specific disabilities. Seguin also emphasized the critical importance of early education. He is considered one of the first early interventionists. His theorizing also provided the foundation for Montessori's later work with the urban poor and children with mental retardation.

The work of Itard, Seguin, and other innovators of their time helped to establish a foundation for much of what we do today in special education. Table 1–4 summarizes the work of European and American pioneer whose ideas have significantly influenced special education in the United States.

The Establishment of Institutions

Taking their cues from the Europeans, other American reformers such as Boston physician and humanitarian Samuel Gridley Howe (1801–1876) spearheaded the establishment of residential programs. A successful teacher of students who were both deaf and blind, Howe was instrumental in establishing the New England Asylum for the Blind (later the Perkins School) in the early 1830s. Almost two decades later, he played a major role in founding an experimental residential school for children with mental retardation, the Massachusetts School for the Idiotic and Feeble-minded Youth. The first institution in the United States for individuals with mental retardation, it is now called the Fernald Developmental Center.

Residential schools for children with disabilities received additional impetus due to the untiring and vigorous efforts of social activist Dorothea Dix (1802–1887). A retired teacher, Dix was very influential in helping to establish several state institutions for people believed to be mentally ill, a group of individuals she felt to be grossly underserved and largely mistreated.

By the conclusion of the nineteenth century, residential institutions for persons with exceptionalities were a well-established part of the American social fabric. Initially established to offer training and some form of education in a protective lifelong environment, these institutions gradually deteriorated, for a variety of reasons, in the early decades of the

TABLE 1–4 Pioneering Contributors to the Development of Special Education

Contributors	Their Ideas
Jacob Rodrigues Pereine (1715–1780)	Introduced the idea that persons who were deaf could be taught to communicate. Developed an early form of sign language. Provided inspiration and encouragement for the work of Itard and Seguin.
Philippe Pinel (1745–1826)	A reformed-minded French physician who was concerned with the humanitarian treatment of individuals with mental illness. Strongly influenced the later work of Itard.
Jean Marc Gaspard Itard (1775–1838)	A French doctor who secured lasting fame due to his systematic efforts to educate an adolescent thought to be severely mentally retarded. Recognized the importance of sensory stimulation.
Thomas Gallaudet (1787–1851)	Taught children with hearing impairments to communicate via a system of manual signs and symbols. Established the first institution for individuals with deafness in the United States.
Samuel Gridley Howe (1801–1876)	An American physician and educator accorded international fame due to his success in teaching individuals with visual and hearing impairments. Founded the first residential facility for the blind and was instrumental in inaugurating institutional care for children with mental retardation.
Dorothea Lynde Dix (1802–1887)	A contemporary of S. G. Howe, Dix was one of the first Americans to champion better and more humane treatment of people with mental illness. Instigated the establishment of several institutions for individuals with mental disorders.
Louis Braille (1809–1852)	A French educator, who himself was blind, who developed a tactile system of reading and writing for people who were blind. His system, based on a code of six embossed dots, is still used today. This standardized code is known as Standard English Braille.
Edouard Seguin (1812–1880)	A pupil of Itard, Seguin was a French physician responsible for developing teaching methods for children with mental retardation. His training program emphasized sensorimotor activities. After immigrating to the United States, he helped found the organization that was a forerunner of the American Association on Intellectual and Developmental Disabilities.
Francis Galton (1822–1911)	Scientist concerned with individual differences. As a result of studying eminent persons, he believed that genius is solely the result of heredity. Those with superior abilities are born, not made.
Alfred Binet (1857–1911)	A French psychologist, Binet authored the first developmental assessment scale capable of quantifying intelligence. Also originated the concept of mental age with his colleague Theodore Simon.
Lewis Terman (1877–1956)	An American educator and psychologist who revised Binet's original assessment instrument. The result was the publication of the Stanford-Binet Intelligence Scale. Terman developed the notion of intelligence quotient (IQ). Also famous for lifelong study of gifted individuals. Credited as being the grandfather of gifted education.



Jerry Cooke/Time & Life Pictures/Getty Images

Institutions at one time were very common across the United States.

twentieth century. The mission of the institutions changed from training to one of custodial care and isolation. The early optimism of special education was replaced by prejudice, unproven scientific views, and fear that helped to convert institutions into gloomy warehouses for the forgotten and neglected (Gargiulo, 2009).

Special Education in Public Schools

It was not until the latter part of the nineteenth century that special education began to appear in the public schools. In fact, in 1898 Alexander Graham Bell (1847–1922), a teacher of children who were deaf, advocated that public schools begin serving individuals with disabilities. Services for pupils with exceptionalities began slowly and served only a small minority of those who needed it. The first public school class was organized in Boston in 1869 to serve children who were deaf. Children thought to be mentally retarded first attended public schools about three decades later when a class was established in Providence, Rhode Island. The Chicago public schools inaugurated a class for children with physical impairments in 1899, quickly followed by one for children who were blind in 1900 (Gargiulo, 2009). By the mid-1920s, well over half of the largest cities in America provided some type of special education services. The establishment of these programs was seen as an indication of the progressive status of the school district. Still, these earliest ventures mainly

served children with mild disabilities; individuals with severe or multiple impairments were kept at home or sent to institutions.

Meisels and Shonkoff (2000) assert that the economic depression of the 1930s and the ensuing world war led to the decline of further expansion of special education programs in public schools; instead, greater reliance was placed on institutionalization. The residential facilities, however, were already overcrowded and provided educationally limited experiences. The postwar years saw an increase in the recognition of the needs of Americans with disabilities. Impetus for the shift of societal attitude resulted from two related factors—the large number of men and women deemed unfit for military service and the large number of war veterans who returned home with disabilities.

With the Second World War behind the nation, the stage was set for the rapid expansion of special education. This growth has been described as a virtual explosion of services occurring at both the state and federal levels. Litigation at all levels, legislative activities, increased fiscal resources, and federal leadership, in addition to social and political activism and advocacy, are some of the factors that helped fuel the movement and revitalize special education (Gargiulo, 2009). Significant benefits for children with exceptionalities resulted from these efforts. For example, in 1948 approximately 12% of children with disabilities were receiving an education appropriate for their needs (Ballard, Ramirez, & Weintraub, 1982), yet from 1947 to 1972 the number of pupils enrolled in special education programs increased an astonishing 716% as compared to an 82% increase in total public school enrollment (Dunn, 1973).

The last decades of the twentieth century have also witnessed a flurry of activity on behalf of students with special needs. Evidence of this trend includes the 1975 landmark legislation PL 94-142, the Individuals with Disabilities Education Act (IDEA) (originally known as the Education for All Handicapped Children Act) and its 1986 Amendments—PL 99-457; they constitute one of the most comprehensive pieces of legislation affecting infants, toddlers, and preschoolers with special needs and their families. The growth of services for preschoolers who are at risk or disabled, infant and toddler programs, the transition initiative, and calls for full integration of pupils with disabilities (discussed in Chapter 6) are additional indications of a changing attitude and expansion of opportunities for children and youth with exceptionalities.

Compensatory Education Programs

The **compensatory education** movement of the 1960s also played a major role in the development of early childhood special education. As the name implies, this effort was designed to compensate for or ameliorate the environmental conditions and early learning experiences of youngsters living in poverty. Such children were thought to be disadvantaged or “culturally deprived” (a popular term in the 1960s). The goal of compensatory education programs was to assist these students “by providing educational and environmental experiences that might better prepare them for the school experience” (Gearheart, Mullen, & Gearhart, 1993, p. 385). The compensatory education movement had its foundation in the idealism and heightened social consciousness that typified America over four decades ago. It was also aided by the convergence of three distinct social issues: President Kennedy’s interest in the field of mental retardation, President Johnson’s declaration of a War on Poverty, and the emerging civil rights movement (Meisels & Shonkoff, 2000).

In addition to sociological reasons, the compensatory education movement was aided by solid theoretical arguments. The cogent and persuasive writings of J. McVicker Hunt (1961) and fellow scholar Benjamin Bloom (1964) raised serious questions about the assumption of fixed or static intelligence. The malleability of intelligence and the importance of the early years for intellectual development were recognized by scientists and policymakers alike. Thus the powerful contribution of early and enriched experiences on later development laid the cornerstone for programs like Head Start. It also set the stage for the concept of early intervention. It was thought that the deleterious effects of poverty could be remediated by early and intensive programming. The emphasis of preschool programs shifted from custodial caregiving to programming for specific developmental gains (Thurman & Widerstrom, 1990).

Representative Compensatory Programs

Project Head Start. Project Head Start came into existence as a result of the 1964 Economic Opportunity Act. Federally sponsored, Head Start

was a critical component of a larger national agenda called the War on Poverty. As the first nationwide compensatory education program, Head Start was conceived as an early intervention effort aimed at reducing the potential for school failure in disadvantaged young children from low socioeconomic (impoverished) communities. Initiated in the summer of 1965 as an eight-week pilot program, Project Head Start served approximately 560,000 four- and five-year-old youngsters in more than 2,500 communities. Since its inception more than four decades ago, Head Start has served more than 25 million children and their families (Head Start Fact Sheet, 2008).

According to Zigler and Valentine (1979), the first volley on the War on Poverty was constructed around three fundamental ideas:

1. compensatory experiences initiated in the preschool years would result in successful adjustment to school and enhanced academic performance;
2. early intellectual growth and development is directly dependent upon the quality of care and type of experiences to which young children are exposed; and
3. socioeconomically impoverished environments include biological, environmental, and other risk factors, which can adversely affect chances of school success and impede intellectual growth.

Head Start was envisioned to be a comprehensive, multidimensional intervention effort aimed at the very roots of poverty in communities across America. It represented a coordinated federal effort at comprehensive intervention in the lives of young children (Zigler & Valentine, 1979). Head Start was unique in its emphasis on the total development of the youngster, on strengthening the family unit, and in its comprehensive nature of the services provided. The goals of the Head Start effort included increasing the child’s physical, social, and emotional development; developing the youngster’s intellectual skills and readiness for school; and improving the health of the child by providing medical, dental, social, and psychological services. Head Start was also unusual not only in its intent—to bring about a change for the child, her family, and the community—but also for its use of a multidisciplinary intervention model wherein the importance of seeing the whole child was recognized (Brain, 1979).



Head Start was the first nationwide compensatory education program.

Cengage Learning

Parents played an unprecedented role in the Head Start program. Parents' involvement and their meaningful participation were considered vitally important. They had a key voice in the local decision-making process in addition to opportunities for employment in the program or for volunteering their expertise. The inclusion of training programs for low-income adults and the establishment of a career development ladder for employees and volunteers also distinguished the Head Start program.

It is important to remember that Head Start was not specifically directed at children with special needs, although many of the youngsters served would today be identified as an at-risk population. The enactment of PL 92-424 in 1972 did require, however, that the project reserve no less than 10% of its enrollment for children with disabilities.

Fortunately, thanks to changes in federal regulations regarding Head Start, this program is now able to play a larger role in the lives of young children with special needs. In January 1993, new rules for providing services to preschoolers with disabilities enrolled in Head Start were published in the *Federal Register*. Some of the many changes guiding Head Start agencies are the following requirements:

- a model designed to locate and serve young children with disabilities and their parents;
- the development of an individualized education program (IEP) for each youngster determined to be disabled;

- quicker screening of children suspected of needing special services;
- revised evaluation procedures for determining who might be eligible for special education and related services; and
- the establishment of a disability services coordinator who would be responsible for overseeing the delivery of services to preschoolers with special needs.

These goals are to be met through a detailed and comprehensive disabilities service plan, which outlines the strategies for meeting the needs of children with disabilities and their families. Among the several provisions are standards that call for the assurance that youngsters with disabilities will be included in the full range of activities and services provided to other children, a component that addresses the transitioning from infant and toddler programs into Head Start, as well as exiting Head Start to the next placement, and a provision stipulating that eligible children will be provided a special education with related services designed to meet their unique needs. Currently, slightly more than 12% of the preschoolers enrolled in Head Start have an identified disability (Head Start Fact Sheet, 2008).

We consider Head Start to be a visionary program model. The framers of the project had the foresight to insist on comprehensive services, meaningful parent involvement, and a multidisciplinary approach to intervention. Many of these aspects can be found in contemporary programs and legislation. Head Start also served as a forerunner of other compensatory initiatives, which we will now briefly examine.

Project Follow-Through. Project Follow-Through was developed in 1967 in response to controversy surrounding the effectiveness of the Head Start efforts. Some educational research data suggested that the cognitive gains of the Head Start experiment were not maintained once the children enrolled in elementary school (Cicerelli, Evans, & Schiller, 1969). Professionals quickly realized that a short-term intervention program was ineffective in inoculating young children against the deleterious effects of poverty. Follow-Through was introduced in an effort to continue the gains developed in Head Start. A new model was designed, which extended the Head Start concept to include children enrolled in

kindergarten through the third grade. Like its predecessor, Project Follow-Through was comprehensive in its scope of services while maintaining the Head Start emphasis on creating change in the home and community. Unfortunately, a Congressional funding crisis precipitated a retooling of the project's original goals and objectives. According to Peterson's analysis (1987), the focus shifted from a service operation very much like Head Start to an educational experiment dedicated to assessing the effectiveness of various approaches aimed at increasing the educational attainment of young disadvantaged and at-risk students. Rather than offering a single model of early childhood education for low-income pupils, Project Follow-Through studied a variety of approaches and strategies, realizing that a singular model would not meet the needs of all children. Local public schools were free to adopt the program model that they believed best met the unique needs of their communities.

Home Start. In 1972 another program variation, **Home Start**, was created. Simply stated, this program took the education component typically found in Head Start centers into a child's home. The focus of Home Start was low-income parents and their preschool-aged children. Efforts were aimed at providing educational stimulation to the children in addition to developing and enhancing the parenting skills of adults. This task was accomplished through the utilization of home visitors who were skilled and trained residents of the community.

Early Head Start. Early Head Start emerged from a growing recognition among service providers, researchers, policymakers, and politicians of the need to extend the Head Start model downward to the birth-to-three age group. This awareness of the need for comprehensive, intensive, and year-round services for very young children resulted in **Early Head Start** (Halpern, 2000; Meisels & Shonkoff, 2000). The 1994 reauthorization of Head Start (PL 103-252) created Early Head Start, a program focusing on low-income families with infants and toddlers as well as on women who are pregnant. The mission of this program, which began in 1995, is to

- promote healthy pregnancy outcomes;
- enhance children's physical, social, emotional, and cognitive development;

- enable parents to be better caregivers and teachers to their children; and
- help parents meet their goals, including economic independence.

Early Head Start incorporates what its framers call a "four corner emphasis," which embodies child, family, community, and staff development (Allen & Cowdery, 2009). Services provided through this program include high-quality early education and care both in and out of the home; home visits; child care; parent education; comprehensive health services including services before, during, and after pregnancy; nutrition information; and peer support groups for parents. Since its beginning, Early Head Start has evolved into a nationwide effort of more than 730 community-based programs serving approximately 85,000 infants and toddlers (Early Head Start Research and Evaluation Project, 2009).

Research Activities

In addition to involvement and action by the federal government, individual scientists and researchers have also been concerned about the damaging consequences of poverty on young children and their families. Two representative intervention projects include the Carolina Abecedarian Project and the Perry Preschool Project. Both of these programs focus on improving the cognitive skills of young children, thereby increasing their chances for later scholastic success.

The Carolina Abecedarian Project attempted to modify environmental forces impinging upon the intellectual development of young children living in poverty. Designed in 1972 as a longitudinal experiment, Craig Ramey and his colleagues (Ramey & Campbell, 1977, 1984; Ramey & Smith, 1977) found that children enrolled in a center-based preschool intervention program who were exposed to intensive and stimulating early learning experiences achieved higher IQ scores when compared to matched age-mates who did not participate in the project. A follow-up of participants found that, at age twelve and fifteen, youngsters exposed to early intervention continued to outperform control subjects on standardized measures of intellectual development and academic achievement. Additionally, these individuals had significantly fewer grade retentions and special education placements (Campbell &

Ramey, 1994, 1995). As young adults, these individuals scored higher on measures of intellectual and academic achievement and were more likely to attend a four-year college (Campbell, Ramey, Pungello, Sparling, & Miller-Johnson, 2002). The Carolina program clearly demonstrates, as we noted earlier, the plasticity of intelligence and the positive effects of early environmental intervention.

Our second illustration is the Perry Preschool Project in Ypsilanti, Michigan. This program is one of the best examples of the long-term educational benefit of early childhood experiences. The Perry Preschool Project was designed as a longitudinal study to measure the effects of a quality preschool education on children living in poverty. Based on the work of Jean Piaget, it strongly emphasized cognitive development. More than 120 disadvantaged youngsters were followed from age three until late adolescence. The results of the investigation can be summarized as follows:

Results to age 19 indicate long-lasting beneficial effects of preschool education in improving cognitive performance during early childhood; in improving scholastic placement and achievement during the school years; in decreasing delinquency and crime, the use of welfare assistance, and the incidence of teenage pregnancy; and in increasing high school graduation rates and the frequency of enrollment in postsecondary programs and employment (BERRUETA-CLEMENT, SCHWEINHART, BARNETT, EPSTEIN, & WEIKART, 1984, p. 1)

Additional follow-up (Schweinhart, Barnes, & Weikart, 1993) demonstrated that, in comparison to a control group, individuals in their mid-20s who participated in this project as preschoolers had higher incomes, were more likely to own a home, had significantly fewer arrests, and had less involvement with community social service agencies.

Despite the methodological difficulties inherent in conducting early intervention research in a scientifically rigorous fashion, these two examples unequivocally illustrate that early intervention generates positive academic outcomes and significantly improves the quality of participants' later lives. We fully agree with Guralnick's (2005) observation that "the early years may well constitute a unique window of opportunity to alter children's developmental trajectories" (p. 314).

A Concluding Thought. It is safe to conclude that, generally speaking, compensatory education programs do benefit young children at risk for limited success in school. The optimism exhibited by the early supporters of various intervention initiatives has been tempered, however, by a host of political, financial, and other factors. Reality has reminded educators, policymakers, and researchers that there are no quick or magical solutions to complex social problems like poverty. Yet we must not be overly pessimistic; education does remain an important vehicle for successfully altering the lives of young children and their caregivers.

Summary

Although early childhood special education is a relatively young field, the forces that have helped to shape its identity have a rich and distinguished history. Drawing upon the work of earlier educational theorists and writers such as Piaget, Vygotsky, Montessori, Dewey, and others, early childhood special education has evolved into a distinct field with its own identity and theoretical underpinnings. Yet it is interesting to note that many of the current practices in early childhood special education (for example, individualized instruction, parent involvement) and the values to which we subscribe are not especially contemporary. Perhaps there is truth to the maxim that "The past is prologue." Three distinct fields—early childhood general education, special education, and compensatory education—have contributed, in their own ways, to the emergence of a wide array of programs and services for young children with special needs and their families. Professionals recognize how very important the early years of a child's life are for later social, emotional, and cognitive growth and development.

Today's early childhood special education is perhaps best conceptualized as a synthesis of various theories, principles, and practices borrowed from each of its parent fields. It is a concept that continues to evolve. We are in a strong position to successfully build on the accomplishments and achievements of the past.

Check Your Understanding

1. Various religious leaders, philosophers, and educational theorists played major roles in the development of early childhood education. List five of them and their contributions found in contemporary early childhood programs.
2. Describe the “gifts” and “occupations” of Froebel’s children’s garden.
3. Explain Dewey’s ideas about educating young children.
4. Identify the major elements of Montessori’s approach to teaching young children.
5. How did Piaget believe intelligence develops?
6. Describe Vygotsky’s concept of zone of proximal development (ZPD).
7. Why would Vygotsky be considered an early advocate of integration?
8. What role did Europeans play in the development of special education in the United States?
9. Define the term *compensatory education*.
10. What is the purpose of Project Head Start and Early Head Start?
11. List five significant events that have helped to shape the field of early childhood special education.

Reflection and Application

1. What evidence do you see of Dewey, Piaget, and Vygotsky in today’s early childhood education settings? What are the strengths of each philosophy? Compare and contrast the three philosophies.
2. In what ways do you see contemporary educators building on the work of earlier philosophers? How does each of the philosophers mentioned in this chapter describe curriculum? What are their fundamental ideas about how children learn?
3. What influence does the environment have on infants, toddlers, and young children in today’s society? What did Dewey say about the environment and its impact on teaching and learning? What did Piaget and Vygotsky say about the environment and early childhood learning?

4. How has the development of compensatory programs helped to strengthen today’s children and families living in poverty? In what ways can early childhood special education programs make compensatory programs available to their children and families? Provide examples.

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2

The Context of Early Childhood Special Education

Definitions and Terminology

- Exceptional Children
- Disability and Handicap
- Federal Definition of Disability
- Developmental Delay and At-Risk
- Early Intervention and Early Childhood Special Education

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- Key Judicial Decisions
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References

Key Terminology

Exceptional children

Disability

Handicap

Developmental delay

At-risk

Established risk

Biological risk

Environmental risk

Early intervention

Early childhood special education

Least restrictive environment (LRE)

Individualized education program (IEP)

Individualized family service plan (IFSP)

Meta-analysis

Ecology

Microsystems

Mesosystems

Exosystems

Macrosystems

Chronosystem

Learning Outcomes

After reading this chapter you will be able to:

- Define the terms disability, handicap, developmental delay, and at-risk.
- Discuss how judicial decisions and legislative enactments have benefited young children with special needs.
- Summarize the major provisions contained in both PL 94-142 and PL 99-457.
- Identify at least four benefits of early intervention for young children with special needs.
- Explain the concept of ecology and its importance to the field of early childhood special education.

Early childhood special education is a relatively young field drawing upon the long history and rich legacy of both early childhood general education and special education in addition to the contributions from compensatory education. Yet early childhood special education is a distinct field having its own identity and purpose. In order to fully appreciate this discipline, several topics basic to the understanding of its development need to be explored. These issues will help provide a firm foundation for the later examination of programs and services for young children with special needs and their families. Attention will be focused on key terminology, the impact of litigation and legislation on the growth of the field, the prevalence of young children with special needs, the research evidence on the efficacy of early intervention, and the validity of an ecological approach for looking at the world of young children with special needs.

Definitions and Terminology

Early childhood teachers serve a wide range of students. An increasing number of these young children exhibit disabilities, some may have developmental delays, and others might be at risk for future school failure. What do these terms mean? Is a disability synonymous with a handicap? What is a developmental delay? What factors jeopardize a child's future academic success? Unfortunately, clear-cut answers to these basic questions are sometimes difficult to achieve. Confusion and misinterpretation are not unusual, even among professionals. Hence, the following descriptions are an attempt to clarify key terminology and provide a common foundation for understanding infants, toddlers, preschoolers, and early primary students with special needs.

Exceptional Children

Early childhood special educators will frequently identify the children they serve as being **exceptional children**. This inclusive term generally refers to individuals who differ from societal or community standards of normalcy. These children will, therefore, require early intervention or an educational program customized to their unique needs. Some exceptionalities are obvious, while others are less obvious, such



Young children with special needs are first and foremost children.

as an infant who is deaf. Furthermore, some young children may greatly benefit from their exceptionalities in their daily lives—for example, a child who is intellectually talented—while in other situations an exceptionality may prove to be a significant problem.

Teachers must not lose sight, however, of the fact that a student with an exceptionality is first and foremost a child—a pupil who is more like his or her typically developing peers than he or she is different. The fact that a young child is recognized as exceptional should never prevent professionals from realizing just how typical the individual is in many other ways.

Disability and Handicap

All too often, professionals, as well as the general public, use the terms *disability* and *handicap* interchangeably. These terms, however, have distinct meanings and are not synonymous. When professionals talk about a **disability**, they are referring to the inability of an individual to do something in a certain way. A disability may be thought of as an incapacity to perform as other children will due to impairments in sensory, physical, cognitive, and other areas of functioning. A **handicap**, on the other hand, refers to the problems that a young child with a disability encounters as she attempts to function and interact in her environment. Mandy, for example, has cerebral palsy. This is a disability. If her disability prohibits her from becoming a professional ice skater, then we would say Mandy

has a handicap. Stephen, a four-year-old who is legally blind (a disability), would have a handicap if his preschool teacher inadvertently used an overhead projector while explaining a cooking activity. A disability may or may not be a handicap depending upon the specific circumstances. For instance, a six-year-old child with braces on his legs might have difficulty walking upstairs but, in the classroom art center, his creativity and talents are easily demonstrated. We should only use the term *handicap* when explaining the consequences or impact imposed on a young child by his or her disability. Gargiulo (2009) urges educators to separate the disability from the handicap.

We have chosen to use the general term *children with special needs* to describe infants, toddlers, preschoolers, and early primary students with disabilities. We cannot stress enough the importance of remembering that a toddler, or any individual with a disability, is first and foremost a person. It is imperative that teachers focus on the child and not the impairment. Early childhood special educators should look for similarities between children with special needs and their typically developing peers, not differences. Attention should also be focused on the children's strengths and abilities, not their disabilities.

Federal Definition of Disability

As we previously noted, early childhood special educators serve a variety of young children with special needs; but who are these children? The federal government, via legislation, the Individuals with Disabilities Education Improvement Act Amendment of 2004 (IDEA) (PL 108-446), defines a student with a disability according to thirteen distinct categories listed in Table 2-1. The government's interpretation of these labels is presented in Appendix B. Individual states frequently use these federal guidelines to construct their own standards and policies as to who is eligible to receive early intervention and special education services.

Developmental Delay and At-Risk

Because of the adverse effects of early labeling, recommended practice suggests that young children with special needs be identified as being either developmentally delayed or in some instances at risk. These terms, in fact, are incorporated in PL 99-457.

TABLE 2-1 Federal Classification of Disabilities

Autism	Orthopedic impairment
Deaf-blindness	Other health impairments
Developmental delay*	Speech or language impairment
Emotional disturbance	Specific learning disability
Hearing impairment	Traumatic brain injury
Mental retardation	Visual impairment
Multiple Disabilities	
*Defined according to individual state guidelines	

This significant enactment requires that local schools provide comprehensive services to children ages three to five with disabilities. The children, however, do *not* have to be identified with one of the federal disability labels found in Table 2-1. The 1991 amendments (PL 102-119) to the Individuals with Disabilities Education Act allow states to use a generic category like "children with disabilities." According to a national survey (Danaher, 2007), 17 states utilize a non-categorical description exclusively when classifying preschoolers with special needs. Examples of these generic labels include "preschool child [student] with a disability" (Colorado, Ohio, New York, South Carolina); "preschool special needs" (West Virginia); "individual with exceptional needs" (California); and "preschool disabled" (New Jersey). Many professionals believe that the use of a categorical disability label for most young children is of questionable value (McCollum & Maude, 1993), unfairly stigmatizes young children, and creates a self-fulfilling prophecy (Danaher, 2007). A noncategorical approach to serving young children with special needs is, therefore, perfectly acceptable as well as legal. Many early childhood special education programs offer services without categorizing children on the basis of a disability (McCollum & Maude, 1993; Spodek & Saracho, 1994a). Thus, instead of a categorical approach, we find that programs serving young children with special needs frequently use the broad terms *developmental delay* and *at-risk*.

As a result of the passage of PL 105–17 it is now permissible, at the discretion of the state and local education agency, to use the term *developmental delay* for children ages three through nine. The most recent reauthorization of IDEA, PL 108-446, reiterated the appropriateness of this term for children ages three to nine (or any subset of this group).

Developmental Delay. Congress realized that establishing a national definition of **developmental delay** would be an almost insurmountable task, and therefore, left the responsibility of developing a satisfactory definition to the individual states. One consequence of this action is the tremendous diversity of criteria found in the various meanings of this term. Many states, according to Shackelford's (2006) analysis, incorporate a quantitative approach when determining who is developmentally delayed. Typical of this strategy is a reliance on data derived from various assessment instruments. Shackelford noted three different kinds of quantitative definitions:

- a delay expressed in terms of standard deviations (SD) below the mean on a norm-referenced assessment (Georgia: 2 SD in one developmental area or 1.5 SD in two areas¹);
- a delay expressed in terms of a difference between a child's chronological age and actual performance level (Alabama: 25% delay in one or more developmental areas); or
- a delay expressed in terms of performance—*n* number of months below child's chronological age (Texas: 2–12 months: 2-month delay; 13–24 months: 3-month delay; 25–36 months: 4-month delay).

Table 2–2 illustrates some of the various criteria used by the states when quantifying a developmental delay. Obviously, there is no one correct way to define this concept. Each approach has its advantages and disadvantages. In fact, 14 states allow for the use of a qualitative determination when considering whether or not a child is developmentally delayed (Danaher, 2007). Nebraska and New Mexico are but two examples of states that permit the use of professional judgment, informed team consensus, or the informed clinical opinions of members of a multidisciplinary team.

A qualitative determination is allowed due to the lack of valid and reliable dependent measures appropriate for infants and toddlers. The predictive validity of these assessment instruments is also suspect. As a result, the regulations accompanying IDEA require that informed clinical opinion be included as part of eligibility determination (Shackelford, 2006; Taylor, Smiley, & Richards, 2009).

There are several advantages to using the term *developmental delay*. First, because it suggests a developmental status rather than a category, it is anticipated that placement of students in developmentally appropriate classrooms will be more likely. Second, it is hoped that this concept will lead to services being matched to the needs and abilities of the child rather than having services decided by a categorical label. Third, professionals believe that the utilization of this term is likely to encourage inclusive models of service delivery instead of services being primarily driven by a disability label. Finally, the use of this label avoids the possibility of misidentifying a young child when the etiology or cause of the child's delay is not clearly evident (Division for Early Childhood, 1996, 2001).

At-Risk. When professionals talk about children being **at-risk**, they are speaking of children “who have not been formally identified as having a disability, but who may be developing conditions that will limit their success in school or lead to disabilities. This can be the result of exposure to adverse genetic, biological, or environmental factors” (Spodek & Saracho, 1994b, p. 16). This definition parallels an earlier description of risk factors identified by Kopp (1983). She defines risk as “a wide range of biological and environmental conditions that are associated with increased probability for cognitive, social, affective, and physical problems” (p. 1081).

In both of these definitions we see that exposure to adverse circumstances *may* lead to later problems in development and learning, but it is not a guarantee that developmental problems will occur. Risk factors only set the stage or heighten the probability that differences might arise. Many young children are subject to a wide variety of risks, yet they never evidence developmental problems. Table 2–3 presents some of the common factors and conditions that can place a child at-risk.

Our understanding of the at-risk concept has been greatly enhanced by the wide acceptance professionals have given to Tjossem's (1976) description of three

¹ Developmental areas include physical, communication, cognitive, social or emotional, and adaptive.

TABLE 2–2 Representative Examples of Definitions of Developmental Delay

State	Criteria
Arizona	50% delay in one or more areas
Florida	1.5 SD in one area or 25% delay in months of age in one area; or informed clinical opinion
Hawaii	consensus of multidisciplinary team; no quantitative data specified
Indiana	2.0 SD in one area or 25% below chronological age; 1.5 SD in two areas or 20% below chronological age in two areas; informed clinical opinion
Montana	50% delay in one area or 25% delay in two areas; informed clinical opinion
New Hampshire	atypical behaviors documented by qualified personnel; or 33% delay in one or more areas
South Dakota	25% below normal age range; 6-month delay; or 1.5 SD in one or more areas
Wisconsin	25% delay or 1.3 SD in one area; atypical development as determined by multidisciplinary team with informed clinical opinion

NOTE: SD = standard deviation.
Areas refers to physical, communication, cognitive, social or emotional, and adaptive areas of development.

SOURCE: Adapted from J. Shackelford. (2006). *State and Jurisdictional Eligibility Definitions for Infants and Toddlers with Disabilities Under IDEA*. (NECTAC Notes 21). Chapel Hill, NC: University of North Carolina, FPG Child Development Institute, National Early Childhood Technical Assistance Center.

at-risk categories. His tripartite classification scheme includes established, biological, and environmental risk categories. These categories are not mutually exclusive and frequently overlap. In some instances, a child identified as being biologically at risk due to prematurity may also be at risk due to environmental factors like severe poverty. As a result of this “double vulnerability,” the probability for future delays and learning difficulties dramatically increases.

Established Risk. Children with a diagnosed medical disorder or known etiology and predictable prognosis or outcome are considered to manifest an established risk. Illustrations of such conditions would be a child born with cerebral palsy, Down syndrome, spina bifida, an inborn error of metabolism such as PKU (phenylketonuria), or severe sensory impairments. Young children identified with an established risk condition *must* be served if the state receives IDEA Part C monies.

Biological Risk. Included in this category are children with a history of pre-, peri-, and postnatal



Cengage Learning

Some young children maybe at risk for future difficulties in learning and development due to biological risk factors.

TABLE 2–3 Representative Factors Placing Young Children At Risk for Developmental Problems

• Maternal alcohol and drug abuse
• Children born to teenage mothers or women over age 40
• Home environment lacking adequate stimulation
• Maternal diabetes, hypertension, or toxemia
• Exposure to rubella
• Chronic poverty
• Primary caregiver is developmentally disabled
• Infections such as encephalitis and meningitis
• Oxygen deprivation
• Child abuse and neglect
• Accidents and head trauma
• Inadequate maternal and infant nutrition
• Genetic disorders such as Down syndrome, phenylketonuria, and galactosemia
• Family history of congenital abnormalities
• Exposure to radiation
• Prematurity
• Rh incompatibility
• Low birth weight
• Ingestion of poisons and toxic substances by child
• Prolonged or unusual delivery
NOTE: Factors are not ranked in order of potential influence.

conditions and developmental events that heighten the potential for later atypical or aberrant development. Examples of such conditions or complications include premature births, infants with low birth weights, maternal diabetes, rubella (German measles), anoxia, bacterial infections like meningitis, and HIV (human immunodeficiency virus) infection.

Environmental Risk. Environmentally at-risk children are biologically typical, but their life experiences and/or environmental conditions are so limiting or threatening that the likelihood of delayed development exists. Extreme poverty, child abuse, absence of adequate shelter and medical care, parental substance abuse, and limited opportunities for nurturance and social stimulation are all examples of potential environmental factors. This risk category, as well as children who are biologically at risk, results in discretionary services. States may elect to provide early intervention if they wish to, but they are *not* mandated to serve infants and toddlers who are biologically or environmentally at risk. Currently, eight states have elected to serve infants and toddlers in these two risk categories (Shackelford, 2006).

Given the magnitude of factors that may place a child at risk for developing disabilities, the value of prevention and early intervention cannot be underestimated. Of course, prevention is better than remediation.

Early Intervention and Early Childhood Special Education

Finally, before leaving this section on terminology, we would like to clarify the terms *early intervention* and *early childhood special education*. Generally speaking, **early intervention** refers to the delivery of a coordinated and comprehensive set of specialized supports and services to infants and toddlers (birth through age two) with developmental delays or at-risk conditions and their families. This term can be found in federal legislation; specially, Part C of the Individuals with Disabilities Education Act (PL 99-457) commonly known as IDEA (to be discussed later in this chapter). Describing the nature of early intervention is not an easy task. Early intervention can be characterized according to type of service provided (physical therapy, vision services), location of service (home, special center), and even service provider (occupational therapist, nurse), to mention just some of the critical features of this concept (U.S. Department of Education, 2001).

The goal of early intervention is two-fold. One purpose is to minimize the impact or effect of a disability, while the second goal is to prevent the occurrence of future learning and developmental difficulties in children considered to be at risk (Smith & Guralnick, 2007).

The label **early childhood special education** is typically used when talking about the provision of customized services uniquely crafted to meet the individual needs of young children three through eight years of age with disabilities. It is important to note that when describing special education, we are not talking about a particular location but rather a system of supports and services for young children with disabilities (Gargiulo, 2009; Walsh, Smith, & Taylor, 2000).

Litigation and Legislation Affecting Children with Special Needs

Key Judicial Decisions

Early childhood special education is an evolving discipline. In addition to drawing upon its three parent fields, judicial action has played a key role in the growth of the field. Litigation instigated by parents and interest groups has helped pave the way in securing numerous rights for children with

disabilities and their families. Since the 1960s and early 1970s, a plethora of state and federal court decisions have continually shaped and defined a wide range of issues that impact contemporary special education policies and procedures. Table 2–4 summarizes some of the landmark cases affecting the field of special education. Many of the judicial remedies emanating from these lawsuits form the cornerstones of both federal and state legislative enactments focusing on children with special needs. Furthermore, many accepted practices in today’s special education programs, such as nondiscriminatory assessments and due process procedures, have their roots in various court decisions.

