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ABSTRACT

This curriculum is for an intensive 5-day institute in team assessment of young children with disabilities. Each of the eight chapters includes text, training activities, and an annotated bibliography. Sample forms and evaluation guides are appended to relevant chapters. The introductory chapter presents an assessment philosophy and notes implications of differences between assessing school-age and very young children. Chapters address the following topics: "Fcundations for a Family Approach to Early Childhood Assessment"; "Development of an Early Childhood Assessment Team"; "Infant-Toddler Assessment--Clinical Procedures and Interpretations"; "Preschool Assessment Clinical Considerations--Procedures and Interpretations"; "Observations of the Play Behavior of Infants and Young Children"; "Foundations for Understanding Parent-Child Interaction"; "Crosscultural Issues in Assessment"; and "Linking Assessment to Program Planning." (DB)

TEAM

ASSESSMENT

IN EARLY CHILDHOOD SPECIAL EDUCATION

A Trainer's Resource Guide

Personnel Development for Infant Preschool Programs

TEAM ASSESSMENT

IN EARLY CHILDHOOD SPECIAL EDUCATION

A Trainer's Resource Guide

Second Edition

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Preface

As services to young children with special needs and their families expand, the need for qualified staff increases. One of the major training needs identified by the field is the assessment of young children with suspected health and developmental needs. For families of infants and young children assessment may be their initial contact with the special education system and at a point of crisis in their lives. Exchange of information about their child's development, service needs and resources available in a sensitive, supportive manner is critical. The knowledge base on typical and atypical development, appropriate assessment practices, family support and team approaches has grown significantly over the past 20 years and training is needed to put that knowledge into practice.

In response to the need for specialized training professionals working with young children and their families, Infant Preschool Special Education Resource Network submitted an application through the California Department of Education and was awarded a federal personnel preparation training grant titled, *Early Childhood Special Education Team Assessment.*

The grant was funded to develop training models and materials from October, 1984 to September, 1987. A major component of the grant was the development of an intensive, eight-day Institute in team assessment. Since the completion of the grant, the Institute has been adapted to a five-day training by Personnel Development for Infant Preschool Programs and is held through the California Department of Education, Special Education Innovation Institute.

Team Assessment in Early Childhood Special Education: A Trainer's Resource Guide is the curriculum for the five-day Institute. This training guide was developed as a response to hundreds of requests for the curriculum. It is divided into eight chapters. Each chapter includes text, training activities, and an annotated bibliography.

Readers who are interested in planning an intensive training on team assessment are referred to *Team Assessment in Early Intervention: Training Issues and Outcomes*, available through Resources in Special Education (RISE). Joining Forces: Early Childhood Team Assessment, a twenty-minute videotape demonstrating team assessment is also available through RISE.

This training guide would not have been possible without the assistance, thoughts, and encouragement of many people. Thank you to the families and children who participated in the institute and taught us about team assessment; to the trainers of the institute whose research and study helped develop this book, and to the participants, who provided on-going feedback during the past five institutes. A special thank you is extended to contributing authors, who volunteered their time and expertise to this project.

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TEAM ASSESSMENT

IN EARLY CHILDHOOD SPECIAL EDUCATION

A Trainer's Resource Guide

Second Edition

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Introduction

Assessment Philosophy

Assessment of infants and preschoolers requires specific expertise and unique philosophical orientation. Although actual procedures may vary from agency to agency, it is generally agreed that practitioners should consider the following assumptions regarding high quality assessments of young children with special needs and their families.

Ecology of Assessment. The child is seen in the context of familial, cultural and community systems. Each of these systems is changing as the child develops, and assessment personnel must take into account the transaction and reciprocity between the child, the family, the culture and community. Assessment must be conducted and interpreted within the framework of how the child functions within these systems.

Assessment Focus. Assessment questions must be carefully defined and focused to be useful for decision making and intervention planning.

Transdisciplinary Team Process. Assessment should be conducted by a team of personnel knowledgeable in child development, atypical development and family systems, who share procedures, data and observations to produce a collaborative assessment process and intervention plan. Parents should be included throughout the assessment process as team members.

Families as Team Members. Family members are included as crucial members of the assessment team, bringing their expertise of the child's strengths and needs and their family's information, resources and needs.

Linking Assessment to Programming. Assessment procedures should be selected in order to provide relevant information for intervention strategies, taking into account current information on available service delivery systems within the community.

Psychometrics. Reliable and valid measures are used, in conjunction with observational data from the team.

Communication of Results. The team produces a report which communicates clear and relevant findings to families, the intervention program staff and other referring sources.

Differences Between Assessing School-Age and Very Young Children

The young child (birth to 4.9 years) is not a small school-age child. The team assessment of the young child must take into consideration the important differences in thinking, motivation and experiences between the young child and the school-age child. The family, culture and environment play a significant role in shaping the child's development. Thus, they must be taken into account throughout the assessment process. These child and family differences will have the following implications on assessment:

Ecologic Assessment

- Involvement of the parent or primary caregiver is critical. The family's concerns, resources and priorities will focus the assessment. Parents can help the assessor to better relate to the child by holding, comforting or sitting near the child. In addition, parents can provide a wealth of information about the child's development, typical behavior, temperament, environment, routines, special needs, likes, dislikes.
- Families are important members of the assessment team. Four potential roles for parent involvement in the assessment process are:
  1. Provide information
  2. Assist in administering assessment tasks
  3. Provide feedback on child's performance
  4. Joint decision making
- Assessment procedures should include observations of an interaction between the caregiver(s) and the child.
- The parents' perceptions and responses to the child's behavior should always be observed.
- The impact of the child on caregivers and the impact of the caregiver(s) on the child must always be considered by the assessment team.
- Questions to consider when assessing the young child:
  - What is the attitude and expectations of caregiver(s) for the growth and development of their child?
  - What is the impact of the child's temperament on the caregiver(s) and family systems?
  - What family and community supports are available to the caregiver(s).
  - What cultural and socioeconomic factors may influence the assessment results?

Behaviors

- The examiner must be able to engage the child in the assessment procedures.
- The young child may not know what behaviors are expected or are appropriate because of the lack of previous experiences or developmental delay.
- Assessment procedures must involve the participation of the caregivers to obtain an adequate understanding of the ecology of the child.
- The child's behavior when relating to the examiner(s) is a critical part of the assessment.

Development

- There exists an interdependence among cognitive, language, sensorimotor and emotional factors which makes it essential to understand the child's functioning in all domains of development.
- Different levels of cognitive skills including sensorimotor, preoperational and concrete operational will impact on the assessment behavior and interpretations of results.
- All children have language and communication skills which must be observed and understood by the assessment team for accurate interpretations of results of assessment.
- The competence of the sensory and motor modalities is critical to assess when observing other developmental domains since many cognitive, language or personal social behaviors depend on sensorimotor skills.
- The child's emotional maturity is understood, to a large extent, in the context of interactions with caregivers and the assessment team.

Psychometrics

- The assessment team should always utilize multiple assessment procedures which include both standardized tests (when appropriate) and informal techniques for play observations, peer interactions and caregiver interactions.
- Standardized assessment procedures for most young children require special training and experience.
- The validity of standardized tests may be inadequate because of existing disabilities or sensorimotor impairment. The assessment team should provide a brief rationale for the assessment procedures chosen.

Team Assessment Issues

An ecologic assessment of the young child should be conducted by an assessment team which includes more than one discipline and at least one caregiver.

- The assessment team must collaborate among disciplines to avoid duplication of assessment procedures.
- The assessment team must share observations and expertise to interpret evaluation findings.
- The assessment team often must collaborate with other community agencies to avoid duplication of services and to obtain other evaluation results.
- Collaboration among disciplines in an assessment team requires sensitivity to issues of professional jargon, role definitions and boundaries, valuing input from other professionals and caregivers.
- Team assessment is effective with young children because of the overlap and interdependence of all domains of development and the expertise required to understand the whole child in the context of his environment.
- The assessment must involve the caregiver(s) on the team, facilitating exchange of observations with the family.

Foundations for a Family Approach to Early Childhood Assessment

Linda Cranor
Parent

The objective of this chapter is to provide professionals with a foundation for early childhood assessment that is based on a child and family focused approach. Professionals will be able to build on the child and family approach by bringing their own area of expertise, skills and knowledge to the information that is presented in this chapter.

This chapter will highlight the importance of:

- The need for a family approach to early childhood assessment
- Understanding families
- Understanding the impact of having a child with disabilities on the family system
- Parent-professional partnerships
- Parent involvement and participation in the early childhood assessment
- Assessment results

About the author: Linda Cranor is the mother of two sons. Her oldest son has multiple disabilities. When this chapter was originally written, Linda was the Parent Specialist for Infant/Preschool Special Education Resource Network.

INTRODUCTION

The referral of a newborn or newly diagnosed young child to an early childhood assessment suggests a definite concern for the child's development. The assessment, although providing necessary and beneficial information to those involved with determining the direction of the child's future, frequently is a difficult and trying experience for the child's family and the professionals.

Professionals have had the choice to work with young children with special needs, however, families have not had the opportunity to make this choice. Families are rarely prepared to meet the additional, unexpected parenting responsibilities a child with a disability requires. Professionals trained in working with children with disabilities typically are unprepared to work with families in such a vulnerable place and time.

Families initially know little about their child's special needs, the impact the handicapping condition may have on the child and family, or services available. It is imperative that the first professionals they turn to for help offer accurate information, appropriate encouragement, and support. Understanding the influence that an initial assessment may have on the parent child interaction, the immediate family unit, and the parent professional relationship is fundamentally important for those individuals who are involved with assessing the special needs of young children.

WHY A FAMILY APPROACH TO EARLY CHILDHOOD ASSESSMENT?

Respect for the whole child

Family focused, early childhood assessment reflects a respect for the whole child, an understanding of the child's and family's unique needs and collaboration with families to meet those needs. It is an transdisciplinary approach that is concerned with the optimal physical, social/emotional and cognitive development of the young child in the context of the whole family.

Placing a high priority on the child's natural interactions with others, especially his/her mother, father and siblings, the family focused assessment demonstrates an awareness that children do not operate in isolation. Because the child's development is directly and indirectly influenced by both people and events (Bronfenbrenner, 1979) a quality early childhood assessment must reflect a high regard for:

- Child's/family's strengths, not weaknesses
- Interaction between the child, the setting and significant individuals
- Family values, cultures, and child rearing practices
- Contributions of other team members
- Linking assessment to intervention
- Parent/family involvement

UNDERSTANDING THE RESPONSIBILITIES AND LIMITATIONS OF TYPICAL PARENTING

The birth of any child will naturally affect the family in many ways. (Snell, 1981) Parents of newborns or newly diagnosed infants with special needs typically feel overwhelmed with feelings of vulnerability, helplessness, and inadequacy. Yet, while in the midst of experiencing grief over the loss of a "perfect" child, (in addition to meeting the day to day demands of caring for a young child) parents typically will be required to immediately "muster up" and take charge of their new special parenting responsibilities. (Trout, 1986). It is essential that professionals understand and respect the strengths and limitations of normal parenting when working with families of children with special needs.

Basic understanding of normal parenting would include the following premises:

- A parent is always a person first. Having a child is one part of a person's many roles. (Buscaglia, 1983)
- Parents are the most capable, consistent long-term care providers, teachers, and advocates for their child.
- Parents teach their children the acquisition of culture, values and self identity.
- Parents provide for the child's basic needs.
- Parenting skills are not "automatic." Parents learn how to parent through interactions with their children.
- New parenting styles must be learned to meet the individual needs and temperaments of each child.

UNDERSTANDING FAMILIES

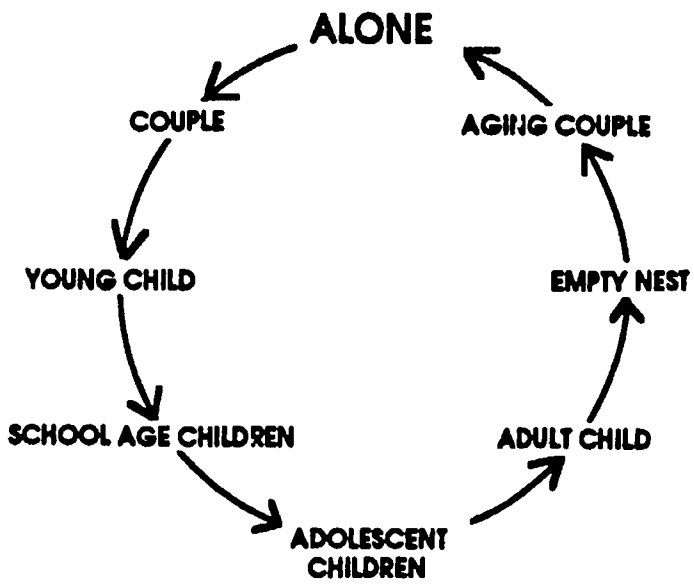
Webster's dictionary, in one of many definitions, defines family as: "A group comprising immediate kindred, especially the group formed by parents and children, constituting the fundamental social unit of civilized societies." This definition of families no longer describes American families. A number of todays families are single parents, grandparents raising children, and foster parents. The following facts demand that we redefine families and how services are provided to families:

- One in five American children live in poverty. (Children's Defense Fund (CDF), 1990)
- Every night an estimated 100,000 children go to sleep homeless. (CDF)
- One in five American girls gives birth before the age of 20. (CDF)
- One-half of preschool-age children have mothers employed outside of the home. (CDF)
- By 1995 it is estimated that 840,000 of America's youth will be in out-of-home placements, including foster care, mental health and juvenille offender placements. (Cimons, 1989)
- In the Napa County, California Infant Program 50% of the children live in foster care. (Snorf, 1990)
- Over 23% of California's children live in single parent households. (Wald, 1989)

It is important for professionals to have an understanding of how families function. Awareness of how the child's handicapping condition may impact the family's life cycle and family dynamics will aid professionals in understanding the unique aspects of families.

Family Life Cycle

The normal process of family life change creates stress in all families. The universal family life cycle as shown illustrates typical times that families may experience change, indicating times of possible increased stress. (Turnbull, 1983)



The health of the family depends on the system's flexibility and adaptability in times of stress. Because families are always in the process of change, stress at certain times is inevitable in all families. Learning how to cope with stress is fundamental to successful family functioning.

Basic Family Functions and Needs

Although family functioning varies greatly depending on culture, norms and values, the maintenance of even the simplest family structure depends on the existence of some very basic needs being met. All families, with or without a handicapped child, have these basic needs. These functions and needs must be met before family's can devote time and energy to other concerns (i.e. the education of their children).

Ann Turnbull (1983) categorizes the Family Functions into eight areas:

Economic:	Generating income, taking care of family financial decisions
Physical:	Health care, physical requirements for home maintenance, food and clothing purchasing
Rest and Recuperation:	Individual and family recreation, enjoying hobbies
Self Definition:	Establishing self identity and self image, sense of belonging
Affection:	Nurturing and love, expressing emotion and intimacy
Guidance:	Problem solving, feedback and advice, shaping values and beliefs
Education:	School work, homework, continuing education, cultural appreciation
Vocational:	Career choice, development of work ethic, support of career interests

Michael Eastman (1982) has organized what he calls "Family Basic Needs" into the following categories:

Home	All families need a safe and adequate home.
Income	Must be able to meet the needs of the family.
Health	Family members need to be in good health, particularly the primary parenting person.
Roles/ Responsibilities	Family members need to be clear on the roles and responsibilities within the family. Who does what? and who is responsible for what?, is crucial.
Leisure Time	Time to relax, often translates into scheduled time for oneself.
Social Time/ Support	Need time to interact with other people. For some families social time with others is enough, for others support groups provide a better outlet.
Crisis Management	All families need to have a pre-planned process for handling a crisis which does not depend on just one person.

Although authors conceptualize family functioning differently, the key point to remember is that parents who are having problems meeting the basic needs of their family will unlikely be able to devote the extra time and energy often required to meet all the additional needs of their young child with a disability. It is important that the assessment team and families collaboratively choose goals and priorities that are most critical to the child and family. Often, this means that professionals must "let go" of goals that the professional deams important.

Family Balance

A helpful framework for understanding families is the family systems theory. According to this theory, families are viewed as a growing and ever changing system with unique structures (who are the members of the family), resources (sources of support and abilities to respond to life situations), functions (how families accomplish things like affection, guidance, maintaining a roof over the family's heads) and interactional patterns (Bailey, 1987). Each member of the family system is influenced by the group as a whole and individually in that system. An event or situation that affects one family member will affect all other family members in some way. For example, if a mother needs to spend more time with one of her children, that will necessitate having less time for other family members or functions of the family. Because each family is unique and all families are complicated systems, it is vitally important for professionals who are primarily involved with one family member to be aware of the profound effect that member has on the entire family system.

Understandably, for professionals and parents alike, it is not always easy to remember that the child with a disability is only one part of the whole family unit. It is extremely important however, that both parents and professionals continue to support the delicate balance of the whole family, while at the same time recognizing the exceptional needs of the young child.

It is the responsibility of professionals to be sensitive to individual family members, especially young siblings and extended family, making sure not to ignore their needs and therefore create additional problems for the family during the assessment process. Providing needed support and encouragement to parents in this time of family struggle and vulnerability is often necessary.

Family Support

A second notion that can be very helpful in understanding families is social systems theory and support. Social systems theory says that social units (e.g., such as families) do not operate in isolation, but they have an affect on one another. Social support is defined as "the resources provided by other persons" (Cohen and Syne, 1985). Social support may include emotional, physical, informational, instrumental and material assistance to maintain well being, promote adaptations to different life events, and foster development in an adaptive manner (Dunst, 1988).

Social support is provided within the family. Informal social support is provided by friends, kin, neighbors, and social organizations such as churches. Formal support can be provided by human services professionals, early intervention programs, and preschool programs.

In applying these concepts to early childhood services, Dunst has examined where families of young children with special needs have derived their support. It is clear that children are greatly influenced by the social support provided by their families. Families naturally derive their greatest support from informal support network such as other family members and close friends. Families often turn to professionals working with their child when informal support is weak or nonexistent. And conversely, if families have rich informal support networks, they may not look to the formal support network, such as an early intervention program for that support. Interestingly, families who are involved in infant programs, have identified the staff as an informal support. This factor emphasizes the importance of the relationship families have with early intervention staff.

When one is providing support, it is essential to remember that all things that are true regarding the role of any family are true for the family of the child with a disability. Families are all different. They are different in sizes, they have different resources and responsibilities. The needs of the child with a disability vary greatly, depending upon age, level of severity, and temperament. Because of these factors, families need to define their own priorities and determine their own degree of involvement in the assessment process.

UNDERSTANDING THE IMPACT OF HAVING A CHILD WITH A DISABILITY

For parents there can be no preparation for the unanticipated event of having a child with a disability and no preparation for understanding the impact that the disability will have on the family unit. At the time the early childhood assessment process occurs, parents are typically enmeshed in feelings of grief and loss. Each family member is unique in how they cope with their own personal grief and how they manage the multitude of emotional dynamics facing them at this difficult time. Unfortunately, there are no easy guidelines to follow when working with children and families who are in such a vulnerable place. Assisting parents in understanding this

impact and supporting them in the coping process is the responsibility of individuals who have chosen to work with children with special needs and their families.

Michael Trout (1986, 1983) interviewed families with children, 0 - 36 months, who were born small enough or ill enough to require neonatal intensive care, who had major anomalies or life-threatening illnesses, who had physical disfigurements, who were mentally and physically handicapped, and who had multiple illnesses, in rural northern Michigan. During the seven year research project, Trout studied the social attachment and social breakdown in those families.

During his interviews with families, Trout observed the following common experiences:

- Dynamics at the birth of a child with a disability or initial identification of disabilities
  Families reported that everyone acted awkwardly. The nurses talked about them, the doctor did not go to their room as often as usual, doctors and nurses withheld information, extended families acted unusual, and didn't visit often. (It is important to remember that parents felt these things, the incidents may or may not have actually happened.)
- The search for diagnosis, prognosis and cause is as difficult as initially learning about the disability.
  Families reported that professionals would not give them information or didn't have information and were cold and unavailable. Parents felt overwhelmed about "why", especially if there was no known etiology. Parents often blamed themselves for real or imagined misdeeds during the pregnancy.
- Grief for loss of perfect/fantasized child
  Families reported on-going loss for their perfect/fantasized child who died at the time of the birth or identification of the disability. One parent said "life and death occured simultaneously at the time of the delivery." The grief process in complicated by the demands of the new baby. It is difficult to grieve the lost child, when the "new" baby demands attention and care.
- Support systems changed
  Families reported breakdowns in their support systems. Spouses stopped interacting because they didn't have any energy left for each other. Spouses stopped talking because they were afraid that their anger, guilt and rage would come out. Old supports (church, extended families, friends) pulled away.
- Loss of family sturcture
  Families reported a loss of their internal stucture. The time pressure of care for their child didn't allow for old family routines or social events. Careers were sidetracked; decisions regarding career advancement were no longer easy. Many families experienced severe financial stress.
- Feelings of guilt
  Families reported ongoing feelings of guilt. Guilt of wanting to "walk out of the situation." Guilt of the normal feelings of frustration and anger any parent has at times towards their child.

It is critical that professionals learn how to relate to the feelings that parents are experiencing in order to develop good relationships with them. Typically, professionals who work in specific disciplines and are assessing the child's growth and development find it much easier to relate to parents around these familiar content areas. Very few assessment staff members are trained in working with families who are experiencing grief; and yet, they are facing it daily. By providing an avenue for clear and accurate sharing of feelings, in an atmosphere reflecting nonjudgment, empathy, and respect, professionals will be aiding parents through a normal process of personal growth. (Moses, 1986)

The sharing process between caring professionals and parents who are experiencing feelings of grief can be a painfully difficult experience. Not only may professionals grieve with parents over life's injustices, these feelings may be experienced over and over again with different children and families. It is also likely that professionals will encounter parents who, caught in the midst of their feelings, will express unjustifiable anger toward them personally. Professionals need to be reminded and encouraged to seek support from co-workers in times of need, understanding that they too are only human.

PARENT/PROFESSIONAL PARTNERSHIPS

In order to obtain an early childhood assessment that accurately reflects the young child's special needs within the context of the whole child and family, a successful parent professional partnership is essential. Because infant and preschool assessment focuses so strongly on close working relationships with parents, the early childhood assessment team has an enormous opportunity to affect positive growth in both the child and parent, consequently building a base for families that may last a life time.

Family members typically come to the assessment process feeling helpless and frequently are looking to the assessment team as the experts. It is apparent that professionals must make an extra effort in establishing the ground work for this partnership.

What professionals can do to foster this relationship:

- Be sensitive to parent feelings.
- Treat parents as equals.
- Use honest, clear communication (Regional Research Institute for Human Services, 1987).
- Offer help in response to family identified needs (Dunst, Trivette, and Deal, 1988. The next four points are also from this reference.)
- Promote a sense of cooperation and joint responsibility for meeting family needs.
- Promote the family member's ability to see themselves as an active agent responsible for behavior change.
- Permit the family to decide whether to accept or reject help.
- Permit help to be reciprocated.

Parent Feelings About Assessment

While it is normal and typical for parents to experience feelings of grief over the loss of their perfect child, it is also normal for parents to have feelings of ambivalence and anxiety about the initial assessment. Not only are parents unfamiliar with the assessment process, they may be feeling worried about the extent to which the disability will impact on the child and family's life. It is important for professionals to be sensitive to the feelings of parents at this time, understanding that this situation would be difficult for anyone.