Key Federal Legislation

Federal legislative intervention in the lives of persons with disabilities is of relatively recent origin. Prior to the late 1950s and early 1960s, little federal attention was devoted to citizens with special needs. When legislation was enacted, it primarily assisted specific groups of individuals such as those who were deaf or mentally retarded. The last 40 years, however, have witnessed a flurry of federal legislative activity, which has aided the growth of special education and provided educational benefits and other opportunities and rights to children and adults with disabilities.

Due to the multitude of the public laws (PL) affecting special education, discussion will be reserved for landmark legislation. We will examine seven

TABLE 2–4 A Synopsis of Selected Court Cases Influencing Special Education

Case	Year	Issue	Judicial Decision
Brown v. Board of Education	1954	Educational segregation	Segregation of students by race ruled unconstitutional. Children are being deprived of equal educational opportunity. Effectively ended “separate but equal” schools for white and black pupils. Used as a precedent for arguing that children with disabilities cannot be excluded from a public education.
Hobson v. Hansen	1967	Classifying students	Grouping or “tracking” of students on the basis of standardized tests, which were found to be biased, held to be unconstitutional. Tracking systems discriminated against poor and minority children. Equal protection clause of Fourteenth Amendment violated.

(continued)

TABLE 2-4 A Synopsis of Selected Court Cases Influencing Special Education *(continued)*

Case	Year	Issue	Judicial Decision
Diana v. State Board of Education	1970	Class placement	Linguistically different students must be tested in their primary language as well as in English. Students cannot be placed in special education classes on the basis of tests that are culturally biased. Test items were to be revised so as to reflect students' cultures. Group administered IQ tests cannot be utilized for placement of children in programs for the mentally retarded
Pennsylvania Association for Retarded Children v. Commonwealth of Pennsylvania	1972	Right to education	State must guarantee a free public education to all children with mental retardation, ages 6–21, regardless of degree of impairment or associated disabilities. Students were to be placed in the most integrated environment. Definition of education expanded. Case established the right of parents to participate in educational decisions affecting their children.
Mills v. Board of Education of the District of Columbia	1972	Right to education	Extended the Pennsylvania decision to include all children with disabilities. Specifically established the constitutional right of children with exceptionalities to a public education regardless of their functional level. Presumed absence of fiscal resources is not a valid reason for failing to provide appropriate educational services to students with disabilities. Due process procedures established to protect the rights of the child.
Larry P. v. Riles	1972, 1979	Class placement	A landmark case parallel to the Diana suit. African American students could not be placed in classes for educable mentally retarded (EMR) children solely on the basis of intellectual assessments found to be culturally and racially biased. The court instructed school officials to develop an assessment instrument that would not discriminate against minority children. The failure to comply with this order resulted in a 1979 ruling, which completely prohibited the use of IQ tests for identifying African American students for placement in EMR classes. Ruling applies only to the state of California.
Jose P. v. Ambach	1979	Timelines and delivery of services	A far-reaching class action lawsuit that completely restructured the delivery of special education services in New York City public schools. Judgment established (1) school-based support teams to conduct evaluations and provide services; (2) stringent timelines for completing evaluations and placement; (3) due process procedures; (4) guidelines for nondiscriminatory evaluation; (5) detailed monitoring procedures; and (6) accessibility of school facilities.

(continued)

TABLE 2–4 A Synopsis of Selected Court Cases Influencing Special Education *(continued)*

Case	Year	Issue	Judicial Decision
Armstrong v. Klein	1980	Extended school year	States’ refusal to pay for schooling in excess of 180 days for pupils with severe disabilities is a violation of their rights to an appropriate education as found in PL 94-142. The court moved that some children with disabilities will regress significantly during summer recess and have longer recoupment periods; thus, they are denied an appropriate education if not provided with a year-round education.
Tatro v. State of Texas	1980	Related services	A U.S. Supreme Court decision, which held that catheterization qualified as a related service under PL 94-142. Catheterization not considered an exempted medical procedure as it could be performed by a health care aide or school nurse. Court further stipulated that only those services that allow a student to benefit from a special education qualify as related services.
Board of Education v. Rowley	1982	Appropriate education	First U.S. Supreme Court interpretation of PL 94-142. Court addresses the issue of what constitutes an “appropriate” education for a deaf student making satisfactory progress. Supreme Court ruled that an appropriate education does not necessarily mean an education that will allow for the maximum possible achievement; rather, students must be given a reasonable opportunity to learn. Parents’ request for a sign language interpreter, therefore, was denied. An appropriate education is not synonymous with an optimal educational experience.
Honig v. Doe	1988	Exclusion from school	Children with special needs whose behavior is a direct result of their disability cannot be expelled from school due to misbehavior. If behavior leading to expulsion is not a consequence of the exceptionality, pupil may be expelled. Short-term suspension from school not interpreted as a change in pupil’s individualized education program (IEP).
Daniel R. R. v. State Board of Education	1989	Class placement	A Fifth Circuit Court of Appeals decision that held that a segregated class was an appropriate placement for a student with Down syndrome. Preference for integrated placement viewed as secondary to the need for an appropriate education. Court established a two-prong test for determining compliance with the LRE mandate for students with severe disabilities. First, it must be determined if a pupil can make satisfactory progress and achieve educational benefit in a regular classroom through curriculum modification and the use of supplementary aids and services. Second, it must be determined whether the pupil has been integrated to the maximum extent appropriate. Successful compliance with both parts fulfills a school’s obligation under federal law. Ruling affects LRE cases in Louisiana, Texas, and Mississippi, but has become a benchmark decision for other jurisdictions as well.

(continued)

TABLE 2-4 A Synopsis of Selected Court Cases Influencing Special Education (continued)

Case	Year	Issue	Judicial Decision
Oberti v. Board of Education of the Borough of Clementon School District	1992	Least restrictive environment	Placement in a general education classroom with the use of supplementary aids and services must be offered to a student with disabilities prior to considering more segregated placements. A pupil cannot be excluded from a regular classroom solely because curriculum, services, or other practices would require modification. A decision to exclude a learner from the regular education classroom necessitates justification and documentation. Clear judicial preference for educational integration established.
Agostini v. Fulton	1997	Provision of services	A U.S. Supreme Court decision that reversed a long-standing ruling banning the delivery of publicly funded educational services to students enrolled in private schools. Interpreted to mean special education can now provide services to children in parochial schools.
Cedar Rapids Community School District v. Garret F.	1999	Related services	A U.S. Supreme Court decision that expanded and clarified the concept of related services. This case affirmed that intensive and continuous school health care services necessary for a student to attend school, and which are not performed by a physician, qualify as related services.
Arlington Central School District Board of Education v. Murphy	2006	Recovery of fees	At issue in this U. S. Supreme Court case is whether parents are able to recover the professional fees of an educational consultant (lay advocate) who provided services during legal proceedings. The Court ruled that parents are not entitled to reimbursement for the cost of experts because only attorneys' fees are addressed in IDEA.
Winkelman v. Parma City School District	2007	Parental rights	One of the more significant Supreme Court rulings. The Court, by unanimous vote, affirmed the right of parents to represent their children in IDEA-related court cases. Ruling seen as an expansion of parental involvement and the definition of a free and appropriate public education. Decision also interpreted to mean that IDEA conveys enforceable rights to parents as well as their children.

significant pieces of legislation that have dramatically affected the educational opportunities of infants, toddlers, preschool children, and school-age children with special needs. Our initial review will focus on PL 94-142, the Individuals with Disabilities Education Act (IDEA), or as it was previously called, the Education for All Handicapped Children Act. This change came about due to the enactment on October 30,

1990, of PL 101-476. Provisions contained in this legislation will be reviewed later.

Public Law 94-142. The Individuals with Disabilities Education Act is viewed as a “Bill of Rights” for children with exceptionalities and their families. It is considered by many individuals to be one of the, if not *the*, most important piece of federal legislation

ever enacted on behalf of children with special needs. Some advocacy groups consider this enactment as a vital first step in securing the constitutional rights of citizens with disabilities (Allen & Cowdery, 2009). The intent of this bill was:

to ensure that all handicapped children have available to them . . . a free, appropriate public education which emphasizes special education and related services designed to meet their unique needs, to ensure that the rights of handicapped children and their parents or guardians are protected, to assist States and localities to provide for the education of all handicapped children and to assess and ensure the effectiveness of efforts to educate handicapped children.
(SECTION 601 (C))

In addition to these four purposes, there are six major components incorporated in this legislation:

1. *The right to a free appropriate public education (FAPE)*—all children, regardless of the severity of the disability, must be provided an education appropriate to their unique needs at no cost to the parent(s)/guardian(s). Included in this feature is the concept of related services, which requires that children receive, for example, as necessary, occupational and physical therapy, as well as speech therapy, among other services.
2. *The principle of least restrictive environment (LRE)*—children with exceptionalities are to be educated, to the maximum extent appropriate, with typical students. Placements must be consistent with the pupil's educational needs.
3. *An individualized education program (IEP)*—this document, developed in conjunction with the parent(s)/guardian(s), is an individually tailored statement describing an educational plan for each exceptional learner. The IEP is required to address (a) present level of academic functioning; (b) annual goals and accompanying instructional objectives; (c) educational services to be provided; (d) the degree to which the pupil will be able to participate in regular education programs; (e) plans for initiating services and length of service delivery; and (f) an annual evaluation procedure specifying objective criteria to determine if instructional objectives are being met.

4. *Procedural due process*—the Act affords parent(s)/guardian(s) several safeguards as it pertains to their child's education. Briefly, parent(s)/guardian(s) have the right to examine all records; obtain an independent evaluation; receive written notification (in parent's native language) of proposed changes to their child's educational classification or placement; and a right to an impartial hearing whenever disagreements occur regarding educational plans for their son/daughter.
5. *Nondiscriminatory assessment*—prior to placement, a child must be evaluated in all areas of suspected disability by tests, which are neither culturally nor linguistically biased. Students are to receive several types of assessments; a single evaluation procedure is not permitted.
6. *Parental participation*—PL 94-142 mandates parental involvement. Sometimes referred to as the "Parent's Law," this legislation requires that parents participate in the decision-making process that affects their child's education. IDEA regulations currently allow assistance to parents as part of a preschooler's IEP if such assistance is necessary for the child to benefit from special education. Parental training activities are also permissible as a related service.

Congress mandated by September 1, 1980, a free appropriate public education for all eligible children age three through twenty-one. The law, however, did *not* require services to preschool children with disabilities. An exception was contained in the legislative language:

except that, with respect to handicapped children aged three to five and eighteen to twenty-one, inclusive, the requirements . . . shall not be applied . . . if such requirements would be inconsistent with state law or practice, or the order of any court, respecting public education within such age groups within the state.
(SECTION 612(2) (B))

Since many states were not providing preschool services to typical children, an education for young children with special needs, in most instances, was not mandated. Although this legislation fails to require an education for our youngest students, it clearly focused attention on the preschool population and recognized the value of early education.

PL 94-142 did, however, contain benefits for children under school age. The enactment offered small financial grants (Preschool Incentive Grants) to the individual states as an incentive to serve young children with special needs. It also carried a mandate for schools to identify and evaluate children from birth through age twenty-one suspected of evidencing a disability. Finally, PL 94-142 moved from a census count to a child count, or the actual number of young children being served. The intent of this feature was to encourage the states to locate and serve children with disabilities.

Public Law 99-457. In October 1986, Congress passed one of the most comprehensive pieces of legislation affecting young children with special needs and their families—PL 99-457. This law, which was originally known as the Education of the Handicapped Act Amendments of 1986, changed both the scope and intent of services provided to preschoolers with special needs in addition to formulating a national policy for infants and toddlers at risk for, and with, identified disabilities.

Farran (2000) believes that one of the assumptions behind the enactment of PL 99-457 was that early intervention is cost-effective, a way of lowering future costs of special education. This rationale is vastly different from the thinking behind the passage of PL 94-142, which was rooted in the civil rights movement and saw an education for children with disabilities as a constitutional right. Thus, PL 99-457 was enacted primarily as a prevention measure.



Today, education for youngsters with a disability is a right, not a privilege.

AP Photo/Janet Hostetter

PL 99-457 contains several parts. Our attention will primarily focus on Part B, the preschool provision, as well as Part H (which is now known as Part C), a new section that allows for services to be provided to infants and toddlers with special needs.

As noted earlier, IDEA contains language that gave states the opportunity, through financial incentives, to provide an education and related services to preschool children with disabilities. This was a permissive or voluntary element of the Act, not a mandated requirement. Trohanis (1989) reported Congressional data, which revealed that less than 80% or 260,000 of the estimated 330,000 exceptional children ages three to five were being served. An estimated 70,000 preschoolers were, therefore, unserved. Koppelman (1986) found that 31 states and territories did not require special education services for preschoolers with special needs. PL 99-457 was enacted to remedy this situation.

Simply stated, Part C is a downward extension of PL 94-142, including all rights and protections. It requires that as of the 1991–1992 school year, *all* preschoolers with special needs, ages three to five inclusive, are to receive a free and appropriate public education. This element of the law is a mandated requirement. States will lose significant amounts of federal preschool funding if they fail to comply. The goal of this legislation was finally accomplished in the 1992–1993 school year, when all states had mandates in place establishing a free appropriate public education for all children ages three through five with disabilities. In fact, five states (Iowa, Maryland, Michigan, Minnesota, and Nebraska) have chosen to mandate services from birth, while Virginia begins a FAPE at age two. Table 2–5 shows the year that each state mandated a free and appropriate public education for children with special needs.

Other provisions of the earlier legislation remain the same, such as an education in the least restrictive environment (LRE), IEPs, due process safeguards, and confidentiality of records. Family services are also recognized as being vitally important; thus, family counseling and training are allowable as a related service. Depending on the needs of the child, service delivery models can either be home-based or center-based, full-time or part-time. As we noted earlier, states are not required to report to the U.S. Department of Education the number of children served according to a disability category. Thus, preschoolers do not have to be labeled with a specific disability, such as mental retardation.

TABLE 2–5 School Year in Which States Mandated a Free and Appropriate Public Education for Preschoolers with Disabilities

Year	State	Year	State
1973–1974	Illinois Michigan* Wisconsin	1990–1991	Montana Nevada Wyoming
1974–1975	Alaska Texas	1991–1992	Alabama
1975–1976	Iowa* Virginia**		Arizona
1976–1977	Massachusetts Rhode Island South Dakota		Arkansas
1977–1978	Louisiana New Hampshire		California
1978–1979	Maryland*		Colorado
1979–1980	Nebraska		Connecticut
1980–1981	Hawaii		Delaware
1983–1984	District of Columbia New Jersey		Florida
1985–1986	North Dakota Washington		Georgia
1986–1987	Minnesota*		Indiana
1988–1989	Utah		Kansas
1989–1990	Idaho		Kentucky
			Maine
			Mississippi
			Missouri
			New Mexico
			New York
			North Carolina
			Ohio
			Oklahoma
			Pennsylvania
			South Carolina
			Tennessee
			Vermont
			West Virginia
		1992–1993	Oregon

*Eligible for services beginning at birth.
 **Eligible for services beginning at age two.

SOURCE: Adapted from A. Lazara, J. Danaher, and R. Kraus, *Section 619 Profile* (15th ed.), 2007. Chapel Hill, NC: University of North Carolina, FPG Child Development Institute, National Early Childhood Technical Assistance Center.

All states were required to modify their state plans and policies to ensure compliance with the law. Funding for serving these children has also dramatically increased.

Part C of PL 99-457 created the Handicapped Infants and Toddlers Program, a new provision aimed at children from birth through age two with developmental delays or disabilities. This component of the legislation is voluntary; states are not compelled to comply. Part C of this statute creates a discretionary program that assists states in implementing a state-wide, comprehensive, coordinated, multidisciplinary, interagency program of services for very young children with developmental difficulties and their families. Each state that chose to participate was required to provide early intervention to children who evidence a physical or mental condition that has a high probability of resulting in a delay such as cerebral palsy or Down syndrome. At their discretion, states may also offer services to children who are medically or environmentally at risk for future delays. As of September 30, 1994, all states had plans in place for the full implementation of Part C (U.S. Department of Education, 1997).

The enactment of PL 99-457 reflects a major shift in thinking regarding public policy and service provision for infants and toddlers with special needs (Harbin, McWilliam, & Gallagher, 2000). This paradigm shift is reflected in Table 2-6, which illustrates pre- and post-IDEA service delivery.

There are several features of this law that are worthy of examination. Under this Act and its accompanying amendments, infants and toddlers are eligible for services if they meet the following conditions:

- they are experiencing developmental delays in one or more of the following areas: cognitive development, physical development, communication development, social or emotional development, or adaptive development;
- they have a physical or mental condition that has a high probability of resulting in a delay (for example, cerebral palsy, Down syndrome);
- or at the state's discretion, they are medically or environmentally at risk for substantial delay if early intervention is not provided.

Eligible children and their families must receive a multidisciplinary assessment conducted by qualified professionals and a written **individualized family service plan (IFSP)**. Similar to the IEP, the IFSP

is designed as a guide to the delivery of services to infants, toddlers, and their families. Developed by a multidisciplinary team, the IFSP, as promulgated in PL 99-457, must contain these components:

- a statement of the infant's or toddler's present levels of physical development, cognitive development, communication development, social or emotional development, and adaptive development;
- a statement of the family's resources, priorities, and concerns;
- a statement of major outcomes expected to be achieved for the infant or toddler and the family;
- a statement of specific early intervention services necessary to meet the unique needs of the infant or toddler and the family;
- the projected dates for initiation of services and the anticipated duration of such services;
- the name of the service coordinator;
- a description of the natural environments in which early intervention services will be provided; and
- the steps . . . supporting the transition of the toddler with a disability to services provided under Part B (preschool).

Unlike an IEP, the focus of the IFSP is on the family rather than the individual child, thereby resulting in a comprehensive and multidisciplinary plan. Parents are viewed as full-fledged partners with professionals. Their participation ensures that services occur within the context of the family unit and meet the unique needs of the child and his or her caregivers. This goal is clearly reflected in the IFSP statement, which addresses the issue of the "family's resources, priorities, and concerns." It is imperative for professionals to remember that while families may have a variety of needs (for example, informational, management, support), they also have strengths and resources that must not be overlooked. Best practice dictates that services should be individualized and responsive to the goals and preferences of the parents (caregivers) while supporting their role as primary decision maker.

A final noteworthy aspect of Part C of IDEA is the concept of service coordination. A service coordinator originally was a professional selected from the discipline closest to the child's primary problem, for example, a speech-language pathologist for toddlers with delayed language or a physical therapist for a young child with cerebral palsy. PL 102-119 not only changed the terminology from *case management* to

TABLE 2–6 Changes in Service Delivery for Infants and Toddlers Resulting from the Passage of Public Law 99-457 (IDEA)

Area	Pre-IDEA Services	Post-IDEA Services
Entitlement	Served only some of the eligible children	Serve all children
Eligibility	Served only disabled children and waited until children evidenced measurable delays	Serve children with diagnosed conditions regardless of whether measurable delays are present May serve at-risk children in order to prevent developmental delay
Early identification	Waited until children came to program	Find children as early as possible
Service array	Confined services to what program offered	Provide an array of services across programs
System	Provide separate, autonomous programs	Provide comprehensive, coordinated, interagency system of services
Focus	Child-centered	Family-centered
Individualization	Offered a package of services	Offer individualized services
Inclusion	Established segregated, self-contained programs	Establish inclusive programs and use of community resources
Disciplines	Disciplines worked autonomously	Disciplines working together to integrate all services (interdisciplinary, transdisciplinary)
Therapies	Provide separate and sometimes insufficient therapies	Provide sufficient integrated therapies
Procedural safeguards	Families had no recourse for complaints	Procedural safeguards in place
Transition	Unplanned traumatic transitions	Planned transition from infant and toddler program to preschool program
Funding	Single primary funding source	Coordinated and use all possible funding sources

SOURCE: Adapted with permission from G. Harbin, R. McWilliam, and J. Gallagher, Services for Young Children with Disabilities and Their Families. In J. Shonkoff and S. Meisels (Eds.), *Handbook of Early Intervention*, 2nd ed. (Cambridge, England: Cambridge University Press, 2000). p. 388.



An individualized family service plan is developed by a multidisciplinary team.

Cengage Learning

service coordination and *case manager* to the less clinical term *service coordinator*, but it also broadened the category of service coordinator to *any* qualified professional who is best able to assist the family. Typically, their roles are to function as an advocate for the family, to ensure the coordination of early intervention services, to monitor the implementation of the IFSP, to assist in transition planning, and to foster family empowerment, among other duties. It is important to remember that the activities and responsibilities of the service coordinator are determined in conjunction with the child's family and are always individualized.

An IFSP must be reviewed every six months (or sooner if necessary) to assess its continual appropriateness. The infant or toddler is required by law to be reevaluated annually. Regulations further stipulate that an IFSP must be developed within forty-five days after a referral for services is made.

PL 99-457 is the culmination of many years of dedicated effort by both parents and professionals from various disciplines and agencies. It represents an opportunity to intervene and effect meaningful change in the lives of the nation's youngest and most vulnerable children.

Public Law 101-476. Arguably, one of the most important changes contained in this legislation was the renaming of PL 94-142 to the Individuals with Disabilities Education Act. The word “children” was replaced

with the term “individuals” and “handicapped” became “with disabilities.” This latter phrase also signifies a change in attitude to a more appropriate people-first point of view. We now realize that an individual's disability is but one aspect of his or her personhood.

PL 101-476 also required that adolescents have an individual transition plan (ITP) as part of their IEP while expanding the scope of the related services provision by adding two services—social work and rehabilitation counseling. A final element of this legislation was the identification of autism and traumatic brain injury as distinct disability categories. Previously, these disabilities had been subsumed under other disability labels.

Public Law 102-119. In 1991, IDEA was amended again by PL 102-119, the Individuals with Disabilities Education Act Amendment. As we noted earlier, PL 102-119 permits states to use a noncategorical label when identifying preschoolers with special needs. Amendments to Part C require that early intervention services are to be in “natural environments” with typically developing age-mates as appropriate for each child. Transition policies and procedures are to be established so that infants and toddlers receiving early intervention services can move smoothly, if eligible, to preschool special education. States are also allowed to use an IFSP as a guide for services for children ages three through five as long as IEP requirements are met. Additionally, states were permitted to use Part C monies for preschoolers with disabilities. Likewise, these amendments allow for the use of Part B funds to serve infants and toddlers with special needs. Finally, the amount of funds allocated by Congress increased from \$1,000 to \$1,500 per child.

Public Law 105-17. IDEA was reauthorized once again via the Individuals with Disabilities Education Act Amendments of 1997. This bill was signed into law by President Clinton on June 4, 1997. PL 105-17 restructures IDEA into four parts, revises some definitions, and revamps several key components ranging from funding to disciplining students with disabilities to how IEPs are to be developed. Highlights of this major retooling are as follows:

- Students with disabilities who bring weapons to school, possess or use illegal drugs, or pose a serious threat of injury to other pupils or themselves may be removed from their current placement

and placed in an interim alternative educational setting as determined by the IEP team, but for no more than 45 days, after a due process hearing has been conducted. Students who are suspended or expelled are still entitled to receive a free and appropriate public education as addressed in their IEP.

- Pupils with disabilities who exhibit less serious infractions of school conduct may be disciplined in ways similar to children without disabilities (including a change in placement), provided that the misbehavior was not a manifestation of the student's disability. Additionally, either before taking disciplinary action, but no later than ten days after, the IEP team must conduct a functional behavioral assessment and develop (or implement) a behavior intervention plan.
- IEPs are now required to state how the student with disabilities will be involved with, and progress in, the general education curriculum. Other provisions stipulate that general educators will become part of the IEP team; short-term instructional objectives will no longer be required, rather, the emphasis will be on measurable annual goals; and lastly, the assistive technology needs of each learner must be considered by the IEP team.
- Orientation and mobility services for children with visual impairments are now included in the definition of related services.
- The present mandate of comprehensive triennial reevaluation of children with disabilities is lifted if school authorities and the student's parents both agree that this process is unnecessary.
- A new section on mediation requires states to offer mediation services to help resolve disputes as an alternative to using more costly and lengthy due process hearings. Parental participation is voluntary and parents still retain their right to a due process hearing.
- The eligibility category of *developmental delay* may now be used for describing children ages three through nine. The use of this term is at the discretion of the state and local education agency.
- Initial evaluations and reevaluations are not restricted to the use of formal, standardized tests. A variety of assessment tools and strategies are to be utilized in an effort to gather relevant, functional, and developmental information. Curriculum-based tests, portfolio reviews, parental input, and the observations of teachers and

related service providers may be considered in determining whether or not the student is eligible for services and in developing the content of the IEP. A student may not be considered eligible for a special education if their educational difficulties are primarily the result of limited proficiency in English or lack of adequate instruction in math and/or reading.

- A new mechanism for distributing federal monies will occur once the appropriation reach a threshold of \$4.9 billion. Upon attaining this level, states and local school systems will receive additional funding based upon 85 percent of the population of children ages three to 21 and 15 percent of the number of children ages three through 21 who are in poverty. This switch to a census-based formula instead of the current enrollment-driven formula was due to a concern that some schools were overidentifying students in order to receive additional funding. No state would receive less than the amount of support it received in the year prior to the activation of this new scheme.

The reauthorization of IDEA requires schools to establish performance goals for students with disabilities in an effort to assess their academic progress. Additionally, these children are to be included in state- and district-wide assessment programs or given alternative assessments that meet their unique needs.

- Early intervention services must be "family-directed" and, to the extent appropriate, these services are to be provided in noninstitutional settings such as the young child's home.
- Child Find requirements are extended to children with disabilities who are enrolled in private schools, including students attending parochial schools. A special education and related services may be provided on the premises of a private school (including parochial) to the extent permissible by law.
- IFSP requirements are modified to include a statement justifying the extent, if any, that early intervention services are not provided in the natural environment.

Public Law 108-446. The most recent of amendments to IDEA are incorporated in PL 108-446, the Individuals with Disabilities Education Improvement Act of 2004. This historic piece of legislation is commonly referred to as IDEA 2004. One of the

goals of IDEA 2004 was to align this law with the **No Child Left Behind Act** (PL 107-110) enacted in 2001. The focus of PL 107-110 was to improve the academic performance of *all* students in reading and math (with science eventually being added) by the year 2014. Particular attention is paid to the achievement of pupils with disabilities, children from low-income families, English language learners, and individuals from racial and ethnic minority groups. The No Child Left Behind Act further requires that teachers are to be highly qualified professionals and that they incorporate scientifically validated practices in their instructional programs (Gargiulo & Metcalf, 2010).

The following summary² represents some of the significant issues contained in PL 108-446.

Individualized Education Program (IEP) Process

- Short-term objectives and benchmarks will no longer be required except for those pupils who are evaluated via alternate assessments aligned to alternate achievement standards.
- Assessment of the progress that a student is making toward meeting annual goals, which must be written in measurable terms, is still required. Reference, however, to the current requirement of reporting to the “extent to which progress is sufficient to enable the child to achieve goals by the end of the year” is eliminated. IEPs will now need to describe how the individual’s progress toward achieving annual goals will be measured and when these progress reports will be made.
- PL 108-446 also requires that the IEP address the student’s “academic and functional performance” instead of the previously used term “educational performance.” This modification of terminology more closely aligns IDEA with the No Child Left Behind Act.

Identifying Students with Specific Learning Disabilities

Although young children are rarely identified with a learning disability, under IDEA '97, when identifying an individual for a possible learning disability, educators typically looked to see if the student exhibited a severe discrepancy between achievement and intellectual ability. IDEA 2004 removed this discrepancy

provision. School districts will now be able, if they so choose, to use a process that determines if the pupil responds to empirically validated, scientifically based interventions, a procedure known as response-to-intervention (treatment). Under these guidelines, rather than comparing IQ with performance on standardized achievement tests, general education teachers can offer intensive programs of instructional interventions. If the child fails to make adequate progress, a learning disability is assumed to be present and additional assessment is warranted.

Highly Qualified Special Education Teachers

The language contained in IDEA 2004 concerning who is considered a “highly qualified” special educator is complementary to the standards promulgated in the No Child Left Behind Act of 2001.

- All elementary and secondary special education teachers must hold at least a bachelor’s degree and be fully certified or licensed in the field of special education in order to be deemed “highly qualified.” Special educators employed as of July 1, 2005, were required to meet this standard.
- Special educators who teach core subjects in elementary schools can obtain highly qualified status by passing their state’s licensing or certification exam.
- This legislation does not address “highly qualified” requirements for early childhood special educators.

Discipline

- PL 108-446 stipulates that when a student is removed from his or her current educational setting, the pupil is to continue to receive those services that enable him or her to participate in the general education curriculum and to ensure progress toward meeting IEP goals.
- IDEA '97 allowed school authorities to unilaterally remove a student to an interim alternative setting (IASE) for up to 45 days for offenses involving weapons or drugs. IDEA 2004 now permits school officials to remove any pupil (including those with and without disabilities) to an IASE for up to 45 days for inflicting “serious bodily injury.”
- Removal to an IASE will now be for 45 *school* days rather than 45 calendar days.
- Behavior resulting in disciplinary action still requires a manifestation review; however, language

² Information adapted from *Teaching in Today’s Inclusive Classrooms* by R. Gargiulo and D. Metcalf, Belmont, CA: Wadsworth/Cengage Learning, 2010.

requiring the IEP team to consider whether the pupil's disability impaired his or her ability to control his or her behavior or comprehend the consequences of his or her actions has been eliminated. IEP teams will now only need to ask two questions:

1. Did the disability cause or have a direct and substantial relationship to the offense?
 2. Was the violation a direct result of the school's failure to implement the IEP?
- IDEA 2004 modifies the "stay put" provision enacted during the appeals process. When either the local education agency or school district (LEA) or parent requests an appeal of the manifestation determination or placement decision, the pupil is to remain in the current IASE until a decision is rendered by the hearing officer or until the time period for violation concludes. A hearing must be held within 20 school days of the date of the appeal.

Due Process

- Parents will encounter a two-year statute of limitations for filing a due process complaint from the time they knew or should have known that a violation occurred. Alleged violations might involve identification, assessment, or placement issues or the failure to provide an appropriate education.
- A mandatory "resolution session" is now required prior to proceeding with a due process hearing. (The parents or school district may waive this requirement and directly proceed to mediation.) School districts must convene a meeting with the parents and the IEP team members within 15 days of receiving a due process complaint. If

the complaint is not satisfactorily resolved within 30 days of the filing date, the due process hearing may proceed.

Eligibility of Students

- School districts will be required to determine the eligibility of a student to receive a special education and the educational needs to the child within a 60-day time frame. (This provision does not apply if the state has already established a timeline for accomplishing this task.) The 60-day rule commences upon receipt of parental permission for evaluation.
- Reevaluation of eligibility for special education may not occur more than once per year (unless agreed to by the school district and parent); and it must occur at least every three years unless the parent and school district agree that such a reevaluation is unnecessary.
- IDEA 2004 modifies the provision pertaining to native language and preferred mode of communication. New language in the bill requires that evaluations are to be "provided and administered in the language and form most likely to yield accurate information on what the child knows and can do academically, developmentally, and functionally, unless it is not feasible to do so or administer."

Assessment Participation

- PL 108-446 requires that *all* students participate in all state- and district-wide assessments (including those required under the No Child Left Behind Act) with accommodations or alternative assessments, if necessary, as stipulated in

TeachSource Video

Foundations: Aligning Instruction with Federal Legislation

Visit the premium website and watch "Foundations: Aligning Instruction with Federal Legislation." After watching the video, answer the following questions:

1. What is your opinion about the appropriateness of the No Child Left Behind Act for early primary students with disabilities?
2. What is the relationship between IDEA 2004 and the No Child Left Behind legislation?

the child's IEP. States are permitted to assess up to 1% of students (generally those pupils with significant cognitive deficits) with alternative assessments aligned with alternative achievement standards. IDEA 2004 further requires that assessments adhere to the principles of universal design when feasible.

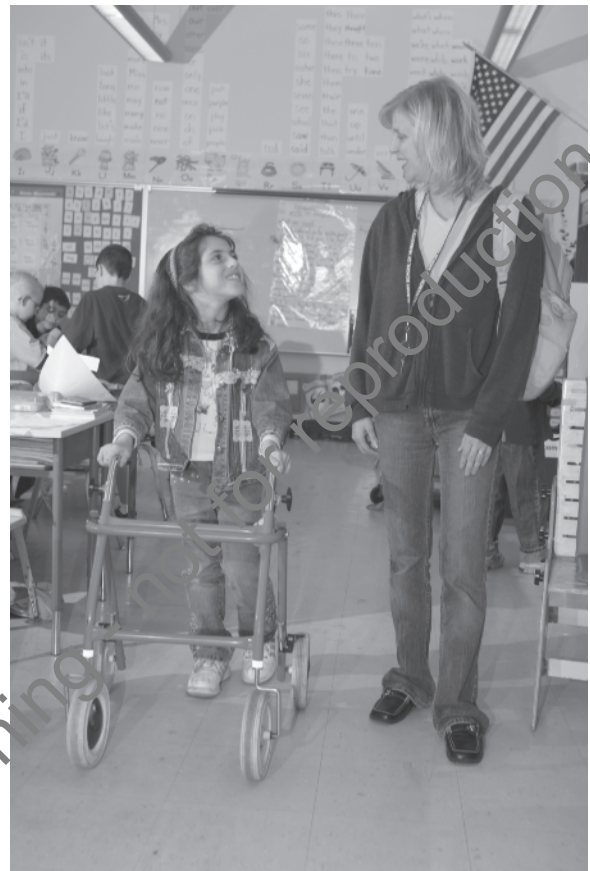
Services for Infants and Toddlers with Disabilities

- Early intervention services are to be based upon peer-reviewed research.
- Individualized family service plans (IFSPs) are to include measurable outcomes for pre-literacy and language skills.
- IDEA 2004 permits states to provide early intervention services from age three until the youngster enters kindergarten.
- IDEA 2004 maintains the use of the label *developmental delay* for children three to nine years of age.

Section 504 of the Rehabilitation Act of 1973³. The six pieces of legislation that we just examined are representative special education laws. PL 93-112, the Rehabilitation Act of 1973, however, is a *civil rights* law. Section 504 of this enactment is the first public law specifically aimed at protecting children and adults against discrimination due to a disability. It said that no individual can be excluded, solely because of his or her disability, from participating in or benefiting from any program or activity receiving federal financial assistance, which includes schools (CEC Today, 1997). Unlike IDEA, this act employs a functional rather than a categorical model for determining a disability. According to this law, an individual is eligible for services if he or she:

1. has a physical or mental impairment that substantially limits one or more major life activities;
2. has a record of such impairment; or
3. is regarded as having such an impairment by others.

“Major life activities” are broadly defined and include, for example, walking, seeing, hearing, working, and learning.



Federal law requires that schools make reasonable accommodations for pupils with disabilities.

To fulfill the requirements of Section 504, schools must make “reasonable accommodations” for pupils with disabilities so that they can participate in educational programs provided to other students. Reasonable accommodations might include modifications of the general education program, the assignment of an aide, a behavior management plan, or the provision of special study areas (Smith, 2002; Smith & Patton, 1998). Students may also receive related services such as occupational or physical therapy if they are receiving a special education through IDEA.

Because the protections afforded by this law are so broad, an individual who is ineligible for a special education under IDEA may qualify for special

³ Information from *Teaching in Today's Inclusive Classrooms* by R. Gargiulo and D. Metcalf, Belmont, CA: Wadsworth/Cengage Learning, 2010.

assistance or accommodations under Section 504. A second grader with attention deficit hyperactivity disorder (ADHD) or an adolescent with severe allergies, for example, would be eligible for services via Section 504, while those students are likely to be ineligible to receive services under IDEA (*CEC Today*, 1997). All students who are eligible for a special education and related services under IDEA are also eligible for accommodations under Section 504; the converse, however, is *not* true.

Similar to IDEA, there is a mandate contained within Section 504 to educate pupils with special needs with their typical peers to the maximum extent possible. Additionally, schools are required to develop an accommodation plan (commonly called a “504 plan”) customized to meet the unique needs of the individual. This document should include a statement of the pupil’s strengths and weaknesses, a list of necessary accommodations, and the individual(s) responsible for ensuring implementation. The purpose of this plan is to enable the student to receive a free, appropriate public education (Smith, 2002). We will examine 504 plans in greater detail in Chapter 5.