Common feelings parents of young children may have about assessment:

- Nervous and frightened
  - Not familiar with assessment process
  - Wondering what will be assessed
  - Worried if child will do well
  - Worried about implications of results
  - Worried about how professionals will view them
  - Concerned about how they'll be treated
- Sadness
  - Acknowledgement of concern is often sad
  - May be first time concerns have been shared outside family
  - May be first time concerns have been validated
  - Assessment process is a reminder of child's problems
  - Assessment tends to focus on what's wrong
  - Surfacing of feelings of grief
- Confusion
  - Mixed feelings about having child assessed
  - Mixed feelings about child
  - Lack of clear diagnosis
  - Differing opinions from doctors
  - Lack of/mixed information about resources
- Relief
  - Feeling that support and help is available
  - Results may validate parent concerns
  - May answer questions
  - Give parents feeling they can do something
- Concerns
  - Emotional impact the assessment has on the child (particularly the preschool aged child who is aware that something unusual is happening)
  - How to emotionally prepare the child for the assessment
  - How parent will address the child's feelings about his/her disability later in life
  - How to explain child's disability and needs to other family members.

Parent as a Team Member/What Does That Mean?

Partnerships between parents and professionals need to involve working together on an equal basis, valuing each others input and using each others strengths. For parents, being part of the assessment team is a new "ball game" and they need to be "taught the ropes."

Family members deserve to know the rules: It is the professional's responsibility to explain the purpose and procedures of assessment and to educate parents to the importance and value of their input. Families need to be informed about what is being observed during assessment. Parents need to know what position they play. The role of the family needs to be clarified. The professionals and families need to discuss and decide how the family will be involved in the assessment. The family ultimately has the decision regarding their level of participation.

Parents/professionals need to agree on goals. Questions to answer are: What are parent concerns? What are parent expectations of the assessment? What does the parent need from the assessment? What is the process for sharing outcomes?

Empowering of Parents

Parents of newborns or newly diagnosed young children especially look to professionals as the experts. Offering parents the opportunity to recognize their strengths, as well as their areas of needed support, should be one of the primary goals of professionals. Supporting parents while at the same time empowering them through an exchange of skills, knowledge, and competencies, is the responsibility of professionals working with families of young children with special needs.

By presenting a positive attitude, providing needed information, and helping parents feel control by involving them in decision making, professionals can begin to build true partnerships with families. At the same time professionals are establishing rapport and learning from parents about their child, parents are beginning to establish a feeling of control and competency.

PARENT INVOLVEMENT AND PARTICIPATION IN EARLY CHILDHOOD ASSESSMENT

In order for an early childhood assessment to reflect the total picture of the young child with special needs, and therefore be valuable to all those involved with helping the child, involvement of either the parent or the child's primary care-giver is essential. Because a quality assessment is the process by which everyone brings their area of expertise together, parents and professionals need to work in a partnership. Provided the opportunity, parents can be involved throughout the assessment process in a number of invaluable ways:

- Helping to plan the assessment
- As a primary resource for information
- Providing assistance during the assessment
- Assessing the quality of child performance

Assessment Planning

The first role that the family can play during the assessment process is to help plan the assessment with the assessment team. During the initial contacts with the family,

members of the assessment team can gather information regarding the family's priorities and information needs for their child. The family's priorities, concerns, and information needs can then shape the assessment process. For example, if a family was concerned about the child being able to play with his or her siblings, then the assessment would include an observation of the child playing with the siblings in addition to further conversations with the family about that concern.

The planning process should also include a discussion of the possible roles that family members could play during the assessment (e.g., sitting next to the child or carrying out activities to explore the child's abilities). The family could then indicate possible roles that they would like to play.

Some questions that members of the assessment team could discuss with the family to help in the planning process include: (*Project Dakota Outreach*, 1988.)

- What questions or concerns do you and others have? (e.g., babysitter, preschool)?
- Are there other places where we should observe your child?
- How does your child do around other children?
- Where would you like the assessment to take place?
- What time of day? (The best time is when the child is alert and parents are present).
- Are there others that should be present in addition to parents and staff?
- What are your child's favorite toys or activities that help him become focused, motivated, and comfortable?
- What roles would you find comfortable during assessment?

Team Assessment

Families play a key role during the team assessment by providing information both about their child as well as how the child fits in the rest of the family. Specific areas of family participation in assessment include:

Family members are a primary resource for their child.

- Provide records and reports
- Offer their skills — demonstrate what works best with child
- Provide the use of their home for home assessment, so child can be seen in natural environment.
- Provide materials
  - Special equipment for proper positioning
  - Toys
  - Special things from home
  - Photographs
  - Something child is fond of
- Provide a family perspective regarding what the child's strengths are, as well as needs

Parent participation in the actual assessment may be encouraged in a number of ways:

- Administer test items
- Conduct a play session with child
- Help assessor better relate to child by:
  - Holding
  - Sitting near
  - Separating from
  - Comforting/explaining

- Involve other family members for purpose of observations in interaction
- Complete a parent assessment tool

Parents, because they know their child better than anyone else, assess the validity of the assessment:

- Was this typical performance?
- Was anything unusual or surprising?
- Were other concerns surfaced?

Research studies have verified the validity of parent observations of their child and have indicated that families are the most accurate sources of information about their child (Vincent, 1980). It is the responsibility of the professional team conducting the assessment to assure that the expertise of the parent is reflected in the assessment. The team needs to help parents recognize their own area of expertise by offering them opportunities for participation and by treating them as valued partners.

In addition to finding out about the family's perspective regarding the child with special needs, the assessment process needs to gain a perspective on the family's strengths and needs related to enhancing their child's development. The process of identifying family strengths and needs should be viewed on an ongoing process of parent-professional collaboration. The process of family's identification of strengths and needs is one that is completed over time as the initial relationship and trust builds, as well as an ongoing basis. The purpose of identifying family's strengths and needs is so that informal and formal supports and resources can be located, so that families can use their capabilities and strengths to obtain required resources in ways that strengthen the child, parent, and family functioning. (Dunst, 1988).

Team members can also talk with the family to help identify sources of support for that family. Sources of support were described earlier in this article (e.g., the family, informal network of friends, the church). Strengths, resources, supports and needs may be identified in one of two ways: 1) through informal open ended discussion with the family or 2) through use of self-report scales that is followed up with discussion with a professional. References for self-report scales and interview techniques can be found in the Annotated Bibliography of this chapter.

The process of identifying strengths and needs does not mean that assessment teams have the license to delve into areas such as assessment of relationships, family stress, and family dynamics. Only the family members can determine for themselves which aspects of family life that they feel is relevant to their ability to help their child grow and develop (NEC*TAS, ACCH, 1988). However, if a family does request help in areas such as marital relationships, then team members with expertise should be a part of the team or a referral should be made to an appropriate resource.

A family centered assessment includes the identification of family strengths, capabilities, support and resources. The role of the team members is to help families identify the many talents that they have that can be used to benefit their child with special needs. Examples of strengths may be the ability to pull together in a time of crisis, strong religious beliefs, a sense of humor.

Darling (Seligman & Darling, 1989) describes six major areas of need for families of young children:

- **Information** about diagnosis, prognosis and treatment
- **Treatment** for the child
- **Informal support** from relatives, friends, neighbors, co-workers and other parents
- **Formal support** from public and private agencies
- **Material support** including financial support and access to resources
- Elimination of **competing family needs**

The needs for each family are unique and are ever changing. The role of the team member in identifying family needs is to encourage the family to share aspirations as well as concerns, help the family clarify the concerns and needs, to be responsive to the family, and establish consensus regarding priority needs and projects for the family (Dunst, 1988).

ASSESSMENT RESULTS

Even when caring and skilled professionals have conducted the assessment and teamed well with the young child's parents, sharing the assessment results is often a very difficult experience. Parents understandably may approach the assessment with conflicting feelings. Often, not only are the family members in the midst of coping with the emotional dynamics of having a child with a handicapping condition, they are also struggling with the anxiety of not knowing how disabled their child will be. To see in writing what parents may or may not know to be fact, or to hear out loud for the first time the extent to which their child's disability has affected his/her development, may cause extreme stress and sometimes unexpected shock for the parent. Professional sensitivity around the issues of the assessment impact and conveying the assessment results to the family is vitally important in helping the young child. Better understanding of the potential dynamics around the assessment will aid professionals in their ability to help families at this time.

Potential Impact of Assessment/Importance of Professional Awareness

The impact of the assessment may be great. It may influence how the family feels about the child and his/her handicap. The sharing of observations provides an opportunity for professionals and parents to discuss how parents feel about their child and his needs. It is important that the assessment results be positive, that the child and family resources and strengths, as well as needs, be highlighted.

It is important to include the critical people in child's life during the discussion of the assessment results. Parents may want to invite grandparents, siblings, babysitters or other family members or friends. Professionals need to be aware that written material remains in child's files forever. The report may be used by professionals who make decisions about the child, but never see him. The report needs to focus on the whole child emphasizing strengths as well as addressing concerns, and be written so parents and other professionals can easily understand it.

The family may have mixed feelings about discussing the assessment. While family concerns are being addressed, fears of the family may be heightened. Anxiety about the cause, the severity and the impact of the handicap may be revived during the discussion. Professionals need to be sensitive to the family's feelings. Time must be dedicated to discussing the feelings of the family, as well as the "facts" of the assessment.

Families may wonder if they can meet all of the child's needs and provide a typical home for the child. The professionals need to support the family, assist them in identifying their strengths and resources and assure realistic goals, that can be carried out during the typical family day, are discussed.

Communication of Results

Presenting sad information to parents about their young child's special needs is the most difficult task professionals involved with the early childhood assessment will be required to perform. Rarely are individuals in early education prepared to work with parents in this manner. And, rarely are professionals prepared for the personal impact these experiences may have on their own feelings. There is no easy way to convey this sensitive information to another individual, consequently one may feel varying degrees of inadequacy and discomfort in this role. Parents, however, need to receive concise accurate information about their child's development, told with sensitivity and support.

By being empathic and non-judgmental along with providing opportunities for parents to openly share their feelings, professionals will be helping to facilitate the growth of the families they are working with. In order to accomplish this, the professional should share their impressions with the family throughout the assessment. Before the family leaves, discuss observations and reccomendations. The following suggestions aid the professional in communicating results with families:

Provide concise, accurate, honest information with care and sensitivity.

- Help parent decide how information will be shared with other family members.
- Emphasize whole child.
  Child's areas of strengths as well as concern
- Try not to overwhelm family with too many details, as confusion may result from too much information. You may want to focus on two or three areas.
- Use language that is familiar and understandable. Explain jargon.

Ask questions frequently/be a good listener.

- Are there misconceptions?
- Is this information in conflict with other information?
- Are there cultural implications? (being aware of these may avoid conflicts)
- In what way may professionals be able to help?

Offer families time to express grief and support them in that experience.

- Understand that grief is normal and healthy; share that information with family
- Help parents feel its okay to show feelings.
- Professionals need to be sensitive about what they say; avoid trite phrases that attempt to wrap up major problems.
- Professional patience is critical.
- Understand that presenting sad information may bring out anger, guilt, denial. This anger is not the professionals fault. There is a difference between parent grieving through anger and "real" anger about insensitivity of professionals.
- Do not be judgmental. This results in:
  Parent feeling their being analyzed
  Erodes parent self-esteem
  Interferes with normal grieving process
  Puts parents on defensive
  Destructive to parent/professional relationship
  Not in best interest of child, family or professional

Linking Assessment Results to Intervention

One goal of early childhood assessment is to develop recommendations for intervention that integrates the child's identified needs naturally into the normal life style of the child and family. This goal is initially addressed in the first contacts with the family when initial information is gathered about the families concerns and priorities. Additional information is gathered about the families priorities and perceptions as well as child characteristics and abilities during the team assessment process. Recommendations can then be formulated based on all of the child and family information that was gathered.

Recommendations should be guided by the family priorities, and should build upon family strengths and resources. The process of arriving at the recommendations and specific plans for intervention will involve negotiation. Family priorities and values are not negotiable, but the strategies, activities and services are. Negotiation between team members and the family include (NEC*TAS, ACCH, 1989):

Information sharing
Active listening
Perception checking
Compromise
Formal agreements to reconsider or re-introduce at another time and
Decisions to join the team to clarify information or to gain insight.

On October 8, 1986, President Regan signed into law P.L. 99-457, a landmark piece of legislation, that mandates a family-focus to services for children birth to five years. More specifically, it mandates that all participating states implement an Individualized Family Service Plan (IFSP) for the birth to two year-old population. California is currently participating in P.L. 99-457 and with the Department of Developmental Services as the Lead Agency, looking at what the IFSP means for California families and agencies. The IFSP is not mandated at this point, since California is in a phase-in period with the law. Some early intervention programs though, are experimenting with the use of the IFSP in their programs. "The purpose of the IFSP is to identify and organize formal and informal resources to facilitate families' goals for their children and themselves. The IFSP is a promise to children and their families– a promise that their strengths will be recognized and build on, that their needs will be met in a way that is respectful of their beliefs and values, and that their hopes and aspirations will be encouraged and enabled." (NEC*TAS, ACCH, 1989).

The process of developing the IFSP entails collaboration and negotiation that is guided by the family's agenda. Professionals should limit their intervention to meeting the needs that families find important. Areas to consider in linking assessment to intervention:

Is there a need for further assessment?
- Explanation of reason to parents
- Who will facilitate?
  - Are there options
  - Does team recommend someone
- Who will make contact?
- What agencies need to be involved?

Intervention Recommendations
- Explanation of early intervention.
- What are the intervention options?
  Looking at child and family needs and priorities
- What does team recommend for intervention?
- Who will organize contacts?
- Explanation of roles of different agencies.

Linking assessment to family
- Is the report with recommendations written in the family's language?
- What are the family's priorities?
- Provide encouragement, moral support.
- Provide assurance—praise parents for abilities and family's strengths
- Recommend activities and strategies that utilize the family's strengths and resources.
- Help parents use their home and natural interactions to teach child.
- Develop an intervention plan that fits well into family routines and schedules.
- Acknowledge that parents of children with special needs have very little spare time.
- Provide resources for parent support.
  Parent groups
  Sibling groups
  Articles
  Books
  Acknowledge importance of parent
  Other parents with children with special needs

Training Activities

Strategy #1

Purpose: To increase professional awareness of parent perspective of early childhood assessment.

Presenters: Parent panel or guest speaker.

Activity:

1. Ask parents to address the following items:

   - Personal and family impact of the early childhood assessment.
   - Suggestions for successful communication with parents.
   - Tips for better understanding families.

Time: 60-90 minutes, which includes time for questions and answers.

Strategy #2

Purpose: To provide participants opportunity to address their own feelings about assessing children with special needs and working with parents.

Materials: Handout #1a: PROFESSIONAL FEELING SURVEY
Handout #1b: PARENT FEELING SURVEY

Activity:

1. Ask parents to complete PARENT FEELING SURVEY (handout 1b) and professionals to complete PROFESSIONAL FEELING SURVEY (Handout 1a)

2. Break participants into small groups of parents and professionals to share their responses.

3. Facilitator to discuss in large group parent and professionals feelings (comparing responses to surveys).

Time: 20-40 minutes.

Strategy #3

Purpose: To provide an opportunity for participants to reflect on their own feelings about handicapping conditions and the impact on the child and family.

Materials: Handout 2: HANDICAP RANKING SCALE

Activity:

1. Ask participants to complete the HANDICAP RANKING SCALE by ranking the handicaps according to the instructions on it. Do not discuss the degree of handicap within the category, just ask them to respond from their own frame of reference.
2. After completing the task, discuss the following questions in small groups.
   a. Was this a difficult task? Why?
   b. What process did you go through to make your decisions?
   c. Have you ever worked with anyone in the category you marked with a 1?
   d. Do you think your ranking is fairly typical of how society-at-large would rank the categories?
3. Have small groups report to large group for further discussion.

Strategy #4

Purpose: Provide professionals an opportunity to better understand family functions and how carrying out these functions may be affected when a family has a special needs child.

Materials: Handout 3: FAMILY FUNCTIONS.

Activity:

1. Ask participants to answer the questions in the FAMILY FUNCTIONS handout and discuss in small groups.
2. Small groups may or may not share back to large group.

Strategy #5

Purpose: To provide participants an opportunity to increase awareness about family stress and need for balance.

Materials: Handout 4: FAMILY STRESS

Activity:

1. Distribute the FAMILY STRESS handout to participants. Ask them to complete according to instructions.
2. Discuss in small group.
3. Optional– Small group report to large group discussion.

Time: 20-40 minutes.

Handout 1a

PROFESSIONAL FEELING SURVEY

1. The first time I assessed a special needs infant or preschooler, I felt...

2. When I'm meeting with parents regarding assessment results, I feel...

3. I wish parents were more...

Handout 1b

PARENT FEELING SURVEY

1. The assessment process makes me feel...

2. When I'm meeting with professionals regarding assessment results I feel...

3. I wish professionals were more...

Handout 2

HANDICAP RANKING SCALE

Categories of handicapping conditions are listed below. Please rank these, from 1 to 7, according to *your own feelings*, on the basis of severity. Which handicap do you feel is the most severe problem a child could have? Which handicap do you feel is second most serious? Which do you feel is third most serious, and so forth. Consider only the individual and his/her problem in adjustment to school and life and the impact on the disability has on the child's family.

Handicap	**Rank**
1. Blindness	_____
2. Physical impairment	_____
3. Deafness	_____
4. Emotional disturbance	_____
5. Learning disability	_____
6. Mental retardation	_____
7. Speech/language impairment	_____
8. Medically fragile	_____

NOTE: Adapted with permission from *Communicating with Parents of Exceptional Children.* Kroth. (1985). (2nd Ed.) Denver, CO: Love Publishing.

Handout 3

FAMILY FUNCTIONS

ECONOMIC
Generating income
Paying bills and banking
Handling investments
Overseeing insurance and benefit programs
Earning allowance
Dispensing allowance

SOCIALIZATION
Interpersonal relationships
Developing social skills

GUIDANCE
Problem solving
Advice and feedback
Shaping basic beliefs and values
Transmitting religious beliefs

PHYSICAL
Food purchasing and food preparation
Clothes purchasing and preparation
Health care and maintenance
Transportation
Home maintenance

SELF-DEFINITION
Establishing self-identity and self-image
Recognizing strengths and weaknesses
Sense of belonging

EDUCATION
Continuing education for parents
School work
Homework
Cultural appreciation

REST/RECUPERATION (fun)
Individual and family oriented recreation
Setting aside demands
Developing and enjoying hobbies

AFFECTION
Nurturing and love
Companionship
Intimacy
Expressing emotions

VOCATIONAL
Career choice
Development of work ethic
Support of career interests and programs

Adapted with permission from *Working with families with disabled members: A family systems approach.* (Table 3) by A. P. Turnbull. J. A. Summers, & M. J. Brotherson. (1983). Lawrence, KS: University of Kansas, Bureau of Child Research.

1. List the three most important functions to your family today.
2. Who in your family is responsible for the first three priorities?
3. Which functions are strengths in your family?
4. Which functions are most stressful for you now?
5. What three functions might be most important ten years from now?
6. When was the last time you organized individual and family recreation?
7. How would these functions be affected when a family has a young child with special needs?

NOTE: Activity adapted with permission from *SEARCH: Exploring the systems of family support. A training program for families of high-risk and handicapped infants.* Jeanne Mendoza, Ph.D. (1986). San Diego University, San Diego, CA.

Handout 4

FAMILY STRESS

Individual and Small Group Activity

There are subgroups within each family. They are:

1. Individual (you)
2. Marital (husband/wife)
3. Parents (child/parent)
4. Children (child/child)
5. Extended (family/grandparents, aunts and uncles, cousins, friends, and neighbors)

How does a special needs child affect the subgroups in a family? (Please write out your answers. They will be discussed in small groups.)

Individual:

_____

_____

_____

Marital:

_____

_____

_____

Parental:

_____

_____

_____

Sibling:

_____

_____

_____

Extended:

_____

_____

_____

NOTE: Activity adapted with permission from *SEARCH: Exploring the systems of family support. A training program for families of high-risk and handicapped infants.* Jeanne Mendoza, Ph.D. (1986). San Diego University, San Diego, CA.

Appendix A

Early Childhood Assessment Parent Fact Sheet

- If you are the parent of a new born or newly diagnosed child with special concerns, chances are you are feeling overwhelmed with the additional parenting responsibilities you now may be facing.
- Entering the Service Delivery System for Early Childhood Intervention is always difficult for families, even when caring and skilled professionals are available for assistance and support.
- Because for you, the parent, there can be no preparation for this unanticipated event in your family's life, it is the role of those of us in early intervention who have chosen to work with special needs children and their families to help your child and you.
- Early Childhood Intervention is an individualized program that is collaboratively developed and implemented by you and professionals to meet your child and family's needs. These helping professionals may include persons with experience and expertise in any of the following areas: early childhood education, special education, physical, occupational or speech therapy, health, psychology or social work.
- Early childhood assessment is the process by which you and these professionals bring your areas of expertise together to best determine your child and family's strengths and areas of need.
- Although, parents at this time often feel totally helpless and inadequate, you do in fact, have much to teach us about your child and family.
- Your involvement and participation in your child's assessment will help professionals learn who your child really is. An assessment that will be useful and valuable to everyone, must include your expertise.
- Research studies have indicated that not only are families the primary resource of information about their children, but also verify the validity of parent observations of their child.
- You are the most capable, consistent, long-term caregiver, teacher and advocate for your child.

Assessment Tips for Parents

- Teach professionals what you know about your child and family.
- Value your observations and instincts and share them.
- Understand that it is normal for parents to feel a range of mixed emotions in this difficult situation.
- Bring someone with you– preferably your spouse or a close friend.
- Express your concerns.
- Be prepared to ask questions.
- Acknowledge your parenting strengths and areas of need.
- Bring professionals the most accurate information you can.
- Ask what the next step is.
- Ask for help for your child, your family or yourself.
- Believe professionals want the best for you and your family.
- Collaborate toward equal partnerships with professionals.

Assessment Tips for Professionals

- Allow parents to teach you about their child.
- Listen carefully.
- Value what they tell you.
- Provide encouragement.
- Make time.
- Provide numerous options for parent involvement.
- Remember this is an unfamiliar experience.
- Let parents know what the next step is.
- Assume there are always questions.
- Bring parents the best information you can.
- Be human
- Believe parents want the best for their children.
- Let them know.

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Development of an Early Childhood Assessment Team

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Team assessment requires that time and effort be spent on developing working relationships with team members. This chapter discusses the "how" to teaming: why team, frameworks for teaming, developing an assessment team and team assessment models.

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Sheila Wolfe's background is in occupational therapy with emphasis in human and program development. Currently she is active in assistive technology. Her main interests are team work, family, parent-professional partnerships and interagency collaboration. When this chapter was originally written, Sheila was an education specialist with Infant Preschool Special Education Resource Network.

WHY IS A TEAM APPROACH TO ASSESSMENT NECESSARY?

A child's growth and development is a complex and multi-faceted process influenced by family, the child's temperament, health and developmental patterns, learning style, community and culture. Because of the dynamic interplay among each of these factors, they must all be considered to obtain an accurate assessment of the child's and family's strengths and needs. This "holistic approach" requires parents and professionals from a variety of disciplines and backgrounds to work together during the assessment process. A total picture can be obtained and an effective plan of intervention for the child and family can be developed only by integrating the knowledge and perspective of each team member.

The benefits of a team approach include:

- Active involvement of family members in identification of the child and family's strengths and needs
- A system for families and professionals to engage in joint problem solving
- A structure for on-going communication among team members
- Sharing of responsibility
- More accurate and comprehensive information gathering, assessment, analysis, program planning and implementation of strategies
- Less duplication and fewer gaps in the assessment process
- More efficient information sharing and long-term program implementation
- Integration of various recommendations into a coordinated plan
- The combining and sharing of expertise through organized opportunities for team members to teach and learn from one another
- More efficient use of time for the professionals, the child and the family
- Increased professional accountability

WHAT AND WHO CONSTITUTES AN ASSESSMENT TEAM?

A team is a group of people working together and problem solving to reach shared goals. An important underlying principle in a team approach to assessment is that "the whole is greater than the sum of its parts." An assessment team evolves as families and professionals develop trust, understanding and respect for each other's perspective. By integrating findings and recommendations, the team is able to provide a "whole" picture of the child and family's strengths and needs.

The composition of the assessment team will vary from agency to agency. Family, professional, agency and community resources and needs shape the composition of the assessment team. Collaboration between agencies and professionals is clearly a benefit

of developing the team assessment process. When developing the team, it is important to consider the purpose of each assessment and what concerns must be addressed in the assessment process for each child and family. Since these factors will vary from one assessment to another, assessment teams will need to involve the disciplines and agencies most able to respond to the concerns in each assessment. There is no one team composition that will be right for every situation.

Family members are a vital component of the assessment team. They know their child better than anyone else and provide valuable information and insight into the child and family accomplishments and needs. Family members should assist in planning and carrying out actual assessment of their child. Family members assist in identifying family resources and needs, analyzing the assessment data and planning intervention strategies. Refer to the "Foundations for Family Approach to Early Childhood Assessment" chapter for further discussion of the role of the family in assessment. In addition to the parents, other assessment team members might include:

Audiologist
Child Care Provider
Child Development Specialist
Extended Family Members
Family Counsellor
Home Visitor
Nuclear Family Members
Nurse
Nutritionist
Occupational Therapist
Physical Therapist
Physician(s)
Special Educator
Speech/Language Therapists
Social Worker
Teacher

Although not exhaustive, this list illustrates the fact that people from a variety of perspectives and expertise each have a valuable contribution to make in the team approach to assessment.

FRAMEWORKS FOR TEAMING

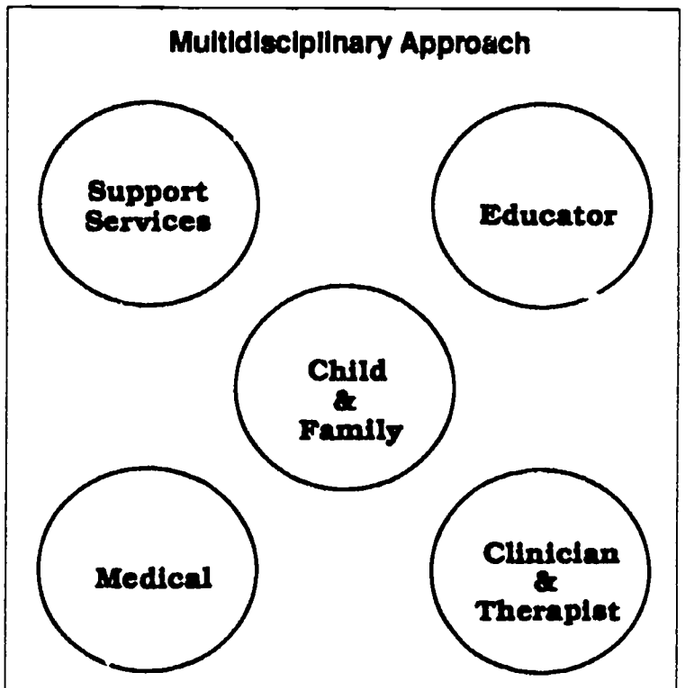
The concept of "teaming" is not new. The importance and value of input from a variety of perspectives has long been recognized as a vital component of serving children with special needs and their families. Recent legislation and federal and state mandates have clearly pointed to the importance of teaming in all aspects of services for children with special needs and their families. California Education Code Part 30, Chapters 4.4 and 4.45 specifically state that programs funded through public education to serve children birth-to-five years with exceptional needs, must implement a transdisciplinary team approach. P.L. 99-457 also highlights teamwork as a component of the planning and service delivery process.

In attempts to clarify the teaming concept, distinction's among the multidisciplinary, interdisciplinary and transdisciplinary teams have emerged.

Multidisciplinary

In the multidisciplinary model, professionals from different disciplines conduct their own assessments and present their findings and recommendations to the family independently. Separate programming plans are developed and implemented. Staff may exchange information informally. A multidisciplinary approach frequently results in:

1. Duplication of effort as each professional often seeks the same information from the family and elicits similar responses from the child.
2. Numerous appointments for the child and family with each specialist.
3. Different and, at times, conflicting interpretations of the child's performance, strengths and needs.
4. Gaps and fragmentation in follow-up recommendations and strategies for intervention.



Adapted from Wisconsin Department of Public Information, *Teaching early childhood exceptional needs: Team resource modules.* (1979).

While the multidisciplinary team approach does provide a more complete picture of child and family needs than can be obtained when only one professional is involved in the assessment, this approach does not emphasize integration of the different perspectives. The end result often is that the family is left to sort out, make sense of, and put together the information and suggestions from many different and sometimes conflicting points of view.

Interdisciplinary

The interdisciplinary team framework recognizes the interrelatedness and overlap among different disciplines. Although separate assessments are conducted, team members exchange information at "case management" meetings. Family members meet with team or team representatives. Though interdisciplinary team members are generally concerned with integrating their perspectives and findings, they tend to maintain the borders and parameters of their own discipline during the actual assessment process and in intervention strategies. Key aspects of the interdisciplinary team approach are:

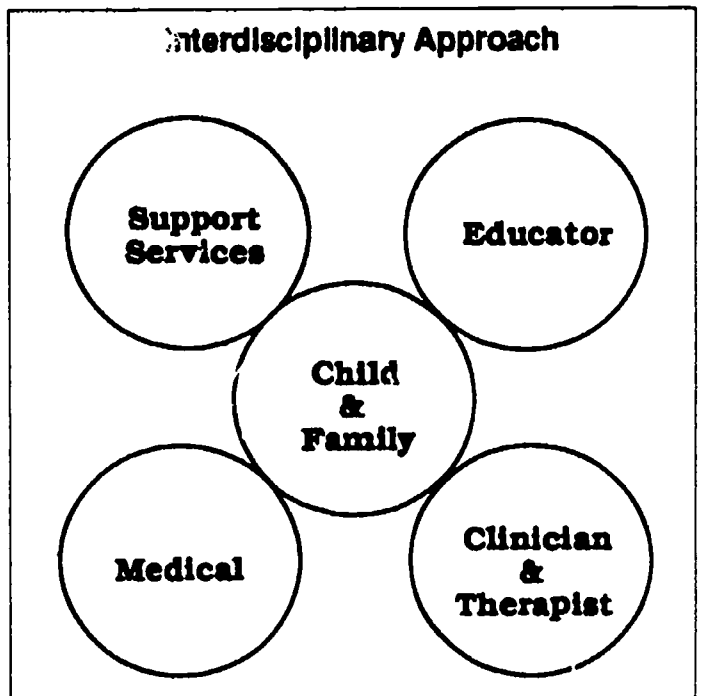
1. Team members assess the child in the same environment.
2. Increased communication between the disciplines around the interpretation of the assessment findings and the recommendations for intervention.
3. Less duplication and fragmentation in the assessment.

4. Fewer appointments are needed for the child and family.

5. Children and families continue to work with several different people, each of whom generally concentrate on their area of expertise.

6. When assessment activities overlap, disagreement between professionals from different disciplines may arise as to whose role/responsibility it is to administer and interpret a particular task or section of the assessment.

7. Once assessment findings are shared, the focus of intervention is in the area of greatest need and will typically revolve around a discipline specific remediation plan.



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Transdisciplinary

A transdisciplinary team framework is also based on the interrelatedness of disciplines, but takes the aspect of interrelatedness one step further. Discipline perspectives are interwoven by having team members teach and train one another in their areas of expertise. In the transdisciplinary team model there is a belief that each profession offers a valuable and unique perspective but different team members, with on-going training and support, can learn to carry out assessments and intervention programs that incorporate key aspects of other disciplines. This is not to say that one discipline subsumes the roles of another discipline, but rather that each professional on the team is committed to learning how to mesh the perspective and techniques of others into their own repertoire, with team support and direction to do so. A commonly expressed concern of transdisciplinary teaming is that one person can be taught to "do it all" without ongoing assistance and input from team members. This is not the case, team members actively support rather than supplant one another when transdisciplinary teaming is carried out effectively. A key concept in this model is the on-going learning and support that team members provide for one another.

In the transdisciplinary model, one assessment and intervention plan is carried out. Family members and professionals work together to assess, make recommendations and implement the program. Key aspects of the transdisciplinary team approach are:

1. Sharing of roles and responsibilities among disciplines.

2. Peer training and support for learning new techniques.

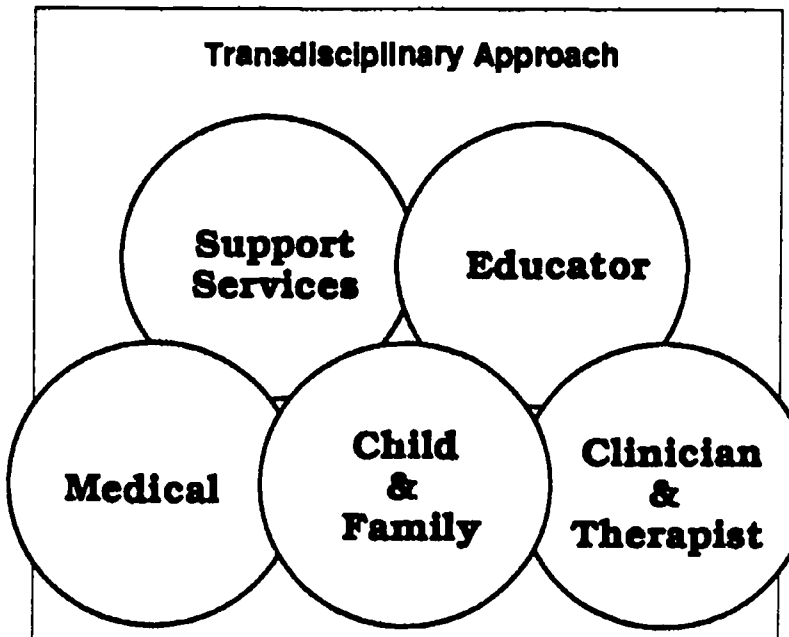
3. Integration of "discipline specific" techniques.

4. A philosophical basis and structure for arriving at team consensus.

5. Usually reduces the number of different people who have contact with the child and family.

6. More opportunity for parents to be active participants in the overall team assessment.

7. Initially may take more time to effectively develop this teaming model and to have all members teach and learn from one another.



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8. May require new approaches to scheduling and to obtaining financial reimbursements.

9. May need time, support and new strategies for linking this model with existing discipline-specified roles, responsibilities and the traditions of large agencies.

CONSIDERATIONS FOR DEVELOPING AN ASSESSMENT TEAM

There is great variation between the agencies that serve young children with special needs and their families. As a result, assessment teams and the assessment process will vary from program to program and agency to agency. Agencies that are developing a team assessment model must consider the community and system in which the team will work. The program resources, the strengths and needs of children and families, and strengths and needs of staff should be reflected in the team assessment model. Each team will have has it's own criteria, composition, special focus, policies, procedures and unique way of conducting assessments. Despite these differences, there are some common elements to the development of successful teams. These include:

Developing a Philosophy of Team Assessment. It is important for administrators, staff members and, whenever possible, family members to discuss and establish a set of common attitudes, values and beliefs regarding what constitutes a quality assessment for young children with special needs and families. A common philosophy serves as the basis for structure and decision making in all aspects of team development. Teams often find that when their philosophy is not clearly developed and defined, the team has reoccurring difficulty in deciding who will participate and how and what things get done.

Establishing the Goals of the Assessment Team. The team's philosophy provides the base for setting the goals and purpose of the assessment and for clarifying the objectives or procedures that will be used by the assessment team. The goals should be clearly stated, easily conveyed to others, evident throughout the assessment, periodically reviewed by the assessment team and reflect the team philosophy.

Clarifying the Assessment Team Priorities. There is always more to be done than can be accomplished in any assessment. Given that the team goals could be reached in a variety of ways, it is important for assessment teams to establish priorities for action. Clearly defined priorities lead to more effective team decision making and help delineate the scope of work for all team members.

Identifying Specific Tasks. With consensus on philosophy, goals and priorities, the team will need to identify the specific or tangible steps and actions that are important to include in each assessment.

Delineating the Skills Needed by the Team. Rather that focusing only on the disciplines or titles of people who should be included in the assessment team, it is more beneficial to focus on the skills that are needed to reach team goals. An example of this might be defining the need for someone with knowledge and experience in working with "typical" children rather than identifying the need for a person with an masters degree in a specific field.

Defining and Negotiating Roles and Responsibilities. A team approach to assessment often involves the redefinition and renegotiation of more traditional, discipline-specific descriptions of roles and responsibilities. This requires staff commitment to teaching and learning from one another and a willingness to define one's role and responsibilities in relationship to other team members and the uniqueness of each assessment. It is critical that each member clearly understands their role and responsibilities as a team member and assessor.

Creating a System for Team Support. There is more to teaming than the specific activities that occur within the assessment. A positive team environment and high staff morale are key components of successful teams and require scheduled time and on-going opportunities for team support and development.

Understanding Team Decision Making. Every team has a process for making decisions but not all teams are clear about how that happens. Most successful teams have found it beneficial to identify what decisions need to be made, who needs to be involved and how decisions are made.

Establishing Linkages with Other Programs and Services. Organizational and administrative support is needed to make the team concept and practice a viable and continuing one. In addition, coordination with other agencies and professionals is needed to insure that the services received by children and families are well coordinated. Team members will need to identify strategies to mesh with and to keep larger systems and other community agencies informed and supportive of the team assessment process.

Planning for On-Going Team Development. Assessment teams need to periodically assess their strengths, needs, accomplishments and barriers to reaching their goals. Based on this evaluation, a realistic plan for staff, team and program development can be established to reinforce the structure and function of the team.

COMMON CONCERNS
AND
QUESTIONS ABOUT TEAMING

Team Models:

TEAMING SOUNDS LIKE A GREAT IDEA BUT HOW DO WE ACTUALLY DO IT?

There is no one way to conduct a team assessment. The philosophy, goals, resources, policies and expertise of each agency will shape the development of the assessment team. Several other factors, including the purpose of the assessment, the cultural and community context of the child and family, and the methods that appear most appropriate to obtaining an accurate picture of the child and family's strengths and needs, are key factors in determining how the team assessment will occur. Common team assessment models are:

1. All team members participate in all phases of the assessment process, for all assessments.
2. A core team completes all phases of the assessment; other team members provide input during the assessment preplanning, discussion of results and formulating recommendations phases.
3. A combination of the two preceding examples, based on the needs of the child and family.

There are five components to a team assessment:

1. Family involvement
2. Referral, intake and assessment planning
3. Assessment of child and family strengths and needs
4. Analysis, discussion and coordination of assessment findings
5. Recommendations and follow-up

It is helpful to look at each of these phases when designing the assessment team process and procedures for your setting; different team members may have different roles and responsibilities during each of these phases.

Family Involvement

In all team assessments, the family and staff plan the assessment together and discuss observations together. The involvement of the family during the assessment component may vary.

- The family members interact with their child during the assessment, carrying out agreed tasks.
- The family observes staff members interacting with the child, offering suggestions throughout the assessment.
- The family member provides a secure environment for the child (for instance, mother holding child on her lap).
- The family shares their observations, concerns, priorities and resources with the other assessment team members.

Referral, Intake and Assessment Preplanning

Referral:

- One team member is designated to receive referrals. The referral contact is the first step of the assessment process; the foundation of the family-professional collaboration begins during this step.
- The program secretary receives referrals, gathers initial information and gives the referral to the appropriate team member.

Initial family contact:

- One team member is designated to make the initial contact with the family. An assessment plan is developed with the family to address their concerns.
- The initial contact responsibility is rotated based on child and family needs and staff expertise and time.

Preplanning meeting:

- Preplanning meetings occur immediately prior to the assessment.
- Preplanning meetings are held at a specified time; i.e., every Tuesday, assessments are Thursday.

Assessment of Child and Family Strengths and Needs Through Joint Observations

- One person interacts with the child, one person conducts the interview with family members and explains the assessment tasks to the family. The other team members observe the assessment and record observations.
- Each team member interacts with the child, taking turns.
- A core assessment team conducts the assessment, which is videotaped. Other team members view the videotape, and provide input during the discussion of findings.

Joint Recommendations

Immediately following the assessment, team members (including the family) discuss their initial observations. Family and professional questions are answered. Team members then meet to discuss the assessment in detail and finalize their recommendations.

- Full team (family and professionals) analyze observations and decide on recommendations.
- Professional team members meet immediately after the assessment to discuss observations and decide on recommendations.
- Professional team members meet at a specified time to discuss the assessment; i.e., preplanning meeting is Monday afternoon, assessment is held Tuesday morning, recommendations are discussed Friday.

The discussion can be organized in the following way:

- The discussion is based on developmental areas; i.e. gross motor, fine motor.
- The assessment questions lead the discussion; i.e. The family is concerned about independent play. What are team member observations related to play?

Report Writing

- All team members write the report together.
- A report coordinator is chosen. Team members individually write sections of the report; the coordinator combines all sections into one report.
- After team discussions, one team member writes complete report.

Follow Up With Family

- Full team meets with family to discuss report. Family questions are answered.
- Report coordinator meets with family to discuss report and answer questions.

How To Team:

EVERYBODY ON OUR TEAM HAS SO MANY GOOD IDEAS AND THERE'S SO MUCH TO DO BUT NEVER ENOUGH TIME! HELP!

There will never be enough time and energy to implement all the good ideas a team can generate. An important plus of teaming is the brainstorming and creativity that is generated. However, part of the problem is remaining focused and on task. When your team feels overwhelmed and/or when you're planning for the future, it's a good idea to review your team's philosophy, goals, accomplishments and most importantly, the priorities that have been established. This information may help you deal with the realities of today and provide some guidance for reallocating, revising or redirecting your resources and efforts. This process can also point to the need for locating and working with other resources to expand and/or enhance your services.

There may also be a personal note to those feelings of being overwhelmed and understaffed....Sometimes, it's helpful just to acknowledge the feelings and don't try to do anything....listening and team support may be enough.

WE CAN CLEARLY SEE THE ADVANTAGES OF TEAM ASSESSMENT, BUT WON'T IT REQUIRE LOTS OF EXTRA STAFF TIME AND MEETINGS?

Staff time and productivity can actually be maximized when team meetings are well planned and efficiently run. Professionals always share information, but often do it in the hall or bathroom. Team meetings provide a way for staff to share observations and information, problem solve together and reach consensus on recommendations and follow-up.

There are several ways to promote the productivity and effectiveness of your team meetings. Teams need to discuss and decide when, where, and how often they will meet and for how long. This will vary according to the location of the t...ns, the purpose for the meeting and availability of meeting space and time constraints of team members.

It is critical to agree on how the meeting will be run. Meeting roles (such as chair-person or recorder) may be assigned, may rotate in a scheduled way or may shift over time as the needs of the team change. Above all, remember that every team member makes an important contribution to the team meeting not only for their expertise and skill, but also because of the role they assume in helping the team function smoothly.

Simple "meeting etiquette" can greatly enhance the productivity of your meeting. A few suggestions are:

Begin and end the meeting at the specified times.

Establish the purpose, process and agenda early in the meeting.

Encourage all members to actively participate.

Avoid getting sidetracked, keep team attention focused on the task at hand.

Keep a written record of team discussions and decisions.

When specific tasks to be done are identified, clarify each team member's responsibility and set a timeline for task completion.

Allow time to review and evaluate the accomplishments of the meeting before it ends.

Set a date and time for the next meeting.

When appropriate, distribute meeting notes to team members following the meeting.

Conflict

WE WERE ALL CHOOSEN TO FORM THIS TEAM BECAUSE OF OUR DIFFERENT STYLES AND SKILLS BUT WE'RE HAVING DIFFICULTY WORKING TOGETHER. ANY IDEAS?

You've recognized the fact that each of you has a different style and different skills, now you can use this insight to identify what each of you can learn from and teach one another. If you haven't already done so, provide opportunities for each member to discuss his/her philosophy of assessment and their background. Acknowledge that each person has something to contribute to the team and that there will probably be overlap in areas of skill and expertise. Allow team members to clarify their personal and professional biases as they relate to working on the team. Ask what support is needed from others to function effectively as team members.

Focus on what needs to get done in order to reach the team goals, staying within the team's priorities. Avoid blaming others for what does or doesn't get done. Identify ways that team member's skills and preferences can support and compliment one another to get the job done.

Individual work styles, as well as professional expertise, will need to be acknowledged. It's important to identify the working styles of each of the team member and to view each style in a positive perspective. If styles are identified in this way, they can be meshed to compliment one another. For example, someone who likes to generate new ideas (the more the better!) may work best with someone who limits the focus of the task and likes to bring activities to closure. Conversely, those who like to bring projects to closure (quickly) may need help from others to consider all of the important variables before making final decisions.

Finally, a team approach works best when an overall team philosophy is established and when the members are flexible and willing to negotiate their roles and responsibilities within the context of the skills and styles of other team members.

IN TEAMING WE VALUE EVERYONE'S INPUT AND EXPERTISE BUT WHAT DO WE DO WHEN WE DISAGREE? DISAGREE STRONGLY?

The first step in solving conflict is prevention. Examples of "preventive medicine" are:

- Planned time to discuss "how the team is doing."
- Discuss, decide and write down group norms (i.e., smoking/no smoking during meetings) and values (we value team members who....) Review periodically.
- Periodically review the team philosophy.
- Try to anticipate possible stressful times (adding/losing staff, budget problems) and develop a plan for handling them.

Disagreements can be healthy especially when they're focused on issues rather than personalities. Discussion from disagreements leads to clarification of the team's goals, purpose, and operating principles. A few ideas on how to stay on the track are:

- Establish guidelines for dealing with conflict in times of peace.
- Plan time to discuss disagreements.
- Verify the facts, clarify assumptions and fill-in missing bits of information.
- Review group norms/values – are they being practiced?
  Acknowledge different belief systems regarding the issue at hand and look for how each belief system may contribute to defining and solving the problem.
- Clarify what the issues are – stating concrete, observable behaviors.
- Acknowledge/ find evidence that supports the notion that there are different ways to get to the same place or reach the same goal.
- Agree on specific actions that those in conflict can support.
- Realize that resolving conflict takes time and requires a supportive environment in order to be addressed or resolved.
- Listen for areas of agreement and use these areas as a spring board for constructive problem solving.
- Always remember humor helps....at the right time.