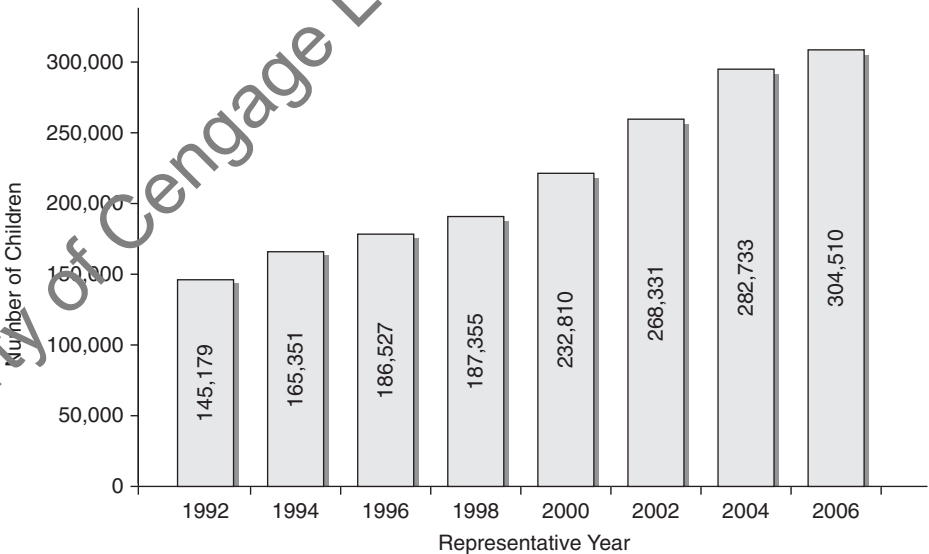
Prevalence of Young Children with Special Needs

The number of young children with special needs receiving services has increased dramatically over the past several years. This growth has been spurred on due to litigation, legislative enactments (especially IDEA and its amendments), and as we will shortly see, a greater awareness of the benefits of early intervention among other factors.

Infants and Toddlers

Recent data provided by the U.S. Department of Education (2009) reveals that 321,894 infants and toddlers birth through age two were receiving early intervention in the 2007–2008 school year. This statistic represents 2.5% of the entire birth-through-age-two population. Over the past several years, the number of infants and toddlers receiving early intervention services has steadily increased. Figure 2–1 illustrates this growth pattern. This trend reflects

FIGURE 2–1 Number of Infants and Toddlers Served Under IDEA in Representative Years



SOURCE: U.S. Department of Education. (2005). *Twenty-sixth Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act, 2004* (Vol.1). Washington, DC: U.S. Government Printing Office, p. 5. Data also available at <https://www.ideadata.org/PartCdata.aspx>

TABLE 2-7 Increase in Number of Preschoolers Served under the Individuals With Disabilities Education Act (Part B)

Ages	Representative Years						Change 1986–2006	
	1986–87	1990–91	1994–95	1998–99	2002–03	2006–07	Numbers	%
3-year-olds	31,162	59,095	104,619	117,698	140,542	165,676	134,514	431.6
4-year-olds	62,327	111,787	179,825	199,924	246,751	246,980	184,653	296.2
5-year-olds	170,415	197,807	240,014	256,015	260,127	301,728	131,313	77.0
Total	265,814	368,689	524,458	573,637	647,420	714,384	450,480	169.4
NOTE: Data reported as of December 1 of each reporting year. Figures based upon data from the 50 contiguous states, Puerto Rico, the District of Columbia, and outlying areas.								
SOURCE: U.S. Department of Education. (1991–2005). <i>Annual Reports to Congress on the Implementation of the Individuals with Disabilities Education Act</i> . Washington, DC: U.S. Government Printing Office, and data available from http://www.ideadata.org/PartBReport.asp								

a 110% increase in the number of children served. This growth pattern is most likely due to greater public awareness, successful Child Find efforts, and program expansion. Currently, slightly more than half of the children (54%) receiving early intervention in 2007 were two years of age.

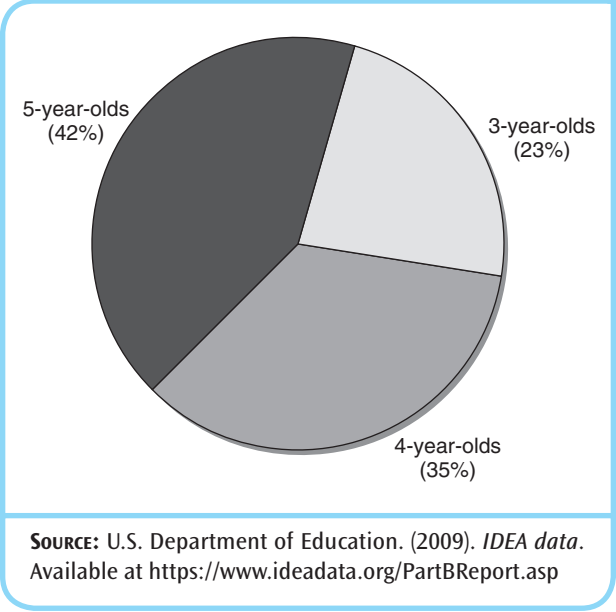
Preschoolers

Figures from the U.S. Department of Education (2009) reveal that more than 710,000 preschoolers ages three to five were served during the 2007–2008 school year under Part B of IDEA. (See Table 2–7.) This figure represents approximately 6.4% of the population of three- to five-year-old children in the United States. Figure 2–2 portrays the ages and the percentage of young children receiving services through IDEA, while Table 2–7 reflects the growth in the number of preschoolers receiving a special education.

Early Primary

Children ages six, seven, and eight who are receiving a special education are sometimes recognized under the developmental delay category, while in

FIGURE 2-2 Percentage of Preschoolers Receiving a Special Education and Related Services in the 2007–2008 School Year



other instances, a categorical label is used. The U.S. Department of Education (2009) reports that 85,130 children ages six through eight were eligible for services under the developmental delay category during the 2007–2008 school year. This figure represents about 6.9% of the more than 1.24 million students in this age range receiving a special education.

The Importance of Early Intervention/Education

Is early intervention effective? Does it benefit young children with special needs and their families? Unfortunately, these are not simple questions and their answers are equally, if not more, complex. It is perhaps best to respond to these queries by saying, “It depends.” The reason we are so vague is that our initial inquiries only give rise to additional questions. For instance, What constitutes intervention? How early is early? Are we looking for short-term or long-term benefits? Who are the children we are talking about—infants and toddlers, young children who are environmentally at risk, children with suspected developmental delays, or preschoolers and early primary students with documented disabilities like Down syndrome or cerebral palsy? Obviously, the population we serve can affect the answer to the question.

Our initial concerns notwithstanding, we believe we can safely answer our primary questions in the affirmative. *Quality* early intervention/education programs *do* make a difference in the lives of young children with disabilities and their families. Guralnick (1998), in fact, considers early intervention to be “the centerpiece of our nation’s efforts on behalf of vulnerable children and their families” (p. 337).

We will now review the reasoning for our position that early intervention/education is effective. We begin by establishing an understanding of what intervention is. Historically speaking, Fallen and Umansky (1985) describe early intervention as the process of intervening upon the lives of young children with disabilities and their families for the purpose of altering the direction and consequences of a disability or delayed development. These experts state that “the action required is individual, but it encompasses any modification or addition of services, strategies, techniques, or materials required to maximize the child’s potential” (p. 160). Likewise, another early viewpoint

comes from Peterson (1987), who believes that the purpose of intervention for young children with special needs is to:

1. minimize the effects of a handicapping [disabling] condition upon a child’s growth and development and maximize opportunities to engage in the normal activities of early childhood;
2. prevent, if possible, at-risk conditions or early developmental irregularities from developing into more serious problems that become deviant to the extent that they are labeled as handicapping [disabling];
3. prevent the development of secondary handicaps [disabilities] as a result of interference from a primary disability. . . . (pp. 72–73)

More recently, Hallahan, Kauffman, and Pullen (2009), in synthesizing the thinking of educators and researchers, echo these early perspectives. These writers offer the following rationale for early intervention:

- A child’s early learning provides the foundation for later learning, so the sooner a special education program or intervention is begun, the further the child is likely to go in learning more complex skills.
- Early intervention is likely to provide support for the child and family that will help prevent the child from developing additional problems or disabilities.
- Early intervention can help families adjust to having a child with disabilities; give parents the skills they need to handle the child effectively at home; and help families find the additional support services they may need such as counseling, medical assistance, or financial aid. (p. 69)

Thus, we can state that, collectively, the aim of early intervention is to affect positively the overall development of the child’s social, emotional, physical, and intellectual well-being. This whole-child approach is important because these aspects are interrelated and dependent on each other (Zigler, 1990).

Over the years, educators and social scientists (Hanson & Lynch, 1995; Howard, Williams, & Lepper, 2005; McCollum & Maude, 1993; Peterson, 1987; Raver, 1999) have identified a variety of reasons why early intervention is important for young children with disabilities and children at risk. Many of these reasons are derived from research evidence,



Early intervention has been shown to positively impact the lives of young children with disabilities.

theoretical arguments, expert opinion, and societal values. Frequently identified themes include:

- A belief that early environmental stimulation can positively facilitate subsequent development and readiness for learning.
- A critical periods hypothesis, which suggests that intervening during key periods in a child's life is vitally important if the child is to acquire more complex skills and competencies later on. The exclusivity of this notion, however, has been challenged by some professionals who advocate that the early years of a child's life are *not* the only crucial period of development; in fact, development continues across the lifespan (Clarke & Clarke, 1976). Similarly, Ramey and Ramey (1998) argue

that there is no compelling evidence to support the belief of an absolute critical period of development such that interventions introduced after a certain age are ineffective. Yet research does suggest that earlier enrollment in intervention programs produces the greatest benefit, implying that it is a matter of developmental timing (Hallahan et al., 2009).

- The intensity of these early intervention efforts can also substantially influence outcome effectiveness (Guralnick & Conlon, 2007; McCormick et al., 2006).
- An assumption that early intervention can minimize the impact of a particular disabling condition like the effect of a severe hearing loss on the development of speech and language and possibly prevent or attenuate the occurrence of secondary disabilities.
- The proposition that intervention programs can ameliorate learning deficits and problems frequently attributed to certain risk factors such as environmental conditions.
- Benefits that accrue to families of young children with special needs and children at risk. These children frequently present many new challenges and additional responsibilities for caregivers and can potentially impact the entire family constellation. Early childhood special education professionals can assist families by providing factual information, emotional support, and specific training as requested. A further role for professionals is to establish meaningful partnerships with parents guided by the principles of enabling and empowering parents (Dunst, Trivette, & Deal, 1988).
- Benefits that extend beyond the child and his or her family to society at large. Early intervention is cost effective. The effectiveness has been documented in terms of dollars saved and the reduced need for special education services at an older age (Guralnick, 2004).

In summary, early intervention/education for children with disabilities has definite advantages for society, the family, and, of course, the child. Early childhood special education can make a significant difference in the quality of life for young children with special needs and their families. In fact, early intervention as a strategy to prevent later problems has almost become conventional wisdom (Kamerman, 2000). Scientists have been able to consistently demonstrate

that well-designed early intervention programs produce modest positive outcomes according to their intended purpose (Bailey, 2000; Guralnick & Conlon, 2007; Ramey & Ramey, 1998; Zigler, 2000). Thus, we are in full agreement with the Rameys' persuasive argument that "early intervention can improve the course of early human development . . ." (p. 118).

Representative Research Evidence on the Effectiveness of Intervention

During the past four decades there have been numerous investigations examining the effectiveness of early intervention with youngsters at risk and young children with documented disabilities. Many reviews and summaries of these efforts have been published (Casto & Mastropieri, 1986; Farran, 1990; Guralnick, 1997; Shonkoff & Hauser-Cram, 1987; White, Bush, & Casto, 1986). As might be expected, the analyses revealed, for a variety of reasons, contradictory findings. As a whole, however, the reports indicate positive outcomes for early intervention, especially when a distinction is made between statistical significance and clinical significance. A group of children who learn to accomplish specific self-help skills, like independently feeding themselves, might not evidence statistical significance due to small sample size, but this accomplishment is important for the youngsters and their families (Bailey & Wolery, 1992). While the research evidence does provide qualified support for the effectiveness of early intervention, several investigators and authors comment on the difficulty of conducting methodologically sound experiments (Bowe, 2007; Farran, 1990; Guralnick, 1988, 1991, 1998). Potential problems in interpreting the research literature lie with the appropriateness of the dependent measures; the absence of control groups; small sample sizes; improper sampling procedures; inappropriate statistical techniques; inadequate documentation of the treatment; the validity of the assessment instruments; and the variability within specific subject populations. Odom (1988) suggests that some of the research difficulties are due to the fact that early childhood special education is an applied discipline and given to answering pragmatic questions; researchers, therefore, have less control over variables in natural settings than in laboratory environments. Despite the shortcomings and the vulnerability of the research efforts, positive conclusions

about the efficacy of early intervention can be drawn. Guralnick (1998), for instance, emphatically states that, "comprehensive early intervention programs for children at-risk and for those with established disabilities reveal a consistent pattern of effectiveness" (p. 323). More recently, this expert in the field of early intervention noted that

The thoughtful implementation of systematic, comprehensive, experientially based early intervention programs . . . will enhance the development of young children already exhibiting intellectual delays (of known or unknown etiology) both by altering their developmental trajectories and by preventing secondary complications from occurring. (GURALNICK, 2005, P. 314)

We will now review some of the research evidence.

We begin with the classic but methodologically controversial study conducted by Skeels and Dye (1939), which significantly influenced the then current thinking about intelligence. These investigators reported an experiment where 13 children under three years of age were removed from an orphanage and placed in an institution for the mentally retarded, where they received a great deal of care and attention from the female residents. A control group of 12 children remained at the overcrowded orphanage and was not exposed to individual stimulation or training. Intellectual assessments were conducted at the time of transfer. When the children were reevaluated 18 to 36 months later, significant differences were observed between the experimental and control subjects. The 13 children placed on the ward with the young women with intellectual disabilities demonstrated an average gain in IQ scores of 27.5 points, while the initially higher-IQ-scoring control children showed a loss of 26.2 points. Each of the children who transferred to the more enriched environment showed an increase in measured intelligence, while all except one of the controls suffered a loss; 10 children had a decrease in IQ score between 18 and 45 points.

Perhaps the most significant finding of this investigation is the long-term follow-up of the subjects into adulthood. Even as adults, the differences between the two samples are significant. Skeels (1966) reports that members of the treatment group maintained their gains and all were self-supporting. Their median grade level attainment was greater than twelfth grade, whereas the children who remained at

the orphanage had a median educational attainment of less than third grade. Differences in occupational achievement were also noted, with the experimental subjects enjoying greater career accomplishment while the controls remained wards of the state or largely worked as unskilled laborers.

Although the methodology of the Skeels and Dye investigation has been criticized, the study did demonstrate that environmental conditions affect development as well as point out that the deleterious experiences of early childhood can be reversed. The work of Skeels and Dye, as Bailey and Wolery (1992) note, “remains as one of the few truly longitudinal studies of intervention effectiveness” (p. 6).

Another pioneering study is the work of Kirk (1958), who investigated the effects of preschool experiences on the mental and social development of children ages three to six with mental retardation. Eighty-one children with IQ scores ranging from 45 to 80 were assigned to either an intervention group or served as control subjects. Two experimental groups were established containing children who lived in the community or resided in an institution. The controls also lived either at home or in a residential environment. Both intervention groups who were exposed to two years of preschool experiences demonstrated significant gains on measures of intellectual and social functioning as compared to young children without the benefit of intervention. The performance of the control children decreased. Follow-up indicated that the experimental subjects retained their advantage until age eight. However, some of the community-based control subjects did catch up to the experimental children after one year of school.

Kirk’s research, as well as the efforts of Skeels and Dye (1939), attests to the malleability of early development in addition to providing strong evidence of the effectiveness of early intervention. As we noted elsewhere, in the 1960s the social conscience of America was awakened. As a nation we became cognizant of the devastating effects of poverty and other social ills on the lives of young children and their families. One consequence of this heightened social awareness was the establishment of preschool intervention programs for poor children, or in contemporary terms, children who are environmentally at risk. The lasting effects of some of these projects were evaluated by the Consortium for Longitudinal Studies. Lazar and his colleagues (Lazar & Darlington, 1979; Lazar, Darlington, Murray, Royce, & Snipper, 1982) issued two major reports summarizing the

results of twelve comprehensive follow-up studies of children enrolled in cognitively oriented preschools established in the 1960s. None of the projects focused specifically on children with special needs, although several selected participants on the basis of low IQ scores (range 50–85). Using original data from each program, Lazar found that environmentally at-risk enrollees had higher achievement and intelligence test scores as compared to children who did not have the benefit of preschool intervention. Their analysis also revealed that early intervention experiences significantly reduced the number of young children placed in special education and retained in their current grade. In comparison to control groups, preschool graduates had more positive attitudes toward school and furnished more achievement-oriented responses in follow-up interviews. Lazar and his coworkers concluded that, overall, the projects produced lasting positive outcomes and were cost effective when compared to later remediation efforts or special class placement. Table 2–8, derived from a composite of empirical investigations, summarizes some of the short- and long-term benefits that result from participating in a well-run preschool program.

The efficacy of early intervention has also been examined with children manifesting an established risk. One population that has received considerable attention is young children with Down syndrome. An example is the work of Guralnick and Bricker (1987). Using

TABLE 2–8 Beneficial Outcomes of High-Quality Preschool Programs

• Enhanced scholastic achievement
• Less grade retention
• Higher IQ scores
• Decreased likelihood of receiving special education services
• More positive attitudes toward school and learning
• Greater likelihood of graduating from high school
• Less likelihood of accessing public assistance
• Greater possibility of securing meaningful employment

stringent criteria for inclusion, these investigators evaluated the outcomes of 11 projects. They concluded, based on the substantial number of “first generation” studies reviewed, that the documented decline in cognitive ability with advancing chronological age typically found in children with Down syndrome can be significantly reduced, prevented, and, to some extent, reversed as a result of early intervention. This significant outcome is consistent across a wide variety of programs incorporating diverse experimental designs.

The issue of maintenance of cognitive gains, however, is not clear-cut, due to limited information and contradictory findings. Equally difficult to answer is the question of when is the best time to begin early intervention. The research evidence is, once again, contradictory. Both of these issues await more extensive and systematic research that is skillfully designed to answer these questions. Despite these shortcomings, empirical investigations strongly speak to the positive benefits of early intervention with children with Down syndrome.

Another illustration of the efficacy of early intervention is the highly visible work of Casto and Mastropieri (1986). These investigators used a comprehensive statistical integration approach known as **meta-analysis**. In this method, all available research (both published and unpublished) incorporating a range of experimental designs is evaluated in an attempt to detect global statistical patterns, which yield an “effect size” reported as standard deviations (SD). Seventy-four studies of early intervention efforts of heterogeneous groups of children were analyzed. Criteria for inclusion were minimal. Overall, the meta-analysis outcomes supported the efficacy of early intervention. Modest gains were observed in children’s test scores—typically standardized intelligence tests or other cognitive assessments. Cognitive measures yielded a mean effect size of .85 SD. When other dependent measures were included, such as motor and language assessments, the effect size was reduced to .68 SD. This means that the typical child with special needs in an early intervention program scored .68 of a standard deviation higher than a counterpart who was not receiving early services.

Casto and Mastropieri (1986) also reported that early intervention programs that are longer in duration and more intense usually demonstrate greater effectiveness. Two intriguing and controversial findings emerged, however, both of which were contrary to conventional wisdom and challenged two widely held beliefs of the field. First, Casto and Mastropieri found

no support for the belief that the earlier the intervention commences (“earlier is better”), the greater its effectiveness. Second, their meta-analyses suggested that greater parental participation does not necessarily lead to enhanced program effectiveness.

As might be expected, professional reaction to these summary statements was swift and intense (Dunst & Snyder, 1986; Strain & Smith, 1986). Critics of the Casto and Mastropieri (1986) meta-analyses assailed the conclusions, claiming that the analysis was methodologically (“apples and oranges approach”) and conceptually flawed. It must be remembered, however, that this investigation was based on an enormously heterogeneous group of children incorporating different intervention methods and procedures as well as employing diverse outcome measures. It would be prudent, therefore, to draw only limited conclusions.

A subsequent and better controlled meta-analysis using a subset of the original database focusing exclusively on children younger than three years of age yielded different and more positive results (Shonkoff & Hauser-Cram, 1987). This more selective analysis revealed that young children with mild disabilities had better outcomes with earlier enrollment, and higher levels of parent involvement were associated with greater child progress and performance.

Our final example is Guralnick’s (1997) extensive examination of “second generation” research studies involving children at risk and children with a broad spectrum of established risks. This review examined the efficacy of early intervention and the variables that impede or enhance its effectiveness, such as child characteristics (type and severity of disability), family characteristics, and program features (curriculum, parent-child interventions, social support). Some of the conclusions gleaned from this work support the following generalizations—the outcomes of intervention are positive, albeit modest; the sheer number of deleterious variables affecting development may be more significant than any one factor; and finally, careful consideration should be given to ecological factors affecting child-caregiver and child-family relationships.

Despite the chronic problems in conducting efficacy evaluations, it is our opinion that early intervention does make a difference in the lives of young children with special needs. It would appear that the field of early childhood special education has moved beyond the global question of whether early intervention works (we believe it does) to more precise

avenues of inquiry: for whom, under what conditions, and toward what outcomes (Guralnick, 1988). Like Bailey (2000), we believe that the debate will no longer be whether to provide early intervention, “but rather how much and what kind of intervention are children and families entitled to” (p. 74). A major task confronting the field will be to identify which early intervention programs work best and what elements are clearly essential to achieve maximum benefit (Zigler, 2000).

Early intervention research is not static, but rather an ongoing process. It can help guide researchers, policymakers, and educators in their quest to develop new models, programs, and services that benefit infants, toddlers, and preschoolers with special needs and their families.

An Ecological Perspective on Young Children with Special Needs and Their Families

One contemporary trend in early childhood special education is to view children as part of a larger social scheme wherein they influence, and are influenced by, various environments. This context, referred to as **ecology**, looks at the interrelationships and interactions of individuals within the environment. The primary advocate of this ecological model is Urie Bronfenbrenner (1977, 1979). From this ecological perspective, Bronfenbrenner attempts to understand the relationship between the immediate environments in which a young child develops and the larger context of those settings. A developing child, therefore, cannot be viewed in isolation but rather as part of a larger social system. We believe it is impossible to discuss children without also describing the context in which they develop and interact—their families and communities. As an illustration, early childhood professionals must have an appreciation for the child’s total environment—home, school, community, and the larger society, in addition to the individuals encountered therein—parents, siblings, classmates, playmates, and therapists, among other people. Spodek and Saracho (1994a) support our viewpoint. They write that:

The influence of the classroom on the young child, many educators believe, cannot be separated

from the influence of the family or from the context in which both the classroom and family exist. Home, school, community, and culture are all linked to each other. (p. 80)

As we just noted, the foundation for our thinking emerges from the theorizing of Bronfenbrenner (1977), who defines the ecology of human development as:

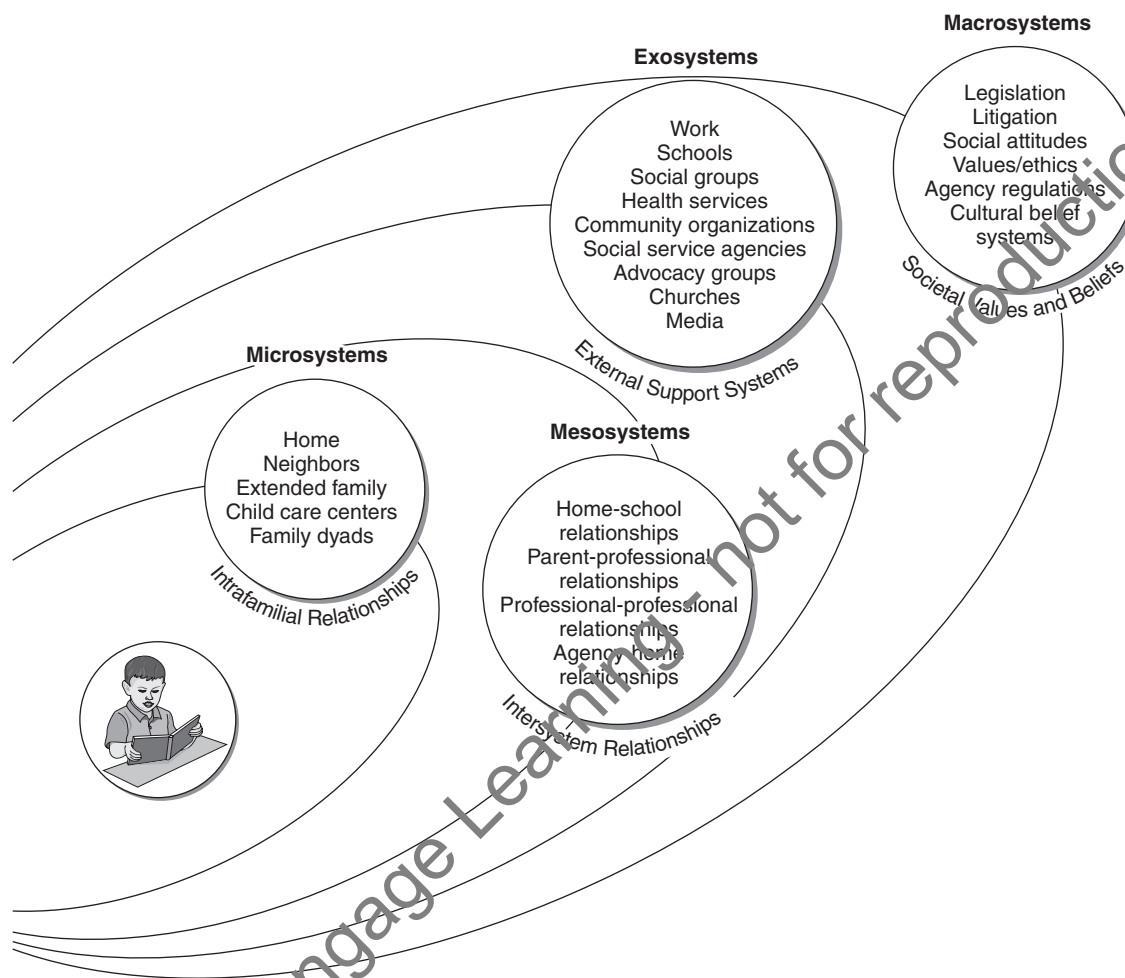
the scientific study of the progressive, mutual accommodation, throughout the life span, between a growing human organism and the changing immediate environments in which it lives, as this process is affected by relations obtaining within and between these immediate settings, as well as the larger social contexts, both formal and informal, in which the settings are embedded. (p. 514)

We further accept his “unorthodox” belief (Bronfenbrenner, 1978) that development is grounded in the context in which it occurs. Basic to this notion is the idea that the contexts in which a person develops are nested, one inside the other, similar to a set of *matryoshka*, or Russian stacking dolls.

Bronfenbrenner identified four environments in which people develop:

- **Microsystems** are those immediate environments in which an individual develops.
- **Mesosystems** are identified as the relationships between various microsystems.
- **Exosystems** are social structures that have an influence on the development of the individual; however, the person does not have a direct role in the social system.
- **Macrosystems**, which are the ideological, cultural, and institutional contexts in which the preceding systems are embedded.

These nested relationships, as they relate to young children with special needs and their families, are portrayed in Figure 2–3. This ecological context provides us with a framework for understanding the world of young children and has led to the contemporary practice of viewing families as systems embedded within other systems. The *microsystem*, according to Bailey, Farel, O’Donnell, Simeonsson, and Miller (1986), looks at relationships within the crucial setting of the child’s family in addition to the environments typically encountered by young children—child care centers, homes of relatives or friends, and in certain circumstances, institutional settings like

FIGURE 2–3 The Ecology of Human Development

SOURCE: Based on D. Bailey and M. Wolery, *Teaching Infants and Preschoolers with Disabilities* (New York: Macmillan, 1992).

hospitals. The second layer, or *mesosystem*, relates to the relationships, at a particular point in a child's life, between caregiver and teacher or physician as well as the interaction of one professional with another. The *exosystem* takes into consideration the social structures that impact family functioning. Early intervention programs as well as health/social service agencies are representative of this third setting (McLean, Wolery, & Bailey, 2004). The final context is the *macrosystem* and includes societal values and attitudes toward individuals with disabilities, in addition to legislative

enactments and judicial remedies, which in turn affect the lives of young children and their families. IDEA is a powerful example of a macrosystem in action.

Of course, the impact of time and history on the spheres of influence surrounding the developing child must also be considered. Bronfenbrenner and Morris (1998) refer to the interaction and influence of historical time on the four systems supporting the youngster as the **chronosystem**.

Kirk, Gallagher, Coleman, and Anastasiow (2009) embrace a concept very similar to Bronfenbrenner's

ecological model. These writers also believe it is vital for early childhood professionals to consider the familial and social context encountered by children with disabilities. The child is seen as being at the center of successive layers of influence, with the family being the primary and frequently most influential context. Other orbits include the peer group (which may include typical and atypical children), schools, and society itself (see Figure 2–3). Like Bailey et al. (1986) and Odom and Wolery (2003), Kirk and his colleagues see the child with special needs in dynamic and complex interaction with many layers of environmental forces.

Recommended practices in early childhood special education (Sandall, Hemmeter, Smith, & McLean, 2005) rely heavily on the importance of the child's family. According to Kirk et al. (2009):

The trend toward early intervention (before the age of 5) increases the importance of the family. Much of the intervention with young children is directed toward changing the family environment and preparing the parent or parents to care for and teach their child. At the very least, intervention tries to generate more constructive parent-child interactions. (pp. 15-16)

The value of the family can be seen in the Head Start commitment to meaningful parent (caregiver) involvement and participation. It is also clearly evident in IDEA and its accompanying amendments.

Successful program planning and intervention, therefore, must take into consideration the fact that the child is part of a system that interacts reciprocally within his or her environment. Bronfenbrenner (1979) observes that accomplishment of a specific task or activity “may depend no less on how he [the child] is taught than on the existence and nature of the ties between the school and home” (p. 3). Vincent, Salisbury, Strain, McCormick, and Tessier (1990) also note that “a change in the child is dependent not just on professional skills or the child's disability, but also upon complex interrelationships among family values, intra- and extra-family supports, and the extent to which service is offered, match what families need and want” (p. 186).

The message is clear. Quality programs for young children with special needs demand that professionals see the child within the context of her family and, in turn, the family's interrelationships and interactions with other, larger social systems.

Summary

Early childhood special educators will serve a wide variety of young children in a diversity of settings. It is imperative, therefore, that early childhood special education teachers have a clear understanding of how children from birth through age eight qualify for special education services. Of equal if not greater importance is our belief that young children with special needs are more like their typically developing peers than they are different. Early childhood special educators should focus on the strengths of each child not their limitations; we need to separate the individual's abilities from his or her disabilities.

The growth of early childhood special education as a discipline has been aided by judicial action and federal legislation. In several instances, principles addressed in various judicial proceedings have found their way into both state and national legislation. Many contemporary special education policies, practices, and procedures are derived from court decisions of the 1960s and 1970s. Likewise, the rights, opportunities, and benefits presently enjoyed by young children with special needs and their families are the result of federal legislative activity.

A question typically encountered by early childhood special educators is, “Is early intervention effective, does it really make a difference in the lives of young children?” Perhaps the best way to answer this difficult query is to say, “It depends.” One of the reasons we are so vague is due to the documented difficulty of conducting a methodologically sound investigation. In spite of this shortcoming, there is a very strong rationale for early intervention and the efficacy of these efforts, in our opinion, has been substantially demonstrated.

The number of young children receiving special education services has grown dramatically in the past several years. This growth is partially the result of litigation, legislation, and the benefits attributed to early intervention. In the 2007–2008 school year, more than 1.1 million young children from birth through age eight were enrolled in some type of early intervention or special education program.

Contemporary thinking in early childhood special education strongly suggests the validity of viewing children as part of a larger social system, wherein they influence and are influenced by various environments.

Children and their families need to be understood in the context in which they develop and interact. There is a reciprocal relationship among the various layers of environmental forces. This ecological perspective encourages early childhood professionals to be mindful of the child's total environment and the key people encountered within these several spheres of influence.

Check Your Understanding

1. What is the difference between a *disability* and a *handicap*?
2. List the advantages of using the developmental delay category in early childhood special education.
3. What is meant by the terms special education and related services?
4. Identify the significance of the following court cases:
 - a. Pennsylvania Association for Retarded Children v. Commonwealth of Pennsylvania
 - b. Mills v. Board of Education of the District of Columbia
 - c. Larry P. v. Riles
 - d. Board of Education v. Rowley.
5. List the major provisions of PL 94-142 and PL 99-457.
6. What is an individualized family service plan (IFSP)?
7. What is the role of a service coordinator?
8. Identify at least four benefits of early intervention for young children with disabilities and individuals considered to be at risk.
9. What general conclusions can be drawn from the efficacy research on early intervention?
10. According to Bronfenbrenner, how should early childhood special educators view young children and their families?

Reflection and Application

1. Trace the evolution of education law for children with disabilities. How have early childhood special educators become better prepared to meet the needs of young children with special needs as result of legislative activity?

2. How has the role of parents changed over the years? What evidence do you see that families/caregivers are involved in the early intervention/early education of their children?
3. How has the development of the IFSP/IEP process improved the education of young children with delays and disabilities? What types of information can an early childhood special educator contribute to an IFSP/IEP meeting? How are the IFSP and the IEP similar? Different?
4. In what ways do you see the philosophy of Bronfenbrenner being incorporated in early intervention programs or early childhood special education classrooms? Do you agree with the Bronfenbrenner's ideas?
5. Conduct a mock IFSP/IEP meeting and write a script that leads to developing a well written individualized family service plan or individualized education program. Be sure to include the family as a key partner in this process.

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MAKING CONNECTIONS

In order to help you understand programs and services for young children with special needs, we would like to introduce three children, Maria, T.J., and Cheryl. We will be talking about the educational needs of Maria, T.J., and Cheryl over the next several chapters. It is our wish that by getting to know these children, you will develop a better understanding of the diversity of services required for young children with disabilities and their families.

Maria Ramirez

Bubbly, outgoing, and affectionate with a constant smile are some of the terms Maria's interventionists use when describing her. This 30-month-old with Down syndrome is the youngest child of Bruce and Catherine Ramirez. Mr. Ramirez is an executive with a local bank. Maria's mother is employed as an intensive care nurse at the regional hospital. Her two older brothers enjoy their role as protector of their little sister. The Ramirez family lives in an affluent section of a small town approximately 50 miles from a large Midwestern city.

A service coordinator comes to Maria's home one morning a week in order to provide assistance with the achievement of her IFSP outcome statements. Due to her parents' work schedule and other commitments, Maria's grandparents provide child care and are prepared to work with her. Maria's entire family is committed to maximizing her potential.

Team members have recommended that Maria transition to an inclusive community-based program in order to receive Part B services. Although the family understands that with the approach of her third birthday, a change in service delivery is necessary, they are reluctant to agree to this recommendation. Maria's parents and grandparents have several concerns. Among their fears are issues of working with a new set of professionals, the length of her day, transportation to and from school, and Maria's interaction with typically developing peers.

Thomas Jefferson (T.J.) Browning

T.J. Browning is a rambunctious little boy who just celebrated his fourth birthday two months ago. He lives with his mother and a 12-year-old stepbrother, Willy. His mom has been separated from his dad for 14 months. The family lives in a large apartment complex for citizens with incomes at or below the poverty level. There are few playmates his own age in the complex. T.J. does not have a close relationship with his older brother; his mom has suspicions that Willy may be involved with a neighborhood gang.

T.J. has been attending the Epps Head Start Center for the past 15 months. In the center, T.J. has few friends. The staff observe that he has a short attention span, is easily distracted, and is overly aggressive. T.J. frequently uses his large size to get what he wants from the other children. Although well-coordinated, he has impairments with fine motor skills and his teachers suspect some cognitive deficits. T.J. receives integrated speech therapy twice a week from a speech-language pathologist. The director of the Epps Center and her staff are concerned about his readiness to attend kindergarten in the fall.

T.J.'s mother is a concerned parent who wants her son to be successful in school. Her job as a waitress limits her participation in center activities and from attending meetings and class field trips.

Cheryl Chinn

Cheryl is a petite first grader attending an elementary school located in a large metropolitan area. She is the youngest of four children. Her father is a senior project manager for a multinational corporation. Cheryl's mom, Elizabeth, does not work outside of the home.