When it becomes apparent that there is repeated conflict that doesn't relate to specific issues it may be time to consider the more interpersonal aspects of teaming. It may be inappropriate for the whole team to become involved in personal conflict between specific people. In this case, it may be best to encourage more discussion between those who disagree outside the team situation. At other times, it may help for the team to work on identifying the conflict and providing team support and ideas for working through the conflict. Outside facilitators may be able to provide a more objective assessment of the conflict and assist teams in resolving issues.

Staff

WE'D LIKE TO HAVE A COMPLETE ASSESSMENT TEAM INCLUDING PEOPLE FROM A WIDE VARIETY OF BACKGROUNDS BUT OUR ADMINISTRATORS SAY THAT WE ONLY HAVE ENOUGH FUNDING FOR TWO OF US. WHO DO WE CHOOSE?

With funding for two full-time positions, there are many different options for developing an assessment team. You may form a core team of two people as discussed in the first question, but remember that two full-time positions can translate into several part-time positions for people from different backgrounds. You may want to hire consultants to work with the team on specific aspects of the assessment process. Another important and often overlooked solution can be found in working with agencies in your community to form an interagency assessment team that combines the resources and expertise of people from different backgrounds into a common process.

It is important to remember that while today's constraints may limit your immediate ability or actions as a team, it is possible to promote changes within systems, to develop new ways of addressing team assessment issues, and to create new alternatives for assessment.

Administrative Support

THERE ARE SEVERAL OF US WHO HAVE BEEN DOING ASSESSMENTS SEPARATELY AND THINK A TEAM APPROACH IS A GOOD IDEA. HOW CAN WE CONVINCE OUR ADMINISTRATORS?

It's important to recognize that most people are trying to do the best job they can and that administrators are no exception. Sometimes however, administrators are faced with issues of limited funding, space and personnel (just to name a few). These issues may overshadow more service related issues and needs. Therefore, it's important for those of you interested in teaming to:

- Enlist the support of parents, key agency personnel and/or other members of the community in preparing information and/or a presentation on the benefits of teaming.
- Identify as clearly as possible, what, in the administrator's perception, are the constraints to forming and developing an assessment team...be sensitive to the administrator's needs and pressures.
- Involve administrators in problem solving around the issues and need for a team approach....this may need to occur over time and may not be resolved immediately.
- Consider a variety of ways to implement the teaming process noting the pro's and con's of each approach.
- Identify and discuss how the team approach will support the goals of your agency.

Evaluation

SOME ASPECTS OF THE WAY WE DO ASSESSMENTS ARE GREAT, OTHER ASPECTS AREN'T SO GREAT. WHERE DO WE GO FROM HERE?

It is important for all teams to periodically evaluate their efforts and to systematically identify their strengths, their accomplishments and their continuing needs. Assessing the "wellness" of the team helps to frame this process in a positive light, avoids the problems associated with focusing only on what is wrong or hasn't been accomplished, and creates an atmosphere for productive and creative problem-solving among team members.

Evaluating and revising the efforts of your team can be done in several different ways, depending on the goals of and the resources allocated to such a process. Teams may choose to focus on how well they are working together by reviewing their philosophy, goals and priorities to determine if and how their actions are working within this context. The considerations for developing a team approach discussed in the previous section may provide the framework for this type of team evaluation and generate discussion and new ideas about how the team should proceed.

Another approach to evaluating, revising and/or revamping the team approach is to focus on the more personal or psycho-dynamic aspects of teaming. This would include evaluating how team members feel about:

- The overall goals of the program
- Their roles and responsibilities
- Any role conflicts that may exist among team members
- Their own participation and influence on the team
- Their commitment and the commitment of others to the team approach
- How they and the rest of the team manage conflict and make decisions about aspects of the program
- The overall support for the team process

This approach allows individuals to express their feelings about working together with other team members and may help to pinpoint particular problems that need further attention. It can also provide a positive focus for areas that both hinder and support effective teaming.

Ideally, it is helpful to look at both aspects of teaming – issues related to how and what work is being done and feelings about how the members of the team are working together. In both cases it is important to focus on what will help the team and it's individual members work together more effectively to provide comprehensive and well-coordinated assessments for the children and families they serve.

Finally, remember to identify the strengths and prioritize needs for team development before launching into action strategies. Limit the areas that need more attention and/or further development so that the team can see it's own progress and feel successful.

Training Activities

Strategy #1

Purpose: To provide an overview and introduction to teaming.

Materials: Handout 1a: TEAMING: AN OVERVIEW
Handout 1b: TEAMING: AN OVERVIEW DISCUSSION

Activity: Complete TEAM SENTENCES

1. Have the group individually complete the TEAMING: AN OVERVIEW form.
2. Lead a large group discussion of the answers, referring to Handout 1b: TEAMING: AN OVERVIEW DISCUSSION.

Time: Allow 10 minutes to complete the form, 30-45 minutes for discussion.

Strategy #2

Purpose: To identify individual temperament styles, and the impact of different styles on teaming.

Materials: Keirsey or another temperament scale

Activity: Review and discuss temperament styles. (If you are working with one team, steps 2 & 3 can be combined into one discussion)

1. Review the temperament scale with the group, identifying each style. Have the group complete and score the scale on an individual basis.
2. Review the individual temperament styles with the large group, generating discussion by asking questions such as: "How many people are a _____ style? What are characteristics of this style that support teaming? May hinder teaming? Do you agree with the style that is identified for you?" (For large groups, break into groups by style. Add time for group to report back to each other).
3. Break the groups up into teams, and ask them to discuss the following statements:
   a. My identified style is _____.
   b. My strengths as a team member are _____.
   c. I need _____ from other team members to function best_____.

Time: Allow 15 minutes for introduction and completion of the scale, 20 minutes for large group discussion, and 45 minutes (depending on size of the team) for team discussion.

Strategy #3

Purpose: To demonstrate examples of teaming models.

Materials: Video of different models of team assessment.

Activity:

1. Lead a discussion on teaming models, covering the following points:
   a. There is no ONE way to conduct a team assessment.
   b. When developing a team assessment model, the following influences must be considered:
      Family and child resources and needs
      Program setting
      Systems issues
      Availability and skill of staff
   c. Teaming provides support and resources for staff and families; not all team members need to "touch" all kids.
   d. What could be accomplished through a team approach that can't be done through a more traditional evaluation model?

2. Show a video of different team models. After each model is shown, have the group discuss the following: (large groups can be broken down into small groups by teams or cross-team grouping)
   a. What is the team model shown?
   b. What are strengths of this model?
   c. What are concerns of this model?
   d. Would this model work for your team? Why or why not?

Time: Allow 20 minutes for step 1. Each video example should be 3-5 minutes, allow 10 minutes to discuss after each model is shown.

Strategy #4

Purpose: To provide feedback on team process.

Materials: Handout 2: ANALYZING THE TEAM ASSESSMENT PROCESS

Activity:

1. Videotape the team conducting an assessment (alternative options can be to have the team bring a videotape they've done, or to complete this activity right after a team assessment that was not videotaped).

2. Complete the team process analysis
   a. Review scale with team.
   b. Use video or recall to record specific examples of behavior.

3. Identify any problem areas or areas that need improvement.

4. Brainstorm solutions and action plan for areas identified in activity 3.

Time: Approximately one hour.

Strategy #5*

Purpose: To assess strengths and needs of the team.

Materials: None

Activity: Have team members discuss their answers to the following questions by citing specific examples on which they based their responses. Instruct the team to focus on issues and actions to illustrate their point rather than people and personalities.

a. Has the team philosophy (beliefs about what constitutes quality services) been delineated and agreed upon?

b. Have the overall goals of the team been clearly defined?

c. Are the team goals clear to and supported by the program's administrators and individual team members?

d. Have the team's priorities for action been established?

e. Do the team's actions accurately reflect the team's philosophy, goals and priorities?

f. Have team members identified and agreed upon specific tasks and activities in order to accomplish the team's goals?

g. Does the team have the skills and expertise to accomplish their goals and, if not, have additional resources been identified and effectively utilized?

h. Have the roles and responsibilities of individual team members been defined and are they understood by other team members?

i. Have there been opportunities to renegotiate roles and responsibilities to increase the overall effectiveness of team?

j. How do the team members relate to one another? Do they work to support one another? Are team members willing and able to teach and learn from one another?

k. Has a process for team decision making been identified? Do the team members understand this process? Does the team follow the identified team decision making process?

l. Is the current structure for conducting team meetings effective?

m. How well does the team interact with the rest of the agency or organization?

n. Are there on-going opportunities for team development?

Time: 45-60 minutes

Strategy #6

Purpose: Team Goal Setting.

Materials: Chart pad, markers

Activity: During a team meeting ask members to complete one of the following questions and discuss their responses with the other members.

a. As I see it, the reason our team (program) is here is to ...
b. It seems to me that what we're trying to accomplish is ...
c. I see the major goals of our team as...

Time: 30-45 minutes

Strategy #7

Purpose: Team Goal Setting.

Materials: Chart pad, markers

Activity: Use the team goals/mission statement as a base for developing objectives, measurable signs or tangible indicators that the team has met their goals. A helpful lead statement for accomplishing this task would be:

We would all know that we were successfully reaching our team goals if...

or

Have team members list 5 or 6 outcomes that they feel would indicate that the team was successfully working towards the established goals. Work as a team to match the desired outcomes with the appropriate goal statements.

Time: 30-45 minutes

Strategy #8

Purpose: To establish team priorities.

Materials: Chart pad, markers

Activity:

1. Work in pairs or small groups to identify the specific activities in which each team member and the team as a whole are engaged.

2. Once the activities have been identified, match each activity with the team goal(s) that each addresses. Identify activities that do not match existing goals. If there are many of these activities, look for why and how these affect team functioning.

3. Review each goal and corresponding activities and work in small groups to prioritize the tasks in each area according

to whether each is a *High, Medium, Low* Priority. Use this information to work as a team and decide on priorities using the same *High, Medium* and *Low* priority categories.

4. Have team members assess their individual work in terms of the overall team priorities before finalizing team priority statements.

5. Regroup and evaluate individual and team activities in accordance with previously identified team goals, desired outcomes and priorities. Finalize written statement of priorities to coincide with the team goals/mission statement.

Time: 2 hours. This activity can be broken up into smaller activities.

Strategy #9*

Purpose: To define and negotiate team roles and responsibilities.

Materials: None

Activity: Individual team members share their perception of what they feel they are expected to do and accomplish. Then have each team member identify how they see their work in relation to the overall team goals and the skills and work of others on the team.

Time: Allow 10-20 minutes per team member and 20-30 minutes for group negotiation and problem solving.

Strategy #10*

Purpose: To define and negotiate team roles and responsibilities.

Materials: None or Chart pad

Activity:

1. Have each team member complete the following statements:
   a. I'd like to be able to do more...
   b. I'd like to do less...
   c. I'm satisfied doing about the same amount of...
   d. I could use some help with...
   e. I think I could help others with...
   f. I'm interested in improving my skills or learning more about...
   g. I'd like to work more with other team members on...

2. Discuss individual team members' responses to the above statements as a basis for defining and negotiating roles and responsibilities among all team members.

Time: Step 1: 5 minutes per team member
Step 2: 30 minutes

Strategy #11

Purpose: To define and negotiate team roles and responsibilities.

Materials: Handout 3: QUESTIONS/SOURCES CHART

Activity: The chart in handout 3 provides a format for assigning roles for a particular assessment. To complete the chart, team members:

1. List assessment questions on the left column.
2. Decide on technique to answer each question.
3. Write the team members name who will implement the assessment strategy in the block that corresponds to the assessment question and chosen techniques.

Time: 60-90 minutes.

Strategy #12

Purpose: Team problem solving and decision making.

Materials: Chart pad, markers

Activity:

1. Identify/clarify problem.
2. Generate solution alternatives (all are acceptable at this point).
3. Review suggested alternatives and rank as: *Good/Better/Best.*
4. Review team goals and major team activities in light of "Best" alternatives.
5. Clarify actions needed for *"Best"* alternatives.
6. Implement solutions.
7. Evaluate results within specified time frame.

Time: one hour

Strategy #13*

Purpose: Action planning and future team development.

Materials: Chart pad, markers

Activity:

1. Identify three things/areas of need to work on in the immediate future: do this individually and then as a group.
2. Prioritize areas to be worked on as: *High/Medium/Low.*
3. Consider which areas are most likely to affect change within the system and how easy/difficult it will be for the team to succeed in that area.
4. Develop timeline for accomplishing/reviewing tasks and delineate levels of involvement for all team members.
5. Set date within four to six months for additional team development sessions/reassessment of the team's strengths, needs, goals and priorities.

Time: Varies, with number of team members.

Strategy #14

Purpose: Bringing a new member on board.

Materials: None

Activity:

1. Schedule team time to meet with new team members to:
   a. Clarify team goals/mission statement and objectives/ tasks.
   b. Define roles and renegotiate roles in view of new member.
   c. Explain team norms or how things get done among team members.
   d. Learn the new member's strengths, needs and working style.
   e. Discuss areas of confusion or uncertainty related to team roles and responsibilities.
   f. Help new members identify what they might need to know in order to do their job effectively.

Time: Varies, with number of team members.

Strategy #15

Purpose: Bringing a new member on board.

Materials: None

Activity: At a team meeting have all team members share:
"When I came to this team I wish someone had helped me...

Time: Varies, with number of team members.

Strategy #16

Purpose: Bringing a new member on board.

Materials: None

Activity: At a team meeting, each team member introduces the person to their right to the new member by saying "Two things you should know about _____ are." The comments can be about working style, interests or humorous stories.

Time: Varies, with number of team members.

Strategy #17*

Purpose: To run a better meeting.

Materials: None or chart pad

Activity:

1. Set up a process for each team member to respond to the following statements:
   a. During meetings it seems to work best for us to...
   b. In order to make our meetings more effective we might want to try to...
   c. During our meeting we need to watch out that we don't get bogged down by...

2. Discuss commonalities/differences of responses. Identify and develop action plan to implement responses agreed upon by team.

Strategy #18*

Purpose: To clarify team norms.

Materials: None

Activity:

1. Have a team meeting to clarify and/or ask questions regarding how the team does things and how the team seems to handle conflict.

2. Have team members work individually and as a group to complete the following statements:
   a. One thing we might change is...
   b. What does everyone think about how we...
   c. It's not written anywhere but...
   d. It's O.K. on this team to...
   e. As a team we try to avoid...
   f. Our team seems to work well because we...
   g. Our team seems to have difficulty...
   h. Our team has a high regard for...

Time: 45 minutes

Strategy #19

Purpose: To establish team values and norms.

Materials: Chart pad, markers

Activity:

1. Lead a discussion on team norms and values.
2. Ask members to complete the statement:
   Our team norms are_____. Record responses.
3. Discuss and clarify responses. Make changes/deletions/additions as appropriate.
4. Agree on team norms by asking "Can we all live with the norms agreed on?"
5. Ask members to complete the statement:
   We value _____ in our team members.
6. Repeat steps 3 & 4 for team values.
7. Develop an action plan to implement norms and values (step 4) asking:
   What resources do we currently have?
   What are barriers to implementing?
   Strategies to implement?

The following chart can be used for this activity:

Team Norms	Resources	Barriers	Strategies
Team Values	**Resources**	**Barriers**	**Strategies**

Time: 1-1/2 - 2 hours

Strategy #20*

Purpose: To promote intra- and interagency collaboration.

Materials: None

Activity:

1. Identify issues/actions/times/places that require the team to interface with the rest of the organization or other agencies.
2. Consider sources of resistance both on the team and within the rest of the organization/agency that interfere with coordination.
3. Review when and how the team successfully and unsuccessfully interacted with the rest of the organization/ agency and analyze key components of each.
4. Identify when and how the team has been able to successfully involve and consult with people from the rest of the organization/agency and vice versa.
5. Check individual/team assumptions about the likelihood that successful interaction is possible.
6. Discuss the benefits/liabilities of interaction with the rest of the organization/agency.
7. Consider how the team goals and activities mesh with the goals of the rest of the organization/agency.
8. Identify rationale and priorities for interfacing with the rest of the organization/agency.
9. Establish framework and strategies for negotiating and coordinating with other key people.
10. Identify the roles and responsibilities of team members related to involvement and coordination with the rest of the organization and with other involved agencies and personnel.

Time: 45 minutes

NOTE: *Starred strategies in this section were adapted with permission from *Improving the Quality of Care: A Program for Health Team Development.* Rubin, I., Plovnick, M. & Fry, F. (1978). Cambridge, MA: Ballinger Publishing Co.

Handout 1a

TEAMING: AN OVERVIEW

1. Two important goals of our assessment team are:

   a. _____

   _____

   b. _____

   _____

2. The advantage I've experienced in being part of an assessment team is:

   _____

   _____

   _____

3. A unique contribution I make to our team from my discipline is:

   _____

   _____

   _____

4. The disadvantage I've experienced in being part of an assessment team is:

   _____

   _____

   _____

5. Our administration views our assessment team as:

   _____

   _____

   _____

6. The single most important issue for our team to address at this training is:

   _____

   _____

   _____

Handout 1b

TEAMING: AN OVERVIEW DISCUSSION

"WHAT" are we as a team? (Question 1)

Definition of Team:
Group of people working together to achieve a common goal through common means.

Philosophy of assessment — the need for consensus.
1. Provides basis and framework for assessment.
2. Helps identify goals and objectives.
3. Helps identify methods best suited to achieve goals.

"WHY" do we team? (Question 2)

Some Advantages: (Linked to philosophy of assessment.)
1. Promotes ecological assessment by stressing "whole child."
2. Enhance implementation of comprehensive assessment plan.
3. Professional exchange of expertise.
   Helps avoid professional "tunnel vision."
4. More efficient use of information and time.
5. Linking assessment and intervention by increased communication with educational and therapeutic staff.

"WHO" are we as a team? (Question 3)

Team composition functionally related to:
1. Philosophy of assessment
2. Assessment setting

Discipline represented: What contribution does each make?

Types of teams: Different methods of teaming.
Pros and cons of each type.

"HOW" do we team? (Question 4)

Definition of Syntality:
Syntality: Behavioral tendencies of a group acting as a group (i.e. the group's personality).

Syntality is the product of:
1. Team process: Interactive functions oriented toward maintaining and perpetuating interpersonal relationships among team members.

Examples:
- Communication and support
- Role relationships and functions
- Conflict resolution
- Decision making and leadership
- Personality and performance
- Integrating individual/team needs

2. Team logistics: Task functions oriented toward accomplishing the work of the team.

   Examples:
   - When, where, how often to meet and for how long
   - Team reporting
   - Type of meeting, meeting agenda
   - Who is responsible for what and when?

"WHEN" do we need team evaluation? (Question 5)

On-going:
- Staff development
- Interface with administration
- Gaining and keeping administrative support
- Interagency relationships
- Other "systems" issues

Periodic:
- Reading team "vital signs"
- When to modify team process or logistics
- Handling change
- When an outside consultant may be helpful

"WHERE" are we in team development? (Question 6)

Review the stages and phases of team development

Handout 2

ANALYZING THE TEAM ASSESSMENT PROCESS

An Individual Perspective Leading to Team Discussion and Evaluation

1. The process we used to clarify the assessment questions was:

   Excellent Good Satisfactory Poor Not Sure

   Examples: _____

2. The way we delineated our roles and responsibilities prior to the assessment was:

   Excellent Good Satisfactory Poor Not Sure

   Examples: _____

3. The way we conducted the family interview and discussion was:

   Excellent Good Satisfactory Poor Not Sure

   Examples: _____

4. Our set-up of the environment for the assessment was:

   Excellent Good Satisfactory Poor Not Sure

   Examples: _____

5. Our interaction with the family during the assessment was:

   Excellent Good Satisfactory Poor Not Sure

   Examples: _____

6. The ways assessment items and activities were presented to the child were:

   Excellent Good Satisfactory Poor Not Sure

   Examples: _____

7. Our team's interactions and support of one another during the assessment were:

Excellent Good Satisfactory Poor Not Sure

Examples: _____

_____

_____

8. The way we brought the assessment to a close with the child was:

Excellent Good Satisfactory Poor Not Sure

Examples: _____

_____

_____

9. The way we brought the assessment to a close with the family was:

Excellent Good Satisfactory Poor Not Sure

Examples: _____

_____

_____

10. Our process for sharing observations, learning from one another, and coming to concensus after the assessment was:

Excellent Good Satisfactory Poor Not Sure

Examples: _____

_____

_____

11. Our process for discussing observations and developing the individualized program plan with the family was:

Excellent Good Satisfactory Poor Not Sure

Examples: _____

_____

_____

OVERALL...

16. I think we did a good job of:

17. I think I'd like to improve my:

18. I think our team was really good at:

19. I think our team had some problem with:

20. In the future I would like to see us:

Signature: _____

Completed following assessment of: _____ on: _____

Handout 3

QUESTIONS/SOURCES CHART

ASSESSMENT QUESTIONS	Previous Assessment & Reports	Parent Interview	Home Observation	Teacher Interview	Classroom Observation	Observation	Peer Interaction Observation	Play Interview & Observation	Curriculum Referenced Tool	Formal Assessment

Annotated Bibliography

Allen, K. E., Holm, V. A., & Schiefelbusch, R.L. (Eds.), (1978). *Early intervention — A team approach.* Baltimore, MD: University Park Press.

This book is an excellent reference for team and early intervention program development. Chapters highlight different aspects of early intervention with the majority of chapters focused on developing a team approach. The chapter, "Interdisciplinary Child Development Team: Team Issues and Training in Interdisciplinariness" provides an excellent overview of the major issues related to developing and maintaining a team approach. The areas discussed include team philosophy, team composition, professional roles and responsibilities, leadership, team meeting strategies, teaming models and training needs.

Doyle, M. & Straus, D. (1976). *How to make meetings work.* New York: Playboy Paperbacks.

The Interaction Method, a process to "stop wasting time and to get things done" (more effectively) at meetings, is described throughout the book and specific examples of its application are included. This book will be helpful for those who are interested in how their team meetings can become more effective.

Fry, R.E., Plovnik, M.S., & Rubin, I. (1975). *Improving the coordination of care: A program for health team development.* Cambridge, MA: Ballinger Publishing Company.

The materials focus on team development to "minimize the stress and energy" often spent on problems related to the need to work as a team and to "maximize the energy and efficiency" needed to accomplish the task. The program is organized into modules for learning that were designed largely for health teams but which can (and have been) easily adapted and applied to teams operating in a variety of settings. The program is designed to assist teams in defining and solving their own problems through a systematic process. This publication is difficult to locate but well worth the search. While new issues are no longer being printed, it is reported that copies can be found in college and university libraries which include a medical center and/or an established school of organizational psychology and management.

Hayes, U. (1976). The National Collaborative Infant Project in T. Tjossem (Ed.), *Intervention strategies for high risk infants and young children.* Baltimore, MD: University Park Press.

This article describes an early intervention program and the transdisciplinary model it utilizes. The rationale for the transdisciplinary approach, staff/parent roles on the team, and personnel training issues are discussed.

Hutchinson, D. (1978). The Transdisciplinary Approach in Curry, J. & Peppe, K. *Mental retardation: Nursing approaches to care.* C.U. Mosby, St. Louis, MO.

This chapter discusses the development of a transdisciplinary team, siting examples from two United Cerebral Palsy projects. The definition of transdisciplinary, dynamics of teaming, group development and benefits of

teaming are discussed. An excellent overview article.

Kiersey, D. & Bates, M. (1984). *Please understand me: Character and temperament types.* Del Mar, CA: Prometheus Nemesis Book Company.

This book is essentially a manual for the Kiersey Temperament Sorter. It explains the basic dimensions underlying the temperament sorter, the major temperament types, how temperament affects work and leadership style, marriage and life style. The temperament sorter, scoring sheets and instructions for administration and scoring are included.

Maddux, R. A. (1986). *Team building: An exercise in leadership.* Los Altos, CA: Crisp Publications, Inc.

This booklet is designed as a self-paced reader of activities, exercises and team building strategies. The booklet's stated purpose is to point out the "differences between groups and teams." Brief statements on a variety of team and leadership issues are presented along with tasks and exercises to help illustrate the point. This booklet would be of benefit to administrators, program managers, team leaders and others with staff and program development responsibilities.

Rubin, I., Fry, R., Plovnik, M., & Stearns, N. (1975). *Improving the coordination of care: An educational program.* Working paper of the Massachusetts Institute of Technology, Alfred P. Sloan School of Management, 50 Memorial Drive, Cambridge, Mass., 02139.

This article focuses on the underlying concepts of team development and problems, which the authors believe are inherent in programs and services that call for coordination of effort among two or more people. The term "interdependent" is used frequently to describe the overall goal of people working together and the information is geared to helping that process evolve and function effectively over time. Copies of the paper may be obtained directly from MIT for $6.00.

Staff Development Handbook: A Resource for the Transdisciplinary Process. (1976). New York: United Cerebral Palsy Association Inc.

This is an especially useful monograph for those interested in the transdisciplinary approach to teaming. The transdisciplinary philosophy is discussed and contrasted with other models of teaming. Issues such as hiring, orientation and commitment of team members, creating a team "learning environment," establishing team goals, and sources and resources for staff development are covered.

Infant-Toddler Assessment: Clinical Procedures and Interpretations

Marie Kanne Poulsen, Ph.D.
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An outline of procedures for the planning, conducting and interpreting of infant assessment is presented in this chapter. Special emphasis is placed on observing the behaviors across all domains of development. Considerations of the interactions between caregivers and infants is stressed, as it relates to disabilities and special needs. The value of a Piagetian framework for interpretation of behaviors is described. An outline of developmental milestones is included.

About the author: Currently, Marie Poulsen's work concentrates on providing services to children and their families who are at risk due to prenatal substance abuse.

ROLE OF ASSESSMENT IN SERVICE DELIVERY

Traditional educational and medical models of service delivery have viewed assessment only as the necessary prerequisite for the obtainment of services needed for children. Typically such assessments focus on psychometric data that will certify a child's eligibility for a particular program. Program planning based on such data usually centers on a deficit model and highlights developmental milestone "failures" that need intervention.

A family-child service model has an entirely different viewpoint on the role of assessment in the delivery of quality services. This model incorporates ecological and holistic perspectives. A holistic approach emphasizes the importance of looking at the individual child in the context of how his developmental and interactional strengths and vulnerabilities, his particular learning strategies, his medical, physical and social history and his particular handicapping condition interact to influence his capacity to effectively deal with persons, objects and events of his world. An ecological perspective provides an appreciation for the child as a member of a family and a cultural community, and as part of many service delivery systems. The family-child service model sees the assessment process as the first significant step in quality intervention and not merely an entry point for intervention programs.

The purposes of the assessment process from ecological and holistic perspectives are to:

a) Empower the parents as part of the assessment team that will be program planning for their child.
b) Integrate previous and concurrent information and recommendations for the parents.
c) Plan an integrated individual program and family service delivery plan in the context of child and family resources and needs.

To ensure that holistic and ecological perspectives are incorporated into program planning for an infant and his family, the following goals of assessment should be included:

a) Assess qualitative information about the child's:
   Motor, language, play, cognitive, emotional and self-help
   Strengths and difficulties
   Capacity for social interaction
   Strategies for learning

b) Determine those differential diagnosis that relate to adaptive functioning and thus intervention program strategies. For example, is observed language difficulty a result of hearing impairment, oral-pharyngeal structural difficulties, failure-to-thrive, specific language delay, cognitive delay, visual impairment, physical disability, severe emotional disturbance and/or child abuse?

c) Understand the impact that the following factors have on the emotional, social, cognitive and motor functioning of the child:
   Mental, neurological, sensory and/or physical handicapping conditions

Medical history/illnesses
Procedures/hospitalizations
Medications
Family stresses

d) Establish a good relationship between parents and a service delivery system:
Building a trusting relationship
Empowering the parents to be members of this and all future transdisciplinary teams

e) Model infant-caregiver interactions for inexperienced or anxious parents.

f) Gather and clarify information about the parents' understanding of the child's strengths, problems and medical conditions.

g) Gather and integrate information about previous and concurrent systems/ resources of service delivery for the family.

h) Gather and integrate program planning information
Current service delivery needs of family; e.g., parent support group, parent education group, respite care, behavior management strategies, developmental intervention strategies.
Specific intervention services for child: physical, occupational and/or speech therapies, dental/medical/nutrition referrals, infant intervention programs.

Preplanning with the Parent(s)

The family-child service model views the parent as an important member of the assessment team. The parent is able to provide considerable insight regarding child's current state and general temperament; supply important medical, social and developmental history; put the child's observed behaviors into the context of his daily functioning; discuss how family stresses have affected the child's behavior and development; and take a leadership role in determining priorities that meet the needs of the child in context of the family's needs and desires.

Empowerment of a parent as a member of the team requires planning. The following are important preplanning components.

- Provide parent with information about purpose, philosophy, procedure and time frame of assessment.
- Discuss parent's role as member of assessment team.
- Request medical, therapeutic and developmental records for team review.
- Select best time for infant assessment in terms of child's feeding, sleeping and temperament patterns.
- Remind parents to bring food, drink, diapers, favorite toys, adaptive equipment, etc.
- Check for need and provision of interpreter.

ASSESSMENT PROCEDURE CONSIDERATIONS

Family as Team Members

The family-child service model sees that the parent plays a pivotal role as a member of the assessment team and as a prime component of the intervention services offered the child. With these values in mind, considerable time and weight should be given to parent's feelings, information, concerns, questions and priorities as part of the assessment process. This may mean that the first contact with the family is comprised of an extended family interview coupled with observing the infant/toddler in free play during that interview process. At times, this may be the first opportunity the parents have had to discuss at length their concerns about their child.

While parents should be cautioned to allow the infant/toddler to try things on his own during the standardized assessment portion, every opportunity should be afforded them to show the examiner how the child can respond with parent modification of the task. As a member of the team the parent is empowered, can provide valuable information and often clarifies discrepancies in perceptions of the child's abilities.

Timing and Pacing of Assessment

Timing and pacing of the formal assessment of the infant/toddler need to be guided by the child's temperament, state and style of interaction. The younger the infant, the more pertinent the information is about the child's state and his capacity to control his state. Each child has his own individual manner of interacting with people, objects and events. Intervention program plans need to take into consideration the suitable pacing of interaction with infants and toddlers. Oftentimes, there is a very fine line between appropriate arousal and over-stimulation.

The timing of assessment needs to heed the ever changing states of wetness, fatigue and hunger. Parents should be prompted to cue the examiner to their child's needs in these regards, and formal assessment should be halted immediately to meet these needs. Factors of heating, overhead bright lights and distracting objects need to be controlled if they interfere with the formal assessment of optimal behaviors.

Positioning During Assessment

Repositioning the child (e.g. protracting shoulders for reaching, placing hands on table for prehension, moving head to midline for visual following and inhibiting primitive reflexes) can often provide a significant change in the accurate assessment of cognitive (as opposed to motor) functioning. The need and use of adaptive equipment to provide head and/or trunk support should be explored, assessed and provided during the assessment process to see how its use affects function.

Multiple Observations

The greater number of sensory and physical involvements there are that affect the child's functioning, the more important it is to see the child more than one time and in more than one setting. At times, the most valuable information about infant/toddler cognitive development cannot be assessed through use of standardized instruments because of the number of items that require visual judgment and motor control. For the youngsters who are blind and physically handicapped, information about cognitive

development can better be assessed in how the child understands, anticipates and signals during daily living activities of mother-child play, bathing, feeding, diapering, dressing, being lifted, going to bed, and how he relates to familiar toys, family members, and household pets.

The following assessment procedures need to be considered and integrated into program planning:

- Allow opportunity for parents to fully express their concerns, questions, information, feelings and priorities.
- Monitor and modify for infant/toddlers's state and capacity to control state and individual need for pacing of interaction with persons, objects and events.
- Monitor infant/toddler's wetness, hunger and fatigue throughout the assessment process.
- Monitor heating, overhead lighting and distractions to the extent that they interfere with assessment of infant/toddlers' optimal functioning.
- Monitor positioning of infant/toddler and assessing how it affects function.
- Monitor need and use of head/trunk supports and how they affect functioning.
- Use standardized assessment procedures to gather baseline information.
- Use non-standardized procedures to add information about optimal functioning and strategies.
- Provide opportunity for parent to work with child if they wish.
- Use multiple assessments.
  Formal assessment, parent interview, informal play
  Center based/home

Parenting Values

The family-child service model in addressing the child as a member of the family, looks closely at how family rules, roles and rituals affect the child's development.

The involvement a child has in the regular, consistent daily living rituals of waking, feeding, diapering, bathing, dressing, sleeping and playing are of critical importance in gaining information about the opportunity a child has to learn how 1) to anticipate events, 2) to internally organize the sequence of events and 3) to develop security from the stability of family happenings.

There are several parenting values that impact a child's psychosocial development. These values should be explored in order to gain a better understanding of expectations placed upon the child and the opportunities he has to develop independence and autonomy.

Values to be explored are:

- Parents' willingness to set limits on child's behavior; e.g., stay at ta. : to eat.
- Parents' willingness to allow normal risk taking; e.g., playing outside, climbing.

- Parents' understanding of the developmental process; e.g., messiness part of learning to eat, clumsiness is part of learning to walk, falling down is part of learning to run.

- Parents' willingness to allow normal negatives; e.g., unhappiness at bedtime, anger at being refused candy.

- Parents' willingness to leave child with other caregiver.

Initial Observations of Infant/Toddler

Infants/toddlers provide valuable information about their temperament, state and style of interactions by the manner which they engage in the assessment process. These factors often play as salient a role in program planning as do the developmental data. Parents are able to validate the significance of behaviors observed.

The examiner can use himself as a means to look at how the infant/toddler deals with separation issues. Of equal consideration is how the child communicates to his parents in times of separation and how he uses them for comfort and solace. Addressing this issue may be more important for parents than teaching them how to enhance developmental skills per se.

The following social and emotional styles of the infant should be assessed and integrated into program planning:

Infant's initial response and accommodation process to an unfamiliar situation
- Style of initial response
- Use of familiar caregiver as source of needed emotional support
- Capacity to accommodate to demands of a new situation
- Response to examiner's strategies to help him accommodate

Infants' interaction with parent (See Appendix A: Psychosocial Development.)
- General initiation of interaction
- General responsiveness to interaction
- Social signaling behaviors: eye contact, prolonged regard, mutual gazing, gaze aversion, turning to voice, vocalizing, joint attention, object pointing, raising arms to be lifted

Fearfulness in familiar and unfamiliar situations
- Characteristics: initial vigilance, prolonged vigilance, continued inhibition of behavior, restrained behavior, constricted behavior
- Capacity to respond to caregiver intervention.

Formal Assessment

Formal assessment calls for the use of systematic observation of standardized procedures. There are several norm-referenced and criterion-referenced assessment tools that will provide a framework for the evaluation of fine motor, gross motor, adaptive behaviors, receptive-expressive language and daily living skills. The tool itself will yield information about the attained developmental level for each dimension of development.

The most useful information for program planning however, will be obtained from observing the *qualitative* skill differences, learning strategies and psychosocial characteristics that impact the child's response to objects, persons, ideas and events during the formal assessment process.

Assessment of qualitative skill differences looks at the manner in which the infant/toddler manifests developmental accomplishments. Examples for four different dimensions are:

Motor: Does the infant pull to stand using a half-kneel position, or does he pull himself up in a less organized way?

Adaptive Behaviors: Does the infant grasp objects only when his hand and object are in the same visual field, or does he bring his hand from out of his visual field in order to prehend the object?

Language: Does the toddler only use words to name objects, or does he combine words with eye contact and pointing for object attainment?

Play: Does the toddler relate objects in doll play in response to an adult model, or does he do it spontaneously using deferred imitation capacity?

An understanding of learning strategies provides important information about how the environment can be structured to enhance the child's learning. Qualitative characteristics to be assessed are the child's:

- Spontaneous exploration of materials and environment
- Spontaneous initiation of activity with persons
- Spontaneous response to objects and to object-to-object relationships
- Response to verbal guidance
- Response to physical guidance (co-active movement)
- Response to modeling by examiner or parent(s)
- Attention to task demands (sizing up nature of task)
- Concentration on task demands (staying with the task)
- Response to organization of materials; e.g., extent to which he is over stimulated by number of objects.
- Response to extraneous sounds and events in the environment
- Response to task shifts

Psychosocial characteristics of the child need to be understood for program planning process and need to be included as developmental objectives in the individual

program plan. Some essential psychosocial developmental capacities are:

- Responsivity to parent/examiner demand vs. doing all tasks on own terms
- Responsivity to verbal praise
- Responsivity to tactile praise
- Shared sense of task accomplishment
- Shared sense of task completion
- Communication to adult for help

Informal Assessment

Standardized scales offer an efficient structure of assessment and follow-up, but need to be supplemented with an informal approach which doesn't have to involve the administration of prescribed items, but can rely on the evaluation of the child's responses in his everyday play, feeding, dressing and social situations. The child can thus be observed in spontaneous interactions with toys, objects and people of his choice.

Informal assessment calls for the use of systematic observations to non-standardized procedures. Several areas of development are usually assessed informally: emotional development, social interaction, presymbolic/symbolic functioning, and select sensorimotor schemas. A protocol for social and emotional assessment observations is included in Appendix A. (See Psychosocial Development.)

Piagetian Framework for Assessment

Piaget's theory provides a framework for the informal assessment of sensorimotor, presymbolic and symbolic schemas. A critical element in assessing infant/toddlers with handicapping conditions is the awareness of the impact that specific conditions have on cognitive development in general and the assessment of optimal cognitive functioning in particular. By mapping Piaget's framework on standardized scales both a fuller assessment and a theoretical framework for intervention is available. Cognitive levels of development can often be identified that could possibly be overlooked through typical assessment procedure.

Most standardized scales focus on evaluation of specific language, adaptive and social behaviors and provide us with valuable information of knowing how a particular disability has influenced the child's sequence and pattern of development. Piaget's contribution is to link such apparently discrete behaviors and show how they represent different stages in the development of cognition.

Piaget's theory provides developmental organization by focusing on the processes the child uses to relate to his world. The value of this approach when working with children with handicapping conditions is that the point of assessment is not to determine if a child has acquired a specific skill at a certain age, but to find out what method or patterns of action the child has developed.

From a Piagetian perspective, sensorimotor schemas are not to be taught per se as a

direct skill, but opportunities need to be provided for their development by the careful selection of experiences, environmental structure and social structure within the context of daily living experiences. The following sensorimotor schemas need to be assessed for program planning:

I. Reflective Stage
- Exercise of inborn schemas
- Isolation of schemas
- Modification of ready-made schemas modified by experience
- Minimal specific responses to objects, sounds and persons

II. Primary Circular Reaction Schema
- Coordination of ready-made schemas to form motor habits
- Repetition of simple schemas directed at infant's own body
- Immediate active regard of object
- Acts on acting, no acting on objects
- Lack of object permanence: no anticipation of future position of dropped or partially hidden objects
- Emergence of anticipatory excitement
- Mutual imitation between parent and self
- Beginning discriminations

III. Secondary Circular Reaction Schema
- Coordination of motor habits and perceptions
- Development of visually-directed prehension of objects
- Use of schemas to reproduce effects on objects
- Acts on objects with variety of schema
- Recognition of object from its parts (development of the index)
- Anticipation of future position of moved or dropped objects
- Increased specificity in anticipatory acts
- Imitation of movements he can see self doing
- Imitation of sounds already in his repertoire
- Beginning word discrimination responses
- Beginning signals for continuing activity

IV. Coordination of Secondary Schemas
- Acts on objects become intentional
- Acts on objects with selective schema
- Minimal object-to-object relations
- Combination of previously learned schemas
- Obtainment of goals not immediately attainable
- Active search for vanished objects
- Imitation of movements with objects
- Imitation of movements he cannot see self performing
- Imitation of unfamiliar speech sounds
- Gestural response to words
- Increased specificity of signals for continued activity
- Momentary regard of objects in images

V. Tertiary Circular Reaction Schemas
- Active experimentation with object

- Object-to-object relationships
- Process oriented action
- Lack of anticipation for results of modified actions
- Discovers of new schemas to solve problems
- Reliance on overt trial and error
- Object permanence through sequence of visible displacements: cannot infer position of invisible hidden objects
- Systematic imitation of new models, imitates actions on objects
- Accommodation to reality demands of objects in self-related activity
- Use of verbal symbols for present persons, events and objects
- Increased regard for images of objects
- Emergence of presymbolic play: symbolic schemas associated with own behavior

VI. Internalization of Sensorimotor Schemas
- Goal oriented object-to-object relationships
- Discovery of new schemas to solve problems through mental combinations
- Object permanence
- Inference of position of invisible hidden objects
- Imitation of complex models: adult schema
- Use of verbal symbols for absent but immediate wants and needs
- Recognition and identification of images of objects and persons
- Deferred imitation applied to toy animals and dolls
- Beginning symbolic play

The assessment of presymbolic/symbolic development includes the following areas of functioning:

- Understanding of the meaning of events and objects
- Pre-verbal/verbal communication and intent to communicate
- Imitative capacity: immediate, deferred
- Problem solving strategies: random use of known schemas, trial and errors, use of mental image
- Play: sensorimotor, presymbolic, symbolic

Informal assessment of free play can be a valuable format for assessing presymbolic/symbolic functioning. A basket of representational and problem solving toys can be presented to the toddler during the parent interview. This procedure will allow for observation of the child's spontaneous interaction with meaningful objects. At a later time, the examiner can engage the child in play to assess imitative capacities in representational object and doll play. A guide for observing toddler play behaviors is included in Appendix B. (See Pre-Conceptual Stage.)

Interpretation Issues

Several factors must be integrated with the behavioral data obtained during the assessment process in order to have a clear understanding of the child's developmental special needs.

The first critical issue is to separate visual, motor, social and language functioning from cognitive data in order not to confuse mental abilities with observed performance. *Assessment of mental abilities must be based on the understanding a child has about persons, objects, and events, not upon his ability to perform certain tasks.*

A second critical issue is to look at those factors that may have influenced the child's current level of functioning, but may not have the same influence on his potential rate of learning in the future.

Factors that need to be considered in the interpretation of assessment data are:

- Prematurity
- Neonatal history
- Impact of specific handicapping conditions
- Physical health of child during the assessment process
- Medical history
- History of hospitalizations
- Family history of separations, stresses and changes
- Experiential opportunity to interact with objects, persons and events
- Cultural variables
- Bilingual exposure
- Medications given to child during the assessment process

Program Planning

Program planning is the natural consequence of an assessment process. At this time the information obtained from the evaluation of the child will be integrated with the parents' priorities in order to develop a meaningful program plan. Comprehensive program planning looks at the needs of a child as a member of the family and responds to his needs and to the family's needs as well; building upon the child's and family's strengths. Some family needs can be addressed by the assessment team and program (e.g., need for more information about a handicapping condition). Other family needs may be more appropriately dealt with by referral to other agencies or to disciplines that are not a part of the assessment team.

The child's needs should be expressed in objectives that include opportunities for skill acquisition, psychosocial interaction interventions, development of presymbolic/symbolic function, learning strategy intervention and provision of environmental and social structures that will make experiences meaningful.

Training Activities

Strategy #1

Purpose: To observe infant behavior

Materials: Appendix B: Preconceptual Stage (Two to Four Years)

Activity:

Option 1

Teams observe infants in a day care center or other group situation, using Appendix B as an observation guideline.

Option 2

Teams observe videotape of infants, using Appendix B as an observation guideline.

Strategy #2

Purpose: To examine the impact of a handicapping condition on infant behavior

Materials: Video of a "typical" child and child with special needs, of the same chronological age. Appendix B: Preconceptual Stage (Two to Four Years).

Activity: Teams observe the video. Using Appendix B as an observational guideline, discuss the differences in the skill attainment and quality of skills of the two infants.

Time: Video — 10 minutes Discussion — 30 minutes

Strategy #3

Purpose: To illustrate the typical development of infants

Materials: Slide show illustrating infants performing various developmental skills.

Activity: Show and narrate slides, lecturing on typical infant development. Emphasize skill development and quality of skill performances.

Time: 45 minutes

Appendix A

PSYCHOSOCIAL DEVELOPMENT
INFANT-TODDLER OBSERVATIONAL CHECKLIST
COMMUNICATION-STRATEGIES
(DRAFT)

Name of Child: _____ Birthdate: _____

Date: _____

Observational situation: _____

_____

_____

_____

Initiates interaction with adults: ☐ yes ☐ no

Initiates interaction with peers: ☐ yes ☐ no

Relationship to child (primary, familiar, secondary):_____

Situation:_____

____ for food and drink	____ for object attainment
____ for diaper change	____ for fun and play
____ for TLC	____ for solace

Comments:

_____

_____

_____

Communication Strategies: Social Signaling

____ vocalizes	____ touches	____ fusses
____ verbalizes	____ pulls to show	
____ cries	____ points	
____ smiles	____ eye points	
____ eye contact	____ laughs	
____ approaches	____ offers toy	
____ raises arms	____ embraces	

Comments:

_____

_____

_____

List combinations; e.g., eye contact/vocalizes/points.

_____

_____

_____

Responds to initiation of adult: ☐ yes ☐ no

Responds to initiation of peer: ☐ yes ☐ no

Relationship to child (primary, familiar, stranger): _____

Situation: _____

Communication Strategies: Social Responses

____ eye contact	____ reaches toward person
____ smiles	____ reaches toward object
____ laughs	____ looks at object
____ approaches	____ ignores
____ touches	____ withdraws
____ embraces	____ watches
____ vocalizes	____ engages in turn taking
____ verbalizes	____ imitates
____ fusses	____ eye aversion
____ cries	____ turns to person
____ tantrums	____ turns away from person
	____ molds to body

Comments:

_____

_____

_____

List combinations (e.g., smiles/vocalizes):

_____

_____

_____

General affect: (+ primary • noted)

____ happy ____ somber ____ sad ____distress ____ placid

____ initiates interaction	____ withdraws from interaction
____ easily evoked smiles	____ easily evoked laughter
____ easily evoked anger	____ indiscriminate attachment

Comments:

_____

_____

_____

Appendix B

PRE-CONCEPTUAL STAGE
(TWO TO FOUR YEARS)
ASSESSMENT OF SYMBOLIC FUNCTION

I. CONSTRUCTION AND CONSOLIDATION OF MENTAL SYMBOLS

Deferred imitation

Materials:	hat, mirror, paper, crayon, dolls, shoe, toy car, telephone, cup, comb, saucer, lipstick, glasses, teapot, blocks, band-aid, doll bottle, doll blanket.
One year old:	Repeatedly applies simple schemas: repeatedly lifts phone to ear or cup to lips.
	Spontaneously responds to reality demands of feeding utensils and objects for which schemas were directly taught: mother teaches him to put phone receiver to ear.
	Imitates by observing a model: i.e., pushes car, lifts receiver to ear, puts hat on head, hugs doll.
18 months:	Spontaneously responds to all objects with self-related activities: He may feed himself, put hat on head, scribble on paper, dial and talk on the phone and comb own hair, but does not ascribe activities to doll or teddy bear.
21 months:	Starts to apply schemas to doll and teddy bear: uses comb and cup with doll.
24 months:	Imitation becomes more detailed, elaborate and accurate, i.e., dials, talks, listens and communicates message from telephone.
	Doll related behavior becomes dominant: doll uses phone.
30 months:	Doll behavior is central: self-related behavior fades; doll becomes agent in its own right, rather than recipient of child's care.