(continued)

MAKING CONNECTIONS

Cheryl was an unplanned pregnancy. Elizabeth was 41 years old when Cheryl was born. Cheryl was born at 30 weeks gestation age and weighed slightly more than four pounds at birth. The first 10 days of Cheryl's life were spent in a neonatal intensive care unit. Developmental milestones were accomplished about six months later than normal. Other than recurring episodes of otitis media, the first few years of her life were unremarkable.

Cheryl was enrolled in a preschool program when she turned three. She attended this program three days a week for two years. Due to a late summer birthday, her parents considered delaying her entrance to kindergarten. She started kindergarten, however, with the other children from her neighborhood. Difficulty in following directions and instructions and with task completion, a short attention span, and social immaturity were soon observed. Cheryl required a "learning buddy" (peer helper) for her academic work. Because school officials were opposed to grade retention, Cheryl was promoted to first grade.

Many of the problems that Cheryl encountered in kindergarten were magnified in first grade. Shortly before a referral for special education services was to be made, Cheryl's pediatrician diagnosed her with attention deficit hyperactivity disorder (ADHD). Cheryl's teacher believes that a 504 accommodation plan would help Cheryl with her impulsivity, distractibility, and short attention span. The use of a peer helper was also continued.

Cheryl's parents are very involved in her education and fully support the development of a 504 accommodation plan. They were reluctant, however, to have their daughter referred for special education and possibly identified under the developmental delay category, especially since two of her older brothers are receiving services for children with gifts and talents.



3

Family-Based Early Childhood Services

Historical and Legal Perspectives

The Changing American Family

Family Reactions to a Child with a Developmental Delay or Disability

Family Systems Theory

- Family Characteristics
- Family Interactions
- Family Functions
- Family Life Cycle

Applications of Family Systems Theory

A Family-Based Philosophy

Family–Professional Partnerships

Key Components of Family–Professional Collaboration

- Cultural Responsiveness
- Effective Communication
- Conferences and Meetings
- Home Visits
- Ongoing Support and Information Exchange

Summary

Check Your Understanding

Reflection and Application

References

Key Terminology

Collaboration

Nuclear family

Family

Culture

Hybrid family

Family systems theory

Family characteristics

Family interactions

Cohesion

Adaptability

Family functions

Family life cycle

Transition

Ecological perspective

Empowerment

Eco-maps

Family-centered practices

Family-based practices

Family-directed practices

Cultural responsiveness

Stereotyping

Communication

Learning Outcomes

After reading this chapter, you will be able to:

- Describe how the relationship between families and service providers in early intervention/early childhood special education (EI/ECSE) has changed over the years.
- Explain family systems theory and provide examples of each element of the approach.
- Discuss the importance of strong family–professional relationships in EI/ECSE.
- Describe the influences that have contributed to the emergence of a family-based orientation in EI/ECSE.
- Describe the key components of family–professional collaboration, as well as strategies to foster positive interactions between families and service providers.
- Explain cultural responsiveness and its importance in family–professional relationships.
- Explain the importance of ongoing, effective collaboration among families and professionals in EI/ECSE.
- Describe strategies for communicating with families, meeting with families, and conducting home visits.

In the field of early intervention/early childhood special education (EI/ECSE), practices associated with the concept of being family-based increasingly have been embraced by personnel from many disciplines concerned with the well-being, education, and care of young children with known or suspected disabilities and their families. Calls have become commonplace for early childhood personnel to adopt a family-based model, to provide support to families, and to appropriately address the needs of young children and families from diverse backgrounds. In fact, Bailey and his colleagues (1998) more than a decade ago recommended that a family-centered perspective should permeate all aspects of early intervention/education services and include, but not be limited to, assessment, team meetings, program planning, intervention activities, service coordination, and transition.

A changing view of families and their participation in their children's EI/ECSE services has emerged over the last several decades. This view involves a true partnership in which families have a right to become involved in early intervention/education services and are encouraged to participate and engage in collaborative activities with professionals to the degree that they choose. A variety of research studies and program models have provided evidence in support of the mutual benefits of such **collaboration**, or working together, among families and professionals (Trivette & Dunst, 2005). Over the years, the roles of family members and professionals have changed to a marked degree and the rationale for building effective partnerships is more compelling than in the past. Further, there has been a dramatic increase in awareness, opportunities, services, and supports for families of young children with known or suspected disabilities. These and other factors related to family-based early childhood services will be examined in this chapter.

Historical and Legal Perspectives

It has long been recognized that the family is the fundamental social institution and the foundation of our society. The family is the primary arena in which a child, with or without a delay or disability,

is socialized, educated, and exposed to the beliefs and values of his or her culture. It is virtually impossible to overemphasize the importance of the development that takes place in the early years and the influence of the interactions that occur among young children and their families. Families play a critical role in facilitating and supporting a child's development, and it is the responsibility of service providers to help families realize the significance of their role. Thus, the importance of collaboration among professionals and families in EI/ECSE cannot be overstated. It is important to note, however, that family involvement in programs for children with known or suspected disabilities is not a new concept. In fact, the history of family involvement in the education of young children with disabilities has been described as an evolving process that has occurred over a number of years. As one early interventionist explained, "We've changed dramatically over the years. We've gone from trying to figure out how professionals can involve parents and provide training to them in areas we think are important to how can professionals provide support to parents in what parents consider important to their child and family." Table 3-1 provides a chronology of the family movement in early intervention/education.

Many factors contributed to the emergence of the emphasis on family involvement in the 1960s and 1970s, among them political, social, economic, and educational issues and events. Political movements, such as the civil rights and women's movements, advocacy efforts, and legislative actions led to the current emphasis that is now placed on the provision of quality programs for young children with special needs and their families. Influences have also come from the fields of general early childhood education, early childhood special education, and compensatory education (e.g., Head Start), as well as from professional organizations. Professional organizations such as the Division for Early Childhood (DEC) of the Council for Exceptional Children (CEC) (Sandall, Hemmeter, Smith, & McLean, 2005), the National Association for the Education of Young Children (NAEYC) (Copple & Bredekamp, 2009), and others have developed recommendations, standards, and policies concerning families. These documents emphasize that the benefits of family-professional collaboration during children's early years extend far beyond the early intervention, preschool, and early primary years.

TABLE 3–1 The Chronology of the Family Movement

1950s	Parents began to organize services and schools for children with disabilities in their communities. National organizations were formed and political action initiated.
1975	PL 94-142, the Education for All Handicapped Children Act (later incorporated into IDEA), established parents' roles as decision makers.
1980s	Grassroots support for parent-to-parent support groups increased.
1983	Legislation established a national program of Parent Training and Information Centers to provide assistance for families.
1986	PL 99-457 (later incorporated in IDEA) mandated that families were to be the focus of services.
1990s	Advocacy movements—early childhood, inclusion, transition, and self-advocacy—grew in numbers and influence.
1997	The 1997 IDEA Amendments placed greater emphasis on the involvement of parents in the eligibility, placement, and IEP processes.
SOURCE: Adapted from N. Flynn and C. Takemoto. <i>The Family Perspective</i>. 1997. In J. Wood and A. Lazzari, <i>Exceeding the Boundaries: Understanding Exceptional Lives</i>. Fort Worth, TX: Harcourt Brace College Publisher, p. 506.	

The Changing American Family

As professionals attempt to provide appropriate services and support to families, the dramatic changes that have occurred in the composition of families over the last several decades are important to recognize. The **nuclear family** refers to a family group consisting of, most commonly, a father and mother and their children. The traditional American family was once viewed as: (a) two parents (a male and a female), who were married to each other and always have been; (b) two or more children from the parents' union; (c) two sets of grandparents, living



Michael Ochs Archives/Getty Images

No longer is there a conventional perspective of a typical American family like the Cleaver family in 'Leave It to Beaver'.

within fifty miles; (d) the mother working in the home and caring for the children; and (e) the father working outside the home and interacting with the children in the evenings and on weekends. This description of the family is much like the television sitcom *Leave It to Beaver*, which was based on the lives of the Cleaver family—a traditional American family of the 1950s. Of course, no longer is it valid to think of a typical family today as a mom who is a full-time homemaker and a working dad along with their children who are all living together.

This conventional perspective of the nuclear family has definitely changed and is continuing to change. In fact, a limited number of families in the United States currently fit this description. The following statistics demonstrate some of the many ways in which the American family and American society have changed:

- Every 33 seconds, a child is born into poverty.
- Every 24 seconds, a child is born to an unmarried mother.
- Thirty-five percent of children are born to single parents.
- More than half of all marriages end in divorce.
- One out of two children will live with a single parent at some point during childhood.
- Twenty-three percent of children live with only their mothers, five percent live with only their fathers, and five percent live with neither parent.

- Of children under age six, 61.7% have all parents in the workforce.
- Thirty-four percent of the homeless population is made up of families with children. (Children's Defense Fund, 2008)

The preceding statistics strongly suggest that no longer is there a typical American family. In other words, the expression “The Cleavers don’t live here anymore” is certainly accurate. It is only realistic to define families more broadly. In American families today, there may be many nuclear family configurations including single-parent families, teen parents, families with adopted children, families with foster children, grandparents raising grandchildren, and blended families, to name a few. The definition of **family** used in this chapter is a group of people related by blood or circumstance that rely upon one another for security, sustenance, support, socialization, and/or stimulation. When a young child was asked to draw a picture of his family, he explained that “A family means having someone to tuck you in bed at night.”

American families have changed in many different ways. A major way in which families have changed is that they have become more culturally diverse. The term **culture** refers to “the foundational values and beliefs that set the standards for how people perceive, interpret, and behave within their family, school, and community” (Turnbull, Turnbull, Erwin, & Soodak, 2006, p. 19). Although some people limit their view of culture to race, national origin, or ethnicity, there are other influences on a family’s cultural identity beliefs, such as religion, language, gender, age, geography, and income. Thus, culture determines how families think, feel, perceive, and behave (Gollnick & Chinn, 2009).

Also represented in today’s society is the **hybrid family**, which Aldridge and Goldman (2007) describe as a “family who redefines itself and produces something new and different from the origins that created it” (pp. 184–185). An example of a hybrid family would be one in which each parent has a different ethnic and religious background. Rather than adopting the cultural and religious practices of one parent or the other, the family chooses to practice a blend of both cultures and a religion that is different from either of their families of origin. They have created a hybrid family that is different from either family of origin. As a result of the changes that have occurred in the families served, professionals face many unique challenges



Children come from diverse family structures and backgrounds, which calls for an individualized approach to effectively serve each child and family.

related to family diversity in the 21st century (Copple & Bredekamp, 2009; Kilgo, 2006).

The changes that have occurred and continue to occur in the structures and cultural backgrounds of families issue a call for the utilization of an extremely individualized approach in family–professional interactions. Each of these family configurations and backgrounds adds to the complexity of interactions among families and professionals. Many factors must be taken into consideration when working with diverse family structures and backgrounds, as well as the impact of these variations on family–professional relationships. Professionals must be sensitive to and aware of the unique characteristics of the families they serve. As families continue to change, professionals must carefully examine and discover the most effective methods of serving families.

Family Reactions to a Child with a Developmental Delay or Disability

When a child with a known or suspected disability becomes a member of the family, whether through birth, adoption, or later onset of the disability, the ecology of the family changes and often the entire family must make adjustments. Each parent or family member responds to a child’s delay or disability in his

or her own unique way, requiring an individualized approach to each family (Bailey et al., 2006; Winzer & Mazurek, 1998). In the same way that professionals realize that all children are individuals, they must also realize that families are also individual and unique entities. Reactions and feelings may be dramatically different from one family to another and from one parent to another (Cooper & Allred, 1992). Professionals, therefore, usually encounter a wide variety of behaviors and emotional responses on the part of parents and other family members.

In the past, some professionals made judgments about families based on a “stage theory” model of parental adjustment in response to having a child with a disability. In recent years, however, this theory has been strongly criticized (Vacca & Feinberg, 2000). The way in which this model evolved is surprising in that it began with a study conducted more than 35 years ago that was designed to assess parents’ perceptions, feelings, and attachments to their children with disabilities (Drotar, Baskiewicz, Irvin, Kennell, & Klaus, 1975). Based on the results of this study, Drotar et al. developed a linear “stage theory” model of parental adjustment that followed a progression of acceptance beginning with shock and moving through denial and anger to a point of reorganization and acceptance. According to this model, parents are ready to deal with the responsibilities of their children with disabilities once they have moved through the various stages of acceptance and have dealt with guilt associated with having a child with a disability (Blacher, 1984). Later in the 1980s, stage theories were challenged by researchers who rejected the idea of families, all of whom are unique, going through the same specific stages of acceptance. Further, they disagreed with the idea of family reaction being judged and categorized according to this continuum. In fact, some researchers suggested that the stage theory of acceptance of a child’s disability is a disservice to families and is an oversimplification of a complex process that families experience (Gallagher, Fialka, Rhodes, & Arceneaux, 2003).

Most professionals in the field of early intervention/education today recognize that families respond differently to having a child with a disability based on a number of characteristics, resources, and supports that are unique to the individual family. Researchers have recognized that a variety of factors can interact to influence a family’s reaction and subsequent adjustment to a child with a disability, which can

include personal characteristics of family members, patterns of family interactions, health and safety factors, and others. Stress factors or needs associated with disabilities also can affect family functioning and partnerships between professionals and families. For example, professionals who work with four-year-old T.J. must carefully consider the influences of his brother’s gang-suspected activities, the neighborhood in which the family lives, his parents’ separation, and other family dynamics. From a more positive perspective, some family characteristics could be considered strengths, such as having a large family or a family with effective coping skills, which may mitigate many of the stresses associated with a child with a delay or disability (Guralnick, 1999).

The needs of the parents reflect not only their ability to cope but also their child’s developmental needs. For example, the demands placed on the professionals who initially break the news of a child’s disability to a family may be very different from those placed on the professionals who help parents deal with the fears associated with the child’s transition into a kindergarten classroom. Another example is that the needs of families of children with disabilities such as autism or complex medical disabilities may be different from the needs of the families of children with speech delays. Professionals must tailor their interactions and provide support based on the individual and ever-changing needs of families. Often families of young children with disabilities, especially those of young children with severe disabilities or medically complex conditions, face difficult issues, such as the following:

- Heavy expenses and financial burdens associated with hospitalization, medical treatment, surgery, and child care, as well as other needs such as special foods, equipment, or transportation;
- Frightening, energy-draining, often recurring crises, such as when a child stops breathing, experiences seizures, or faces life-threatening situations;
- Continuous day-and-night demands on families to provide routine but difficult care-giving tasks (e.g., feeding, suctioning, monitoring);
- Constant fatigue, lack of sleep, and little or no time to meet the needs of other family members or to participate in recreational or leisure activities;
- Difficulty locating qualified child care and respite care for children with severe disabilities, which can interfere with the parents’ abilities to fulfill

work responsibilities, participate in social activities, etc.;

- Jealousy or feelings of rejection among siblings who may feel the child with a disability requires *all* the family's attention and resources; and
- Marital problems arising from finances, fatigue, and lack of time to devote to the relationship (Allen & Cowdery, 2009)

Professionals must remember that a team effort is required to understand and support each family according to its unique needs. Depending on each family's needs, team members may need to rely on the expertise of health care, mental health, and social service professionals. It is important to remember, however, that the effect of a child with a disability on the family may be positive, negative, or neutral (Turnbull et al., 2006) and can change over time. As emphasized in the American Indian proverb, "Never judge another man until you have walked a mile in his moccasins."

Family Systems Theory

Utilization of a family systems theory model has become the recommended approach in early intervention/early childhood special education. The fundamental belief underlying **family systems theory** is that a family is an interactional system with unique characteristics and needs. A family operates as an interrelated and interdependent unit; therefore, events and experiences that have an impact on particular family members also will affect the other members of the family or the entire family unit (Minuchin, 1988; Turnbull et al., 2006). Each family member may have his or her own set of needs that may or may not be congruent with the needs of other family members or with the needs of the family as a whole. Because of the relationship that exists among family members, professionals must consider the entire family unit as the possible focus of their attention. As described earlier, recommended practice suggests that professionals should apply family systems theory by individualizing their relationships with each family, just as they individualize their work with each child with a disability (Turnbull et al.).

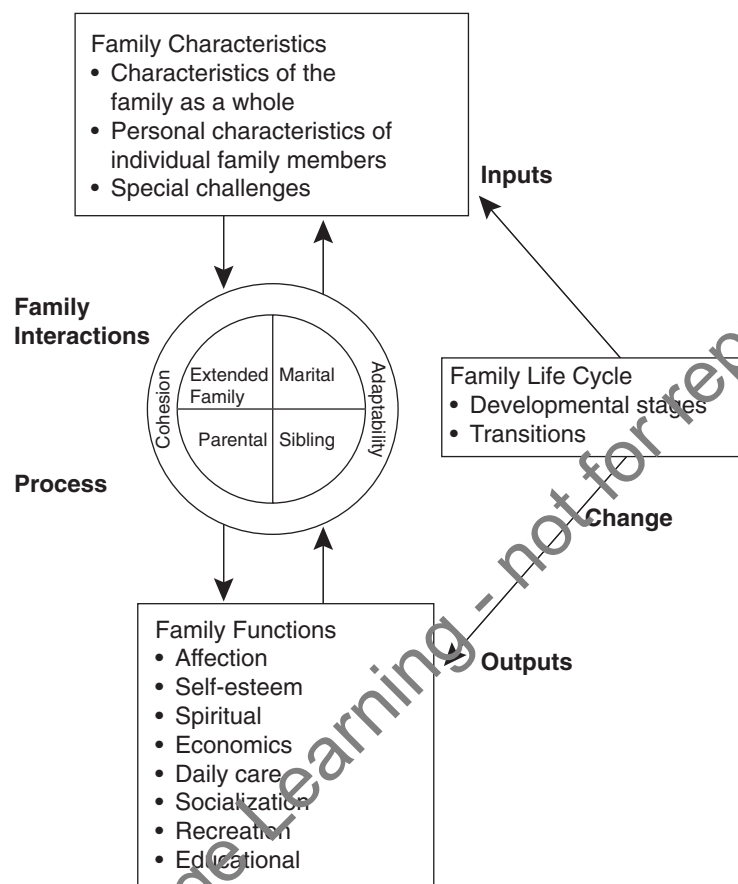
Family systems theory was adapted by Turnbull, Summers, and Brotherson (1984) to focus specifically on families of young children with disabilities. Their family systems conceptual framework includes the following four key elements, which are interrelated.

1. Family characteristics are the attributes of a family, such as its cultural background, financial well-being, size, age, geographic location, abilities, and disabilities.
2. Family interactions refer to the daily relationships among family members.
3. Family functions are the needs and interests of family members met by the family, including social, emotional, educational, or physical needs such as health care or child care.
4. *Family life cycle* refers to all the changes that affect families and influence family resources, interactions, and functions.

Figure 3–1 provides a visual display of the components of the family systems theory model. What follows is a discussion of each component of the family systems theory model.

Family Characteristics

The first element of family systems theory is **family characteristics**, which are the dimensions that make each family unique (e.g., family size and form, cultural background, geographic location). Additionally, each family member's health status (both physical and mental), individual coping style, and the nature of the child's disability are included as personal characteristics. A final component includes special challenges that families can face, such as poverty, substance abuse, and parents who themselves have disabilities. Collectively, these variables contribute to each family's unique identity and influence interactional patterns among the members while also determining how the family responds to its child's disability (McCormick, Stricklin, Nowak, & Rous (2008). It is easy to understand how a large family living below the poverty level in a rural location might adapt differently than an affluent suburban family with only one child with a disability. In both examples, the families may be successful in their adaptation; however, their responses, needs, and adaptive strategies may be very different.

FIGURE 3–1 Family Systems Conceptual Framework

SOURCE: Adapted by permission from Turnbull, A. P., Summers, J. A., and Brotherton, M. J. (1984). *Working with families with disabled members: A family systems approach* (p. 60). Lawrence, K S: University of Kansas, Kansas Affiliated Facility.

Family Interactions

The second component of family systems theory is **family interactions**, which is composed of the relationships that occur among and between the various family subsystems or subgroups. These subsystems include the following:

1. marital (husband–wife);
2. parental (parent–child);
3. sibling (child–child); and
4. extended family (nuclear family, friends, neighbors, larger community including professionals) (Turnbull et al., 2006).

How a particular family interacts depends, in part, on the degree of cohesion and adaptability in

interactions. These two factors influence the quality of interactions and can only be interpreted within the context of the family's cultural background.

Cohesion that occurs in families is a type of emotional bonding that holds them together (Olson et al., 1989). It determines the degree of freedom and independence experienced by each member of the family unit. Cohesion occurs along a continuum of behavior ranging from enmeshment to disengagement. Highly enmeshed families are overly cohesive, which can impede the development of independence in individual family members. Families who are highly enmeshed are viewed as being overly protective and having weak boundaries between the subsystems. Conversely, rigid subsystem boundaries characterize disengaged families—believed to have a low degree of

cohesiveness. In this situation, families are depicted as being under-involved, and the child with a disability may experience an absence of support (Minuchin, 1988). Ideally, well-functioning families seem to achieve a balance in cohesiveness in that the “boundaries between systems are clearly defined and family members feel both a close bonding and a sense of autonomy” (Seligman & Darling, 1997, p. 9).

Adaptability is the family’s ability to change its power structure, role relationships, and rules in response to crises or stressful events occurring over a lifetime (Olson, Russell, & Sprenkle, 1980; Turnbull et al., 2006). Like cohesiveness, adaptability occurs along a continuum from rigidity to chaos and is influenced by the family’s cultural background and other factors. When a stressful event occurs, rigid families respond according to prescribed roles and responsibilities and are often unable to adapt to the demands of the new situation. According to Seligman and Darling (1997), this type of behavior places a family at-risk for becoming isolated and disengaged. When a child with a severe disability becomes a member of a family, some form of accommodation or adjustment is usually required. Yet, in a rigid family with a clear hierarchy of power, the child care needs will more than likely become the responsibility of the mother with little or no assistance provided by other family members. On the other hand, how a chaotic family would respond to this situation is unpredictable due to few or inconsistent rules. Turnbull et al. (2006) describe chaotic families as being characterized by constant change and instability. In many situations, there is no family leader and the few existing rules are frequently altered, resulting in significant confusion, particularly for young children who need parental consistency and predictability. Most well-functioning families appear to maintain a balance between the extremes of high and low adaptability (Nichols, 2007; Taibbi, 2007).

Family Functions

The third element of the family systems theory is **family functions**, which refers to the eight interrelated activities that are necessary to fulfill the individual and collective needs of the family. These eight areas, with examples of each, are as follows.

1. *affection*—emotional commitments and display of affection
2. *self-esteem*—personal identity and self-worth, recognition of positive contributions

3. *spiritual*—needs related to church, religion, or God
4. *economics*—production and utilization of family income
5. *daily care*—day-to-day survival needs such as food, shelter, and health care
6. *socialization*—developing social skills, establishing interpersonal relationships
7. *recreation*—leisure time activities for both family and individuals
8. *educational*—involvement in educational activities and career choices

Turnbull et al. (2006) identify these nonprioritized functions as “output” and emphasize that it is impossible to discuss family functions without considering the other three main components of the family systems framework. While these tasks and activities are common to all families, they are likely to be affected by the presence of a child with a disability.

A concern of most parents today, particularly for those employed outside the home, is not having enough time to carry out family functions and meet the needs of the family. Further, families will be required to devote more time to addressing the needs of a child with a disability in most cases (Berry & Hardman, 1998; Brotherson & Goldstein, 1992). Figure 3–2 provides the words of Helen Featherstone, who is the author of the book *A Difference in the Family* (Featherstone, 1980). As the mother of a son with severe disabilities, Featherstone describes the difficulties she faces each day as she struggles with not having enough time to complete all the tasks required of her. In this passage, she writes about an occupational therapist asking her to add a 15-minute regimen to her daily routine, which she simply could not do due to lack of time. Although this took place many years ago, it illustrates the importance of professionals being sensitive to the extreme demands placed on families of children with disabilities.

In most cases, families have individualized priorities for each of the family functions. In one family, meeting the daily needs of having food and shelter is of utmost importance, while for another family, the emphasis may be on needs in the areas of education or recreation and leisure. A family living in poverty would probably place greater emphasis on daily needs. A teenage single mother may be focused on completing high school, as well as hanging out with friends. Berry and Hardman (1998) also note

FIGURE 3–2 Where Will I Find the Time?

I remember the day when the occupational therapist at Jody's school called with some suggestions from a visiting nurse. Jody has a seizure problem, which is controlled with the drug Dilantin. Dilantin can cause the gums to grow over the teeth; the nurse had noticed this overgrowth, and recommended innocently enough, that [his] teeth be brushed four times a day, for 5 minutes, with an electric toothbrush. The school suggested that they could do this once on school days, and that I should try to do it the other three times a day; this new demand appalled me; Jody is blind, cerebral palsied, and retarded. We do his physical therapy daily and work with him on sounds and communication. We feed him each meal on our laps, bottle him, bathe him, dry him, put him in a body cast to sleep, launder his bed linens daily, and go through a variety of routines designed to minimize his miseries and

enhance his joys and his development. (All this in addition to trying to care for and enjoy our other young children and making time for each other and our careers.) Now you tell me that I should spend 15 minutes every day on something that Jody will hate, an activity that will not help him to walk or even defecate, but one that is directed at the health of his gums. This activity is not for a finite time, but forever. It is not guaranteed to help, but "It can't hurt." And it won't make the overgrowth go away but may retard it. Well, it's too much. Where is that 15 minutes going to come from? What am I supposed to give up? Taking the kids to the park? Reading a bedtime story to my eldest? Washing the breakfast dishes? Sorting the laundry? Grading students' papers? Sleeping? Because there is not time in my life that hasn't been spoken for, and for every 15-minute activity that is added one has to be taken away.

SOURCE: Excerpted from *A Difference in the Family* by Helen Featherstone. Copyright © 1980 by Basic Books.

that some families, particularly those with limited resources, may require assistance in several areas, while others may need support in only a few areas. The amount of support families request from professionals also will vary depending upon specific family circumstances.

Family Life Cycle

Family life cycle is the fourth element in the family systems theory framework. This component of the theory refers to developmental changes that occur in families over time. Most of these changes are fairly predictable, such as going to kindergarten; however, they can be non-developmental or unexpected, such as the untimely death of a family member, divorce or marriage within a family, or the unplanned birth of a child. These changes alter the structure of the family and, in turn, impact relationships, functions, and interactions. Researchers have identified as few as six to as many as twenty-four developmental stages that occur in families (Carter & McGoldrick, 1999). Regardless of the number of stages, each stage brings with it change, additional demands, and a new set of stressors. How the family responds to these situations determines, in part, the way in which the family functions. The movement from one stage to another and the accompanying adjustment period is considered to be a **transition**. Transitions tend to be stressful events for families, but especially for families of young children with disabilities. For many families, it is a time of challenge and uncertainty as to what the next stage holds for the child and family as well. For instance, when a child begins preschool or a preschooler moves to kindergarten, this can cause



Without appropriate planning, transitions encountered by young children with known or suspected disabilities and their families (e.g., graduating from preschool, beginning kindergarten) can cause increased stress.

TABLE 3–2 Potential Family Life Cycle Issues

Stage	Parental Issues	Sibling Issues
Early Childhood (Birth–Age 5)	• Obtaining an accurate diagnosis • Informing siblings and relatives of diagnosis • Seeking to find meaning in the disability • Clarifying a personal ideology to guide decisions • Addressing issues of stigma • Locating services • Participating in IFSP/IEP meetings • Identifying positive contributions of the disability • Setting expectations	• Less parental time and energy for sibling needs • Feelings of jealousy over less attention • Fears associated with misunderstandings of the disability
School Age (Ages 5–8)	• Establishing routines to carry out family functions • Adjusting emotionally to educational implications • Clarifying issues of inclusion vs. special class placement • Participating in IEP meetings • Locating community resources • Arranging for extracurricular activities	• Division of responsibility for any physical care needs • Oldest female sibling may be at risk due to increased responsibilities • Limited family resources for recreation and leisure • Informing friends and teachers • Possible concern over surpassing younger sibling • Issues of inclusion into same school • Need for basic information about the disability

SOURCE: Adapted from Barber, P. A., Turnbull, A. P., Behr, C. R., & Kerns, G. M. (1998). Family systems perspective on early childhood special education. In S. L. Odom & M. B. Karnes (Eds.), *Early intervention for infants and children with handicaps* (p. 194). Baltimore: Brookes.

heightened anxiety and significant stress. Transition plans are written as part of the IFSP for birth to three-year-olds and as part of the IEP for three- through eight-year-olds.

According to family systems theory, life cycle functions are highly age related. As a family moves through the life cycle, the priorities shift when the family encounters new situations (Seligman & Darling, 1997). Turnbull et al. (2006) discuss four major life cycle stages and the accompanying issues that the family of a child with a disability may encounter along the family’s journey. The life cycle of a family typically includes the stages of the early childhood years, the school-age years, adolescence, and adulthood. In an earlier publication, Barber, Turnbull, Behr, & Kerns

(1998) describe the developmental issues that a child with a disability presents to his or her family during the early childhood years (birth through age eight) as presented in Table 3–2. Professionals must remember, however, that the way in which a family adapts to various stages throughout the life cycle is highly individualistic. Not all families successfully negotiate life cycle changes without support from professionals.

It is important to acknowledge that all families may experience a number of stresses at different points in time, and a family’s behavior may seem extreme at times; however, most families eventually achieve a healthy balance. It is important to remain focused on the family’s strengths and resources rather than the needs, challenges, and stresses it encounters.

Applications of Family Systems Theory

Understanding the family as a social and emotional unit embedded within other units and networks enables service providers to better grasp the complex nature of families and to work with them in more effective ways. Utilizing this view allows professionals to realize that events and changes in one unit may directly and indirectly influence the behavior of individuals in other social units. A systems perspective considers events within and between social units as supportive to the extent that they have positive influences on family functioning. Each family member is viewed as a system and as a part of many other systems, such as the early intervention program, school, community, and society.

Internally, as described earlier, the family system has basic functions that provide a broad framework through which a variety of roles and tasks are carried out. These functions change in response to developmental shifts in the family itself, as well as individual family member shifts. The structure of the family system and any changes in the structure may have an impact on all other elements.

In the family systems framework, the development of individuals and families is seen as a dynamic process of person–environment relationships. Therefore, the behavior of a child, a family, or a child and family is viewed as a part of a set of interrelated “systems” that powerfully influence one another. By understanding experiences and activities of families and assessing the influences on the family, professionals can work with families to design strategies to promote well-being in the family system. For example, if Maria’s service coordinator realizes the close relationship Maria’s brothers have with their 30-month-old sister, the brothers can be encouraged to participate in some of the learning activities and strategies designed to be used at home, which will benefit Maria.

Bronfenbrenner’s (1979) **ecological perspective** emphasizes that power emerges from the nature and structure of human relationships. For example, an infant’s need to develop trust is actualized within the primary relationship system of the family. This need may also be strongly influenced by other social systems, such as the neighborhood, child care program, and other systems. **Empowerment** is a concept used for many years by individuals in helping professions.

Most professionals would agree that it is much more accurate to describe this concept as a process rather than an end state. In early descriptions by Vander-slice (1984), family empowerment was defined as a process through which individuals increase their ability to influence those people and organizations that affect their lives, as well as the lives of their children and others they care about. Empowered individuals or families seek to have control over their lives and to take action to get what they need for themselves and their families (Dunst, Trivette, & Deal, 1988; Turnbull, Turbiville, & Turnbull, 2000). It is within the family ecology that children and parents develop their sense of power. Dunst, Trivette, & Deal (1988) remind us that empowered parents and families have three enabling characteristics:

1. the ability to access and control needed resources;
2. the ability to make decisions and solve problems; and
3. the ability to interact effectively with others in the social exchange process to gain the resources they need.

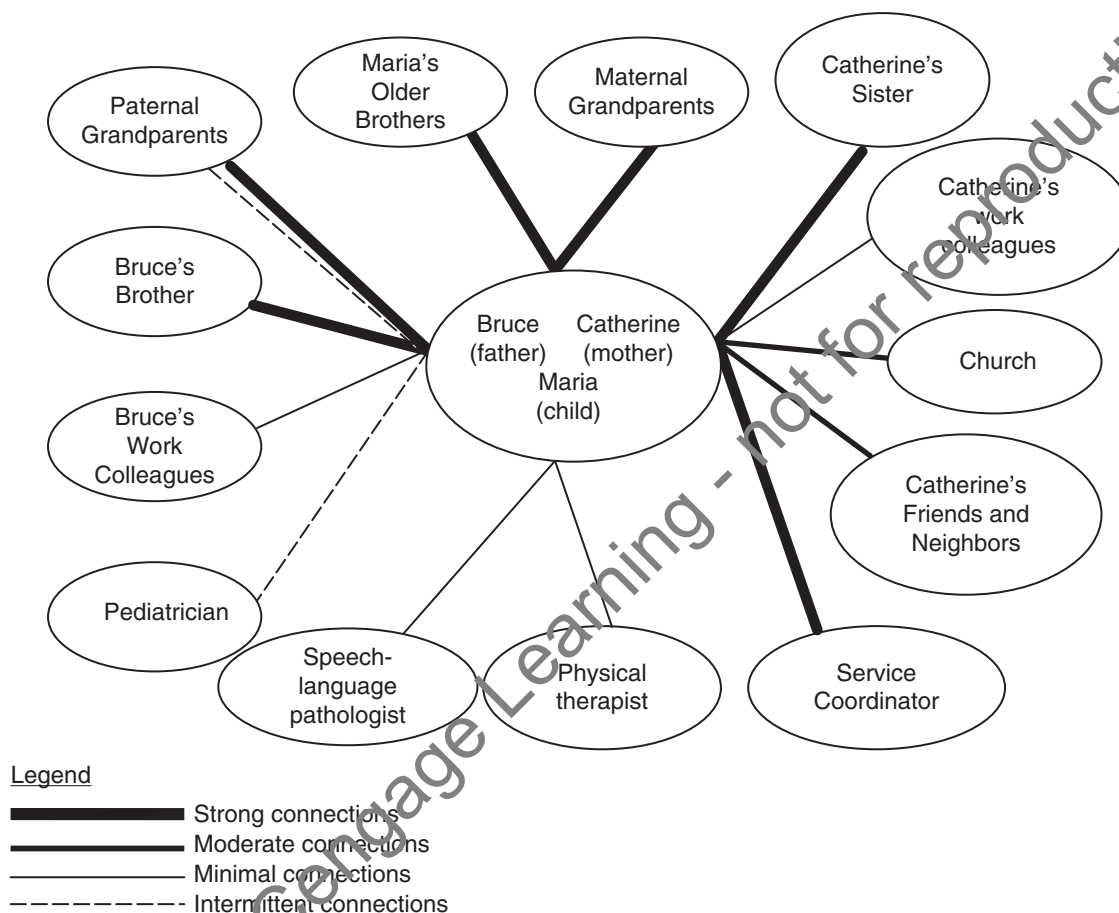
Because individual needs, interests, affective development, and perceptual orientation evolve within the family ecology, the underlying premises of a family systems model are highly related to the empowerment paradigm. These premises include the following (Swick & Graves, 1993):

1. behavior takes place in a systems context;
2. individual development is intimately interrelated with the family’s development;
3. family development is systematic; and
4. events that influence any family member have some direct or indirect influence on the entire family system.

Within the family system, trust, attachment, self-esteem, social attitudes and behaviors, and many other processes and skills emerge in a nurturing, empowered family (Brubaker, 1993; Nichols, 2007; Taibbi, 2007). A sense of power or a sense of powerlessness is developed in the family ecology. It is important for professionals to remember that the concept of empowerment is dynamic, interactive, and process oriented. Professionals who embrace the empowerment paradigm share the assumption that all families have strengths. Professionals are in a strategic position to promote positive, empowering interactions

MAKING CONNECTIONS

Eco-Map----Maria Ramirez and Family



with families by providing quality programs for young children, involving parents in partnerships, and supporting families in all aspects of early intervention/early childhood special education services.

One of the most important functions of empowerment is to provide skills that promote self-sufficiency. Empowerment may grow through a family's changes in self-perception, increased self-confidence, ability to set goals, acquisition of skills to attain goals, and the opportunity for supported practice (Dunlap, 1997). In most cases, empowerment means promoting access to resources, competence, and self-efficacy

(Bandura, 1997; Hanson & Lynch, 2004; Heflinger & Bickman, 1997; Nichols, 2007; Taibbi, 2007). Relationships between professionals and families can be fostered through family empowerment because families develop trust of professionals and professionals come to view families as part of an equal, reciprocal partnership (Swick, 1996; Turnbull et al., 2006). Families, with the support of professionals as needed, take actions to solve problems and get what they need for their child and family (Turnbull et al., 2006).