Symbolic play

Materials:	dollhouse, miniature objects such as doll family, furniture, cars, dishes, blocks, clay, deferred imitation materials.
Pre-symbolic: (12-18 mos.)	Toddler puts into action symbolic schemas associated with his own behavior -- pretends to sleep, eat and comb his hair.

Type 1A: (21 mos.+)	Child projects symbolic schemas onto new objects – pretends to comb, wash and feed teddy bear.
Type 1B: (24 mos.+)	Child projects imitative schemas onto new objects: child borrows schemas from adult models – he and dolls drive a car, wash the dishes, use the telephone and rock the baby.
Type 11A: (2-3 years)	Child identifies one object with an absent one: broom becomes a horse, a branch becomes a broom, a cup becomes a telephone, hat is a purse, a rock becomes a dog.
Type 11B: (2-3 years)	Child identifies his own body with that of other people or things – child becomes an airplane, rabbit or Aunt Molly.
Type 111: (3-4 years)	Play becomes elaborate, complex and episodic – child may wash, iron Raggedy Ann's clothes, bathes and dress her and then take her to Aunt Sally's under the elm tree or he may stack the boxes, count the money and become Mr. Jones at the supermarket.
	Child uses symbolic play to correct a forbidden reality or neutralize a fear: lighting matches, riding a skateboard, getting a shot or meeting a snake.

Graphic Imagery

12 months:	Imitated marking – toddler bangs crayon on paper: will accommodate to reality demands by imitation.
18 months:	Uncontrolled spontaneous scribble – toddler knows he can record act of movement and spontaneously scribbles.
24 months:	Controlled scribble – child progresses in mastery of movement, makes single outline figures and keeps marks on paper.
30 months:	Fortuitous realism – child makes chance discovery that form scribbled is a form perceived. Child names drawing after it is made, i.e., a circle becomes an apple, a man or a cookie.
36 months:	Failed realism – intention begins prior to execution. Child responds to inner reality rather than optical reality. Child draws disconnected elements of hat and head, or head and legs.
42 months.	Intellectual realism – child's drawings grow in conceptual attributes. Child draws 5 parts by age four and 8 parts by age five, etc.

II. Language

Pre-symbolic

12-24 months:

Toddler utters words in close proximity to situation to which child's knowing is attached.

Words used to name persons, animals, objects and events with which he actively is involved or uses words to express immediate needs and desires.

Words not assigned to one class of objects, but to a number of similar experiences: "dog" is any animal playing outside.

Symbolic

2 years:

Words used to recall events and to describe events and actions. Child returning from the park reports: "birdie in tree, fly away, all gone."

50-250 words
2-3 word phrases
Follows simple commands
Names pictures, objects, persons, animals
Identifies body parts
Poor articulation
Spontaneously imitates phrases
Asks "What's that?" questions

3 years:

500-1000 words
3-4 word sentences
Gives full name and age (by fingers)
Describes action in pictures
Uses plurals
Recites 1-2 nursery rhymes
Asks "What/Where" questions

4 years:

1500 words
4-5 word sentences
Speech is understandable
Knows colors
Follows 2 stage commands
Asks how and why questions
Reports events

III. GROWTH OF PHYSICAL KNOWLEDGE (discrimination, recognition, identification and comprehension)

Objects, persons, events and their properties
Images of objects, events and persons
Forms concepts
Color concepts
Size concepts
Space concepts
Number concepts

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Preschool Assessment: Clinical Considerations Procedures and Interpretations

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Several concepts of preschool behavior and development are discussed to provide a framework for the team assessment of preschool age children. Differences between young children and school age children are described which relate to thinking, controls, and early language skills. The assessment model places major emphasis on behavior observations and interactions between caregivers and the child. Information about the planning and conducting of both formal and informal assessments is described.

NOTE: Gordon Ulrey's background includes extensive work with young children with multiple handicaps. He has authored the text book, "Psychological Assessment of Handicapped Infants and Preschoolers," (1982) and numerous articles. When this chapter was originally written, Gordon was the Director of the Early Childhood Special Education Team Assessment Institute.

INTRODUCTION

Certain principles and concepts are reflected in quality assessment of preschoolers with exceptional needs and their families. They include: 1) the purposes of assessment, 2) the characteristics and developmental patterns of preschool children, and 3) certain factors that yield information that is helpful in understanding the preschool child. The assessment model that is developed by an assessment team that assesses preschoolers needs to reflect these concepts and principles.

PURPOSES OF PRESCHOOL ASSESSMENT

The purposes of quality preschool assessments are:

- To gain information about developmental levels in order to appreciate relative strengths and to ensure that program planning will not be limited to a deficit model.
- To determine differential diagnoses; e.g., is observed language difficulty a result of hearing impairment, oralpharyngeal structural difficulties, specific language delay, cognitive delay, visual impairment, physical disability, severe emotional disturbance, and/or child abuse.
- To understand the impact that specific sensory and/or physical handicapping conditions have on emotional, social and cognitive development.
- To gain information regarding service delivery needs of family: parent support group, parent education group, respite care, behavior management strategies, developmental intervention strategies.
- To gain information regarding services for child: physical, occupational and/or speech therapies, dental/medical/nutrition referrals, preschool intervention programs, intervention/supports in normal preschool settings (preschool programs, daycare, home).
- To establish a good relationship between parent and service delivery system by: a) building a trusting relationship and b) empowering the parents to be members of this and all future transdisciplinary teams.

PRESCHOOL CHILD CHARACTERISTICS

Little Child. The preschooler (2 to 6 years) is not just a little school-age child. The team assessment of the preschooler must take into consideration the important differences in thinking, motivation, and experiences between preschool chil-

dren and those who are school age. Assessment procedures and knowledge of school-age children do not necessarily extrapolate downward when applied to preschoolers. Cognitive and emotional factors influence the behavior of the preschool child in important ways that affect testing and interpretations of results.

Behavior Differences. Many behaviors which occur during the preschool period would indicate a learning deficit or psychopathology if observed in a school-age child (6 to 12 years), but are normal and expected for the younger child. A frequently observed example is the reversal of letters and numbers which correlate with specific learning disabilities in children over about the age of seven. However, reversals are common with children under six years of age.

Rapid Developmental Change. There is a wide range of maturation of the neurological functions and significant differences between the rate at which preschool-age boys and girls acquire early skills (Chall & Mirsky, 1978). A host of developmental changes occur during the transition from infancy to school age that alter the child's behavior, such as emerging expressive language skills and increasing emotional autonomy from parents.

PRESCHOOL CHILD DEVELOPMENT

Examiners' appreciation of the child's perception and understanding of events has been enhanced by Piaget's model of cognitive development. Piagetian theory and recent studies of preschool cognition provide a framework for understanding the cognitive and behavioral differences between preschoolers and school-age children.

Concept Development

Preoperational Thinking. The preschool child's thinking and reasoning are in transition from the sensorimotor level to the level at which there is use of mental symbols and language. During infancy, sensorimotor intelligence is expressed by adaptive actions in the form of interactions with objects. Between two and six years, the child learns to internalize this knowledge by way of symbolic representations. However, the preschool age child's conceptual understanding of the world is incomplete and the child's thinking is different than the school-age child's.

Preoperations and Action. Piaget (1951) and Piaget and Inhelder (1969) have described the preschool child's thinking as "preoperational." The Piagetian model provides a conceptual framework for understanding the child's behavior relative to his or her current level of understanding events in the environment. The child's thinking is described as preoperational because of the child's restricted, one dimensional point of view which is limited in focus on a single action or direction of an operation. An action or operation is understood in terms of how it moves or changes without an appreciation of the reciprocal effect of the reverse of the action. For example, if the examiner shows a preschool child two identical pieces of clay and then elongates one, the child will often state that one is now "bigger" because it is longer; in other words, the child will focus on length, but will not account for width. The child is demonstrating preoperational thought.

There are numerous implications for how a preschooler's behavior might differ from that of the school age child who is often functioning at the concrete operational level (in which the actions or operations are understood as reversible or reciprocal). The difference can be seen in comparing the understanding of causality between preschoolers and school age children. If both groups are asked a question such as, "Why do clouds move?" the preschoolers might say, "Because of the sun," while the school age children might say, "Because of the wind." The preschooler's thinking is based on associations lacking an appreciation of causal relations that have reciprocal effects. The fact that the sun is seen when clouds are seen is a sufficient preoperational explanation of the event. Therefore, the question "Tell me more about it." is irrelevant to the preschooler. In contrast, concrete operational thought shows appreciation of a relationship between wind and clouds and the child can understand that more explanation of an answer is needed.

Egocentricism. In Piaget's theory, the preschooler's thinking is "egocentric" in that only one viewpoint is taken or expressed. This results in minimal regard for ensuring that a listener understands an explanation. The child is unable to assume the role of another person or to recognize other viewpoints. In contrast, the school-age child is generally more concerned about giving the "correct" answer and monitoring feedback which indicates that the answer was understood. The preschool child generally has not developed a concern for the listener's understanding, feels no need to justify his or her reasons, and fails to see a contradiction in the logic used. As a result, a major problem during assessment is the young child's minimal concern for ensuring that the examiner understands an explanation or solution to a task. The child will respond to the approval or disapproval of the examiner, but may not perceive the examiner's concern about the incomplete or incorrect aspect of a test response.

Gelman (1978) suggests that young children may monitor test feedback poorly because they have not "learned the rules." However, very young children do appear to be capable of some appreciation of another's perspective when tasks are adequately structured. In addition, the child can appreciate adult responses of pleasure or displeasure, but may not associate them with performance. An example of not having "learned the rules" is the lack of response by the preschool child to a social reinforcement (smiling or "good stacking"); the preschool-age child who does not continue an activity or work harder has not yet learned to be "reinforced" by pleasing an adult. One cannot assume that the contingent reinforcer was effective because of the child's limited experience or the fact that the child learns more by the involvement with a task at a level he or she can understand than by a general social reinforcer. In contrast, the child may continue a task not understood simply because of the interaction with the examiner with little regard for mastery of the task. In either case, this child may only be responding to one dimension of the test procedure.

Associative Thinking. Preoperational thought, when compared to the thinking of older children, can give the impression of loosely associated thinking and distorted logic. It is the lack of balance in the reasoning (only considering one aspect of an operation) that characterizes preoperational thinking. Because of this, the clinician must be aware of the age appropriateness of the child's reasoning. For example, to be able to evaluate a deficit in the child's cognitive skills, the assessment team must carefully observe the child's responses and inferred reasoning

during problem solving; the evaluator cannot simply focus on the right or wrong answers. Instead, the challenge for the assessment team is to determine why the child failed the task and at what level it was understood.

Preoperational Concept Development. Piaget has described in some detail the child's development of preoperational concepts of classification, numbers, and spatial and temporal relations. In addition, test items on several formal standardized preschool cognitive measures can help reveal a child's level of understanding and knowledge of how skills are developing. For example, during assessment of a child's counting skills and skills related to number concepts (Gelman & Tucker, 1975), the evaluator(s) could follow-up a failure on a "number concept" item with other levels of the task.

Behavioral Controls

Testing Limits. The child's nonverbal behavior also indicates the limited dimension and egocentricism of preoperational thinking. Two and three year-old children often seek to test behavioral limits, and may refuse items or may be easily distracted by items of more intrinsic interest. In part, this is related to the child's emerging sense of self as an individual to a struggle for autonomy. Indeed, the two-year-old is infamous for resistance and independence during testing. The behavior reflects the child's unwillingness or "inability" to assume the perspective or point of view of the examiner. This limited viewpoint indicates preoperational thinking, the child's attempts to define boundaries between him or herself and the environment, and appropriate development of behavioral controls. Although resistance and struggle make a reliable assessment difficult, they provide important information about the child's emotional development and should be noted as "normal" behavior reflecting the child's level of emotional functioning. For example, assessing a five or six year-old who requires frequent limit setting and is manipulative to avoid the test procedures may indicate the emotional maturity of a two to three-year-old child.

Controls Internalized. At the three to six-year level, the child's behavior becomes less of a struggle with limits, and elaborate strategies evolve to obtain desired outcomes. With increased language and extensive imitative behaviors (identification with parent figures), the child uses "manipulation" or appeal to adults to gain some control. The coyness of the three to five-year level is well known and appears to insure adult attention and approval. The child's imitation skills allow for "adult-like" behaviors that lack the operational understanding of the adult. The child begins to model the parent's verbal and nonverbal behaviors with less appreciation of how it is perceived by others. During an assessment, this may be seen in the form of various social behaviors such as more eye contact, smiling, physical closeness, or verbal responses. These behaviors are ways of getting attention but generally lack a concern about being correct or appropriate; in this sense they are cognitively egocentric.

Engaging Social Behavior. The engaging and manipulative behavior of the 3 to 6 year-old are seen as emotionally appropriate. The major problem for the examiner is that these behaviors may not be contingent on task performance behaviors. The assessment team will often have to structure and restructure tasks to elicit the optimal attending to a task from the child. For example, the child may not state an obvious verbal answer or complete a task because he or she is not attending to

the cue that this is a valued response. This is again part of not having "learned the rules" for test and school behavior. More flexibility and creativity are required to sort out what the child knows. The evaluators simply cannot assume that the child values answering specific test items correctly just because a correct answer was expected.

Language Development

Early Language Behavior. Because many major language or communication skills emerge during the preschool period, knowledge of normal language development is important for the assessment team evaluating young children. There are several language behaviors that may be mistaken for a language disability. One example is a general developmental consideration that some dysfluency is expected as the child learns new words or is constructing more complex sentences. While dysfluency is normal at two to three years of age, it may also occur normally when previously undeveloped speech is emerging at 4 or 5 years; this may be misinterpreted as a sign of a stuttering deficit. As a general rule, the dysfluency should be considered in the context of the child's developing language. A second developmental consideration is that there are frequently some expected substitutions of sounds in the child's articulation skills, such as "wabbit" for "rabbit."

Language Concepts. The assessment team should be aware of differences between spontaneous speech and the child's conceptual understanding. A child may apparently have age appropriate social speech (such as, "Hello, how are you today?"), but have below age level conceptual understanding of words (such as defining words or explaining events). In short, the young child's verbal behaviors must be understood in terms of "normal" language and the child's own development to avoid misinterpretation of formal and informal observations. The use of a language sample from a spontaneous play situation is useful for comparing formal test responses to informal speech.

Eye Contact. When eye contact is poor, the child may be seen as having an emotional problem. Instead, this method of interaction may be partly secondary to auditory processing problems and/or poor social learning; it is not necessarily an indicator of serious emotional concerns. This is somewhat unique to the preschool period, because language and social skills are emerging for the first time and depend on interaction between experiences and maturation. When an assessment team observes a child with poor eye contact, they should then explore opportunities that the child has had in learning standard English as well as cultural and familial factors that relate to expectations for eye contact.

Verbal Comments. The assessment team must appreciate the level of difficulty of verbal commands used during an evaluation. Many tasks which attempt to measure concepts, such as "alike" or "similar" may be failed because of complex verbal instructions by the assessor. Knowledge of language level acquisition is invaluable for interpretation of performance on tasks that require verbal receptive and/or expressive skills.

FACTORS TO CONSIDER IN PRESCHOOL ASSESSMENT

There are many factors that can contribute to a preschooler's behavior during a team assessment. The situations that have elicited behavior must be carefully observed and the examiner(s) must remember that many deficits and developmental delays may be secondary to environmental and psychological factors. The assessment team must be able to determine a child's relative strengths and weaknesses in a developmental and environmental context to obtain a reliable and valid assessment of the child. A careful consideration of five general areas is necessary to interpret assessment results and address assessment questions. These are: a) behavioral controls, b) level of developmental skills, c) integration of developmental skills, d) interacting and relating skills and e) environmental supports (ecological factors).

Behavioral controls. These include the child's self control and selective attending skills, as well as the child's need for structure in the environment and tolerance of frustration or failure. To make a judgment about controls, the team must observe or have information about the child in a variety of settings, and must have the knowledge of age appropriate expectations for young children. In other words, the evaluators must know what the child's behavioral controls are relative to his or her age level and experiences. Information from teacher and parents is essential to determine the child's behavioral controls and is obtained from their reports and observations. The examiners must know if the child is currently on any medications that may influence behavior (such as treatment for seizures or a cold).

Level of developmental skills. Formal measurements of the child's current developmental skills based on appropriate norms for his or her age group may be needed. The child who functions with no learning problems will not need an intelligence test, although a screening test may be useful. The team must determine the extent of usefulness for standardized measures of language, cognitive, social-emotional, and motor skills. The use of multiple measures which include informal observations and observations from several settings is essential to obtain valid data and to plan relevant educational programming. When no formal tests are used the team should provide a rationale in the written report and feedback to the parents.

Interaction of developmental skills. The various modalities that affect development in all domains should be considered by the assessment team. The child's capacity for sensory sensation (e.g., visual or auditory acuity), perception, memory, and integration of modalities (e.g., visual and motor skills used together) should be assessed. The relative skills in language and nonverbal skills should also be considered, for example, does the child have any specific learning deficits relative to his or her general cognitive skills? What are the child's strengths and weaknesses, and what learning style is evidenced? The assessment team must ensure that program planning emphasizes strengths and will not be limited to a deficit model.

Interacting and relating skills. The child's relative level of adaptive behavior should be considered (e.g., toilet training, spontaneous play). Also the child's eating patterns/problems and sleeping patterns/problems should be explored. Observations of a child's play, interactions with the examiner(s) and interactions with caregivers are essential to assess emotional maturity. How does the child relate to peers, teachers and strangers? What is the child's pattern of initiation and responsivity to persons (adults/peers), objects, and events? Does the child show age appropriate emotional and adaptive behaviors? This information is obtained by observing the child's play, using an adaptive behavior rating scale and conducting a structured parent child interaction.

Environmental supports. Knowledge of the child's environment is essential for the assessment team. Questions to be answered include how the child interacts with parents and how stable the primary care providers are. What is the family makeup and rituals? What languages are spoken at home? Awareness of the relationship between cultural differences and opportunities for learning is an important part of interpreting a team assessment. What opportunities has this child had relative to the children he or she is compared with on the test norms and in the school situation (current or future)? How much structure and stimulation does the home and preschool (if applicable) provide? Information can be obtained by observing parent-child interactions, teacher interviews, and parent interviews (in the home when possible).

MODELS FOR ASSESSING PRESCHOOL-AGE CHILDREN

There are many assessment tools or techniques which will yield helpful information in addressing the above mentioned factors. Two informal techniques are illustrated in the next two sections. These techniques are: 1) parent-child interaction observations and 2) observations of a child with his/her peers in a mainstreamed environment.

Parent-Child Interaction Observations

A structured interaction with a parent and the child reveals important information both diagnostically and for planning interventions. The examiner should observe an interaction sequence in which the parent presents a task that the child is likely to pass, another that the child is likely to fail, as well as observing 5 to 10 minutes of spontaneous play between the child and caregiver.

Procedures for Parent-Child Interaction

Part 1. Spontaneous play with a variety of options. The team provides the parent and child with toys that are appropriate for different developmental levels. The child or parent is instructed simply to select any activity and play in their "usual" manner.

Part 2. Parent teaches a task the child is able to do. The team asks the parent to perform a task that earlier observations suggest will be easily completed by the child. Tasks that are analogous to test items using peg boards, form boards, or blocks provide tasks that can easily be demonstrated for the parent.

Part 3. Parent teaches a task the child has been unable to do. The team instructs the parent to give the child a difficult task. The parent is to teach the child the task if the first attempt is failed. Activities should be used that are not part of the standardized tests.

What to Observe

Observations should be made of the interactions that occur between the parent and child. When both parents are available it is important to have each parent go through all three parts of the interaction sequences. The team attends to three questions when assessing the interactions: (a) How does the parent structure the activities? (b) How does the parent/child respond to the success of the child? (c) How does the parent/child respond to the failure of the child?

Observations can also be made of the caregiver and the child's communication abilities. For example, an observer may want to gain information of the caregiver's and child's turn taking abilities and interactional strategies for program planning purposes.

Observations of turn taking abilities may include: (McDonald and Gillette, 1984).

- Length of turn taking; e.g., How long did a conversation last? 1 or 2 turns to 5 or more turns
- Modality of turn taking; e.g., Nonverbal—touching, smiling, pointing, etc. Use of sounds—vocalizations. Use of words—verbalizations.
- Initiation and responsivity (Who tended to initiate/respond in the interaction? Was it equal or did one party tend to take one role more?).
- Communication match (did both partners communicate about the same topic? Was the length of utterances that the caregiver used matched/ slightly more elaborate than the child's verbalizations?)

Examples of interactional strategies that can be observed when a child is at the preverbal or early verbal level include: (Russo and Owens, 1982).

- Parent interactional strategies
  - Imitation
  - Expansion (immediate repetition of word order but more grammatically complete)
  - Natural reinforcement (child is give object or shown an action that relates to the child's utterance).
- Child interactional strategies
  - Attending
  - Referencing (directing one's attention to an object or event)
  - Verbalizing

Please refer to Appendix A for a sample chart to record some of these observations.

The behaviors observed are very useful for explaining a child's handicap to a parent or teacher using examples from the interaction sequence. The team must be sensitive to stresses on the parent caused by the expectation for performance and by being observed.

Observations of a Child with Peers in a Mainstreamed Environment

In order to look at programming options for preschoolers, it is helpful to observe and note those social skills which are behavioral expectations in early childhood classroom environments. Johnson & Mandell developed an observation instrument which looks at the following social skills behaviors:

- Child asks for help when needed
- Plays well with others
- Obeys classroom rules
- Attempts to talk for short period of time
- Completes tasks with a minimum of adult assistance
- Initiates interactions with peers
- Observes and sometimes initiates interactions with other children
- Makes simple decisions
- Practices turn talking
- Respects others feelings and belongings
- Follows simple directions
- Uses verbal vs. non-verbal means to express feelings

The observations should be conducted in a variety of settings and during different types of activities. The Social Observation for Mainstreamed Environments (SOME) is reproduced in Appendix B.

Training Activities

Strategy #1

Purpose: To demonstrate the unique perspective that different disciplines bring to an assessment.

Materials: Videotape of a preschool-age child playing alone and interacting with the caregiver.

Activity:

1. Ask participants to observe the video.
2. Break into small groups, of mixed disciplines.
3. Discuss/compare observations.
4. Feedback to large group.