Many teams have found **eco-maps**, or family maps, to be useful in fostering collaboration among

professionals and families and also in depicting and using important information such as family structure, strengths, and resources. According to McCormick, Stricklin, Nowak, & Rous (2008), eco-maps were “originally developed as a . . . visual representation of the family system at the beginning of intervention” (p. 18). Developing an eco-map requires specific steps: (1) identifying informal family supports, (2) identifying strengths and relationships, and (3) identifying formal family supports (Hartman, 1995). The eco-map can be used to link the IFSP or IEP goals/outcomes to support services for children and families and to review informal and formal family resources. The Making Connections feature provides an example of an eco-map developed with Maria’s family to learn more about the family structure, examine needed services, and establish rapport with the Ramirez family. For example, the service coordinator who works with 30-month-old Maria must consider that Maria’s interactions with her brothers, grandparents, friends from her affluent neighborhood, therapists who visit weekly, other significant people, and experiences in her life will have a profound influence on Maria.

A Family-Based Philosophy

Several themes have emerged for those who work with families of young children with disabilities to carefully consider. First, there is the recognition that families are all very different. They differ in their concerns, resources, priorities, and other areas; therefore, an individualized approach to working with families must be used to address each family’s specific needs. Secondly, families should be partners with professionals in planning, providing services, and making decisions regarding issues such as the child’s placement and the family’s level of involvement in early intervention/education services. This relationship must include valuing and supporting the equality within the partnership. Finally, families are viewed as the ultimate teachers and decision makers for their children. A family-based perspective should be apparent in all aspects of early childhood services. An example of a family-centered early intervention philosophy, developed at the Frank Porter Graham Child Development Center, can be seen in Table 3–3. Early childhood programs all over the country have

embraced a family orientation that is the cornerstone of early intervention and early childhood special education (Turnbull et al., 2007)

As described previously, this family philosophy in early childhood special education has evolved over time. Dunst, Johanson, Trivette, and Hamby (1991) traced the history of the role of professionals in working with families of young children with special needs in the following order: professional-centered, family-allied, family-focused, family-centered, family-based, and family-directed. Most recently readers in the field of early intervention and early childhood special education have espoused a family directed model of early intervention/education as included in IDEA 2004.

The first model described by Dunst et al. (1991) is a professional-centered activity whereby the professional was the sole source and dispenser of expertise. Families were considered dysfunctional and incapable of resolving their own problems. The family-allied model came next—families served as teachers of their children, implementing family interventions prescribed by the professionals. This perspective gradually gave way to a family-focused emphasis. Service providers at this stage viewed families in a more positive light. Families were seen as competent and capable of collaborating with professionals; however, most professionals still believed that families needed their assistance. In the family-centered model, the family is the center of the service delivery system. As such, services are planned around the family, based on its individual needs. This approach is consumer driven—professionals are working for the family. Other terms that have been used in recent years include family-driven and family-directed. Regardless of the term used, early intervention/early childhood special education programs today believe that the family is the primary decision maker. Professionals provide support to families and assist them as needed in fulfilling their goals.

Using the view of the family as a system, the ecological and empathetic perspectives, and the empowerment paradigm, professional planners are acknowledging families as strong, unique, and able to identify their own concerns and resources. The concept of **family-centered practices** in this context refers to specific techniques and methods of working with families. As described by Dunst, Johanson, Trivette, and Hamby (1991), family-centered practices stress focusing on family strengths and enhancing family skills and competencies. Families are not

TABLE 3–3 Family-Centered Philosophy in Early Intervention

Family-centered	Professionals should recognize that the family is the constant in the child’s life while the service systems and personnel within those systems may be involved only episodically.
Ecologically based	As professionals work with families, they need to consider the interrelatedness of the various contexts that surround the child and family.
Individualized	Since the needs of each child and each family may differ, services should be individualized to meet those unique needs.
Culturally sensitive	Families come from different cultures and ethnic groups. Families reflect their diversity in their views and expectations of themselves, their children, and professionals. Services should be provided in ways that are sensitive to these variations and consistent with family values and beliefs.
Enabling and empowering	Services should foster a family’s independence, existing and developing skills, and sense of competence and worth.
Needs-based	Approach starts with a family’s expressed interests and collaborates with families in identifying and obtaining services according to their priorities.
Coordinated service delivery	Families need access to a well-coordinated system of services.
Normalized	Programs should work to promote the integration or inclusion of the child and the family within the community.
Collaborative	Early intervention services should be based on a collaborative relationship between families and professionals.
SOURCE: Adapted from The Carolina Institute of Research on Infant Personnel Preparation, Frank Porter Graham Child Development Center, The University of North Carolina at Chapel Hill.	

mere recipients of services, but are active partners in planning and implementing service delivery processes (Kilgo & Raver, 2009). The goals of each program must contain elements that assist in supporting families as they strive to meet the needs of their children with special needs.

As Maria’s mother noted when Maria was six months old, she still couldn’t sit up and didn’t smile, make sounds, and play like her brothers did. My pediatrician connected me with an early intervention program, and now Maria is receiving services that really help her. She is making lots of progress and we are learning what we can do to help her. We now know that we weren’t doing anything wrong. Maria just doesn’t do things as quickly as other children her age. But now she is making progress and we have lots of support.

In the *DEC Recommended Practice Guidelines*, Trivette and Dunst (2005) clarify the parameters of **family-based practices** (see Table 3–4). Ultimately, family-based practices supply the supports necessary for families to have the knowledge, skills, and resources to provide their children learning opportunities and experiences that promote child development. Thus, family-based practices potentially have child, parent, and family strengthening and competency-enhancing consequences. The *DEC Recommended Practice Guidelines* provide the foundation for high quality services for young children with disabilities and their families.

A longstanding belief held by professionals in the field of early intervention and early childhood special education is that families need both informal and

TABLE 3–4 DEC Recommended Practices: Family-Based Practices**Families and professionals share responsibility and work collaboratively.**

- F1. Family members and professionals jointly develop appropriate family-identified outcomes.
- F2. Family members and professionals work together and share information routinely and collaboratively to achieve family-identified outcomes.
- F3. Professionals fully and appropriately provide relevant information so parents can make informed choices and decisions.
- F4. Professionals use helping styles that promote shared family/professionals responsibility in achieving family-identified outcomes.
- F5. Family and professionals' relationship building is accomplished in ways that are responsive to cultural, language, and other family characteristics.

Practices strengthen family functioning.

- F6. Practices, supports, and resources provide families with participatory experiences and opportunities promoting choice and decision making.
- F7. Practices, supports, and resources support family participation in obtaining desired resources and supports to strengthen parenting competence and confidence.
- F8. Intrafamily, informal, community, and formal supports and resources (e.g., respite care) are used to achieve desired outcomes.
- F9. Supports and resources provide families with information, competency-enhancing experiences, and participatory opportunities to strengthen family functioning and promote parenting knowledge and skills.
- F10. Supports and resources are mobilized in ways that are supportive and do not disrupt family and community life.

Practices are individualized and flexible.

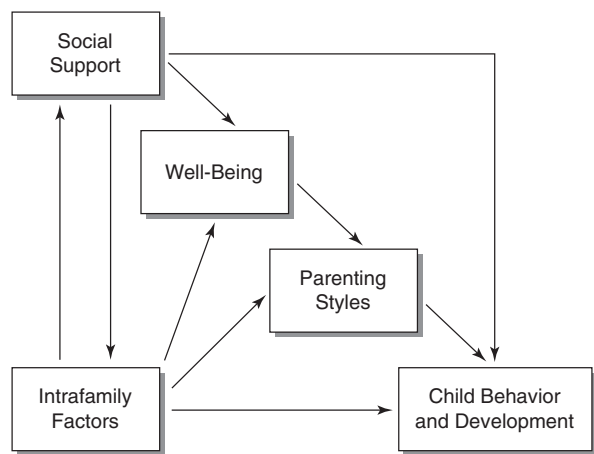
- F11. Resources and supports are provided in ways that are flexible, individualized, and tailored to the child's family's preferences and styles, and promote well-being.
- F12. Resources and supports match every family member's identified priorities and preferences (e.g., mother's and father's may be different).
- F13. Practices, supports, and resources are responsive to the cultural, ethnic, racial, language, and socioeconomic characteristics and preferences of families and their communities.
- F14. Practices, supports, and resources incorporate family beliefs and values into decisions, intervention plans, and resources and support mobilization.

Practices are strengths and assets-based.

- F15. Family and child strengths and assets are used as a basis for engaging families in participatory experiences supporting parenting competence and confidence.
- F16. Practices, supports, and resources build on existing parenting competence and confidence.
- F17. Practices, supports, and resources promote the family's and professional's acquisition of new knowledge and skills to strengthen competence and confidence.

SOURCE: "Recommended Practices in Family-Based Practices," by C. M. Trivette and C. J. Dunst, in *DEC Recommended Practices in Early Intervention/Early Childhood Special Education* (pp. 45–46), by S. Sandall, M.L. Hemmeter, B. Smith, and M. McLean 2005, Longmont, CO: Sopris West.

FIGURE 3–3 Model of the Direct and Indirect Influences of Social Support and Intrafamily Factors on Families



SOURCE: C. Trivette, & C. Dunst (2000). Recommended Practices in Family-Based Practices. In S. Sandall, M. McLean and B. Smith (Eds.) *DEC Recommended Practices in Early Intervention/Early Childhood Special Education*. Longmont, CO: Sopris West, p. 40.

formal resources and supports in order to have the knowledge and skills, as well as the physical and psychological energy and time, to engage in child-rearing responsibilities and parenting activities that promote their children's development (Bronfenbrenner, 1979; Bronfenbrenner & Morris, 1998). In the *DEC Recommended Practice Guidelines*, Trivette and Dunst (2005) report research evidence that social support has positive effects on family well-being. Figure 3–3 contains a model they used to illustrate the direct and indirect influences of social support on personal and family well-being, parent-child interactions, and child behavior and development. According to this model, "social support and resources directly influence the health and well-being of parents, both support and health/well-being influence parenting styles; and support, well-being, and parenting styles directly and indirectly influence child behavior and development" (p. 108). Through this model, it is easy to recognize the far-reaching impact of family-based practices and the importance of utilizing such an approach.

A family-based approach can result in benefits to both the child and family (Guralnick, 1997). Benefits of a family-based approach include, but are not limited to, the following areas: (a) child functioning,

(b) parent skills and emotional well-being, (c) parents' view of service effectiveness and sense of control over their child's care, (d) problem-solving ability, (e) capacity of families to care for their child at home, (f) service delivery, (g) cost effectiveness, and (h) family empowerment (Beach Center on Families and Disability, 1997).

Evidence of the effectiveness of a family-based approach, as well as direct experience, has encouraged programs throughout the country to embrace family-based practices (Sandall et al., 2005). Finally, the most recent terminology used is **family-directed practices**. This term was included in the IDEA Amendments, which stated that early intervention services must be "family-directed".

To be successful, early childhood professionals, across disciplines and settings, must hold a set of values that place families at the center of the service delivery process and as the directors of the services for their children. This marks a dramatic shift from past practices when professionals focused solely on the child and designed interventions based on what they thought was best with little or no input from the family. Professionals have exchanged the role of expert for the role of partner in a relationship where professionals provide support for families. The focus is on the strengths and capabilities of families, with families making fully informed choices and decisions regarding services for their children. As one service provider explained, "We've come a long way from trying to get all families involved in their children's education in the same manner. Today families are at the center of services and we provide support to them as they deem appropriate".

Family-Professional Partnerships

One of the most important responsibilities of early childhood personnel is the development, nurturance, and maintenance of effective relationships with families. There is now a general acceptance and understanding that parents and families are the child's first and most important teachers. Recommended practice suggests that the best type of relationship that can develop between families and professionals is one in which families are viewed as full-fledged partners. This type of true collaboration requires shared trust and equality in the relationship. Like any relationship, family-professional partnerships take time and effort to sustain.



Cengage Learning

To build a positive relationship between service providers and families, trust must be established and ongoing communication should occur.

The rationale for the development of collaborative partnerships between families and professionals has been emphasized in early childhood special education for many years. The rationale includes the following: (a) family members spend more time with a child who has a disability than anyone else; (b) parents have more information about the child than anyone else; (c) how a family “works” will determine what type(s) of intervention will “work” for the family and child; and (d) families have the ultimate control over the services provided for their children and themselves. “No matter how skilled professionals are, or how loving parents are, each cannot achieve alone what the two parties, working hand-in-hand, can accomplish together” (Peterson & Cooper, 1989, p. 208).

The foundation for building positive relationships between service providers and families must include a mutual understanding of their roles in supporting children’s development and learning. This process of mutual understanding can allow both parties to empathize and discover ways to support one another in their roles. The early years are not only a formative period for young children, but also a critical and challenging time for families and professionals (Galinsky, 1990; Turnbull et al., 2006). Families often need and welcome support as they face the many challenges of family life during the early years of the life of a young child with a developmental delay or disability.

Early childhood programs with strong family components have contributed to children’s later school success. For some time, effective professionals have been participants and supporters of parent–professional partnership efforts. Initial experiences and interactions of children, parents, and professionals in early childhood programs should be positive, nurturing, and caring. Professionals should learn as much as possible about each child and family in order to maximize the possibilities of the child’s success. Service providers who are inviting and encouraging to families are much more likely to build a positive relationship with the family. It is the professional’s responsibility to find ways, rather than excuses, to develop partnerships with family members. Young children with special needs are the ultimate beneficiaries of these partnerships. An understanding of each family from a systems perspective will provide insight and understanding that will help service providers approach families as partners in the early development and education of their young children.

Key Components of Family–Professional Collaboration

As described throughout this chapter, families and professionals interact on a variety of levels to address the needs of young children with known or suspected disabilities. Effective family–professional collaboration is the foundation of early intervention/education. Some key components of family–professional collaboration include (a) cultural responsiveness, (b) communication, (c) meetings and conferences, and (d) ongoing support and information exchange. What follows is a discussion of each of these dimensions with suggested strategies.

Cultural Responsiveness

The influence of culture is one of the most critical effects on the relationships that develop among families and professionals. As described earlier in this chapter, culture is the blend of thoughts, feelings, attitudes, beliefs, values, and behavior patterns that are shared by ethnic, racial, religious, or social groups. Culture is especially relevant to relationships between families and professionals because culture

includes many different factors that shape one's sense of group identity, including, but not limited to, geographic location, income status, gender, sexual orientation, language, disability status, value of education, and occupation. It is the framework within which individuals, families, or groups interpret their experiences and develop their visions of how they want to live their lives. As we examine the influence of culture on family-professional relationships in early intervention/education, Turnbull et al. (2006) emphasize the importance of considering the following aspects of culture, each of which may have a direct or indirect effect on the relationship between professionals and families:

- *Religion* and the beliefs and customs associated with religion are likely to influence such things as the holidays families celebrate and the appropriateness of professionals discussing with them associated activities (e.g., holiday events, schedules, traditions, and practices).
- *Language* can influence all aspects of communication with families if families do not speak English or are unable to read in English (or any other language).
- *Race*, which may influence the likelihood of families experiencing racism and discrimination, may foster skepticism about trusting others of a different race.
- *Ethnicity* may have an impact on families' feelings of belonging or perceptions of themselves as outsiders in early intervention/education programs.
- *Gender* may influence beliefs about the roles that various family members should assume in advocating for their children, as well as communicating with professionals.
- *Age* of the family members can influence the life experiences they have; for example, teenage mothers who have parental responsibilities or grandparents who are raising their grandchildren.
- *Geography* often creates certain opportunities and barriers to family-professional partnerships; for example, differences exist in rural settings where families live long distances from an early intervention/education program without public transportation or inner-city settings where families have to alter their lifestyle due to violence and crime.
- *Income* may influence the resources available to families and the extent to which their housing,

medical care, and nutrition are adequate to meet the needs of children with delays, disabilities, or other special needs. (p. 10)

Professionals must understand that culture shapes a family's attitude about its child's disability, health and illness, child-rearing practices, communication style, choice of intervention goals, and view of professionals. It is also important to understand that culture is not a static concept. In fact, there is considerable variation within cultural groups that can change over time. Further, the influence of culture can vary from family to family even when families have similar cultural backgrounds. As described earlier, many hybrid families and cultures are served in early intervention/education in the 21st century (Aldridge & Goldman, 2007); therefore, professionals often face challenges related to cultural diversity (Bredenkamp & Copple, 2009; Kilgo, 2006). *DEC Recommended Practices* (Sandall et al., 2005) suggest that family-professional relationship building should be individualized and accomplished in ways that are responsive to each family's cultural background.

Cultural responsiveness is a complex concept involving the awareness, acknowledgement, and acceptance of each family's culture and cultural values. Cultural responsiveness requires professionals to view each family as a unique unit that is influenced by, but not defined by, its culture. As such, professionals must avoid **stereotyping**, the generalized belief about members of a cultural group. Stereotyping occurs when assumptions are made that all individuals within a cultural group share the same perspectives or react in a predetermined manner. Such assumptions limit the ability to understand and develop relationships with families (Matuszny, Banda, & Coleman, 2007). We are not suggesting that professionals know everything there is to know about the culture of families they serve in early intervention/education. What we suggest, however, is that professionals gain an understanding of each family's cultural values, which will help facilitate effective interactions with families (Hains et al., 2005). After gaining general knowledge about a family's culture, more specific information can be learned by talking to the family, asking for clarification, and seeking the family's guidance in understanding. The following is an example of what could be said to a family in an attempt to seek clarification. "I read that people who

practice the Sikh faith believe that all of life is sacred and that playing with food such as eggs is not appropriate. Is that true of your family? Since eating solid foods is a goal for your child, what should we know to assist with this?”

To effectively serve children and families representing diverse cultural backgrounds, the following strategies are recommended.

- Service providers should read as much as possible about the cultural backgrounds of the families with whom they work.
- Service providers must understand that there are many hybrid families and cultures.
- When professionals meet with the families, they should let them know that they are prepared and ready to learn from them.
- Service providers should ask appropriate questions and listen to what the families tell them.
- Based on what is learned from families, practices should be adapted as needed to ensure they respect and include the values, beliefs, and customs of families.
- Service providers should use multiple resources to become more culturally competent. For example, they should participate in ongoing staff development and learn from families, other service providers, policy makers, and members of the cultural communities served by the program.

When professionals and families have differing cultural beliefs and practices, these can serve as barriers to the development of their relationships (Harry, Kalyanpur, & Day, 1999). The importance of professionals understanding differences between their own perspectives and those of families from other cultures and ethnic groups cannot be overstressed. In order to do this, each service provider must carefully examine his or her own cultural background, beliefs, and values. In doing so, the provider will become more capable of understanding the individual perspectives that are unique to each family and how they differ from that provider's own background and beliefs. Service providers who fail to recognize values and beliefs of families are prone to make biased and faulty judgments about families that may weaken their relationships with them. Collaboration among families and professionals when there are cultural differences requires respect, trust, and cooperation. It

is the professional's responsibility to cope with and value differences in order to address these differences in positive ways.

Effective Communication

As we have come to realize, one of the most important elements in relationships between families and professionals is effective communication. To maximize learning and guide the child's development in positive ways, professionals and families must maintain an open, honest relationship, which of course is dependent on effective communication (Whitbread, Bruder, Fleming, & Park, 2007). Thus, communication skills rank among the most necessary of all the skills possessed by early childhood professionals.

In its most basic form, **communication** is the ability of two or more people to send and receive messages. Many forms of communication are used during interactions among families and professionals, both nonverbal and verbal. Not everyone has perfected his/her communication skills; however, it is important to point out that verbal and nonverbal communication skills and strategies can be learned and improved with practice.

Nonverbal communication involves body language that conveys information. Body language includes facial expressions, eye contact, posture, voice, physical proximity, and gestures. Desirable facial expressions, for example, could include eyes being at the same level as the parents', direct eye contact (except when culturally proscribed), warmth and concern reflected in facial expressions, and appropriately varied and animated facial expressions. Table 3-5 provides examples of desirable nonverbal communication skills.

Verbal communication refers to both oral and written language. Well-developed listening and observation skills are necessary for effective parent-professional relationships. Table 3-6 provides tips for using active listening and observation strategies. Table 3-7 provides examples of verbal communication skills that can be used to improve the effectiveness of communication. These strategies and skills can be practiced and perfected over time.

As in any relationship, effective communication between families and professionals involves a clear understanding and knowledge of the expectations, obligations, and responsibilities of each party in the relationship. It is important for the professional to

TABLE 3–5 Examples of Desirable Non-verbal Communication Skills

Facial Expressions

Comfortable eye contact
Warm, encouraging facial expressions
Occasional smiles (when appropriate)

Posture and Gestures

Use of appropriate gestures
Body leaning slightly forward (attentive, but relaxed)
Absence of repetitive movements (e.g., tapping fingers, shaking foot)

Voice

Can be heard clearly, but not loud
Warmth in voice tone
Natural speech tempo

Physical Proximity

Three to five feet between speakers (e.g., whether seated in chairs, sofa, or on floor)

communicate clearly about the policies and practices of the program. Professionals are advised to provide parents with information before they enter the program and review it on an ongoing and as-needed basis. Parents and other family members need to know about various aspects of the program such as the assessment process, related services, health and safety requirements, daily schedules, home visits, and other program features. Information can be provided via a program handbook, newsletter, and website. Having sufficient information about the program requirements helps to lay a positive foundation for an effective partnership.

Communication must be regular and useful to be effective. Communicating information that is not useful to families or communicating too infrequently will do little to facilitate the achievement of the family's goals for their child. A number of methods of communication should be available (e.g., notes, e-mails, meetings, telephone calls, communication notebook). Regardless of the method of communication or when it occurs, professionals must be willing to listen to and respect the families' points of view.

The way in which professionals communicate with and provide support to families plays a strong role in fostering positive parent–professional communication (Banks, Santos, & Roof, 2003). Professionals are encouraged to use responsive communication strategies, based on each family's unique characteristics, needs, and preferences. For example, specific strategies may be needed when families have linguistic differences. Depending on the family's primary language, different support may be required to enable communication. Bilingual and bicultural staff, mediators, and/or translators may be needed with some families.

The following list of suggestions (Gargiulo, 2009) for working with families is designed to facilitate effective communication, and ultimately, the development of a useful and meaningful relationship among families and professionals.

- *Listen to families!* In order for professionals to understand the family's vision for their child, communication is of the utmost importance. Professionals must often probe to solicit families' perspectives. In addition, they must practice active listening and make an effort to confirm the perceptions of the family's intent and meaning. Through interactive listening and observation, attempts can be made to understand what families are saying, what they are feeling, and what they want for their child. Acknowledgement of the family's vision and a willingness to follow the family's lead will help to establish the trust necessary for an ongoing working relationship.
- *Realize that the family knows its child better than anyone else.* Professionals must make every effort to learn from each family the relevant information about its child. Families know the most about the child, his or her needs, and how those needs should be met. Therefore, professionals should show respect for the families' knowledge and understanding, and convey a feeling of acceptance of the information they can offer. Further, opportunities should be created for parents and other family members to provide this type of meaningful information. Professionals should never underestimate the importance of communication and the power of their words in their relationships with families. According to reports from parents, some of the most helpful comments made by professionals include statements such as, "I value your input,"

TABLE 3–6 Tips for Active Listening and Observation

Stop talking.	Allow the person with whom you are communicating to formulate responses to your questions. Show that you want to listen and be helpful. Pay special attention to the feelings behind the facts and avoid preparing your next statement while the other person is talking.
Put the speaker at ease.	Relax and make the appropriate eye contact with the person with whom you are communicating. Remember, some cultures do not engage in direct eye contact.
Ask appropriate questions.	Ask open-ended questions, which will encourage the other person to answer with more than “yes” or “no” responses. Ask only one question at a time in a clearly phrased manner. Offer a chance for the other person to elaborate on his or her statements.
Make appropriate comments.	Be encouraging. Demonstrate attending skills (e.g., nodding, making neutral vocalization—“yes” or “oh”).
Demonstrate reflection skills.	Use reflective paraphrasing by stating in your own words what you believe the speaker has said. The speaker can then either confirm or deny your understanding and contradictions may be cleared up. Be sure to also reflect on what you perceive to be the speaker’s feelings as well. (e.g., “You sounded distressed when . . .” or “Were you relieved when . . .?”)
Exhibit openness.	Be willing to make statements in which you reveal something that may be personal or private to you. For example, “I was sad when . . .” or “I was frightened by . . .”
Share topic selection.	Allow the person with whom you are communicating to indicate his or her preference with regard to whether or not to discuss a certain topic. The individual may wish to postpone the topic until a later time.
Remain objective.	Work to avoid jumping to conclusions in conversations. Be on the lookout for negative feelings you may already have about the other person’s point of view. Do not allow your emotions to interfere in your conversation. Accept his/her feelings and do not take ownership of them.
Attend to person’s concerns.	Attend to the topics or issues that are important to the person with whom you are communicating. Try to listen as if you share his or her concerns.
Develop attention to detail.	Work on your skills at identifying physical characteristics of feelings. Although we generally associate facial expressions with certain feelings, you must really know the person with whom you are communicating. For example, they may smile most when they are the most hurt.
Focus.	Be sure to focus on the other person and focus out extraneous details. Surveying the room often gives the appearance of lack of interest and attention.

SOURCE: Adapted from *Families and teachers of individuals with disabilities: Collaborative orientations and responsive practices* (2001), by D. J. O’Shea, L. J. O’Shea, R. Algozzine, D. J. Hammitte (Eds.). Boston, MA: Allyn & Bacon, pp. 260.

TABLE 3–7 Examples of Communication Skills

Listening Skills

Paraphrasing—Responding to basic messages.
“You are feeling positive about this approach, but you are confused as to the best way to implement it.”
Clarifying—Restating a point or requesting restatement to ensure understanding. “I’m confused about this. Let me try to state what I think you have said.”
Perception checking—Determining accuracy of feeling or emotion detected.
“I was wondering if the plan you chose is really the one you want. It seems to me that you expressed some doubt. Is this correct?”

Leading Skills

Indirect leading—Getting a conversation started.
“Let’s start with you describing how things are going with the first strategy.”
Direct leading—Encouraging and elaborating discussion.
“What do you mean when you say there is no improvement? Give me a recent example of an incident at home.”
Focusing—Controlling confusion, diffusion, and vagueness.
“You have been discussing several problems with T.J.’s behavior at home. Which of these is most important to you?”

Reflecting Skills

Reflecting feelings—Responding to the emotion expressed.
“It sounds as if you are feeling very frustrated with this situation.”
Reflecting content—Repeating ideas in new words for emphasis.
“His behavior is making you wonder about the effectiveness of these strategies?”

Summarizing Skills

Summarizing—Pulling themes together.
“Let’s take a look at what we have decided thus far. We have agreed to try a different morning schedule and to use the same strategies for one more week.”

Informing Skills

Advising—Giving suggestions and opinions based on experience.
“Based on my experience as a teacher, I can tell you that this approach has worked with many children.”
Informing—Giving information based on expertise, research, and training.
“I recently attended a workshop series on positive behavioral support techniques for group situations. Perhaps some of these strategies would help make the groups in your classroom work more effectively.”

SOURCE: From *The Helping Relationship: Process and Skills*, 4th ed. (pp. 66–67) by L. M. Brammer, 1988, Englewood Cliffs, NJ: Prentice Hall. Adapted with permission.

- “I’ll follow your lead,” and “You’re the expert on your child.”
- Use a two-step process when initially informing parents that their child requires early intervention/early childhood special education services. After sharing diagnostic information, it is strongly suggested that

families be given time to comprehend and absorb the information. Parental/family concerns must be dealt with prior to proceeding with matters such as intervention recommendations. These issues can be addressed in follow-up meetings according to the family’s readiness.

- *Explain the terminology and avoid the use of jargon.* Most families have no previous experience with developmental delays or disabilities. This may be their first exposure to the terminology that is used in early intervention/early childhood special education. Their conceptualization of such terms as eligibility, developmental delay, or disability may be different from that of professionals; therefore, the terminology used should be made clear to families. Further, everyday language should be used when possible and professional jargon and acronyms (e.g., IEP, IFSP) should be kept to a minimum.
- *Keep families informed.* A variety of two-way communication techniques can be used when discussing a child's abilities and performance. Respect, concern, and a sincere desire to communicate and collaborate in all aspects of services must be demonstrated. Professionals should develop alliances with families based on the common goal to help the child.
- *Recognize that diverse family structures and parenting styles, as well as other factors, will influence each family's interactions and level of involvement.* Open communication with families allows professionals to understand the family dynamics and individual differences, which are part of each family. Professionals should respect the family's right to choose their level and style of participation in early intervention or early childhood special education services.
- *Support families in embracing realistic optimism.* In working with each family, professionals must work to achieve a balance between being optimistic and realistic about the future of each child. Children's strengths should be stressed, along with their needs. Families should be supported as they analyze, plan, and prepare for their child's future. As one mother stressed, "What families need most from professionals is hope and encouragement".
- *Be accountable.* Trust, consistency, and dependability increase the chances of an effective relationship developing. If service providers agree to assume specific responsibilities or gather information for the family, they must always follow through. Accountability demonstrates to the family that the family can depend on those professionals providing services.

Following these suggestions will not necessarily ensure a successful relationship with all families, but it can assist in helping to establish a mutually respectful tone in relationships.

Conferences and Meetings

Most early intervention and early childhood special education programs offer a variety of meaningful activities for coordinated planning such as group meetings, individual meetings, or conferences. In each of these activities, communication is critical. Perhaps the most utilized way of communicating with families is through individual meetings or conferences. These meetings or conferences can take place in a variety of settings, use a variety of formats, and occur for various reasons, including families' participation in the planning process. When possible, meetings should be conducted in family-friendly settings where families feel comfortable.

Effective meetings with families require advanced planning. Families should be contacted prior to the meeting to discuss the purpose of the meeting, what is to be accomplished, and the process that will be followed during the meeting. Input should be solicited from families regarding the specific topics they wish to discuss. The length of meetings should be established in advance. Further, families should be assured of the confidentiality of the information shared during meetings.

At the beginning, the purpose of the meeting should be reviewed, the amount of time allotted should be restated, and again confidentiality should be emphasized. During the meeting, professionals should share any information they have about the issues or topics and ask for any information or input that the family members might have. Professionals should try to keep the discussions focused on the issues or topics being discussed. All information should be synthesized during the meeting. Regardless of the issue or topic, families' input should be solicited and used to establish priorities and to develop a plan to address these priorities. Families appreciate professionals who are not rushed and who discuss specific tasks, behaviors, and abilities. Any meeting should conclude with a summary and consensus regarding next steps. When possible, meetings or conversations should end on a positive and encouraging note.

One of the major ways in which families are active participants in the program planning process is through the meetings that take place in the development of the individualized family service plan (IFSP) and the individual education program (IEP). The intent of the IFSP and IEP is to provide more accountability and to increase the level of family

participation. As described in the previous chapter, IFSPs are written for birth to three-year-olds and IEPs for children three years and older. Detailed information about these individualized plans can be found in Chapter 5.

As also mentioned previously, a specific requirement of Part C of the Individuals with Disabilities Education Improvement Act 2004 is to enhance the capacity of families to assist in meeting each child's special needs. Much of the literature concerning the IFSP consists of recommended practices designed to guide the development of the IFSP and the delivery of services. Dunst, Trivette, and Deal (1994) state that the IFSP is the cornerstone of the family-based model.

Several conclusions have emerged from the literature on the outcomes and implementation of IFSPs. Gallagher and Desimone (1995) reported that there are a significant number of positive outcomes that provide confidence that the IFSP procedure, when implemented correctly, can result in parents and service providers having a clear picture of the child and the plans for intervention. Gallagher and Desimone offered the following suggestions for making the processes of using the IFSP more beneficial:

1. *Parents and professionals should be prepared.* Both parties need to be better informed about the plan and processes. Stakeholders needed to implement the plan. An orientation meeting and a videotape of a successful session could be most helpful to families.
2. *Sufficient time should be devoted to the process.* The development of an effective plan, with input from all parties, requires considerable time. Just like a the relationship between professionals and parents, time is needed for the development and maintenance of the plan.
3. *Reviews and updates are mandated.* The document must be reviewed regularly and checked for its effectiveness. Of course, the law requires a six-month review, but at least one person should assume the responsibility for regular ongoing reviews and updates.

Similar to the IFSP, the IEP process provides an opportunity for families and professionals to share information and concerns about the child. Both the family and professionals can reap benefits from positive partnerships. This process can also help the family better understand the program in which the child

is enrolled, which in turn may boost the confidence of the parents in the way they view the program and staff. Another benefit of the IEP is that it is meeting the intended goal of providing information about the child's progress in academic and other areas of development. Effective use of IFSPs and IEPs can be a tremendous help to the service providers in delivering appropriate services and educational programs to young children with disabilities and their families.

Regardless of the type of meeting or conference that occurs between families and professionals, strategies are needed to facilitate coordinated planning and communication during conferences and meetings. Professionals should carefully select times for conferences and strive to plan times that are mutually agreeable. Some programs provide child care and assist with transportation. Being flexible in planning to meet families' needs demonstrates to families that the professionals are committed to involving them.

In planning for meetings or conferences with families, it is important to realize that families from diverse cultures may view time differently from how the professionals do and schedule meetings accordingly. If the family is linguistically diverse, arrangements must be made for native-speaking individuals (when needed) to make initial contacts and serve as a link between family and professionals. Also, there are times when trained interpreters must be used during conferences.

Home Visits

Home visits are another format through which coordinated planning and collaboration occur among families and service providers. Service delivery through home visiting is the keystone of family-centered intervention in Part C services for birth to three-year-olds with known or suspected disabilities. Home-based early intervention services are provided so that learning can take place in the natural environment. In addition, home-based services have a number of other benefits. Working with families and children in the natural environment provides for optimal carryover and generalization. It permits the parent-professional relationship to develop on a more informal and personal level. According to Hanson and Lynch (1995), families involved in home-based services develop more positive relationships with professionals with whom they work and are more likely to follow through on recommended activities as identified in

FIGURE 3-4 Example of a Family Scale to Evaluate their Early Intervention Experiences**Parenting Experiences Scale**

Please circle how many times a staff member from your child's early intervention program has worked directly with your child during the past three months.

Not At All	1-2 Times	3-4 Times	5-6 Times	7-8 Times	9-10 Times	11-12 Times	More Than 12 Times
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Please circle how many times a staff member from your child's early intervention program has worked with you to help you promote your child's learning and development during the past three months.

Not At All	1-2 Times	3-4 Times	5-6 Times	7-8 Times	9-10 Times	11-12 Times	More Than 12 Times
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Thinking about all your contacts with your child's early intervention program staff, how often have the staff interacted with you in the following ways:

	Never	Some of the Time	About Half the Time	Most of the Time	All the Time
Give me information to make my own choices	1	2	3	4	5
Responded to my concerns and desires	1	2	3	4	5
Pointed out something my child or I did well	1	2	3	4	5
Worked with me in a way that fit my schedule	1	2	3	4	5

Parents often have different feelings and thoughts about being a parent. Please indicate the extent to which each of the following statements is true for you:

How true is each of the following for you:	Not At All True	A Little True	Some-times True	Mostly True	Always True
I feel good about myself as a parent	1	2	3	4	5
I enjoy doing things with my child(ren)	1	2	3	4	5
I am the best parent I can be	1	2	3	4	5

Thinking about your involvement in your child's early intervention program, how much influence can you have in terms of getting information and supports you want from the early intervention program?

No Influence At All					Influence About Half the Time					Influence All the Time
0	10	20	30	40	50	60	70	80	90	100

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MAKING CONNECTIONS

Home Visit with Maria's Family

Based on the information presented in the vignette about Maria, the following is an example of the format for a home visit with the Ramirez family.

1. *Arrival and greeting.* The service coordinator is greeted by Maria's mother, Catherine, and Maria's grandparents. They exchange greetings and general information (e.g., important events that have occurred, what has been happening since the last home visit).
2. *Information exchange and review.* The service coordinator and Maria's family review and discuss the prior visit, the strategies or interventions that have been used, and the progress that has been made toward achieving the desired outcomes. Maria's mother explains that she is pleased with the strategies being used and comments on the progress Maria has made in several areas. The service coordinator observes Maria in order to review and reassess the appropriateness and success of the interventions and strategies in light of her progress.
3. *Development of new goals/outcomes and modification of strategies.* Based on the review of the prior goals/outcomes and family priorities, strategies or techniques can be modified.

This phase may include an examination of family routines to determine how and when strategies will be used. Demonstration or modeling by the professional(s) will enable the family to understand why a strategy is selected and how it relates to the child's outcomes.

Practicing the new strategies can be helpful with encouragement and specific feedback provided to the family. Time should be allowed for extensive discussions and questions by both the professional(s) and the parent or other family members. During this phase of the meeting, the home visitor should remain sensitive to the individual needs of the family and the circumstances in the home.

4. *Closure.* At the end of the home visit, the service coordinator summarizes the session to ensure mutual understanding of what has been accomplished and decisions that have been made. Mrs. Ramirez asks several questions to make sure that she understands all that has been planned. The service provider provides a record of the visit using pictures and instructions for the strategies for follow-up. They agree that the next home visit will take place the following week at the same time.

the IFSP. As McWilliam (1999) points out, "The child does not learn from home visits—the family does" (p. 24). With thoughtful planning, flexible implementation, and frequent monitoring, home visiting can be a highly successful service delivery model with many benefits for families and service providers (Brady, Peters, Gamel-McCormick, & Venuto, 2004).

Because home visits require professionals to enter a family's home, special consideration should be given to honor the family's privacy and preferences regarding the logistics of the meeting (e.g., time of day, location). Families should be given choices in scheduling that are convenient and flexible. In some cases,

families may not want home visits to occur because they may feel that having service providers in their home is intrusive (Klaus, 2008). In such instances, other arrangements can be made for services to be provided (e.g., child care center, early intervention program). When conducting home visits, there are a number of practical factors to consider. Home visitor safety is an important consideration. When traveling in the community and entering homes, service providers should follow basic safety precautions.

Regardless of where the services are provided, careful planning must take place so that the family understands the expectations. The following are



Well-structured home visits have benefits for the child, family and service providers.

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examples of decisions to be made prior to the visit so that the family will know what to expect:

- How long will the visit last?
- What will be the agenda and format of the visit?
- Will the family participate actively in the session?
- How will other family members (e.g., siblings, grandparents) be incorporated into the visit?
- How will progress be monitored and family satisfaction determined?

It is important to remember that the purpose of home visiting is to provide families with the skills and supports to meet the family priorities/outcomes identified on the IFSP or IEP. Therefore, it is more likely for the families to experience satisfaction if the expectations of the home visit are clear.

The Making Connections feature provides an example of the process that is followed during a home visit with the Ramirez family. Figure 3-4 provides a sample family evaluation form that was used to gain input from Maria's family about their experiences with early intervention services and the information and support they were provided.

Ongoing Support and Information Exchange

We have come to realize in the field of early intervention/early childhood special education, that families can be the best advocates for their children

when they are provided with information, as well as encouragement, support, and optimism (Trivette & Dunst, 2004). Families who are supported and have the information they need are more likely to respond to early intervention/education services in a meaningful way. Professionals should be familiar with the various resources that are available and be ready to share this information with families. Some of the most widely used ways to share information with families of children with disabilities include pamphlets and other materials, newsletters, and online resources, as well as linking families to community resources. Modes of ongoing communication include classroom/program visits, group parent meetings, newsletters, Web pages, communication notebooks, phone calls, e-mails, audio recordings, and parent-professional conferences. Professionals must strive to provide information and support that is coordinated, coherent, and well-suited to each family's needs (Kaczmarek, 2007).

In addition to the information and support provided by early intervention/early childhood special education professionals, many families benefit from the support and guidance of other families who also have children with disabilities (Klemm & Schimanski, 1999). A family may establish a relationship with another family or families may become members of parent-to-parent organizations that exist on the local, state, or national levels. Many of these organizations have websites, listservs, chat rooms, and discussion boards. Networking with other families offers opportunities for them to problem-solve regarding various issues and creates opportunities for enrichment and learning from one another as well.

Summary

A specific requirement of IDEA is to enhance the capacity of families to meet the special needs of their children. This requirement explicitly acknowledges the families of young children with known or suspected disabilities as the central focus of early intervention/early childhood special education services and the primary decision makers in the service delivery process. Professionals are continuing to make changes in policy and practices in an attempt to move families to the center of the service delivery system.

As has been indicated throughout this chapter, a family-based philosophy is the cornerstone of recommended practice in early intervention/early childhood special education. Rather than asking families to adjust to programs' policies and needs, recommended practice suggests that programs must adjust services according to families' concerns, priorities, and resources. Families are seen as full partners in early intervention/early childhood special education programs.

A family-based approach is founded on a family systems model. That is, young children with special needs are viewed as part of their family system, which in turn is perceived as part of a larger network of informal and formal systems. What happens to one member of the family often affects all members, and each family member has his or her own needs and abilities. Thus, professionals must devise an individualized approach for each family served. To do this, professionals need a thorough understanding of how families operate and the impact that the birth of a child with a known or suspected disability, or the diagnosis of a child's disability, may have on how families function. Further, professionals must know how to engage in collaborative relationships with families and other professionals in meeting the needs of young children with disabilities.

The idea of strong relationships between families and professionals who work with young children with disabilities is proving to have many benefits. However, many changes have occurred in families, laws, and interactions between service providers and families. These changes contribute to a complex challenge for personnel in providing appropriate learning experiences and services for young children and their families. It is very important for service providers to consider the concerns, priorities, and resources of families and to view the family as a system with many interacting forces.

Here are some basic understandings in good family-professional partnerships:

- The relationship professionals develop with a family has a powerful effect on the child's learning.
- All families deserve to be valued, respected, understood, and appreciated.
- An open, trusting relationship between family members and service providers is essential to successful early intervention/education. This relationship develops over time.
- Professionals cannot make family members do things their way; pressure impedes relationship building.
- Start where the family is, listening to family members' points of view, reflecting on what they say, clarifying their thoughts and feelings.
- Professionals often think they are right; however, a family may have a solution the early interventionist/educator did not consider—that is the beauty of partnerships!

Check Your Understanding

1. How has the relationship between families and professionals changed in early intervention/early childhood special education changed over the years? What circumstances have influenced this process?
2. Describe the reactions of a family to a child with a developmental delay or disability.
3. What is the rationale behind the use of a family systems model?
4. Identify the four key elements of a family systems model. Explain the characteristics of each of these elements.
5. How does the concept of *cohesion* differ from *adaptability* in the family systems theory model?
6. What kinds of influences have contributed to an emergence of a family-based philosophy in programs for young children with special needs?
7. Discuss reasons why an effective family-professional relationship is critical to successful programs for young children with disabilities.
8. Discuss key components of family-professional collaboration and strategies to ensure successful implementation of each component: (a) cultural responsiveness, (b) effective communication, (c) conferences and meetings, (d) home visits, (e) ongoing support and information exchange.

Reflection and Application

1. Identify a family situation that you have experienced and discuss how the family systems theory could have been applied to your interactions with that family.
2. Observe in an early childhood special education setting. What evidence is there that families are a key part of the program's mission? How do

professionals work in partnership with families? What types of services are being provided to the families?

3. How might families be involved in meeting the needs of Maria, T.J., and Cheryl? What specific roles might the families play? How can the ECSE teacher help support families in the roles they play? In the development or implementation of an IEP, explain how the teacher could provide support to the families to encourage their involvement.

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Assessment and Planning for Young Children with Special Needs

Part 2



Cengage Learning

Chapter 4
Assessment of Young Children with Special Needs

Chapter 5
Delivering Services to Young Children with Special Needs

Chapter 6
Curriculum for Young Children with Special Needs

4

Assessment of Young Children with Special Needs

Assessment Purposes, Procedures, and Types

- Assessment Purposes
- General Assessment Considerations
- Types of Assessment in Early Intervention/
Early Childhood Special Education

Considerations and Cautions in the Assessment of Young Children

- Problems with Traditional Assessment Practices
- Inappropriate Use of Intelligence Tests with Young Children
- Limitations of Assessment Instruments for Young Children with Disabilities
- Characteristics of Young Children and Their Families
- Culturally Biased Assessment Instruments

Recommended Assessment Practices for Young Children with Disabilities

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Purposes of Assessment

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- Eligibility Procedures and Instruments

Assessment for Program Planning

- Purpose of Assessment for Program Planning
- Family Involvement in the Assessment Process
- Ecological Assessment
- Methods and Procedures for Collecting Information

Progress Monitoring and Program Evaluation

- Monitoring Child Progress and Outcomes
- Family Input in the Monitoring Process
- Overall Program Effectiveness

Summary

Check Your Understanding

Reflection and Application

References

Key Terminology

Assessment	Criterion-referenced tests	Authentic assessment	False negative
Screening	Curriculum-referenced tests	Portfolio assessment	False positive
Eligibility	Reliability	Developmental domains	Arena assessment
Program planning	Validity	Intelligence tests	Program planning assessment
Progress monitoring and evaluation	Content validity	Culturally biased assessment	Ecological assessment
Multidisciplinary team	Instructional validity	Apgar Scale	Protocol
Standardized tests	Construct validity	PKU screening	Functional skill
Tests	Concurrent validity	Screening	Progress monitoring
Performance	Predictive validity	Referrals	Program Evaluation
Norm-referenced tests	Observational assessment	Child Find	Formative assessment
Developmental age score	Play-based assessment	Sensitivity	Summative assessment
Percentile ranks	Interviews	Specificity	

Learning Outcomes

After reading this chapter, you will be able to:

- Explain the four primary purposes of assessment in early intervention (EI) and early childhood special education (ECSE) for children birth through age eight.
- Describe the types of assessment procedures used in EI/ECSE.
- Discuss issues associated with traditional assessment practices used with young children.
- List recommended practices for conducting appropriate assessments of young children.
- Differentiate between assessment for determining eligibility and assessment for program planning in EI/ECSE.
- Explain the importance of family involvement and family preferences being emphasized in the program planning process.
- Describe four methods that can be used to collect assessment information.
- Identify the steps in an ecological assessment process.
- Explain the importance of progress monitoring and evaluation.

The assessment of young children with disabilities is an integral component of early intervention (EI) and early childhood special education (ECSE) services for children birth through age eight. In order to implement recommended assessment practices for young children with delays or disabilities, professionals must consider the major purposes of assessment, guidelines for conducting appropriate assessments, and strategies for linking initial assessment with program planning and progress monitoring. In this chapter, an overview of assessment is provided; issues associated with the assessment of young children and recommended practices are identified; and assessments conducted for the purposes of screening, eligibility, program planning, and progress monitoring are described.

Assessment Purposes, Procedures, and Types

First, the definition of **assessment** must be considered in order to understand the comprehensiveness of the assessment process. McLean, Wolery, and Bailey (2004) describe assessment as the process of gathering information for decision making. Bagnato and Neisworth (1991) emphasize that early childhood assessment is a flexible, collaborative decision-making process in which teams of parents and professionals repeatedly revise their judgments and make decisions. Richard and Schiefelbusch (1991) describe assessment as “a multi-level process, beginning with screening procedures and continuing through diagnosis, planning of intervention, and program monitoring and evaluation” (p. 110). These definitions suggest that assessment is a dynamic, ongoing process allowing for various decisions to be made about children with delays, disabilities, or other special needs. In reality, many different types of assessment take place simultaneously and on several different levels.

Next, the origin of the word assessment should be considered. The word assessment can be traced to the Latin word *assidere*, which means to “sit beside.” Assessment in ECSE is designed to be an experience through which professionals and families work together and exchange information to benefit the child’s growth and development (Division for Early Childhood, 2007; Woods & McCormick, 2002).

Assessment, rather than referring to a “test,” is a systematic process for obtaining information from a variety of sources (e.g., observations, interviews, portfolios, tests) to be used in making judgments about each child’s characteristics, needs, and progress. Assessment should be viewed as a fact-finding and problem-solving process shared by families and professionals. Figure 4–1 illustrates the components of the assessment process in EI/ECSE. As can be seen, collaboration among professionals representing multiple disciplines and families is needed throughout each step of the assessment process.

Assessment Purposes

Assessment information is gathered to be used in making a decision in one or more of the following areas:

1. screening
2. eligibility
3. program planning, and
4. progress monitoring and evaluation.

McCormick (1997) noted “assessment, planning, intervention, and evaluation are overlapping activities” (p. 223). As illustrated in Figure 4–2, the areas of assessment are linked and each area of assessment is designed to answer specific questions and inform decisions made about young children (Botts, Losardo, Notari-Syverson, 2007). These various assessment purposes necessitate different instruments and procedures to be used by qualified professionals representing various disciplines.

General Assessment Considerations

As described previously, the Individuals with Disabilities Education Act (2004) requires that a **multidisciplinary team** be involved in the assessment of young children. A multidisciplinary team refers to the involvement of two or more professionals from different disciplines (e.g., physical therapy, special education, speech-language pathology) in early intervention/early childhood special education activities. Transdisciplinary teams, the type of team model often used in EI/ECSE, are composed of family members and professionals representing a variety of disciplines who address specific assessment questions. For example, children with sensory

FIGURE 4–1 Components of a Collaborative Assessment Process in Early Intervention/Early Childhood Special Education Leading to Goals and Outcomes

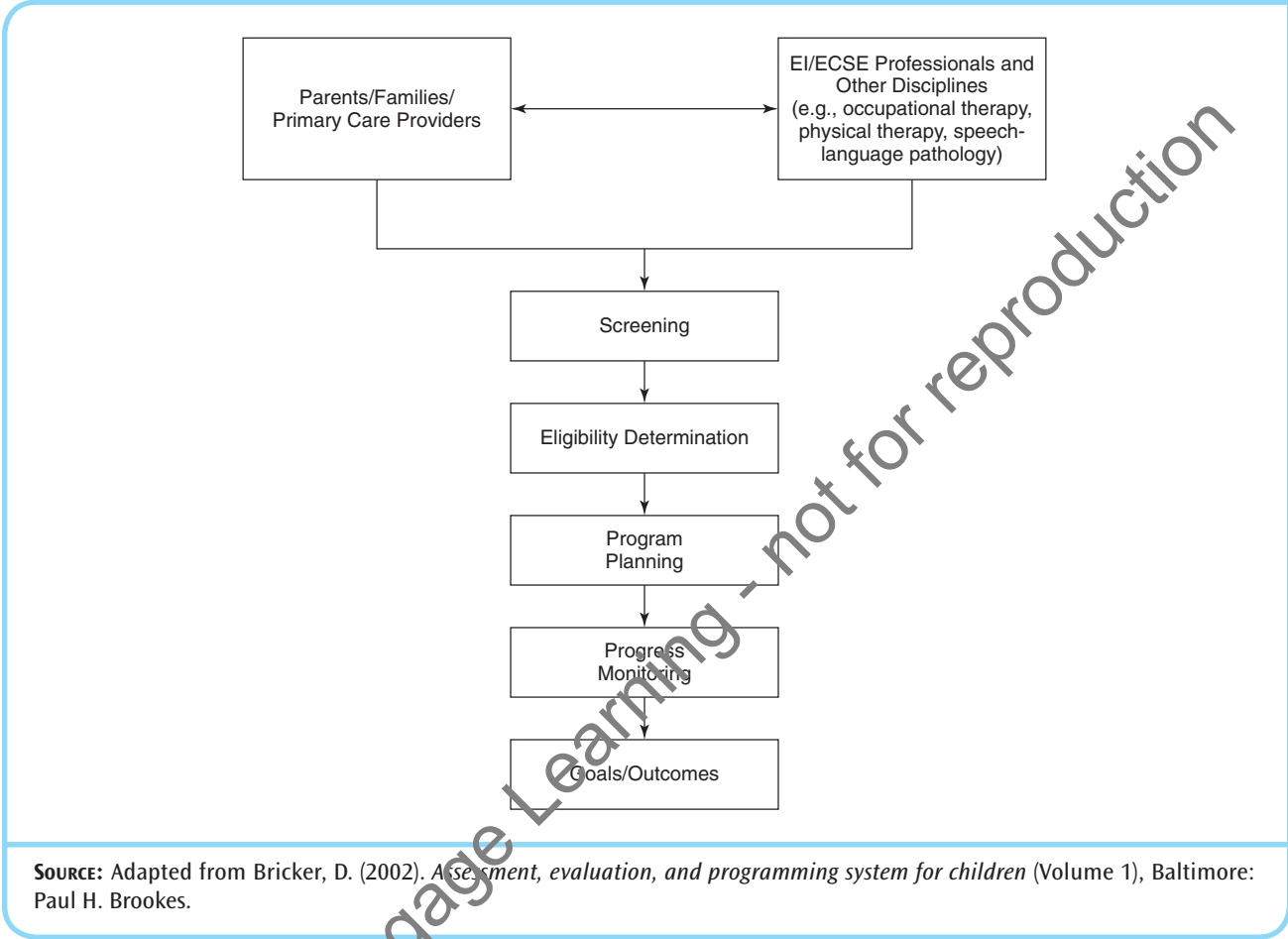
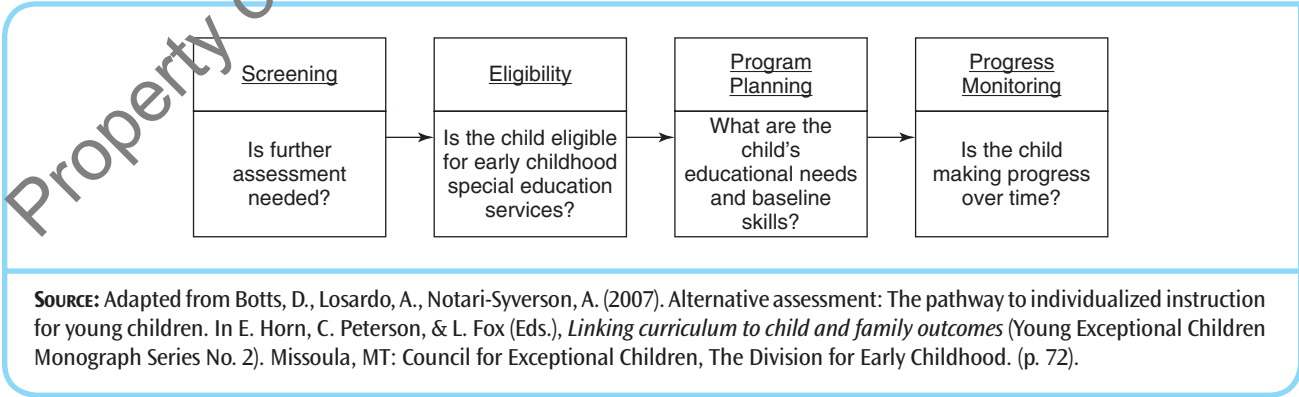


FIGURE 4–2 Linked Assessment Process



needs (e.g., hearing or visual impairments) or children with developmental needs (e.g., visual impairments, communication delays, movement problems) require professionals on the team to have expertise in those areas (e.g., vision specialist, speech-language pathologist, physical therapist, occupational therapist). Although legislation and recommended practices call for assessments to be conducted by a team, which includes the family and professionals from a variety of disciplines, professionals must realize that a large number of team members may be confusing or overwhelming to family members. Professionals must be sensitive to family preferences and remember that the assessment process should be individualized and appropriate for each child and family.

Types of Assessment in Early Intervention/Early Childhood Special Education

Because early childhood is a unique period of development, different types of assessment instruments and procedures have been developed specifically for young children. Common assessment procedures in EI/ECSE include: norm-referenced tests, criterion- or curriculum-based instruments, observations, interviews, and other measures. Because there are many purposes of assessment, tools designed for one purpose are in most cases inappropriate to use for a purpose other than that for which they were intended (Division Early Childhood, 2007; Grisham-Brown & Pretti-Frontczak, 2003). The instruments and procedures selected will depend on a number of factors such as the purpose of the assessment, state and program guidelines, and preferences of professionals and families (Andersson, 2004). In addition to standardized measures, informal assessment measures are recommended that are less prescriptive and more specific to the context in which they are used.

Assessment Instruments. Depending on the purpose of the assessment, different types of tests may be appropriate (Andersson, 2004). Of the different types of assessment measures used with young children, formal testing has been the procedure most frequently used during the initial phases of assessment (i.e., screening, eligibility determination). During formal testing, **standardized tests** are administered. It is important to remember, however, that **tests** are a predetermined collection of questions or tasks to

which predetermined types of responses are sought. A standardized testing instrument is one by which the individual child's **performance**, or the child's behavior that is exhibited while putting specific skills into action, is interpreted in relation to the performance of a group of peers of the same age group who have previously taken the same test—a "norming" group.

Norm-referenced tests provide a score that is relative to other children in a particular group—that is, the source of the norms (Cohen & Spence, 2003). Norm-referenced tools have certain advantages; they compare children to other children of the same age for eligibility purposes, report reliability and validity information, and can usually be administered in a short period of time. A disadvantage of norm-referenced tools, particularly for children with delays or disabilities, is that the administration of the tests usually takes place in unfamiliar settings (e.g., clinic, testing room) rather than the natural environment. Another problem is the lack of useful information they provide for determining functional, appropriate outcomes. Further, norm-referenced measures are often biased against children with disabilities and children from culturally or linguistically diverse backgrounds (Sattler, 2008).

Norm-referenced tests for children ages birth through five result in quantitative scores, often reported as **developmental age scores** (i.e., the average age at which 50% of the normative sample achieved a particular raw score) and **percentile ranks** (i.e., the percentage of the same-aged population that performed at or below a given score). The developmental age for children with delays or disabilities usually will differ from his or her chronological age depending on the effects of the child's delay or disability. For early primary-level students, ages five through eight, norm-referenced tests provide standard scores, percentile ranks, and grade-level equivalents in various subject areas (e.g., reading, math, science). This allows ECSE teachers to compare the child's performance to performances of other children of the same age (Sattler, 2008).

Criterion-referenced tests are used to determine whether a child's performance meets an established criteria or a certain level of mastery within various developmental domains (e.g., cognitive, motor, self-care), content areas (e.g., math, literacy), or within a detailed set of objectives. These tools provide information about a child's attainment of specific levels of competence. Specific strengths of criterion-referenced

instruments are that they usually offer a continuum of skills linked to the curriculum that can be useful for program planning purposes and monitoring individual progress. Criterion-referenced measures may be administered in the natural environment, and they allow professionals to adapt or modify items to help children demonstrate competence. Limitations of criterion-referenced instruments are that they are time-consuming to administer and may include items that are not appropriate or functional for all children. Criterion-referenced measures may be biased against children with delays or disabilities, as well as children representing culturally or linguistically diverse backgrounds.

Curriculum-referenced tests are similar to criterion-referenced measures; however, curriculum-referenced tools are used to interpret a child's performance in relation to specific curriculum objectives. In most cases, curriculum-referenced tools are most relevant for program planning purposes (Cohen & Spenciner, 2003; Sattler, 2008). In recent years, curriculum-referenced tests have been used more frequently during the eligibility process because they provide useful information in making eligibility decisions (McLean, 2005).

Although a detailed description of the psychometric aspects of assessment instruments is beyond the scope of this chapter, it is important that these concepts be understood by those who are responsible for the selection of specific assessment tools to be used during any phase of the assessment process. Reliability and validity are two of the psychometric concepts that should be considered. **Reliability** refers to the consistency or dependability of an assessment tool. In other words, does the test measure what it is supposed to measure in a dependable manner? If T.J. was given the same test on different occasions, would his performance on the test be the same each time? If so, the examiner could assume with some confidence that the results were reliable or free of error. Or if several children were given the same test and received different scores on the tests, the test administrator would want to know that the variability in the scores was actually due to the differences in their abilities. The examiner needs to feel confident that the test is consistently measuring what it is designed to measure. Reliability is important for making generalizations about children's learning and development. Reliability is represented by a figure between .00 and 1.0, with values closer to 1.0 showing evidence of better reliability.

Another important psychometric property of an assessment instrument is **validity**, which is the extent to which an assessment instrument measures what it was designed to measure. Validity is represented by a figure between .00 and 1.0, such that values closer to 1.0 indicate better validity. Several different types of validity should be of concern to early childhood special educators, as well as professionals representing other disciplines. The first is **content validity**, which refers to how well the test represents the content it purports to measure. A second type of validity is **instructional validity**. This is the extent to which the information gained from an assessment instrument would be useful in planning intervention programs for young children with disabilities. A third type of validity, **construct validity**, focuses on the degree to which a test addresses the constructs on which it was based. A fourth type of test validity is **concurrent validity**. This type of validity is concerned with how well a test correlates with other accepted measures of performance administered close in time to the first. Finally, **predictive validity** focuses on the extent to which a test relates to some future measure of performance. When professionals are selecting an assessment measure, attention should be focused on the reliability and validity information reported in the manuals of the assessment instruments (Sattler, 2008).

Authentic Assessment. Authentic assessment is a comprehensive term used to represent the process of observing, recording, collecting, and otherwise



Assessment information is collected in a variety of ways to document the progress each child is making.

documenting what children do and how they do it for the purpose of making educational decisions (Losardo & Notari-Syverson, 2001). Assessment of behavior and interactions in familiar environments in which a child participates provides authentic information. This information can be gathered using a variety of processes and organized in such a way that it provides a comprehensive overview of a child's performance on authentic, meaningful tasks over time (Division for Early Childhood, 2007; Losardo & Notari-Syverson, 2001).

Observational assessment is a systematic process of gathering recordings of young children's behavior in real-life situations and familiar settings within their environments. Assessment procedures often include systematic observations of the interactions between children and their parents, primary caregivers, or peers. Several different strategies can be used to structure the observations and organize the information that is gathered such as checklists, rating scales, and structured observations (Division Early Childhood, 2007; Hanson & Lynch, 1995). **Play-based assessment** is an example of an observational procedure used frequently in early childhood education for infants, toddlers, and preschoolers. During play, children spontaneously and authentically demonstrate knowledge and skills. Play-based assessments provide a nonthreatening way to collect information regarding the level of development of young children (Linder, 2008). Play-based assessments support the observation of children in a play situation, which allows them to demonstrate behaviors that they typically exhibit under normal circumstances.

Interviews are forms of assessment that can be used to gather information regarding the areas on which to focus during the assessment process, specific information about the child (e.g., how a child responds to various situations), or other types of information that may be relevant to the assessment process. Because these interviews, or conversations, take place with a particular purpose in mind, it is important to have some structure to ensure that the intended goal(s) are achieved. Although suggested a number of years ago by Winton and Bailey (1988), the following phases are still recommended today for family interviews:

1. preliminary preparation (preparation for the meeting)
2. introduction (review of the purpose of the meeting)
3. inventory (discussion of the information and determination of the parents' perceptions)

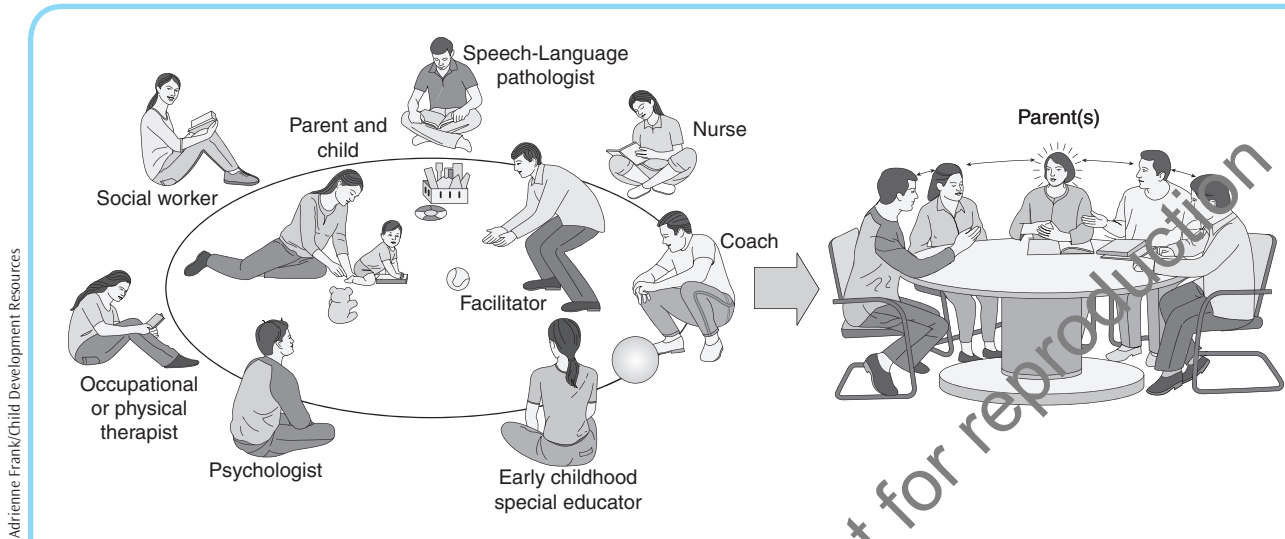
4. summarizing (review of the options), and
5. closure (summary of what took place in the meeting)

Interviews, or conversations between the professionals and families or caregivers, require some structure; however, they should be flexible enough for everyone to feel comfortable with the process (Turnbull, Turnbull, Erwin, & Soodak, 2006).

Recent recommendations regarding assessment indicate a need for an increase focus on the *process* of assessment rather than just the *product* of assessment (McLean, Wolery, & Bailey, 2004; Neisworth & Bagnato, 2005). One recommended informal method through which this can be accomplished is an **arena assessment** process. An arena assessment is conducted by a group of professionals from various disciplines along with the child's family. This group of professionals and family members is referred to as a transdisciplinary team. As you may recall from the previous chapters, transdisciplinary teams plan and provide services within and across discipline boundaries to deliver integrated services. This team jointly collects information about specific developmental areas as well as the interrelatedness of these areas within the child. One or more of the team members usually conducts the assessment while other team members, including the parents, observe the assessment process. An integrated assessment report is then completed by the participating professionals, including input from the family. Figure 4–3 provides a visual example of the participants in an arena assessment, which include the child, family members, and professionals representing various disciplines as needed.

Considerations and Cautions in the Assessment of Young Children

Although each assessment instrument carries its own organizing framework, many are organized around **developmental domains**, which are the key areas typically addressed in comprehensive assessments of young children. Most assessment instruments for young children seek to measure development in one or more of the following skill domains: cognitive skills, motor skills, communication skills, social skills, and adaptive skills. These domains represent

FIGURE 4–3 Example of Arena Assessment

SOURCE: From the *Example of Arena Assessment*, L.J. Johnson, et al (eds.), 1994. Paul H. Brookes.

interrelated areas of development that are usually the focus of assessments for young children. Assessment procedures should be comprehensive in coverage and focus on children's overall abilities rather than on one or two developmental areas alone. Although separate areas of development can be defined (e.g., motor, communication, cognition), these areas are not independent but interact in complex ways. Professionals must attempt to gain a holistic picture of children's abilities that cuts across all developmental domains (Division for Early Childhood, 2007). Each of these skill domains and content areas are described in greater detail in Chapter 6.

Problems with Traditional Assessment Practices

Much debate in recent years has focused on assessment approaches and procedures appropriate for young children with special needs and their families (Neisworth & Bagnato, 1996; 2000; 2005). One of the biggest issues has been the use of standardized, norm-referenced tests with young children. Bronfenbrenner (1977) cautioned against over-reliance on this type of assessment when he described the assessment of young children as "the science of the strange behavior of children in strange situations with strange adults for the briefest possible period of time" (p. 513). Conventional, standardized assessment instruments are

often inappropriate even for use with children experiencing typical development. The *inappropriateness* of such measures is even greater when used with young children with disabilities. As Bagnato, Neisworth, and Munson (1997) point out:

Assessment of infants and preschoolers remains dominated by restrictive methods and styles that place a premium on inauthentic, contrived developmental tasks, that are administered by various professionals in separate sessions using small, un motivating toys from boxes or test kits, staged at a table or on the floor in an unnatural setting, observed passively by parents, interpreted by norms based solely on typical children, and used for narrow purposes of classification and eligibility determination. (p. 69)

Assessment measures and practices must become compatible with, rather than at odds with, the behavior and interests of young children birth through age eight (Division Early Childhood, 2007; Neisworth & Bagnato, 2005).

Standardized, norm-referenced tests were designed to be used for screening, diagnostic, and eligibility purposes. Unfortunately, these tools too often are misused by professionals for purposes other than those for which they were intended, such as to design intervention goals and procedures (McLean, Wolery, & Bailey, 2004). In addition, standardized norm-referenced measures were designed to be used

in conjunction with other sources of information. Too often, however, these measures are used exclusively. The real problem arises when the test results do not provide an accurate representation of a child's typical behavior or optimal performance.

As the field of early intervention/early childhood special education has evolved, it has become increasingly apparent that traditional assessment approaches should be replaced with procedures that are more appropriate for use with young children (Division Early Childhood, 2007). McLean (2005) called for a paradigm shift in assessment for young children due to the many issues and challenges associated with the assessment of young children, such as: (a) the problems associated with the use of intelligence tests for young children; (b) the limited number of appropriate instruments for young children with disabilities; (c) the nature and characteristics of young children and families; and (d) the cultural bias and lack of cultural sensitivity in traditional assessment procedures. Although there are other issues and challenges associated with the assessment of young children, these issues are highlighted in the following section.

Inappropriate Use of Intelligence Tests with Young Children

A problem that unfortunately continues to occur in early childhood is the over-reliance on **intelligence tests** to determine children's outcomes. An intelligence test is a standardized measure of intellectual functioning. Although the inappropriate use of standardized tests with young children has been criticized for a number of years, the misuse and abuse has continued (Neisworth & Bagnato, 1992; 1996; 2005). There are a number of possible explanations for the continued emphasis on intelligence testing with young children. Professionals who are responsible for assessment may be unfamiliar with more appropriate ways to determine a true estimate of the abilities of young children (McLean, Wolery, & Bailey, 2004). Another reason may be that an extensive amount of time is required to conduct a thorough assessment using authentic measures (e.g., observations, family interviews) across multiple settings (e.g., home or school). Due to limited professional knowledge, time constraints, and other factors, standardized testing continues to be used in inappropriate ways with young children with delays or disabilities. Based on what has been learned about assessment, professionals

must find ways to conduct thorough and appropriate assessments of young children (Division Early Childhood, 2007).

Limitations of Assessment Instruments for Young Children with Disabilities

Another assessment problem is the relatively small number of assessment instruments available that are appropriate for young children with disabilities. Most standardized tests are designed for children experiencing typical development and will not reflect the abilities and needs of children with disabilities. The presence of a disability can further complicate the task of accurately assessing the abilities of young children. For example, when a child has a physical, communication, or sensory disability, professionals must be extremely skilled in order to obtain an accurate assessment of the child's abilities. The most effective assessment protocols rely on sensitivity to the age of the child and the nature of the child's disability or delay.

A variety of strategies may be necessary to collect accurate information such as incorporating adaptations into the assessment, using alternative sensory modalities and/or methods of communication, and gaining information from families. In addition, the developmental impact of a disability must be taken into consideration. A child with a visual impairment or physical disability, for example, may not have experienced some of the same activities as nondisabled children (e.g., independent exploration of the environment, riding a tricycle or bicycle, or climbing a tree). Another problem, given the nature of many standardized assessment instruments, is that families are not able to participate as equal partners in the assessment process. Although a parent report is included as part of some standardized testing instruments, the parent reports often cannot be used for scoring purposes. Professionals must select assessment measures carefully to ensure that they are appropriate for the children and families with whom they are working.

Characteristics of Young Children and Their Families

The nature and characteristics of young children can be particularly challenging during the assessment process. In many cases, unfortunately, professionals have continued to rely on procedures utilized with older children even though the characteristics or nature of

young children make the procedures inappropriate for them. Young children are poor candidates for traditional assessment procedures due to their short attention spans and the difficulty they have in following adult directions. Further, anxiety is often produced by children's interactions with unfamiliar adults and settings.

As we all know, young children are most comfortable with the people whom they are most familiar, such as their parents or primary caregivers. If possible, young children should not be separated from their parents during an assessment procedure. Often young children respond to separation by becoming more anxious and do not display optimal skills and behavior under these conditions. Assessment results will be more accurate if professionals allow time for children to become familiar with them. Familiar surroundings may help children feel more at ease and yield a more accurate portrayal of their abilities. If children do not feel comfortable, their performance often will not reflect their true ability. Assessments must be designed to make young children feel at ease in order to gain an accurate appraisal of their abilities and needs. The ultimate goal of assessment should be to elicit each child's typical pattern of behavior, the skills mastered, and the optimal level of performance (Division for Early Childhood, 2007).