Time: Video: 10 minutes
Discussion: 20 minutes
Feedback: 10 minutes

Strategy #2

Purpose: Introduction to preschoolers and assessment.

Materials: Handout 1: DEAR ABBY LETTERS

Activity:

1. Distribute DEAR ABBY LETTERS Handout, and ask team to read.
2. Lead discussion to answer the following questions:
   a. Is this typical or cause for concern?
   b. If it is a cause for concern, what would you recommend? If group is large, break into subgroups to discuss.

Time: 30 minutes for discussion of as many letters as can cover.

Strategy #3

Purpose: To evaluate and plan future preschool assessment models.

Materials: None

Activity: After presenting material in this chapter ask the participants to break up into small groups (by teams or 3-4 people if not in teams). Ask them to discuss the following questions:

1. What strategies for assessing preschoolers do you currently use? (e.g., parent-child interaction, observation of play, interview of preschool teacher, etc.)
2. What strategies would you like to incorporate in your assessemnt process?
3. How can you begin to incorporate these strategies?

After the groups have discussed the questions, ask several groups to report significant learnings to the large group.

Time: 30 minutes for small groups, 10-15 minutes for large group.

Strategy #4

Purpose: To gain experience in observing and interpreting parent-child interaction.

Materials: Videotape of a preschool child interacting with the caregiver.
In spontaneous play
Caregiver teaching a task that the child can do
Caregiver teaches a task that the child is unable to do

Activity:

1. Present pertinent information regarding parent-child interaction video to the audience.
   What the caregiver brings to the interaction?
   What the child brings to the interaction?
   Any pertinent information about environment?
2. Ask the participants to view the video and to focus on the following three questions:
   a. How does the caregiver structure the activities?
   b. How does the caregiver/child respond to the success of the child?
   c. How does the caregiver/child respond to the failure of the child?
3. Break the audience into small groups for the discussion.
4. Discuss/compare observations.
5. Have small groups give feedback to the large group.

Time: Video: 10 minutes
Discussion: 20 minutes
Feedback: 20 minutes

Handout #1

DEAR ABBY LETTERS

Development in the Preschool Years—Normal or Unusual?

The following "Dear Abby Letters" are typical of concerns from family members and teachers who live with or work with preschool age children. Sometimes these concerns are indicators that a child has a health/developmental problem and sometimes they are just examples of typical development and behavior during the preschool years.

Please work in pairs and respond to one of the "Dear Abby" letters. Should the behaviors described be considered typical or unusual for the situation? What would you recommend? If an assessment is indicated, what type of assessment would you do, who should be involved and how should it be done? Please try to be as realistic and as specific as possible.

If you have time to respond to more than one letter, please go ahead.

#1

Dear Abby,

My husband and I are both college graduates and expect that our children will be as well. Our two oldest boys (ages 7 and 10) have always excelled in school. Because they've both done so well, we are confused and a little worried about our youngest son who has just turned four.

We sent Peter to a highly recommended preschool in our area when he turned three. Recently some of our friends began talking about how well their children were doing in the school reading program and how pleased they were with the alphabet and math worksheets they were bringing home. Peter had never shown us any worksheets with numbers and letters — his papers were usually shapes, things he had colored or simple art projects. Of course we called his teacher immediately to ask why Peter wasn't bringing home the right worksheets and to see how he was doing in the reading program. She told us that she didn't think Peter was ready for the "word and number recognition program" since his attention span was very short and that he needed more practice in gross motor activities before he "settled into paper and pencil tasks." We were very upset but the teacher tells us we shouldn't worry and that Peter should calm down and catch up by the time he goes to kindergarten.

Peter is an active little boy, not as athletic as our other two, not very talkative and isn't interested in books as our other two boys were when they were his age. I wonder if he has a learning disability? What do you think? If so, what should we do? If he doesn't have a learning disability what can we do to help him catch up?

Lynn and Burt Yup

#2

Dear Abby,

I am ten years old and I have a problem. My mom and dad work and we have a baby sitter who takes care of us when they're gone. The trouble is that our baby sitter always makes me watch my sister. My sister is three but she's like a baby. She cries a lot, still wears diapers, is always falling down, pretends she doesn't hear me when I yell at her and is afraid of everything! When I tell my mom this she says I have to be nicer to the baby and help her do things. I think it's weird and last week I heard our baby sitter talking on the phone and she said my sister isn't "developing right."

What does my baby sitter mean? Don't you think we better take my sister to the doctor and see if she's O.K.? Are all three-year-olds such babies?

Susan

#3

Dear Abby,

My almost three-year-old is driving me crazy. I had a lot of trouble breast feeding him and my doctor had me switch him to soy formula when he was six weeks. It was okay for a while but then he got a bad cold and ear infection. The hearing specialist said we were lucky to have caught the infection in time. He didn't start walking until he was fourteen months old and still doesn't say much. I try to show him how to play with toys but he doesn't catch on very quickly. He seems to understand what I say but sometimes he just refuses to do what I ask him to. I take him to the park but he winds up hanging on to my leg and screams when I try to put him on the swings and slide.

My mother says I just need to spend more time with him. My sister says he's slow. My girlfriend says he's doing okay and that he'll catch up. My doctor says I could have him checked at a special center. When I called for an appointment they asked what problems he had and if I wanted a screening or a full evaluation. I didn't know what to say so I hung up. Maybe he's okay and I'm the one that has a problem. What should I do?

At My Wit's End

#4

Dear Abby,

I am a child care teacher and I need some advise about what to do with a little girl in my class. She is 3-and-one-half years old and has two brothers (aged six and seven) who come to the center before and after school. Her parents work hard and when they come to pick up the children they seem tired and rushed.

I am worried about Carlita because she hasn't said a word all year and because she seems so withdrawn. At first we thought it was just because she wasn't used to the place and that in time she'd warm up. She was an easy child to care for, followed directions, played quietly alongside the other children and didn't get into any trouble. We didn't suspect anything was wrong until we tried to complete the developmental checklist and, even though we did it in Spanish, she didn't say a word. She also gave up easily when it was hard for her to do something and needed a lot of encouragement to keep going. According to the checklist she seems to be functioning about 24-30 months.

Her brothers are very talkative, both in Spanish and English. They say they've moved a lot and that Carlita doesn't like it. They also said that she cries before school, sometimes gets sick in the morning, but seems better at night.

There's a good chance that the family will be moving at the end of the year so we hate to bring up problems if there's nothing really wrong and she's just shy. What should we do?

Trying To Do A Good Job

#5

Dear Abby,

My grandma and mom read what you say all the time and think you're really smart. That's why I had my sister help me write this letter to you—maybe you can help me.

Pretty soon I'm going to be five and then I can go to kindergarten. It sounds like fun but my preschool teacher says I'm going to have trouble in school. She says I won't be able to run around, that I'll get in trouble for hitting other kids and that I need to know a lot more number and letters and how to write my name.

I have a pretty good time in preschool but the teachers yell at me and say I'm not listening. Sometimes I hit other kids but that's because they get in

my way or take my toys. I don't always know exactly how to do everything and I don't really like coloring in the lines or cutting on the dotted line. I like to move around a lot and I don't like having to take a nap.

I heard my mom and dad talking (they didn't know I was listening) and my mom said she was worried I was "hyper." My dad said I was just a typical boy. I'm confused...what am I?

Bobby

#6

Dear Abby,

I am at my wit's end. My four-year-old is driving all of us crazy. He never minds anymore, and if it's not one thing, then it's another. Lately he's taken to saying "NO" to our every request, and he's cranky and irritable far more often than usual. He's been having nightmares and when he awakens he says that "scary monsters" are chasing after him.

I just don't know what to do, Abby. It's as if we can't do anything right with him; the way he's negative and sassy with us. It seems almost like he wants us to get angry at him and it scares me Abby. What are we doing wrong? How can we help him? Please help us.

Distraught Mother

Appendix A

OBSERVATION OF COMMUNICATIVE ABILITIES

Communication (nonverbal/verbal)	Initiation	Response	Interactional Strategy	Modality

Appendix B
SOCIAL OBSERVATIONS FOR MAINSTREAMED ENVIRONMENTS (SOME)

Child's Name: _____ Date: _____

Individual(s) observing the child: _____

Individual observing the classroom: _____

Other settings in which child was observed: _____

Directions: In the first column, mark a plus (+) if the child usually exhibits the behavior, a minus (-) if the child tends not to exhibit the behavior. In the second column, mark a plus if the classroom teacher expects the children to exhibit the behavior, a minus if the behavior is not one of the classroom expectations. Use the third column for noting any related observations or concerns. In the fourth column, write in proposed resolutions to areas of concern; that is, in areas where the behaviors are expected but are not exhibited by the child.

Behavior	Child's Performance	Classroom Expectations	Comments	Resolution
1. Asks for help when needed:				
2. Plays well with others:				
3. Obeys class rules:				
4. Attends to task for short periods of time:				
5. Completes tasks with minimum adult assistance:				
6. Initiates interactions with peers:				
7. Initiates interactions with adults:				
8. Observes other children:				
9. Imitates other children:				
10. Makes simple decisions:				
11. Practices turn taking:				
12. Respects others' belongings:				
13. Respects others' feelings:				
14. Follows simple directions:				
15. Uses verbal vs. nonverbal means to express feelings:				
16. Other:				
17. Other:				

Recommendations: _____

_____

Signatures: _____

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Observations of the Play Behavior of Infants and Young Children

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The chapter describes the wide range of play behaviors and suggests several models for organizing observations. Specific suggestions for structuring play to observe language, developmental functioning and emotional development are described. The importance of mastery and symbolic function of play is discussed.

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IMPORTANCE AND FUNCTIONS OF PLAY

Play is among the most important means for fostering a child's development. Physical, emotional, social, and cognitive development are all fostered by play. For the infant and preschool child, play is as important a mode for learning and growth as is school for the older child. While it is an activity enjoyable in and of itself, young children take their play very seriously. Through play children develop and practice newly acquired skills (motor skills, language skills, etc.). They also learn to master situations that are potentially overwhelming to them. By symbolically repeating in play unhappy or difficult experiences, the child actively attempts to master traumatic situations which were experienced passively. Through social play and symbolic role-taking play, children learn about the complexities of social situations. Play also serves to enhance self-esteem through the child's pleasure and satisfaction in creative self-expression.

Why Observe Play?

By observing a child's play; e.g., by observing the kinds of materials he chooses to play with, and the way in which he uses those materials, we can gain valuable insights regarding his functioning in a variety of developmental areas.

An observation of the parent and child, or sibling and child, at play can demonstrate how the two communicate and interact, what games they enjoy, and skills they have accomplished together. Parents and teacher can observe play together to share information and insights about the child. Families and the child are usually more comfortable during play than a formal assessment. Therefore, reliable data is obtained.

Developmental Considerations and Play

Piaget's theory provides a framework for observing the developmental phases of play:

Practice Play/Sensorimotor Play. The play between birth and approximately 1 1/2 years often involves the exercising of muscle movements and behaviors, and the practicing of particular actions and their effects on the environment. We can see the infant repeat the same sound, repeatedly splash in water, bang to produce a noise. A major purpose of practice play is skill mastery. Through such practice the infant learns to master his body, to manipulate objects in the environment, and to grasp the nature of physical reality. This intrinsically satisfying activity thus forms the foundation needed for higher forms of play.

Symbolic/Imaginative Play. By the second and third years of life, practice/sensorimotor play occurs along with an increasing degree of fantasy play. Toddlers and preschoolers engage in make-believe play that involves their perceptions of the social and physical world and events which they have experienced. They now can use play as an aid in dealing with their conflicts, as when a young child "shoots" the fierce toy monsters and thus "saves" the toy baby. Through symbolic play children learn not only about roles and relationships, but also about such concepts as time, space, and number.

From roughly the second through the fifth or sixth years of life, the child's symbolic play becomes increasingly rich. With increasing age the young child is better able to distinguish fantasy from reality, to maintain a sense of orderliness and organization in play, and to portray complex emotional themes.

Year 3 (2-3 year old). The child represents events experienced, but roles shift quickly and play is fragmentary.

Year 4 (3-4 year old). Roles become richer and more complex, play is still somewhat fragmentary, and the child does not always reliably distinguish between reality and fantasy.

Year 5 (4-5 years old). Roles and play themes are relatively complex, and the child is mostly reliable in differentiating pretend play from that which is real.

Year 6 (5-6 year old). Very rich sociodramatic play, with play used actively and successfully as an aid in mastering fears.

Latency Age Play. By around 6 years of age, with firmer, more accurate ideas about reality and decreasing egocentrism, the child's play becomes more reciprocal and logical. Fantasy play diminishes, and the play of elementary-aged school children now involves games with rules and activities that involve greater degrees of logic, cooperation and competition with others, strategy, and more complex communication. Board games now become possible for the child to play.

Young children show various degrees of social interaction during play. The categories which follow are not truly developmental; they do not reflect a truly sequential line of achievement. They should be considered more as descriptive categories, rather than developmental.

Solitary Play. The child stays by him/herself during play, or perhaps occasionally watches others play from a short distance.

Parallel Play. The child ventures closer to others who play. While he/she seems to enjoy the presence of other children, he/she does not sustain social interaction, but plays alongside them.

Associative Play. The child is involved in more interaction with other children (they may exchange toys and comments, for example), but lacks organized reciprocity.

Cooperative Play. Each child has a specific function or plays a specific role and engages in reciprocal "give and take" activity, such as playing "doctor" or "family."

Culture, Socioeconomic Status and Play

The amount and quality of play are influenced by the time, space and materials available to the child. The expectations of caregivers regarding their child's competencies, as well as the value placed on caregiver-child involvement will also affect

the quality of play. The wide variations in the make-believe play of children of different cultures no doubt reflects their different values, activities, and traditions. The degree to which a child is overburdened by social responsibilities and by the lack of supportive models may very well hinder the development of rich symbolic play. It appears that the fostering of make believe play in children is enhanced by the degree to which their parents are engaged in interaction with them (Rogers, 1982).

Differences in the quality of play in different cultures may also relate to possible biological differences among children. Chinese babies, for example, have been found (Freedman, 1979) to not cry as easily as Caucasian infants, quickly stop crying when held, and more easily soothe themselves without adult attention. While it is likely that no direct relationships exists between biological predisposition and play, the interaction of environmental influence along with biologically based differences is crucial in understanding cultural differences in play.

Of course, there is wide variation in behavior within a particular culture; all young children of a particular culture will not play in the same way. What is most important in observing and understanding the play of young children is to be aware of the particular beliefs, traditions, and family style(s) of a given culture. It is important also to be aware of not imposing one's own cultural orientation onto other groups. In keeping with the idea of parents as team members, it will be important to elicit how the parent views his or her child within the culture. Also, the parent can be an effective informant regarding particular culture perspectives.

Handicapping Conditions and Play

The degree to which young children's play is substantially affected by handicapping conditions is determined by a number of different factors, including: the nature and extent of the handicap, the degree of personal attention and interaction the child receives, parental attentiveness, socioeconomic status, whether the child has been institutionalized, and the extent and quality of early intervention the child has received.

Mental Retardation/Developmental Delay. A number of studies have suggested that children with mental retardation/developmental delay show a limited and shallow repertoire of play activities regarding their use of materials, their expression of symbolic themes, and their social play with other children. Yet many of these studies did not control for SES, institutionalization, or other important variables. Mogford (1977) suggests that evidence from better designed studies suggest that children with mental retardation/developmental delay can play at levels appropriate to their mental ages, provided that they have had sensitive parental attention and stimulation and materials appropriate to their developmental level. Thus, environmental supports seem to have an important role.

Physical Handicaps. Some physical handicaps tend to disrupt the normal development of sensori-motor play. Significant motor handicaps can prevent the child from effectively exploring and understanding his environment, manipulating objects as a way of understanding their properties, and generally experimenting on the world to learn about how it works. If a child cannot fully act on objects to experience their comings and goings, it is possible that his concept of object performance can be delayed. Also, with limited and delayed understanding of the concrete world, such children may experience difficulty or delay in achieving the more abstract and symbolic aspects of play.

Blindness. Blindness clearly hinders the development of play. The blind infant can not locate objects and attain them at will. He/she also has a very difficult time in establishing a lasting image of himself, other people, and the objects in his world. The development of symbolic play is impeded; the blind child is often quite delayed in his establishment of the symbolic function and representational thought. Yet the role of the environment is important in determining the extent of the blind child's difficulties. From Fraiberg's (1978) perspective it appears that the distortions of play that some blind children show (e.g., limited practice play, stereotypes, rituals.) are due to environmental and/or sensory deprivation, and that such distortions of play are not seen in well stimulated, neurologically intact blind children.

Deafness. The literature concerning the effects of deafness on play is more equivocal. While some studies suggest that hearing impaired children engage in less symbolic solitary play and less cooperative play than their hearing counterparts, other studies suggest that the development and quality of play of deaf children are relatively unaffected by their handicap. (Mogford, 1977) It is likely that as with other handicapping conditions, early intervention in the form of a hearing aid before age 2, and early language training may enhance a hearing impaired child's play. Effective intervention seems to contribute significantly to the development of play skills.

Autism. Autistic children are severely handicapped in their development of play. Appropriate toy play, social play, and symbolic play are usually severely limited. Repetitive motor movements, idiosyncratic approaches to toys, play with a limited number of objects, need to preserve sameness, and isolation in play are typical.

THE OBSERVATIONAL SETTING

There are many settings in which to observe play.

Home. Provides a naturalistic and familiar setting for the child and less controlled of a situation for the examiner. Parent-child interaction and peer interaction can be observed.

Classroom. Provides opportunities for observation of structured activities and dealing with a learning situation with an adult. Free play and peer interaction may be observed also. It may be difficult to observe play in a classroom with a large number of students.

Playground. Typically instructural play, interactions with peers, and gross motor activity are observed.

Assessment Room. Provides opportunities for observation of structured and unstructured play under more controlled conditions for the assessment but in an unfamiliar setting. Opportunities to observe social interaction are limited.

Day Care. Interactions with caregivers other than parents and social interaction with other children can be observed.

It is important to plan the physical environment for a play observation. The room needs to be large enough for free exploration and gross motor activities. Toys with similar themes; i.e., sand box, shovel, trucks, pouring utensils, should be grouped together. Toys should be on low shelves or the floor. Tables and chairs are not necessary. A rug is important for infants or children with severe physical impairment. A permissive and relaxed atmosphere is crucial. The child and family should feel at ease and free to experiment and explore. A relaxed atmosphere is achieved by beginning with free play, being patient and allowing the child to move at his or her own pace, and being playful! After free play, more structured activities can be attempted.

The quality of the environment, the kinds of toys and play materials available, and the people available to the child will all affect the quality of the child's play. Each setting has its own advantage and disadvantage for observing play.

Parents are co-collaborators regarding the understanding of their child's play. Important information can be gleaned while observing the child play in the parent's presence. It is also important, however, to observe the child without the parents present, as different themes may be expressed without the parents there. Having parents watch their child play behind a one-way mirror can be useful to parents and staff. If parents are to observe their child's play, it is most useful to have a staff member present to discuss with the parent the various aspects of the child's play.

Teaming and the Play Process

Since play affects so many areas of development, naturally the entire team can be involved in play observation. Several modes of involvement are feasible:

- One team member record, one member interact with the child
- Team members rotate recording and interacting with the child
- Videotape review
- Consultation/discussion based on detailed observational notes

It is important to remember that family members are team members. During the family interview, the role that parents would like to have should be discussed. Family members can play with their child, record observations, use the video equipment or observe through a mirror. The role of the family member will have will depend on the child and the family's comfort level, concerns and desires.

Planning for a Play Observation

As for all assessment techniques the family interview prior to the play observation is an important arena for planning. During the interview it is important to discuss:

- Family member's concerns and questions — this will help to guide the purpose of the observation
- History of the child's development — to assist in determining the developmental level of toys to include in the observation
- Role family members would like to carry out
- Child's favorite toys and activities — inclusion of these toys will assist the assessment team in developing rapport with the child

How to Observe Play

The purpose of the play observation will determine how the play situation is set up.

Play may be observed for a period of time during a typical program activity; e.g., free play at arrival time, or may be a planned, structured activity. When planning a play observation consider whether the activity should be:

- Child directed or adult directed
- Structured or unstructured
- Be an individual observation or a few children
- Child with family members

An unstructured observation is child directed, and is an excellent opportunity for observing what motivates the child, the method of mobility, favorite toys and activities, socialization skills and communication skills.

Structured play observations are controlled by the adult. The assessment team can structure the environment by choosing where the play will occur, what toys/materials will be ulitized, and who will be present. A structured observation can range from semi-structured (put out certain toys for the child) to a very structured situation (adult directed, with specific toys).

The choice of toys is important. Based on family information and past reports, choose toys the child is successful with, and some toys at higher developmental levels. Play with one inch cubes can provide a valued "quick screen." Observing how the child plays with the cubes can provide insight to his/her developmental level of functioning.

Always begin the play observation with free play. Free play provides time for the child and family to become comfortable, for the assessment team to build rapport with the child and family and to observe toys and play activities the child chooses. An assessment team member can join the child's play through interactive games such as playing ball. The most structured, adult directed activities should be last.

OBSERVATION OF DEVELOMENTAL FUNCTIONING

Observation

A child will often demonstrate his or her greatest abilities when the child and family members are comfortable and interacting with familiar toys. The play observation provides such an atmosphere.

The play observation is a natural link between assessment and intervention planning. Skills, learning styles, favorite toys, and motivating factors can be observed during play and considered when planning intervention. The assessment team may want to observe the following themes during a play observation:

- Approach to situation
  - Does the child approach toys/situations independently?
  - How does the child approach play? (fear, excitement)
- Attending behavior
  - Length of time on task
  - Distractibility
- Functional Use

  - Fine motor skills
  - Correct use of objects
  - Theme of play
- Exploration
  - Length of time explores
  - Senses used
  - How explores
- Problem Solving
  - Toys
    - How manipulates
  - Situation
    - How child sets up situation
    - How leaves unwanted situation
- Concepts
  - Size
  - Positive/Negative
  - Colors
- Combinations/Relationships
  - Item use together
  - Item use with self
- Categorization
  - Create play area according to theme
  - Size, shape, color, function
- Response to sudden change
  - Noise, intrusion
- Sequence of Play
  - How many themes
  - Active to nonactive
  - Mobility from toy to toy
- Socialization
  - Alone or with others
  - Reaction to others joining in play
- Imitation
  - Peer
  - Adult
- Communication
  - Nonverbal
  - Verbal
- Special interests
  - Preferred toys/games
- Reaction in general to play situation
  - Enjoyment
  - Frustration
  - Indifference

It is often very informative to attempt to "push" a child to higher levels of play. For instance, if the child is holding a doll, the adult can comment "Baby is hungry" to observe if the child will feed the doll. If the child does not respond, the adult can feed another doll, observing if the child imitates the feeding.

Observation Forms

It is helpful to have an observation form available when observing play. The content of the form will be dictated by the purpose of the observation. Are you observing toy

preference? peer interaction? motivation? The observation form may be developed by the teacher to fit his/her needs, or a form developed by others may be adopted.

Narrative Form: A narrative form provides space for the observer to record all activities that occur during a set observation time. (For an example, see Handout 4)

Graphs/Charts: Graphs and charts provide an outline and guidelines for noting specific behaviors, with a small amount of writing during the observation. They can be designed to reflect the specific purpose of the observation. (For an example, see Handout 5)

Tape Recorders: An excellent method of recording communicative interaction among children.