Assessment of young children offers a unique opportunity to involve family members and other primary caregivers and gain their input and optimal information about each child (Division Early Childhood, 2007; Woods & McCormick, 2002). Families may be anxious about assessments and may not understand the purpose of each stage of the assessment process. As one parent commented following an assessment of her child, "I was concerned about my daughter passing the test. I didn't know if she would score high enough to get into the early intervention program." Another parent remarked that she went home from the assessment and made her child practice the skills he had missed. From these examples, it is clear that these mothers did not understand the purpose of the assessment process. They thought that the objective was to achieve a certain score that was high enough to get into a program. The professional's role is to provide information that will make families and caregivers fully aware of the purpose of each step in the assessment process. Pre-assessment planning is recommended as a way to provide opportunities for professionals to share information about the assessment process and for families to provide input to the professionals. Another important component of any

assessment procedure is a period for explaining the process and answering parents' questions, usually before and after the assessment is conducted.

Culturally Biased Assessment Instruments

Young children who will potentially be eligible to receive early intervention or early childhood special education services are characterized by their diversity along a number of dimensions including culture, ethnicity, language, family structure, composition, values, socioeconomic status, etc. Professionals have struggled for many years with how to employ appropriate, nonbiased assessments of young children that do not penalize them based on their cultural background or experience. A **culturally biased assessment** is one that measures only skills and abilities valued by the dominant Western culture. Thus, those children from nondominant or non-Western cultures are placed at a unique disadvantage. Problematic situations often exist when traditional, standardized assessment measures that are culturally biased are used. An example of potential bias can be found in a commonly used screening tool that contains a test item that asks 4- to 6-year-old children to indicate "what a shoe is made of" with the acceptable answer being "leather." A child whose familiarity with shoes is limited to tennis shoes or sandals would not be given credit for providing the correct answer if he or she answered "rubber," "cloth," or "plastic." This item would be missed due to the child's lack of familiarity with leather shoes. It is easy to see the many potential problems associated with cultural bias in assessment tools and processes; therefore, professionals must strive for accurate and appropriate assessments of children from diverse backgrounds, which requires attention to the uniqueness of each child's culture and experience.

Recommended Assessment Practices and Procedures for Young Children with Disabilities

Driven by many years of experience and research demonstrating the limitations of traditional, single-dimensional assessment procedures, a number of recommended practices have emerged (Division Early Childhood, 2007; Sandall, Hemmeter, Smith, & McLean, 2005; Sandall & Schwartz, 2008; Taylor, 2009).

TABLE 4–1 Assessment Principles and Practices with Examples

Principles/Practices	Examples
Team-based assessment	Assessments should be conducted by a team, with equal status afforded to the family and to professionals.
Multidimensional assessment	Assessment information should be collected in a number of child and family domains.
Multimethod assessment	Assessment information should be collected using a variety of techniques, such as direct testing, observation, and interviews.
Multisource assessment	Assessment information should be collected from a number of sources knowledgeable about the child, including families, caregivers, and professionals.
Multicontext assessment	Assessment should occur across a number of environmental contexts, including the home, school, child care, or other relevant natural environments.
Culturally appropriate assessment	Assessment procedures should respect and be responsive to the unique culture of each child and family.
Proactive assessment	Assessment procedures should be designed to identify strengths, concerns, resources, needs, and priorities for intervention planning; emphasis should be placed on assessing resources, strengths and concerns, rather than deficits.
Ongoing information exchange and collaboration	The collection of assessment information should be an ongoing process that facilitates collaboration among families and professionals.

There is growing consensus that assessment should be considered a process, not a single procedure. Experts in the field of early childhood special education agree that “assessment should be an ongoing, collaborative process of systematic observation and analysis” (Greenspan & Meisels, 1994, p. 1). Table 4–1 contains a list of assessment principles and practices with examples provided of each. As can be seen in this table, assessment of young children should be multi- or transdisciplinary, multidimensional, multimethod, multisource, multi-context, culturally appropriate, proactive, and involve ongoing information exchange and collaboration.

Recommended Practices and Standards for Assessment

New directions and standards for the assessment of young children with delays or disabilities have been suggested (Division for Early Childhood, 2007;

Neisworth & Bagnato, 2005; Sandall et al., 2005). As described several years ago by Bagnato and Neisworth (1999), assessment must reflect essential qualities. Assessment must be useful, acceptable, authentic, collaborative, convergent, equitable, sensitive, and congruent. These qualities remain important today as important elements of recommended assessment practices in early intervention/early childhood special education (Sandall et al., 2005).

The Utility of the Assessment. Above all, the assessment information that is collected must be useful. The assessment of young children requires a careful subjective and objective appraisal of a child’s performance in natural learning environments. Thus, a number of professionals from diverse backgrounds, as well as the child’s family, are included in the process. This requires a blending of assessment models and an understanding of different methods and terminology

used by professionals representing various disciplines so that the information will be useful to all members of the team. All assessment information must be combined, including information from families, to make important decisions about the child's need for services, individually targeted skills, and methods to be used in providing support to the child and family.

The Acceptability of the Assessment. To make the assessment process acceptable, it is recommended that the methods, styles, and materials for assessment must be mutually agreed upon by families and professionals (Neisworth & Bagnato, 2005). Assessment methods may range from separate assessments completed by EI/ECSE teachers and other professionals in a variety of settings to an arena format where all participants assess skills at the same time in the same setting. Assessment methods and styles may vary from direct testing to observations in natural contexts. Observational information may be more acceptable and may have more social validity due to the child's comfort level in performing skills in natural environments and within the context of play and everyday routines. In addition, the testing materials used must be acceptable and adaptable for children with various disabilities (e.g., physical, visual, cognitive); therefore, materials within the natural environment are usually most appropriate.

The Authenticity of Assessments. Establishing the authenticity of assessments may be especially important due to the number of professionals who may be involved and the diverse information gathered during the assessment process. Using multiple sources of information collected from those most familiar with the child (e.g., family members, child care providers, and teachers) and within natural contexts will ensure the authenticity of the information and result in information that is useful in determining the priorities for intervention.

Collaboration in the Assessment Process. The assessment of young children requires the highest degree of collaboration due to the number of professionals who may be involved along with the child's family. An initial assessment is completed by a number of professionals, along with the family, to determine if the child is eligible for services. Thereafter, the assessment team may vary in content due to the changing needs of the child. The use of the arena assessment



Observation of a child's performance during play and everyday routines can provide valuable information during the assessment process.

format and the presence of a facilitator make the assessment process more collaborative and, therefore, more understandable and useful to all participants. Collaboration is enhanced by the use of jargon-free language, especially when the terminology of various disciplines is combined.

Convergence of Assessment Information. Assessment requires the convergence of differing opinions that affect not only the child's progress in these skill areas but also the areas that are greatly affected by deficits in other areas. All information should be considered when the assessment team examines results and determines targeted skills for children across integrated developmental domains.

Equity. Equity in assessing young children with delays or disabilities can be a major issue when using standardized tests. Unfortunately, on a standardized test, the assessment instrument may not be valid if the materials are adapted. Children with disabilities or delays often take longer to complete a task and may not do as well in a "one-shot" testing situation; therefore, multiple observations yield more accurate and authentic results. Recommended practices suggest the use of additional measures, such as curriculum-based instruments and multiple observations in natural settings, to accurately determine each child's skill level.

Sensitivity of Assessment. Assessment instruments selected for children with significant delays or disabilities should be capable of reflecting some type of progress over time and after repeated administrations of the instrument. It would be insensitive to use inappropriate measures that repeatedly yield no developmental gains. More appropriate observational data that indicate small increments of change and progression of functional skills within the natural environment should be utilized.

Congruence. The DEC recommended practice guidelines assert that “early childhood assessment materials and methods must be developed specifically for infants and preschool children and match the styles and interests of typical young children” (Neisworth & Bagnato, 2005, p. 21), which applies to early primary-level students as well. In assessing the skills of young children with delays or disabilities, this may be interpreted to mean that materials and activities should be carefully selected to match children’s chronological age rather than their developmental level so that the materials and activities focused on during the assessment process are congruent with those of their typically developing peers.

Cultural Considerations

As we have described, it is essential that the child’s and family’s cultural and linguistic backgrounds be considered in the assessment process to limit bias and promote communication and collaboration among the family and professionals (Division Early Childhood, 2007; Lynch & Hanson, 2004). In designing the process, the team must utilize the most effective strategies for gathering information based on each child’s and family’s unique background. Standardized instruments can be particularly problematic when they are not in the child’s primary language or developmental expectations are different within the child’s culture. Further, the child-rearing practices or patterns of adult-child interaction may be different in a child’s culture, which may have a confounding influence in the assessment process.

Lynch and Hanson (2004) offer a number of suggestions for collecting information about children and families with diverse cultural and

linguistic backgrounds. They suggest using alternative approaches to traditional assessment, such as conducting observations and interviews. In addition, Table 4–2 contains guidelines to be used in the assessment process with children representing diverse cultural and linguistic backgrounds.

Purposes of Assessment

The remaining portion of this chapter will focus on the purposes of assessment. The types of assessment will be discussed in the order of screening, eligibility, program planning, and progress monitoring and evaluation. Table 4–3 provides a definition of each type of assessment and describes the kind of information typically gathered, the type of decision made, and the time at which the information is gathered.

Assessment teams must consider the purpose of each assessment and gather initial information at the onset of the process. The following are some general considerations, which will vary depending on the purpose of the assessment.

- What is the purpose of this assessment or why is it being conducted (e.g., screening, eligibility, program planning, progress monitoring)?
- What are the characteristics of the child (e.g., age, physical abilities, communication skills, temperament, and special needs)?
- Who will take the lead or be in charge of coordinating the assessment (e.g., service coordinator, early childhood special educator, physical therapist)?
- Where will the assessment sessions take place (e.g., home, child care program, classroom, playground)?
- Who will be involved in the assessment (e.g., parents, other family members, early childhood special educator, related service professionals) and what roles will these individuals assume (e.g., facilitator, observer)?
- When will the assessment sessions take place (e.g., in the morning, after child’s nap)?
- How will the assessment be conducted (e.g., formal testing, observation, interview)?

TABLE 4–2 Guidelines for Assessing Children from Diverse Cultural and Linguistic Backgrounds

Before the assessment

Learn about the child’s and family’s cultural and linguistic backgrounds.

- Talk directly to the family with an interpreter if necessary.
- Consult with others who are familiar with the culture.

Ask the following questions:

- What is the family’s level of acculturation to the U.S. culture?
- What are the literacy practices in the home?
- Which languages can the child and family understand and speak?

During the assessment

Explain the purpose of and procedures for the assessment to the child and family members and others who will participate in the process.

Provide the child with meaningful and culturally appropriate learning experiences. Use culturally relevant materials and activities.

- Be aware of cultural differences in communication styles that may influence the child’s responsiveness to the examiner’s prompts and teaching strategies.
- Consider having a family member or an interpreter assist in the teaching if the child does not respond well to the examiners.
- Use visual nonverbal prompts and teaching strategies if the child has difficulty speaking English.
- If the child speaks more than one language or dialect, observe whether the child is aware of the differences between languages and can translate and explain words.
- Use simple words and sentences. Try to learn a few words and sentences in the child’s and family’s language.

After the assessment

- Avoid making assumptions.
- Take time to reflect on the information gathered during the assessment.
- Ask caregivers for their opinions on the representativeness of the assessment results.
- Solicit feedback from the family and/or the interpreter, if present, on the cultural appropriateness of communication and teaching styles.

SOURCE: Adapted from: Losardo and Notari-Syverson, (2001). *Alternative approaches to assessing young children*. Baltimore, MD: Paul H. Brookes (p. 190).

- What areas of development or domains will be assessed?
 - What instrument(s) will be used (e.g., formal test, checklist, play-based measure)?
 - How will the assessment area(s) be set up (e.g., amount of space needed, equipment or materials needed)?
 - What skills or behaviors are important to the child’s family (e.g., walking, talking, social skills, and independence)? What are the family’s priorities (e.g., toilet training)?
 - What skills or behaviors are important to the child in his environment (e.g., walking, communicating, toileting, turn-taking)?
 - What adaptations are necessary for the child to display optimal skills (e.g., use of an alternative communication system, adaptive seating)?
- A plan can be formulated regarding how the assessment process will be implemented for each child and family based on the answers to these questions and the family’s preferences.

TABLE 4-3 Description of the Types of Assessment and the Decisions Made

Type of Assessment	Type of Information Gathered	Decision(s) Usually Made	When Information is Gathered
Screening A procedure designed to identify children who need to be referred for more in-depth assessment.	Potential for developmental disability or delay; vision; hearing; health and physical.	Whether a child should be referred for more in-depth assessment.	Prior to entry into a program.
Eligibility A comprehensive diagnostic process to determine if a child meets the criteria to be eligible for services.	Comprehensive diagnostic information that is standardized, norm-referenced, and comparative.	Whether a child is eligible for a program or services as specified in the state's criteria for eligibility.	Prior to entry into a program.
Program Planning A procedure used to identify desired goals/outcomes for the IFSP or IEP and how to design instruction.	Evidence of the child's skills and behaviors; family preferences and priorities; family resources and strengths; settings in which the child spends time and the demands of those settings.	What type of routines, activities, materials, and equipment to use with the individual child; style(s) of learning to use with the child; adult and peer interactions that may work best with the child.	Ongoing process; intensively at the beginning of a program year, during the first several weeks of entry in a program; during and immediately after any major changes in a child's life.
Progress Monitoring and Evaluation A process of collecting information about a child's progress toward outcomes, the family's satisfaction with services, and the program's effectiveness.	Evidence of the child's skills and behaviors in comparison to those skills at entry into the program; family satisfaction and indication of whether their priorities have been met; child's ability to be successful in the setting in which he/she spends time.	To determine the effectiveness of programming for an individual child or group of children; to determine changes in a child's skill and behaviors; to determine family satisfaction; to evaluate a program's overall effectiveness.	Ongoing to determine whether intervention is effective and if outcomes have been achieved; at the end of a program year or cycle; when dictated by administrative policy and funding sources.

SOURCE: From Davis, M. D., Kilgo, J. K., and Gamel-McCormick, M., *Young children with special needs: A developmentally appropriate approach*. Copyright © 1999 by Allyn & Bacon.

Screening Young Children

In reality, the screening process begins immediately following birth. Routine examinations of infants serve as a means of predicting abnormalities. One of the first screenings experienced by infants and their

families is the **Apgar Scale** (Apgar & James, 1962). Infants are screened at 1-minute and 5-minute intervals following their birth in the following areas: (a) heart rate, (b) respiration, (c) reflex response, (d) muscle tone, and (e) color (see Figure 4-4).

The 5-minute Apgar has been found to be an accurate predictor of future developmental progress

(Batshaw, 1997). A low Apgar score may indicate that further medical assistance is needed or that a referral should be made for a more in-depth assessment. Blood and urine tests are additional routine procedures used to detect metabolic disorders such as phenylketonuria (PKU), referred to as a **PKU screening**. Through early identification of PKU and appropriate intervention, which includes a restricted diet, many of the adverse outcomes associated with PKU, such as mental retardation, can be prevented.

Screening is the use of a process of gathering information designed to identify, from within a large population of children, those who need to be referred for further evaluation (Fewell, 2000). **Referrals** for screenings are usually made by professionals from various disciplines that come into contact with young children and suspect them of having delays in development. According to federal legislation, each state must establish a **Child Find** system of locating children who may have a developmental delay or disability, which makes them eligible for early intervention/early childhood



David Joel/Photographer's Choice/Getty Images

The screening process begins immediately after birth through routine examinations of newborns, using such measures as the Apgar Scale.

FIGURE 4-4 The Apgar Evaluation Scale

			1 min.	5 min.
Heart rate	Absent	0		
	Less than 100	(1)		
	100 to 140	(2)	1	2
Respiratory effort	Apneic	(0)		
	Shallow, irregular	(1)		
	Lusty cry and breathing	(2)	1	2
Reflex response	No response	(0)		
	Grimace	(1)		
	Cough or sneeze	(2)	1	2
Muscle tone	Flaccid	(0)		
	Some flexion of extremities	(1)		
	Flexion resisting extension	(2)	1	2
Color	Pale blue	(0)		
	Body pink, extremities blue	(1)		
	Pink all over	(2)	0	1
TOTAL			4	9

special education services. Child Find requires community and interagency collaboration with professionals from a variety of disciplines and agencies (e.g., Head Start, education, social services, and public health) working together. Child Find teams are responsible for conducting public awareness campaigns to inform the community so that referrals for screening will be made. Advertisements often are disseminated through the local media, grocery stores, shopping malls or other places frequented by families of young children. Examples of the types of professionals who frequently make referrals are physicians, nurses, or other health professionals in high-risk nurseries, health clinics, or pediatricians' offices. As a result of extensive Child Find efforts, often families, other caregivers, and members of the community also make referrals.

Screenings can be accomplished by using a variety of procedures, including specific instruments or checklists, observations of the child, and parent

interviews. Screening involves a quick look to see if a child's skills are adequate or whether there is a discrepancy from normal expectations that warrants further assessment. A screening procedure may last anywhere from 5 to 15 minutes. Although the Child Find process varies from state to state, many states offer screenings for preschoolers prior to entering kindergarten. In some states, screening is mandatory before children enter kindergarten. The purpose is to identify children with potential developmental issues, vision problems, hearing concerns, etc. As stated earlier, the results of screening determine whether children have the potential for a developmental delay or disability and should be referred for a comprehensive evaluation to determine if they are eligible for services. Table 4-4 contains sample instruments that are often used for screening purposes.

A screening tool should be selected based on a number of specific criteria. Accuracy, for example,

TABLE 4-4 Selected Screening Instruments Used in Early Intervention/Early Childhood Special Education

Instrument	Age range	Domains	Publisher
Ages and Stages Questionnaires (ASQ)	Birth–60 months	Communication Gross motor Fine motor Problem-solving Personal-social	Paul H. Brookes Publishing Co.
Battelle Developmental Screening Test (BDST)	Birth to 7 years, 11 months	Personal Social Adaptive Motor Communication Cognition	Riverside Publishing Company
Developmental Indicators for the Assessment of Learning-Revised (DIAL-3)	2–6 years	Motor Concepts Language Behavioral	Pearson Education
Denver Developmental Screening Test II (DDST-II)	2 weeks–6 years	Personal/social Fine motor Adaptive Language Gross motor	Denver Developmental Materials Inc.

FIGURE 4-5 Potential Outcomes for Screening

	Referred for evaluation	Not referred for evaluation
Eligible for special services	Sensitivity (accurate referral)	False negative (underreferral)
Not eligible for special services	False positive (overreferral)	Specificity (accurate nonreferral)

this is important for several reasons. Some children who need services may be missed, and are, therefore, not referred if a screening tool is not accurate. Sometimes children who do not need services are referred for evaluation and, therefore, overreferral is also a problem when a tool is not accurate. A screening tool's rate of under- and overreferral is related to its sensitivity and specificity. **Sensitivity** refers to a screening instrument's ability to identify children who need additional assessment. The less sensitive a screening instrument is, the greater the number of underreferrals or false negatives there will be from the results (see Figure 4-5). A **false negative** designates a child who needs special services but was not referred by the screening. **Specificity** refers to the capacity of a screening procedure to accurately rule out children who should not be identified. In other words, a test that is specific will not refer children who do not need further assessment. Losses in specificity result in an increased number of overreferrals or false positives. A **false positive** designates a child who has been referred by the screening but does not need special services. The levels of sensitivity and specificity measure the screening tool's validity, which tells us the extent to which a test measures what it says it measures. Data on the number of false positives and false negatives should be available and at an acceptable ratio. Great care should be taken when selecting screening tools to ensure that they are indeed valid and accurate. When an instrument is accurate, the likelihood of inappropriate referrals is minimized.

The simplicity of a screening tool is another important criterion. The administration and scoring of instruments should be quick, easy, systematic, and usable by professionals from a variety of disciplines. Another important criterion of a screening tool is that it should be comprehensive, focusing on multiple areas (e.g., educational, health, behavioral, and environmental concerns). Ideally, a screening instrument should be inexpensive to administer yet still be accurate.

Another criterion is that screening tools should provide for family input and involvement. Because of the wide range and variations in typical development and behavior during the early years, the screening process for infants and young children is often difficult. Parent involvement can alleviate some of these difficulties. Most screening tools typically include observations, parent reports, or some combination of the two. A comprehensive screening process includes the gathering of information about a wide range of children's abilities and, of course, parents have the most extensive information. A technique that has been used to gather information is a parent-completed screening questionnaire. Although parent-completed questionnaires provide important developmental information, not all parents are willing or able to complete independent questionnaires. This determination should be made based on each family's desire and ability, which may change over time. See the accompanying Making Connections feature for an example of how T.J.'s mom gradually became more comfortable with the assessment process.

Determining Eligibility for Services

After a young child is found to be in need of further assessment through the screening process, a comprehensive eligibility assessment should be conducted to determine whether infants, toddlers, preschoolers, and early primary-aged children do, in fact, meet the eligibility requirements for early intervention or early childhood special education services. This phase of the process is most often conducted by a team of qualified professionals from several disciplines (such as special education, speech-language pathology, physical therapy, and others as needed). Children are given a battery of assessment instruments to

MAKING CONNECTIONS

T.J.'s Mom and the Assessment Process

T.J.'s mother was initially reluctant to participate in the assessment process by completing questionnaires and answering all the questions about T.J.'s development. It wasn't because she didn't care about T.J.—that wasn't the case at all. She simply did not understand how useful this information could be and how important her role was in the assessment process. Although she was reluctant at first to have T.J. participate in the screening and be referred for a comprehensive assessment, she soon developed a relationship with the service providers, learned to trust them, and became more involved as a member of the team during the assessment process and beyond.

determine if they meet the eligibility requirements according to the Individuals with Disabilities Education Improvement Act Amendment of 2004 (IDEA).

Eligibility Criteria

Over the past several years, there has been much discussion regarding eligibility criteria and categories for infants and toddlers, preschoolers, and early primary-level children with known or suspected disabilities to receive early intervention and special education services. Recall from Chapter 2, according to federal legislation, each state determines the eligibility criteria for infants and toddlers. Through IDEA 1991, each state was given the option to use a developmental delay eligibility category for preschoolers. In the absence of an identified disability, children can be determined eligible for receiving services based on the particular eligibility criteria established within his or her state (for example, 25% delay in one or more developmental domains). Of course, this decision depends on state and local eligibility criteria that specify precisely how eligibility is determined in a particular program. For early primary-level children, the IDEA 1997 allowed for the developmental delay eligibility category to be extended to age nine if states desire. However, states and localities are still required by IDEA and its amendments to develop definitions of developmental delay thoughtfully so that the outcome will be eligibility procedures that are based on knowledge of young children with delays and disabilities and will ensure appropriate services for them and their families. Children within

the 3- to 9-year-old age range may also qualify for special education services by meeting the criteria for an IDEA disability category, such as visual impairment, hearing impairment, or autism. This is explained in greater detail in Chapter 2.

Eligibility Procedures and Instruments

To determine if young children meet the eligibility guidelines for early intervention or special education services, procedures must be used to determine if a child's skills are significantly different from a large group of children whose development falls within the typical range. This determination has traditionally been made by comparing a child's performance to the expected performance of children of the same age and, therefore, the assessment instruments are administered in a controlled manner. For example, the same materials, directions, and scoring procedures are used each time a tool is administered. Although norm-referenced tools have traditionally been required as the primary means for determining eligibility, many leaders in the field of early intervention/education have suggested the use of curriculum-based measures for eligibility purposes (Bagnato, 2005; McLean, 2005). As stated previously, recommended practice suggests that no major decision about a child's eligibility should be made based *solely* on the results of a single test. Decisions regarding eligibility should be based on multiple assessment measures.

A sample of the numerous instruments used for eligibility determination is included in Table 4–5. A number of other instruments are available,

TABLE 4-5 Select Assessment Instruments for Determining the Developmental Status of Young Children

Name of Instrument	Age range addressed	Developmental domain(s)	Results	Publisher
Battelle Developmental Inventory (2nd ed.) (BDI-2)	Birth to 7 years, 11 months	Personal social, adaptive, motor, communication, cognitive ability	Developmental levels in each domain	Riverside Publishing
Bayley Scales of Infant Development (2nd ed.) (Bayley-III)	Birth to 42 months	Cognitive, language, motor, social-emotional, adaptive	Standardized S scores for mental & motor development; description of social-emotional & adaptive behavior	Pearson Assessment
Carolina Curriculum for Infants and Toddlers with Special Needs (3rd ed.) (CCITSN-3)	Birth to 36 months	Personal-social, cognition, cognition-communication, communication, fine motor, gross motor	Status in each curriculum domain	Brookes Publishing
Carolina Curriculum for Preschoolers with Special Needs (2nd ed.) (CCPSN-2)	2–5 years (i.e., developmental age)	Personal-social, cognition, cognition-communication, communication, fine motor, gross motor	Status in each curriculum domain	Brookes Publishing
Developmental Assessment of Young Children (DAYC)	Birth through 5 years, 11 months	Cognition, communication, social-emotional development, adaptive behavior, physical development	Standard scores, percentile ranks, and age equivalents in each curriculum domain; General Development Quotient (GDQ)	Pro-Ed Publishing
Hawaii Early Learning Profile Strands (Birth to age 3 years) (HELP Strands, 0–3)	Birth to 36 months	Regulatory/sensory, cognitive, language, gross motor, fine motor, social-emotional, self-help	Developmental age levels in each domain	VORT Corporation
Hawaii Early Learning Profile (Preschool) (HELP-P)	3–6 years	Cognitive, language, gross motor, fine motor, social-emotional, self-help	Developmental age levels in each domain	VORT Corporation
Learning Accomplishment Profile-Diagnostic (3rd ed.) (LAP-D3)	30–72 months	Fine motor, gross motor, cognition, language	Child's skill level in comparison to normative scores	Kaplan Early Learning Company

SOURCE: Adapted from: J. Taylor, J. McGowan, and T. Linder. The Program Administrator's Guide to Early Childhood Special Education: Leadership Development and Supervision Baltimore: Paul H. Brookes (2009) (p. 74).

depending on the age of the child, that allow professionals to evaluate strengths and needs in specific developmental domains (e.g., communication, social) and subject areas (e.g., language and literacy, mathematics). What these instruments have in common is that they all measure a child's skills and development as compared to a norm group of children who have previously completed the test. If a child's test scores fall significantly below the scores of the children in the norm group, this serves as a signal that he or she may have a developmental delay and be eligible for early intervention or early childhood special education services.

The team collaborates to determine a child's eligibility for services by reviewing the child's health records and medical history, determining the child's current level of functioning in major development areas, and assessing the child's individual strengths and needs. Observations and other assessment procedures should be used to support the findings from assessment instruments. By collecting additional information from the child's family and other caregivers and by observing the child's behavior in natural settings, examiners can make an informed decision about the presence of a developmental delay or disability and need for services. Parents and other family members can add valuable information to the eligibility decision by participating in the assessment process in a variety of ways. Parents can provide information informally through discussions with team members; they can complete questionnaires, checklists, or parent reports; and/or they can be present in the room with their child during the assessment. Often they can provide feedback regarding the skills or behaviors the child is demonstrating (e.g., whether this is typical behavior, other skills or abilities the child has demonstrated, or supplemental information).

Professionals are encouraged to be sensitive to families when discussing eligibility assessment information. Following are recommendations developed by Cohen and Spenciner (2003) for sharing eligibility information with families:

- Provide family members with an opportunity to receive the assessment report in a one-to-one setting rather than during a large team meeting (e.g., IFSP or IEP meeting), which allows the family time to ask questions and reflect on the information prior to the larger, full-staff meeting.

- Be honest and straightforward regarding the delay or disability and eligibility for services.
- Be sensitive to families if they are not ready to hear details.
- Allow time for families to express their feelings.
- Be willing to say when you do not know the answer to questions.
- Offer to provide additional information and suggest additional resources.
- Be available to the family for further discussions.
- Arrange to have a native-language interpreter available if families need assistance.

Assessment for Program Planning

In order to plan efficient, effective programs and interventions for young children with delays or disabilities, appropriate **program planning assessment** must occur. Assessment conducted for program planning purposes must be a continuous process that focuses on each child's skill level, needs, background, experiences, and interests, as well as the family's preferences and priorities. Ongoing assessment provides the basis for constructing and maintaining individualized programs for young children with disabilities. The initial assessment procedures used to determine eligibility are distinctly different from the assessment procedures necessary for program planning. Table 4–6 illustrates the major ways in which these two types of assessments differ.

Recommended practices in early intervention and early childhood special education recognize the importance of the link between assessment and curriculum to ensure that program content is meeting the needs of the child and the concerns of the family (Bagnato et al., 1997; Neisworth & Bagnato, 2005). As explained previously, in recent years, formal assessments have been found to be inappropriate for program planning, which has resulted in a shift away from the use of formal assessment measures toward the use of informal means of assessment (e.g., curriculum- or criterion-based instruments, observations, family reports, and play-based measures). Each of these methods will be discussed later in this chapter. Assessment procedures that are appropriate for

TABLE 4–6 Comparison of Assessment for Eligibility and Program Planning

Assessment for Eligibility	Assessment for Program Planning
Compares a single child to a large group of children.	Identifies the child’s current levels of developmental skills, behaviors, and knowledge.
Uses instruments, observations, and checklists with predetermined items or skills.	Determines the skills and behaviors necessary for a child to function in the settings where he or she spends time.
Determines if a child’s skills or behaviors fall below a specified cutoff level.	Determines those skills, behaviors, and knowledge that the child’s family and primary caregivers have set as priorities for the child to learn.
Designed to differentiate children from one another.	Designed to determine the individual child’s strengths and learning style.
Assessment instrument items do not necessarily have significance in the everyday lives of young children.	Assessment instrument items are usually criterion-based or focus on functional skills that may have importance in the everyday lives of young children.
SOURCE: From Davis, M. D., Kilgo, J. K., and Gamel-McCormick, M., <i>Young children with special needs: A developmentally appropriate approach</i> . Copyright © 1998 by Allyn & Bacon.	

determining a child’s eligibility for services (standardized, norm-referenced instruments) should not be used in isolation and should not be relied upon to plan instructional programs or interventions for young children with disabilities (McLean, 2005; Neisworth & Bagnato, 2005).

In order to make an accurate appraisal of the child’s strengths and needs, assessment for program planning purposes focus on the whole child within the context of his or her natural environment(s) (e.g., home, child care, or school settings). Collecting information of this nature is critical to designing individualized programs and planning appropriate interventions and supports for young children and their families.

Purpose of Assessment for Program Planning

The purpose of program planning assessment is to answer a number of questions related to the child’s



Cengage Learning

Assessment is a process requiring a collaborative effort between families and professionals that occurs on an ongoing basis.

abilities, the desired child and family outcomes, the types of services to be provided, and the intervention strategies to be used. EI/ECSE professionals employ

recommended practices for conducting program planning assessment when they do the following:

- Select assessment tools and practices that are individualized and appropriate for each child and family;
- Report assessment results in a manner that is both useful for planning program goals/outcomes and understandable and useful for families; and
- Rely on materials that capture the child's authentic behaviors in routine circumstances (Sandall et al., 2005).

Assessment information collected for program planning purposes is used to develop an individualized family service plan or individualized education program for each child and family. Recall from Chapter 1 that the IFSP and IEP are intended to be planning documents that are used to shape and guide the day-to-day provision of services to young children with developmental delays or disabilities. The IFSP is required for the provision of early intervention services for eligible infants and toddlers, age birth to three, and their families. The IEP is used for special education services delivered to eligible children ages three and older. IFSPs and IEPs contain individualized outcomes and goals that can be determined by conducting an inventory of the skills needed by the child to participate in a variety of natural environments as just described. This process, an ecological inventory, allows information to be gathered that has relevance to each child and family. When this method is used, the IFSP or IEP should be developed according to the family's routines (e.g., at home, school, and other environments) and priorities. Thus, goals and outcomes contained in the IFSP or IEP should be developed to reflect the necessary skills the child will need to participate in natural environments and routines within those environments (Noonan & McCormick, 2006).

When conducting assessments for the purpose of program planning for young children with disabilities, Bailey and Wolery (1992) suggest that the following goals be accomplished:

1. The identification of developmentally appropriate and functional goals/outcomes;
2. The identification of the unique styles, strengths, and coping strategies of each child;
3. The identification of parents' goals or outcomes for their children and the needs or priorities for themselves;

4. The formation and reinforcement of families' sense of competence and worth;
5. The development of a shared and integrated perspective among professionals and family members regarding the child's and family's needs and resources; and
6. The creation of a shared commitment to the collaboratively established goals/outcomes.

Through the accomplishment of these goals, the team members should be provided with the information necessary to make program planning decisions regarding the activities and strategies to meet the unique goals and outcomes of individual children and families.

Family Involvement in the Assessment Process

As stressed throughout this chapter, parents and other family members can provide a wealth of information about the child, as well as information about the family as a whole (Hendricks & McCracken, 2009). Although addressing family concerns, priorities, and resources is not a new concept in EI/ECSE, it has received increased attention in recent years due to the emphasis on IFSPs for families with children under age three and an increased emphasis on family-based practices in all aspects of services for young children with special needs ages three through eight. Thus, it is most important that family members be encouraged to become active members of the assessment team. If family members are willing and able to play an active role in the assessment process, their involvement will ensure the validity of the established goals and outcomes.

An approach that has been used for many years to help make certain that the family has input into the assessment process is referred to as "top-down" or "outcome-driven" assessment (Campbell, 1991). This model suggests using family-identified outcomes for the child as the starting point of the assessment. In other words, the family's vision for the child becomes the central focus of the assessment process (Turnbull et al., 2006). At what level would the family like to see the child functioning in terms of skills and abilities (e.g., in the next six months, year, three years)? What are the family's priorities? For example, one family's top priority might be for the child to be able to communicate and feed herself, while another family might want the child to be toilet trained and develop

friendships with peers. In what environments would the family like the child to be able to participate? For example, does the family want the child to be in an inclusive preschool or kindergarten program?

An effective early childhood special educator recognizes the uniqueness of each family and realizes the importance of families having opportunities to provide input into the assessment process and serving as integral members of the team. Assessment information should be collected from families on an ongoing basis, be an integral part of the planning process, and be a collaborative effort; therefore, it is essential for families to be confident that the assessment process will maintain privacy and confidentiality.

A family-based approach suggests that families participate in the assessment process at the level they feel is appropriate for them. Regardless of the degree to which the family chooses to participate in the assessment process, the manner in which it participates, or the format in which it provides information, the family's participation and the information it provides serve invaluable purposes in program planning. According to Turnbull et al. (2006), families should be offered options for participating in the assessment process. Some of the areas in which families can provide input include the following:

- Collaborate with professionals in planning the assessment process (where, when, and how it will take place, who will be involved);
- Determine to what extent they want to be a part of the assessment process;
- Provide information about their children's developmental history, play and interaction preferences, and daily routines and schedule;
- Provide information about the settings where their children spend time and the demands placed upon their children in those settings;
- Report on their children's current skills, where and how those skills are used by the children, and under what circumstances the skills are exhibited;
- Report on their children's strengths, abilities, and needs in multiple settings;
- Share information about their children that will not be gained through traditional measures;
- Share their priorities, resources, and concerns; and
- Share their visions for their children's future.

Each family's preferences must be considered before information is gathered. Some potential areas

in which information can be gathered from families include their need for support, information, education, and services, and so forth. Information can be collected from families in a variety of ways—through interviews, observational methods, parent reports, instruments, and other measures. An ongoing conversational approach with families, in lieu of formal family interviewing, is used in some programs to promote relaxed and natural conversation with families. Some families may prefer providing information through a written format, such as a family needs questionnaire or checklist. Informal tools are preferred in most instances (Banks, Santos, & Roof, 2003).

Along with the different instruments available to identify family concerns, priorities, and resources, some EI/ECSE programs have developed their own measures. Regardless of the measures used, families should be encouraged to identify their concerns and resources and determine their priorities for their children and the family as a whole. Gathering information from families about their concerns, priorities, and resources is an important component of the assessment process (Kilgo & Raver, 2009). Professionals should realize that the range of concerns families may have is considerable. Families of young children with known or suspected disabilities often feel overwhelmed and unsure of where to begin. Professionals can provide information to help them sort out their concerns and make decisions about their priorities. It is likely, however, that their concerns and priorities will change over time. (Turnbull et al., 2006). Examples of possible family concerns include how their children's medical needs can be met or how their children will be treated when they begin preschool. Family priorities, for example, might be how to learn more about the child's disability or how to communicate with the child. Family resources might include reliable transportation, relatives who live nearby, and community support.

Ecological Assessment

For assessment information to be useful, emphasis must be placed on the context in which children develop and the influence of the environment on skill acquisition. It is essential that the environment(s) in which a child functions and the skills needed to be successful in those environments are considered during the assessment process (Vanderheyden, 2005). Thus, **ecological assessments** are increasingly being

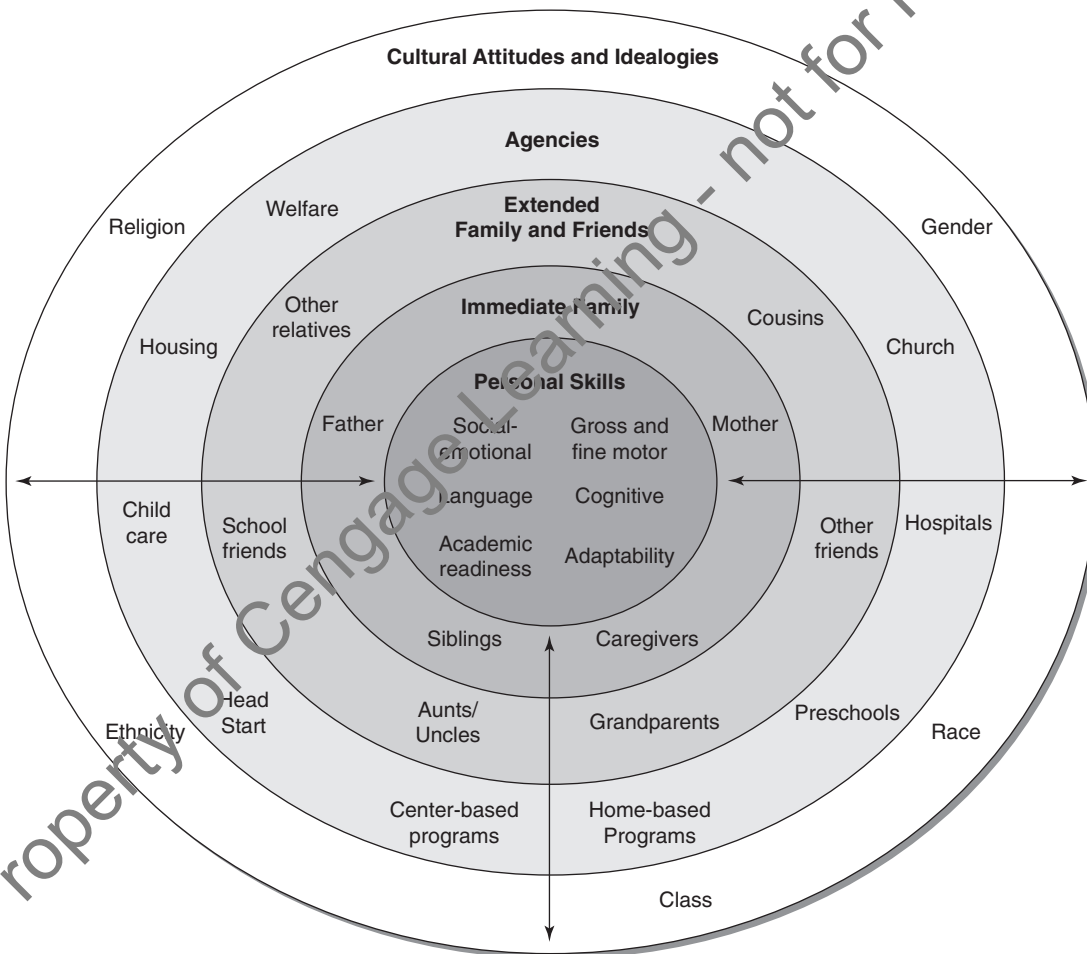
used to replace traditional assessment practices when planning interventions for young children with disabilities. An ecological assessment provides for functional goals and objectives to be generated within the natural environment. McCormick (1997) emphasizes the twofold purpose of an ecological assessment:

1. To generate information about the social, educational, and functional activities and routines in natural environments where the child is to be an active and successful participant; and

2. To determine the resources and supports needed for the child to participate in and receive maximum benefits from activities and routines in the environments. (p. 237)

Bronfenbrenner's (1979) theory of human ecology stresses that the interconnections between environments (e.g. the connection between home and school) influence what actually takes place within an environment (e.g., a child's learning within the home, child care, school, or community). Figure 4-6 shows that

FIGURE 4-6 Assessment in the Context of the Environment



SOURCE: From Introduction (pp. 1–8) by E. V. Nuttall, K. Nuttall-Vazquez, and A. Hempel, in *Assessing and screening preschoolers: Psychological and educational dimensions*. E. Vazquez Nuttall, I. Romero, and J. Kalesnik (Eds.). 1999. Needham Heights, MA: Allyn & Bacon.

the focus of assessment should be on a child's skills and abilities within the context of his environments.

As discussed previously, children's skills are not developed or displayed in isolation. Instead, each child's development is strongly influenced by the demands or expectations of his or her environment. For example, some environments require strong social or communication skills, while others call for advanced levels of independence. Several important aspects of a child's environment must be considered in program planning:

1. the expectations of the family or primary caregivers
2. the cultural parameters, and
3. the expected level of participation based on the child's age and ability

The demands placed upon children by the contextual aspects of the environment can have a tremendous influence on their development and the skills or behaviors they display. For example, if T.J. lives in a neighborhood in which all of the children learn to ride bicycles at an early age, then he might be motivated to learn to ride his bike at a young age. Or if a family lives in a warm climate and goes to the beach or pool on a frequent basis as a family activity, then the children may be likely to learn to swim or participate in water sports at an early age.

An ecological assessment considers the skills needed by a child to participate in his or her environment throughout the day. The specific environments, expectations, and levels of participation are defined by the child, his or her family and other primary caregivers, the community, and the family's culture. This type of assessment is distinctly different from the type of traditional child assessment in which the child's skills are observed and recorded. The product of an ecological assessment is not the skill level at which a child is functioning; however, it provides a greater understanding of the context and expectations that are important for the child. For example, when an ecological assessment takes place for T.J. at a Head Start center, the observer notices that there are several times in which the children are required to make transitions from one activity to another during the morning routine when prompted by the teacher. These transitions are an important part of this particular environment. Based on this observation, the team learns that these transitions are important requirements within the environment in which T.J. will be participating. With this

information, the team conducting the assessment will know to focus on T.J.'s ability to make transitions like the ones that occur in his early childhood program.

The contexts, conditions, and expectations identified through an ecological assessment assist the team members in identifying those skills that should be examined during the assessment process. Furthermore, the ecological assessment allows the assessment team to determine the skills necessary for the child to be successful in his current settings. In other words, the result of the ecological assessment is a **protocol**, or assessment format, that can be followed to decide the skill areas on which to focus and the specific skills to be observed during the assessment.

An ecological assessment regards the family members and other primary caregivers as critical contributors to the assessment process. Family members and caregivers may include parents, siblings, grandparents, child care providers, or other significant people in a child's life, such as neighbors. These individuals, in addition to teachers, occupational therapists, physical therapists, speech-language pathologists, and others, will determine which of the individual child's skills are important to focus on during the assessment. Conducting ecological assessments of children within their natural environments requires a step-by-step approach. By assessing the environments in which children live and the expectations associated with those environments, the skills to be targeted can be better determined. Program planning can logically grow from the assessment information that is collected.

Conducting an ecological assessment will help members of the assessment team in determining the location of the assessment. The best place to determine if a child has a **functional skill** is in the environment(s) where he or she uses that skill. A functional skill is a basic skill that is required on a frequent basis (e.g., eating, toileting, requesting assistance, turn taking) in the natural environment. For example, if eating independently during meal time is an important skill for a particular child, the assessment team will know to conduct some portion of the assessment during a meal, either at home, at school, or in another setting. An ecological assessment approach usually will result in a more precise child assessment. The assessment team will know what skills on which to focus, what materials or activities the child prefers, and the setting(s) in which to conduct the assessment. The result of a thorough ecological assessment is a road map for the program planning phase of the assessment process.

Methods and Procedures for Collecting Information

The *DEC Recommended Practice Guidelines* (Sandall et al., 2005) suggest standards to address when gathering useful information for planning intervention. The whole child should be considered when planning programs for young children with disabilities rather than segmenting their abilities in the various developmental areas. In Maria's case, for example, she has a diagnosis of Down syndrome with delays in several developmental domains (e.g., communication, self-care, cognitive skills). In order to meet her multiple needs, program planning assessment should address all areas of development, which must function together to perform most tasks. As we all know, most activities or tasks require the combined use of several different skill areas. Thus, in order for program planning assessments to focus on the whole child, a variety of measures (such as criterion- and curriculum-referenced tools, observations, and interviews) should be used in a variety of settings (home, child care, school, playground, etc.). Using an arena assessment format, as described earlier in this chapter, provides optimal opportunities for families and professionals to cooperatively plan intervention goals from the same perspective using an appropriate assessment instrument whose purpose is to link assessment with intervention.

The types of measures most often used are curriculum-referenced or criterion-referenced instruments, which can provide the team with useful information to assist in program planning (Bagnato, Neisworth, & Munson, 1997; Neisworth & Bagnato, 2005). As described previously, a criterion-referenced assessment is one in which an individual child's response(s) is compared to a predetermined criterion or level of performance in an area of knowledge or skill, rather than to a group of children or normative group. Results are typically reported as levels of proficiency, such as an emerging skill or mastery of a skill. The criteria used to determine if a child has acquired a skill are often flexible ones that can have different interpretations for different settings. On curriculum-referenced measures, each assessment item relates directly to a specific educational objective in the program's curriculum. Curriculum- and criterion-referenced measures provide a level of flexibility that is not available with standardized,

norm-referenced instruments. Because the skills being assessed are within a natural context, represent specific skills that have been determined by the child's family and other team members to be valuable to his or her development, and are generally listed in a developmental sequence, they often can be very useful in program planning. On a cautionary note, it is important to remember that many curriculum- or criterion-referenced instruments are drawn from items on standardized tests, thus decreasing their relevance to the child's unique needs and to the necessary program planning to meet those needs. Curriculum-referenced measures do allow team members to determine how important skills are within the context (environment) in which they are used.

One of the recommended practices for assessment noted by Neisworth and Bagnato (2005) is that the EI/ECSE team use only those measures that have high treatment validity (i.e., link assessment, individual program planning, and progress evaluation). In order to ensure that the entire process is linked, the selection of appropriate instruments and measure is of critical importance. Criterion- or curriculum-based instruments are recommended for program planning and establishing a link between assessment and intervention (Bagnato et al., 1997).

Table 4–5 includes examples of widely used curriculum-referenced instruments that provide a strong linkage to program planning and implementation. The *Assessment, Evaluation, and Programming System (AEPS)* (Bricker & Waddell, 2002) is one example of a comprehensive instrument designed to use observational techniques to obtain assessment information within the context of the natural environment. The *AEPS* and other curriculum-based measures usually are multidomain instruments that subdivide major developmental milestones into smaller increments. For example, the *AEPS* subdivides fine motor skills into three strands: reach, grasp, and release, and functional use of fine motor skills. Each of the strands is further divided into goals and objectives that link the assessment process to the preparation of an educational plan to guide intervention.

The items on the *AEPS*, as is usually true with curriculum-based measures, follow a typical developmental progression. The curriculum activities that correspond to test items are designed to teach skills related to the identified needs of the individual child. Another example of a curriculum-based instrument is the

Carolina Curriculum (Johnson-Martin, Attermeier, & Hacker, 2004a; Johnson-Martin, Hacker, & Attermeier, 2004b), which provides developmental markers for assessing young children across developmental domains. The *Carolina Curriculum* also provides suggestions for modifying test items for children with motor or sensory impairments. Another instrument, the *Hawaii Early Learning Profile (HELP)* (Parks, 2007; VORT, 2004) provides developmental assessment and curriculum activities for home and preschool environments. For early primary-level students, ages five through eight, a variety of curriculum- and criterion-referenced assessment instruments are available in various content areas (e.g., language and literacy, mathematics, science, social studies).

Criterion- and curriculum-referenced tools are examples of measures that can be used to collect information for program and intervention planning. Other methods include: informal, teacher-made checklists or tests, play-based measures, observations, and interviews with the family or other primary care providers. The accompanying Making Connections feature contains a description of the characteristics of program planning assessment and examples of the various types of information that can be gathered to plan programs for young children with delays or disabilities. In program planning for T.J., the team could use a criterion-referenced instrument to measure his abilities in cognitive, communication, and motor development. They could devise situations to determine how T.J. performs particular skills in the context of the natural environment(s), such as riding a tricycle or eating a meal. More than likely, the team would also observe social interactions during a play situation with his peers.



Progress is monitored for each child in different areas of development within the context of the natural environment.

Progress Monitoring and Program Evaluation

The final purpose of assessment to be discussed involves **progress monitoring** and **program evaluation**. As previously described, the efficacy of early intervention and early childhood special education has received much attention during recent years with the result being an increased awareness of the importance of ongoing progress monitoring and evaluation as it relates to the improvement and expansion of services for young children with special needs and their families. Progress monitoring of outcomes helps ensure continuous feedback that is necessary to inform decision making about all aspects of early intervention/education services.

EI/ECSE programs must have a set of procedures for collecting and using data to monitor the effectiveness of program efforts (Sandall, Schwartz, & Lacroix, 2004). A comprehensive evaluation plan in EI/ECSE services should represent the scope of the most important components of intervention: the child, the family, and the program. Without this critical feedback regarding all of these interlocking components, EI/ECSE can never fully meet the desired

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Program Planning for T.J.

The chart below shows characteristics of program planning assessment, a description of the procedures that are used, and what was used during T.J.’s assessment process.

Characteristic	Description	Example
Assessment should include a variety of measures in a variety of settings.	The assessment procedures include the use of curriculum-referenced tests, teacher-devised and informal tests, direct observation in natural settings (e.g., home, classroom), and interviews with people who know the child best.	The teacher uses developmental scales to assess T.J.’s communication, motor, and cognitive development. She devises some testing situations to determine how he performs particular skills. She observes him during play sessions with other children to note his social interaction, play, and language skills. She observes him at lunch and in the bathroom to identify his self-care skills. She interviews his parents, former teachers, and therapists to secure additional information.
Assessment results should provide a detailed description of the child’s functioning.	The results include a description of (a) the child’s developmental skills across all relevant areas, (b) what the child can and cannot do, and (c) what factors influence the child’s skills/abilities.	The teacher analyzes the results of her assessment activities, summarizes what T.J. can and cannot do in each area, and describes what factors appear to influence his performance (e.g., what toys he appears to like, which children he interacts with, what help he needs on different tasks, and what appears to motivate his behavior).
Assessment activities should involve the child’s family.	The family should receive information from professionals, observe the assessment activities, provide information about the child’s development and needs, gather new information, and validate the assessment results.	The teacher plans the assessment with the family. She asks them about how T.J. performs different skills, how he spends his time, and what concerns and goals they have for him. She allows them to observe the testing. She asks them to gather information on some skills at home. She reviews the results with them and asks them to confirm, modify, and qualify, and—if necessary—refute the findings.
Assessment activities should be conducted by professionals from different disciplines.	Frequently, assessment from the following disciplines is needed; speech/language therapy, physical therapy, audiology, social work, health (e.g., nurses, physicians), psychology, nutrition, special education, and possibly others.	The teacher coordinates the assessment activities of the team. Because of T.J.’s communication delays, a speech/language pathologist assesses him. An audiologist assesses his hearing, a physical therapist and an occupational therapist assess his motor skills, and the special education teacher assists the kindergarten teacher in assessing his social and cognitive skills.

(continued)

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Characteristic	Description	Example
Assessment activities should result in a list of high-priority objectives.	Assessment activities will identify more skills than are possible to teach; therefore, those of most value are identified. All team members, including the family, are involved in this decision. Skills are selected to be focused on if they are useful to the child, have long-term benefits, and/or are important to the family.	After the results have been analyzed, the team (including the parents) meets to review the findings. They discuss which skills T.J. needs to learn, which ones will be most useful, which will result in long-term benefits, and which are most important to his family. The most important skills are listed as goals on his individualized educational program (IEP).

SOURCE: Adapted from M. Wolery, P. Strain, and D. Bailey, Reaching Potentials of Children with Special Needs, in *Reaching Potentials: Appropriate Curriculum Assessment for Young Children* (Vol. 1). Edited by S. Bredekamp and T. Rosegrant, (Washington, DC: The National Association for the Education of Young Children, 1990), p. 100.

outcomes for young children with disabilities and their families. Table 4–7 shows the questions, purposes, and procedures that are the focus of assessment conducted for program monitoring and evaluation.

As suggested for many years, evaluation in early childhood programs must be multidimensional and comprehensive (Johnson & LaMontagne, 1994; Neisworth & Bagnato, 2005). For children receiving EI/ECSE services, the measurement procedures should match the specific outcomes for which they are designed. This usually includes information that reflects the children’s attainment of targeted skills documented on the IFSPs and IEPs, state and/or program standards, and global outcomes. In addition, the outcome of various family variables (e.g., family satisfaction, family outcomes) should be measured. Last, specific aspects of the overall program should be evaluated using the recommended practice standards promulgated by the major professional organizations, such as the Division for Early Childhood (DEC) of the Council for Exceptional Children and the National Association for the Education of Young Children (NAEYC).

An ongoing evaluation plan is recommended that encompasses a schedule of data collection.

This schedule includes initial program planning assessment, ongoing monitoring of IFSP and IEP outcomes/goals, family outcomes, evaluation of program effectiveness, and annual evaluation across all program participants. Ongoing examination of child outcomes provides the team with realistic feedback about child progress. In addition, systematic data-based evaluations hold professionals accountable not only to themselves but also to the children and families they serve. All measures should be conducted on a schedule that includes a **formative assessment** (during program operation) and a **summative assessment** (at the completion of services). Formative assessment examines children’s learning for the purpose of improving the quality of teaching and overall learning rather than for evaluating individual children. These types of assessments are often conducted at the beginning of the year and are ongoing. Summative assessments summarize learning to gauge if children as a whole have met overall program goals and outcomes. Most standardized measures are summative and are not designed to provide feedback during the learning process. These types of assessments are usually conducted at the end of the program or school year.

TABLE 4-7 Program Monitoring and Program Evaluation: Assessment Questions, Purposes, and Procedures

Assessment Questions	Purposes	Procedures
• Once intervention or instruction begins, is the child making progress? • Should the intervention or instruction be modified?	• To monitor the child’s program • To understand the appropriate pace of intervention • To understand what the child is capable of doing prior to and following intervention	• Curriculum- or criterion-referenced assessments • Observations • Interviews • Checklists • Family reporting • Portfolios • Permanent product samples • Journals
• Has the child met the goals of the IFSP or IEP? • Has the child made progress? • Has the program been successful for the child and family? • Does the child continue to need services? • Has the program achieved its goals?	• To determine whether the program was successful in meeting the child and family goals (IFSP) • To determine if the program was successful in meeting the child’s IFSP/IEP goals • To determine if the child continues to need services • To evaluate program effectiveness	• Curriculum- or criterion-referenced assessments • Observations • Interviews • Questionnaires • Family reporting • Surveys

SOURCE: Adapted from Cohen, Libby G., & L. J. Spenciner (2003). *Assessment of young children*, White Plains, NY: Longman.

Monitoring Child Progress and Outcomes

Collecting individual, child-focused information can serve as a valuable monitoring tool to provide input about child outcomes and program effectiveness. Data should be collected regularly and systematically and used in making intervention decisions. A variety of methods should be used to ensure a collection of reliable, valid, and useful progress-monitoring data (Branscombe, Castle, Dorsey, Surbeck, & Taylor, 2003; Wolery, 2004) and adequate time to review and interpret the data to inform and change practice (Grisham-Brown & Pretti-Frontczak, 2003; McAfee & Leong, 2002). Such data may be collected through direct observation of specific child behaviors; the use of curriculum- or criterion-referenced measures; permanent product samples (e.g., videotapes); ongoing performance data collection; and family reporting. Regardless of the methods used, it is critical for data to be linked to a child’s goals and be used to adjust the intervention and program activities in accordance with changes in a child’s development and progress made toward achieving the goals. As

described many years ago, child evaluation serves the following distinct, yet complementary, functions in early intervention/early childhood special education programs:

1. It guides the development of individual programming;
2. It provides feedback about the success of individual programming; and
3. It provides a system for determining the value of an intervention system designed to benefit groups of children (Bricker & Littman, 1982).

There are many ways to collect data and record children’s progress (Hojnoski, Gischlar, & Missall, 2009). Table 4-8 provides a description of some of the different methods or monitoring procedures that can be used.

The Making Connections features provide examples of how observational data are collected to monitor T.J.’s and Maria’s progress, which includes anecdotal recording, interval recording, and time sampling. One example shown in the Making Connections feature is anecdotal recording. By using this

TABLE 4–8 Methods of Recording Data for Monitoring Progress

Monitoring Method	Description of Data Collection Procedure
Event recording (frequency count)	Each occurrence of the target behavior is recorded, and at the end of the observation, a total number of occurrences is calculated, yielding the number or frequency of behaviors. Best used with behaviors that are short in duration and have a clear beginning and end (e.g., positive behaviors, such as requests and social initiations, or negative behaviors, such as hitting or calling out). Uses some indicator of the occurrence of the behavior, such as tally marks on a recording form.
Time sampling	Specific time intervals (e.g., 30 seconds, 2 minutes) are selected and used in observing and recording the target behavior. Sampling methods yield an approximation of the frequency of behavior as opposed to a precise recording of actual frequency.
Partial-interval time sampling	A predetermined time interval is used, and the target behavior is recorded if it occurs during any part of the interval, yielding a percentage of total intervals (or percentage of observation) that the behavior is observed. Occurrence of the target behavior is recorded only once during an interval regardless of whether there are additional occurrences of the behavior. Best used with frequently occurring behaviors.
Whole-interval time sampling	A predetermined time interval is used, and the target behavior is recorded if it occurs and is maintained during the entire interval. If the behavior begins and ends before the interval has elapsed, the target behavior is not recorded as occurring. This method yields a percentage of total intervals (or percentage of observation time) that the behavior is observed. Best used with behaviors that are longer in duration; otherwise, the method will underestimate the occurrence of the behavior.
Momentary time sampling	Interval is divided into a “rest” part and a “watch” part. Observation of the target behavior occurs only for a portion of the predetermined time interval or during the “watch” part of the interval (e.g., last 5 seconds or a 15-second interval). The target behavior is recorded as occurring only if it occurs during the “watch” part of the interval. This method yields a percentage of total intervals (or percentage of observation time) behavior is observed and is best utilized with high-frequency behaviors or behaviors that are longer in duration.
Duration	The elapsed time between onset and offset of the target behavior is recorded. Duration data can be summarized by each occurrence or by the total duration of the behavior during the period of observation. Observer starts the stopwatch when the behavior begins and stops the watch when the behavior ends. Best used with behaviors with a clear beginning and end, where the dimension of interest is how long behavior lasts and where the behavior is longer in duration (e.g., on-task, pro-social, or out-of-area behaviors).
Latency	The elapsed time between the prompt of request for behavior and the performance of the target behavior is recorded. Observer starts the stopwatch when the prompt or request is given and stops the watch when the target behavior is initiated. Latency data can be summarized by each occurrence. Best used with behaviors that have a clear beginning and are signaled by some type of prompt (e.g., compliance).

SOURCE: Hojnoski, R., Gischlar, K., & Missall, K. (2009). Improving child outcomes with data-based decision making: Collecting data. *Young Exceptional Children*, 12(3), p. 39.

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Monitoring T.J.’s Progress

T.J.’s teacher observed him in the classroom setting to monitor his progress in the area of fine motor skills. Below are two examples of the data collection methods she used, anecdotal recording and time sampling.

Example of Anecdotal Recording

Child’s name: T.J. Date: 1/22 Time: 9:20 a.m.
Observer’s Name: J.K. Location: Preschool Classroom

Anecdote:
T.J. was playing with the small blocks. He was putting one block on top of another. He was having difficulty balancing the blocks on top of each other. He attempted to build a tower of 3 blocks. His teacher approached him and he turned away. Just then A.K., another child in the room, walked over to where T.J. was playing. T.J. picked up the blocks and started to take A.K.’s blocks. A.K. began to retrieve the blocks. Teacher noticed this incident and encouraged A.K. to move to another part of the room.

Comment:
Need to find out why he was having difficulty balancing the blocks.
Why did T.J. turn away from his teacher? Need to observe T.J. in other settings.

Example of Time Sampling

Child’s name: T.J. Date: 3/19 Time: 11:10
Observer’s Name: J.K. Location: Preschool Classroom

Time	Observation	Comment:
11:10	Watching block building	
11:12	Watching A.K. color	Switches hands
11:14	Writing name	
11:16	Moves to block area	
11:18	Playing with blocks	
11:20	Playing with blocks	Switches from right hand to left, right again
11:22	Playing with blocks	

format, teachers can make notes about significant events concerning a child’s behavior and activities or record observations of the child’s physical or emotional state on a given day, which may be factual or an interpretive form of data. If information recorded is a teacher’s subjective interpretation, this should be made clear in the written narrative. Anecdotal records may entail written notes on specific behaviors, including events that preceded and followed

each behavior observed (e.g., skill development for a child in a specific domain, what words a child uses during certain activities, and in what situations a child engages in spontaneous verbalizations). Anecdotal records may involve more lengthy written narratives in some instances, describing the sequence of events when a child exhibits a certain behavior (e.g., temper tantrum, seizure, accident involving the child). Anecdotal records usually focus on the content or style

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Monitoring Maria's Progress

Maria's service coordinator developed a system to monitor her progress in toilet training and participation in play activities. Below are two examples of the data collection methods she used, anecdotal recording and time sampling.

Example of Time Sampling

Name: Maria Date: 2-17-10
Objective: Maria will urinate when placed on potty
Key: D = dry W = wet V = vocalized P = placed on potty
+ = urinated in potty - = did not urinate in potty

Time	Monday	Tuesday	Wednesday	Thursday	Friday
8:00	D	D	D	D	D
8:30	W	W	P-	VP+	P+
9:00	D	D	W	D	D
9:30	D	D	D	D	D
10:00	D	VP-	D	D	D
10:30	VP-	D	D	VW	VP+
11:00	W	W	VP+	D	D
11:30	D	V	D	D	D

An Interval Record Using One Minute Intervals

Interval

Behavior	Child	Total	Percentage	1	2	3	4	5	6	7	8	9	10
Requests help	Maria	9	90%	X	X	X	X	X	X	X	X	X	0

of behavior or situations in which behavior occurs rather than the frequency or duration.

Another frequently used method to monitor progress is through the collection of samples of a child's work at regular intervals for qualitative comparisons of the child's progress over time (e.g., drawings of a person, writing name or numbers, art work, sample worksheets on pre-academic work). Audio recordings of a child's speech or video recordings of a child's skills

represent other methods of data collection that can be especially useful in providing concrete evidence to show parents and other team members what the child can do and the progress he or she is making.

A recommended format to keep a record of children's progress is through the use of a **portfolio assessment** process, a type of authentic assessment system widely used in early childhood education. A portfolio assessment is a means to provide

a comprehensive overview of a child's performance on authentic, meaningful tasks in natural environments over time (Losardo & Notari-Syverson, 2001). More specifically, a portfolio is a systematic and organized record of children's work and behaviors that can be used to monitor their knowledge, skills, and achievements over time (Artel & Spandel, 1991; Jarrett, Brown, & Wallin, 2006; Lynch & Struewing, 2001). A portfolio may simply be a container for carrying documents such as a notebook or pizza box covered in contact paper (LaBoskey, 2000), or it may be created using an electronic format. No specific rules dictate a portfolio's appearance; however, a portfolio should be well organized so that relevant materials can be located with minimal effort. These collections are used as evidence to monitor the growth of the child's skills, behavior, knowledge, and even his or her interests, attitudes, or personal reflections. Table 4–9 provides guidelines for developing and implementing a portfolio assessment process.

In addition, portfolios can serve as a record of teachers' and other team members' observations and comments about children's activities and behaviors; video or audiotapes of significant activities; checklists of skills (for example, vocabulary words used spontaneously); photographs of children's work or activities in which they have engaged; a wide selection of the child's work (such as art work, writing samples); summaries of teacher observations; anecdotal records of specific events; information shared by parents or family members; and any other evidence of children's skills and progress. The information and materials that are included in a portfolio can be selected by any member of the team—the teacher, therapists, paraprofessionals, family members, or even the child (Shores & Grace, 1998). Depending on the specific purpose, the portfolio can be divided into different sections according to IFSP or IEP goals, types of documents (e.g., photographs, drawings, anecdotal notes, test results), developmental or curriculum areas, sources of information (e.g., teachers, specialists, family), or context (e.g., classroom, home, community).

The information that is collected via the portfolio assessment process meets many of the criteria required in program planning and progress monitoring. That is, it is collected over time; it relies on multiple sources of information; it collects information from many different individuals about children's skills; and most importantly, it collects skill information in the setting where the child has demonstrated the skill.

The information collected is used to document progress that is being made toward the accomplishment of each child's individual outcomes.

Family Input in the Monitoring Process

If collected properly, family input is invaluable in monitoring child and family status within the larger context of determining program effectiveness. As IFSPs and IEPs are implemented, information should be collected from families regarding the appropriateness of the goals and outcomes, the success of the plan in meeting the child's needs, and the family's concerns and priorities. The IFSP or IEP should be modified based on the feedback provided by the family or upon the family's request. In addition to families having opportunities to evaluate the effectiveness of the IFSP or IEP, they should also have multiple opportunities to provide input into the overall effectiveness of the early intervention/early childhood special education program and the services they are receiving. Information can be collected regarding their perceptions of the program staff, the policies and procedures, the team process, and so on.

Overall Program Effectiveness

Program evaluation has been defined as an objective, systematic process for gathering information about a program, or set of activities, which can be utilized for the following purposes:

1. to ascertain a program's ability to achieve the originally conceived and implemented goals;
2. to suggest modifications that might lead to improvement in quality and effectiveness; and
3. to allow well informed decisions about the worth, merit, and level of support a program warrants.

In order for evaluation to be effective, it must be designed with a specific purpose in mind. Early childhood programs must have well developed purposes and evaluation plans prior to the beginning of services to increase the programs' ability to document outcomes.

Early childhood programs that serve young children with disabilities and their families must consider a number of issues when designing evaluation plans. Several years ago, Bailey and Wolery (1992) posed several questions to provide insight into the overall quality of a program. These questions are still relevant today in determining overall program quality.

TABLE 4–9 Guidelines for Implementing Portfolio Assessment

- Start portfolios at the beginning of the year.
- Caregivers and other team members should identify in advance the purpose for the portfolio, as well as expectations for children’s work.
- Children should be told the purpose of their portfolios.
- Establish types of documentation for each goal and criteria for evaluating work.
- Develop plan for when and how data will be collected and by whom.
- Date all work promptly.
- Determine who will evaluate the portfolio.
- Identify ways to involve the child and family in work selection and evaluation.
- If necessary, teach children the skills needed to participate in this process.
- Portfolio contents should be representative of children’s work, growth, and accomplishments.
- Explain to caregivers and children the reasons for selecting samples.
- Decide how to organize the portfolio.
 - Content areas
 - IEP goals
 - Themes
 - Chronological order of work
- Decide who owns the portfolio and where it will be stored.
- Establish clear, agreed-on guidelines to manage access to the portfolio and ensure confidentiality.
- Determine criteria for monitoring children’s progress.
- Practitioners can schedule quarterly conferences with children, family, teachers, and other team members to review the portfolio. At these meetings, discuss team member observations and documentation to check for subjectivity and bias. Daily debriefings with other team members can help track the various types of documentation being gathered.
- Criteria for evaluating the portfolio may include:
 - Quantity, quality, and diversity of items,
 - Organization of the portfolio,
 - Level of student involvement,
 - Meaningfulness of caption statement,
 - Quality of summary statements about growth and change.

SOURCE: Adapted from A. Losardo, & A. Notari-Syverson, (2001). *Alternative approaches to assessing young children*. Baltimore, MD: Paul H. Brookes Publishing.

1. Can the program demonstrate that its methods, materials, and overall service delivery represent recommended practices?
2. Can the program demonstrate that the methods espoused in the overall philosophy are implemented accurately and consistently?
3. Can the program demonstrate that it attempts to verify empirically the effectiveness of interventions or other individual program components for which recommended practice has yet to be verified?
4. Can the program demonstrate that a system is in place for determining the relative adequacy of client progress and service delivery?
5. Can the program demonstrate that it is moving toward the accomplishment of program goals/outcomes?
6. Can the program demonstrate that the goals, methods, materials, and overall service delivery system are in accordance with the needs and values of the community and clients it serves?

These answers can provide a clear and realistic framework for understanding and monitoring the operations and effectiveness of early intervention/early childhood special education programs.

Summary

Assessment of young children with disabilities or delays is a comprehensive process with overlapping components rather than a single procedure. Assessments of young children are conducted to help professionals and families to make informed, evaluative decisions at several levels. The type of decision to be made will determine the purpose of the assessment as well as the assessment tools to be used or the processes that will be followed. Depending on the purpose of the assessment, the assessment process can be formal and/or informal and can include testing, observations, interviews, portfolios, and/or other procedures.

Conducting appropriate assessments of young children has been the topic of discussion and debate for several years. Some of the issues have included the following:

1. the overreliance on intelligence testing
2. the limited number of tools appropriate for young children

3. the nature and characteristics of young children and families
4. culturally biased assessments

Recommended assessment practices have dramatically changed over the last several years. Because of the limitations of standardized and formal assessment tools, informal procedures are more widely used with young children. It is important to remember that the key component of an appropriate assessment is for the assessment team members to gain an accurate representation of the child's current abilities and behaviors in the context of his natural environment as he interacts with adults and peers.

Assessment must be useful, acceptable, authentic, collaborative, convergent, equitable, sensitive, and congruent. Because assessment is an ongoing process that begins with screening and continues with diagnosis, eligibility, and program planning, as well as progress monitoring and evaluation, assessments are conducted for three different purposes that have been described in this chapter. *Screenings* are conducted to identify children who may have a delay or disability. Through screenings, the determination is made if children should undergo more in depth assessment procedures. *Eligibility assessments* determine if children meet the requirements of a given program or service. *Program planning assessment* is designed to collect information about the child's intervention needs.

In order to determine the effectiveness of intervention, children's progress towards the attainment of their individual goals and outcomes, as well as family outcomes, must be monitored. Progress monitoring should be conducted regularly and frequently and should take place in authentic, naturalistic settings. This will provide a record of children's progress and indicate whether any interventions should be changed. Furthermore, information must be collected regarding family satisfaction and overall program effectiveness.

Check Your Understanding

1. Provide a definition of assessment in early intervention/early childhood special education.
2. Identify and describe the four purposes of assessment in EI/ECSE.
3. Describe four types of assessment procedures commonly used in EI/ECSE.

4. Discuss problems or issues associated with the assessment of young children and provide suggestions for addressing them.
 5. List at least five recommended procedural guidelines for conducting appropriate assessments of young children.
 6. Describe how professionals can ensure that assessments are culturally appropriate.
 7. Differentiate between assessment conducted for screening purposes and assessment designed to determine eligibility.
 8. Describe the difference between assessment to determine eligibility and assessment for program planning purposes.
 9. Explain the importance of considering family preferences in the program planning process.
 10. Describe strategies for including families in the assessment process and discuss the advantages for including them in the assessment of young children.
 11. Describe four different methods that can be used to collect assessment information.
 12. Provide a rationale for considering (as part of the assessment process) the environments or settings where children spend time and the demands placed on them in those environments.
 13. Explain how each of the following levels of evaluation should be addressed in the overall evaluation plan of an early childhood program in which children with disabilities are served: (a) child level, (b) family level, and (c) program level.
 14. Explain the importance of monitoring the progress of young children with disabilities.
3. Examine several assessment instruments used in early intervention/education. Compare and contrast the instruments in terms of purpose, age range, domains, cost, administration, psychometric properties, inclusion of family, cultural and linguistic considerations, and usability of results for individualized program planning.
 4. Review systems used to monitor progress within an early intervention, preschool, and early primary settings. How are they similar and how do they differ? Interview an early childhood special education teacher for recommendations on monitoring progress.
 5. How might the families of Maria, T.J., and Cheryl be involved in the assessment process? What specific roles might the families play? How can the E/ECSE teacher help support families in the roles they play? In assessment for program planning and progress monitoring, explain how the teacher could provide support to the families to encourage their involvement.

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Reflection and Application

1. Observe the assessment process in an early intervention/early childhood special education setting. What was the purpose of the assessment? Who was involved in the process? Where did it take place? What was done to prepare the environment prior to the assessment? How was rapport established with the child and family prior to the assessment?
2. Discuss with an early interventionist or educator his/her role in each component of the

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