Video Recorders: Provide opportunities for the staff as a whole to view film together. Provides opportunity for viewing with parents. May be given to families as a record of child's activities in the program.

THE PLAY INTERVIEW

The play interview provides a framework for observing the child's emotional status. It is a potentially rich source of information. Typically, the play interview occurs within an office setting, with child and examiner present. A parent is also involved.

The play interview provides opportunities for free play, structured, and unstructured play activities. It provides opportunities to observe how well developed a child's coping skills are with respect to situations which might be frustrating or raise the child's anxiety level. In order to facilitate our observing the broadest possible spectrum of the child's functioning, a variety of toys are made available. Toys which are useful in helping the child to express himself in a variety of different ways are chosen. It is important that there be a variety of toys, but not of such number to be overwhelming to the child. It is also important that the toys made available be broadly developmentally appropriate. The following are some of the potentially useful models of expression with examples of toys:

Aggressive Activity. Monsters, dinosaurs, gun

Regressive Activity. Baby bottle, toy toilet, bed and blanket, baby

Family Relationships. Doll house and furniture, doll family

Communication and Expression. Paper and crayons, clay, puppets, toy telephone

"Cognitive" Oriented Play. Blocks, containers for filling and dumping, noisemaker, paper and crayons

Special Toys: Unique to a child's particular situation.

Organizing the Data: Categories for Observation (Greenspan, 1981)

In observing play, three crucial elements exist:

1. There must be a fully accurate description of the observed behavior.
2. One must have knowledge of the child's age-appropriate functioning.
3. Not only the play contents ("what goes on"), but also the play process ("how does it happen"), and the play structure (how is it organized and how are themes linked) must be observed.

The following categories of observation can be utilized when observing play in any setting:

Physical/Neurological/Cognitive Development. One might observe the child's posture, gait, balance, fine motor coordination, quality of speech and language, activity level, problem solving skills.

Overall Emotional Tone. What is the quality of the child's mood during play?

Capacity for Human Relationships. How does the child relate to you? To other children, if present? How does the child's relationship with you evolve over time?

Affects and Anxiety. What emotions does the child show during play? How appropriate to the context are they? How deeply felt do they seem to be? What kinds of things seem to make the child anxious? How is the anxiety handled?

Use of the Environment. How does the child explore and use his surroundings? For example, does the child fearfully stay in just a corner of the room, does he explore freely, or does he impulsively move from one area to the next?

Thematic Expression and Development. What themes are expressed in the child's play? Are they linked together logically or is the child's play difficult to follow and disorganized? Are the themes of age-appropriate relevance? Are the themes rich and deep, suggestive of a well-developed inner life?

Subjective Reactions. How do you feel with the child, and what can your feelings about the child tell you about the child?

When a child's play is observed in the context of a knowledge of age-appropriate norms and functioning, much can be inferred about the nature of the child's thinking and what is important to him. We can glean information regarding current levels of functioning, worries and concerns, and emotional complexities. The sequence and flow of the play themes, how these themes are related and the affects attached to them, provide valuable information with which to hypothesize about the child's conflicts.

OBSERVATION OF LANGUAGE

Children's play is a rich source of information about a child's communication skills. The observation of free and structured play complements other sources of information of assessment data (e.g. formal testing and parent interview). In a play setting, assessors can observe a child's communication skills (both verbal and non-verbal.) Marshall (1961) observed that children tended to produce their most elaborative language in a play setting. The observation of play allows for looking at interaction patterns between the child and others. The observation of play allows for a comparison of the child's emerging symbolic functioning in both play and language skills.

McCune-Nicolich and Carroll (1981) provide a framework for observing and relating early play and language skills.

Looking at Communication Skills

- Form of language — "how a child says something"
  - Make a judgement about articulation skills in conversation.
  - Record the sounds that infants make during play, to judge their repertoire of sounds.
  - Look at the average length of sentences (e.g., one word sentences).
  - Analyze sentences used in play for specific grammatical forms. (e.g., use of verbs).
- Content of language — "what does a child talk about"
  - Analyze utterances for semantic concepts (e.g., "go car" represents action-object relationship).
  - Look at vocabulary and concept development (e.g., "big" "not big")
- Use of language — "reasons for communication"
  - Preverbal communicative intentions: What a child communicates to us using gestures. It's very important for children to communicate their needs/desires on a non-verbal level first. Roth and Spekman (1984) provide a framework for observing this. (See Table 1, Handout 1)

    Communicative intentions at a one-word level: Children next communicate many of the same intentions using words, that they previously had using gestures. (See Table 2, Handout 2)

    Communicative intentions at multi-word level: Children then again expand sentence length to communicate the same intentions as before. They also learn new skills. (See Table 3, Handout 3)
- Interaction Patterns
  - Turn taking abilities in communication
  - Initiation, responsivity in communication
  - Conversational abilities
  - (Refer to *Foundations for Understanding Parent-Child Interaction* for more information.)

Collecting the Information

The communication information you are collecting will determine how the play is observed and recorded. A language sample should be taken by audio or video taping. A familiar person (parent, sibling) should be included in the play observation.

During the observation, the assessors role is to evoke and encourage the child's language without structuring form and content. The assessor follows child's lead, trying not to be the primary speaker.

Suggested Toys for the Observation:

- Variety that are age appropriate
- Have limited number of books, because it encourages naming behavior in adults ("What's this?") to the exclusion of other interaction patterns
- Ask parents to bring favorite toys
- Use toys that encourage turn taking (ball)
- Other toys such as windup toys which encourage requesting intention ("Wind this up for me.")

It is important to chart the information collected for further review and discussion. An example is to set up a chart that keeps track of the context and the utterance. (McLean, Snyder-McLean, 1983.)

Training Activities

Strategy #1

Purpose: To observe play.

Materials: Video of children of different ages at play.

Activity: Teams observe video of different age level children engaged in spontaneous play. Discuss observations and differences in the play observed.

Time: Observe video: 10 minutes Discussion: 20-30 minutes

Strategy #2

Purpose: Compare/contrast the benefits of structured and unstructured play observation.

Materials: Video of a structured and unstructured play situation.

Activity: Teams view video and compare/contrast the information obtained from the structured and unstructured play observation. What are the benefits of a structured observation? Unstructured? What are the weaknesses of each?

Time: Observe video: 10 minutes Discussion: 30 minutes

Strategy #3

Purpose: To observe play utilizing an observation guide.

Materials: Play Interview categories of observation listed in this chapter.

(or)

Handout 1, 2, or 3 (depending on age of child)

(or)

Handout 4

(or)

Handout 5

Activity:

1. Observe a child in a play situation, using one of the observational guides.
2. Discuss observations, answering the following questions:
   a. What did you observe?
   b. How much information were you able to observe?
   c. Was the observational guideline useful? Why? or Why not?

Time: Observation time will vary. Discussion: 30 minutes

Handout 1

TABLE 1
PREVERBAL COMMUNICATIVE INTENTIONS

Intention	Descriptive Example
1. Attention seeking	
a. to self	Child tugs on mother's jeans to secure attention.
b. to events, objects	Child points to airplane to draw mother's or other people attention to it.
2. Requesting	
a. objects	Child points to toy animal that he wants.
b. action	Child hands book to adult to have story read.
c. information	Child points to usual location of cookie jar (which is not there) and simultaneously secures eye contact with mother to determine its whereabouts.
3. Greetings	Child waves "hi" or "bye."
4. Transferring	Child gives mother the toy that he was playing with.
5. Protesting/Rejecting	Child cries when mother takes away toy. Child pushes away a dish of oatmeal.
6. Responding/Acknowledging	Child responds appropriately to simple directions/Child smiles when parent initiates a favorite game.
7. Informing	Child points to wheel on his toy truck to show mother that it is broken.
8. Interactional	Child vocalizes to establish and maintain interaction with mother.

NOTE: Items #1-7 from: Roth, F., & N. Spekman, (1984). Assessing pragmatic abilities. In *Journal of Speech and Hearing Disorders, 49,* 2-17. Used with permission.

Handout 2

TABLE 2
COMMUNICATIVE INTENTIONS EXPRESSED AT THE SINGLE-WORD LEVEL

Intention	Definition	Example
1. Naming	Common and proper nouns that label people, objects, events and locations.	"Dog," "Party," "Table"
2. Commenting	Words that describe physical attributes of objects, events and people, including size, shape and location; observable movements and actions of objects and people; and words that refer to attributes which are not immediately observable such as possession and usual location. These words are not contingent on prior utterances.	"Big," "Here," "Mine"
3. Requesting object		
a. present	Words that solicit an object that is present in the environment.	"Gimme," "Cookie" (accompanied by gesture and/or visual regard)
b. absent	Words that solicit an absent object.	"Ball" (child pulls mother to another room)
4. Requesting action	Words that solicit an action be initiated or continued.	"Up," (child wants to picked up), "More"
5. Requesting information	Words that solicit information about an object, action, person or location. Rising intonation is also included.	"Shoe?" (meaning "Is this a shoe?") "Wadaet?" (what that?)
6. Responding	Words that directly complement preceding utterances.	"Crayon" (in response to "What's that?") "Yes" (in response to being tickled), "Yuk" (child pushes away unwanted food)
7. Attention seeking	Words that solicit attention to the child or to aspects of the environment.	"Mommy!" "Watch!"
8. Greetings	Words that express salutations and other conventionalized rituals.	"Hi, "Bye," "Nite-nite"

NOTE: Categories have been adapted from Dale (1980), Dore (1974), and Halliday (1975).
Roth, F. & N. Spekman. (1984). "Assessing Pragmatic Abilities," In *Journal of Speech and Hearing Disorders; 49*, 2-17.

Handout 3

TABLE 3
COMMUNICATIVE INTENTIONS EXPRESSED AT THE MULTIWORD STAGE OF LANGUAGE DEVELOPMENT

Intention	Definition	Example
1. Requesting information	Utterances that solicit information, permission, confirmation or repetition.	"Where's Mary?" "Can I come?"
2. Requesting action	Utterances that solicit action or cessation of action.	"Give me the doll." "Stop it." "Don't do that."
3. Responding to requests	Utterances that supply solicited information or acknowledge preceding messages.	"Okay." "Mary is over there." "No, you can't come." "It's blue."
4. Stating or commenting	Utterances that state facts or rules, express beliefs, attitudes, or emotion or describe environmental aspects.	"This is a bird." "You have to throw the dice, first." "I don't like dogs." "I'm happy today." "My school is two blocks away." "He can't do it."
5. Regulating conversation	Utterances that monitor and regulate interpersonal contact.	"Hey, Marvin!" "Yes, I see." "Hi," "Bye," "Please." "Here you are." "Know what I did?"
6. Other performatives	Utterances that tease, warn, claim, exclaim or convey humor.	"You can't catch me." "Watch out." "It's my turn." "The dog said 'moo.'"

NOTE: Adapted form Dore (1977, 1978a). Roth, F. & N. Spekman. (1984). "Assessing Pragmatic Abilities." In *Journal of Speech and Hearing Disorders; 49*, 2-17. Used with permission.

Handout 4
NARRATIVE FORM

Child: _____ Date of Observation: _____

Setting: _____ Time of Observation: _____

Observer: _____ Length of Observation: _____

Describe environment: (Where? Who is present? What toys/objects available?)

_____

_____

_____

_____

_____

_____

Behavior Observed: (Who initiates activity? What is occurring? How are toys manipulated? What communication strategies are used?)

_____

_____

_____

_____

_____

_____

_____

_____

Handout 5

OBSERVATION OF TOY USE

Child: _____

Setting: _____

Date: _____

Observer: _____

Toy Use	Name of Toy			
Looks at:				
Reaches towards:				
Picks up:				
Brings to mouth:				
Manipulates:				
Touches				
Pounds				
Turns				
Takes apart				
Puts together				
Other				
Other:				

Key: R = Right Hand
L = Left Hand
B = Both Hands

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Vonansky, W. Assessment of social and emotional development. In Paget & Brachan, *The psychoeducational assessment of preschool children.* New York: Grune & Stratton.

Annotated Bibliography

Brown, C.C. & Gottfried, A. (1985). *Play interactions: The role of toys and parental involvement in children's development.* Johnson & Johnson Baby Products.

This book discusses how toys or play materials and parental involvement in the process of play interactions contribute to young children's development. The book is divided into five sections: 1) origins of play, 2) play and developmental processes, 3) social significance of play, 4) parent-child interactions in different populations and 5) consequences of play materials and parent-child interactions.

Chanie, P. (1979). *Learning through play.* Johnson & Johnson Baby Products.

This book discusses play from a theoretical point of view. Topics discussed are: What is play? How does play contribute to infant and child development? How can we improve the quality of play experiences in children?

Garwood, S.G. (1982). *Topics in early childhood special education: play and development.* Gaithersburg, MD: Aspen Publications.

The theory, research, and application of play are addressed in this journal. Topics discussed are: Piagetian theory translated into assessment and intervention approaches, differences in play among various special needs groups, effects of the play setting on behavior, relationship between infant play and coping skills and emotional stability and the effects of a parental intervention program on imaginative play.

Greenspan, S. (1981). *The clinical interview of the child.* New York: MacMillon.

An indepth description and discussion of Greenspan's framework for the assessment of young children through play.

Linder, T.W. (1990). *Transdisciplinary play-based assessment: A functional approach to working with young children.* Baltimore, MD: Paul Brookes.

The transdisciplinary play-based assessment process is described. Numerous case studies, specific guidelines and observation forms are included.

Neisworth, J.T. (Ed.). (1985). *Topics in early childhood special education: Developmental toys.* Austin, TX: Pro-Ed.

This journal provides a cross section of contemporary theory and practice related to the developmental use of toys. Topics covered are: how toys can influence the type of play activity, the influence of the physical environment on child development, classification of toys, an examination of the correlation of simple object manipulation and later developmental functioning, social and cognitive benefits of various play materials, books as toys, and selecting, adapting and using specific toys in relation to specific special needs.

Rogers, S. (1982). Developmental characteristics of young children's play. In Ulrey, G. & Rogers, S., *Psychological assessment of handicapped infants and young children.* New York: Thieme-Stratton.

This chapter discusses current theory and research on cognitive, social, and emotional aspects of play, as well as the effects of various handicaps on young children's play.

Westby, C. (July, 1980). Assessment of cognitive and language abilities through play. *Language, Speech, and Hearing Services in Schools. (XI),* 154-168.

A symbolic-play language scale is presented. The scale describes ten stages in the development of symbolic play abilities and relates the language concepts and structures associated with each developmental play stage. Use of this scale for evaluation and remediation planning is discussed.

QUESTIONS/SOURCES CHART

ASSESSMENT QUESTIONS	Previous Assessment & Reports	Parent Interview	Home Observation	Teacher Interview	Classroom Observation	Parent/Child Interaction Observation	Play Interview and Observation	Curriculum Referenced Tool	Formal Assessment
WHAT 1.What tasks/skills are mastered or not mastered? 2.Are enough behaviors sampled to get an accurate representation of what a child can and can't do? 3.What underlying constructs of development are mastered or emerging?									
HOW 1.Ecology a.Parent-child interaction: -How does the parent teach, deal with successes and frustrations of the child? -What cues do the parent/child give? -How do the parent and child read each other's cues? -Initiation and responsivity?									
b.Child-child interaction: -How does the child learn from other children? -How child initiates and responds to nteraction? c.Family schedule. d.Parental goals/concerns. e.Culturally appropriate testing materials/ situations.									

Foundations For Understanding Parent-Child Interaction

Mary S. Krentz, Ph.D.
Clinical Director
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The chapter describes the importance of caregivers and infant interaction and the assessment of early social and emotional development. The wide range of infant behaviors and corresponding parent responses are discussed. Implications for specific developmental disabilities, as well as cultural differences, are described as they relate to implications for interventions.

About the author: Mary Krentz is a licensed psychologist who is presently the Clinical Director of Child and Family Therapy Center in Concord, California, and has a private practice in Oakland. Her special areas of expertise include parent/child interaction, high-risk infants, attachment, child abuse and neglect, and psychological assessment. When this chapter was originally written, Mary was the Director of Integrated Special Infant Services, San Francisco.

CONCEPTS IN PARENT-CHILD RELATIONSHIPS

The earliest interaction between an infant and his or her primary caregiver is fundamental for the infant's social and emotional development. Not only has this first relationship been thought to serve as a prototype for later love relationships but a secure attachment formed during the first year of life has been associated with later development of imaginative and symbolic play, competence of play and curiosity. Securely attached children are also found to be more cooperative with adults, more likely to exhibit internalized control of their behavior, to show more positive affect and to have greater enthusiasm. The quality of infant-parent attachment is also related to important patterns of socialization in the child such as relationships with peers, problem-solving style, affective involvement, expression of affect and cooperation with adults.

Reciprocity

Both the infant and the caregiver contribute to the interaction and to the quality of the relationship. The idea that a child is a product only of how the parents raised him or her is simplistic and doesn't account for the tremendous effect that a child can have on a relationship. The quality of a parent-child relationship is formed by the dynamic give and take between the two partners. (Lewis, 1984) outlined the following Infant Developmental Principles:

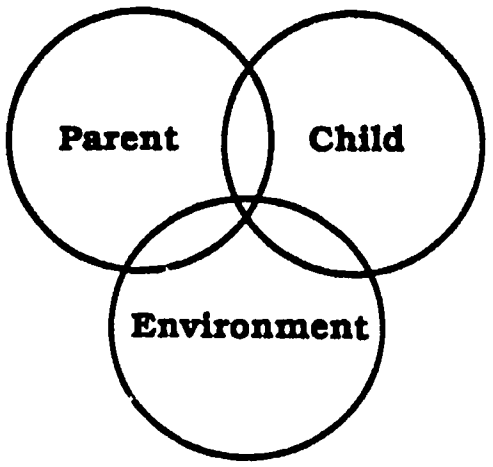
Infants are ACTIVE. They participate in their own development and act on their environment. As early as 10 weeks, infants show interest and increased activity when their movements cause audio-visual stimuli to occur.

Infants are COMPETENT. Babies come well equipped. They are able to see, hear, smell, and respond to touch. They're very capable of signaling their caregivers through crying. New infant research shows that an infant can differentiate its mother's milk from another woman's milk in the first few days of life.

Infants are SOCIAL. Babies come with systems in place for carrying out interaction. At birth, their visual acuity is greatest at 8 1/2 inches which allows them to focus on a parent's face when feeding. They prefer figures in a configuration of a face to random figures and the pitch of a woman's voice.

Infant development proceeds from UNDIFFERENTIATED to DIFFERENTIATED. Early competencies of a child are interrelated and interdependent. Cognitive, social and linguistic abilities are interdependent during infancy and move to specific and separate capacities as a child grows older.

THE TRANSACTIONAL APPROACH



The transactional approach suggests that capacities of the parent, of the child, and factors in the environment interact to produce the quality of the parent-child relationship.

Determinants of the Interaction

Infant. The infant brings a certain disposition or temperament to the interaction as well as certain capacities. Areas to include in the evaluation are:

- Cognitive abilities
- Motor abilities
- Emotion
- Social abilities
- Temperament
- Appearance
- Ability to regulate and control state
- Infant's responsiveness (alerting, visual responsiveness, auditory responsiveness, cuddliness, consolibility, irritability, smiling)
- Communicative intent
- Infant's ability to initiate interactions

Parent. The parent brings a basic style and level of parenting skills. Areas which should be included in the assessment are:

- Parent's perception of the infant (e.g., How they describe the infant?)
- Parent's expectations for child (e.g., Are they developmentally appropriate?)
- Knowledge about the child's handicap (e.g., Is parent realistic?)
- Parent's feeling about the handicap (e.g., What does it mean to the parent to have this child with this particular impairment?)
- Parent's response to different aspects of the child's development.
- Parent ability to function in the larger environment (stability of relationship/ employment, socioeconomic status, quality of marital relationship)
- Level of parenting skills (flexibility, patience, use of limit setting)

Environment. The environment will impact on the quality of the parent-infant interaction. Environmental areas to assess are:

- Availability of support networks (i.e., extended family, friends, church)
- Reaction of support network to handicapping condition
- Availability of other resources (respite care, medical providers)
- Stability of living situation

The Interaction Between Parent-Child

Areas to evaluate in the interaction:

- What is the predominant affect of the relationship?
- How does the affect change or shift in the relationship?
- How does interaction start? Who is the leading partner? Is this shared?
- How does interaction continue? Does the infant sustain interaction with the parent? Does the parent notice and accept infant's withdrawal cues?
- Is parents' behavior contingent on the infant's?
- How does infant's pace and timing fit with the parent's pace?

- Do the partners take turns in the interaction?
- What modalities do the partners communicate through? Vision? Touch? Voice? Kinesthetically?

IMPACT OF HANDICAPPING CONDITIONS ON PARENT-CHILD RELATIONSHIP

Partnerships in which one member of the dyad has an area of vulnerability or area of incompetence are at higher risk for less rewarding interaction. Selma Fraiberg's (1977) seminal articles on children who are blind poignantly describe the impact of the disability on the caregiver's responsiveness, the parent-infant relationship and the very difficult tasks of adapting the interaction to the child's handicap.

Few empirical studies have been done of the impact of a handicapping condition on the parent-child relationship. Some studies that have been done include Thoman, Becker, and Freese (1978) who studied pairs in which there was a child who was delayed (at 5 weeks) showed less social interaction, less looking, and had more caregiving and more holding. Infants showed mixed cues and rapid behavioral state changes. Mothers showed more frequent but briefer episodes of feeding and holding. Vietze, Abernathy, Ashe and Faulstich (1978) studied pairs where a child, at one year of age, had developmental delay and were similar to pairs in which child was typical. The high and low functioning developmentally delayed groups of children didn't differ significantly in maternal vocal behavior but the lower functioning group showed less contingent responsiveness to maternal vocalizations. Please refer to "Parent-Infant Interaction" by Marci J. Hanson in *Atypical Infant Development* for a fuller discussion.

Specific Handicapping Conditions

Cognitive Impairments. Terdal, Jackson, and Garner (1976) studied cognitive impairments. Children were divided into three groups according to level of cognitive impairment. Mothers showed equivalent levels of interactive behavior. Children differed in response to interactions with children in low groups responding only 49% of the time while children in middle and high groups responded about 80% of the time. Mothers of children in lowest group were more directive and not as consistent in providing positive feedback.

Jones (1977, 1980) found that mother-child interaction was more mother-directed in pairs where there was a child who had Down syndrome and more child-dependent in typical pairs.

Serafica and Cicchetti (1976) found few differences in attachment behaviors between Down's syndrome and children without developmental delay, although children with Down's syndrome showed less crying when the mother left the room.

Physical Disability. Kogan, Tyler and Turner (1974) studied children with cerebral palsy from age one to four years. They found a decrease in mother's affection and acceptance of the child over time.

Blind. Fraiberg (1977) found that children who are blind exhibit attachment milestones at later ages than typical children but that the smile discrimination of familiar persons, person permanence and separation protest to develop.

Deaf. Schlesinger and Meadow (1972) found that mothers of hearing children showed more permissiveness, nonintrusiveness, nondidactic behavior, creativity and flexibility. Attachment and separation behaviors were similar between deaf and hearing groups.

Parent-Child Interaction Assessment Tools

Various researchers, clinicians and educators have attempted to systematize the observation of parent-child interactions. These attempts have several purposes; 1) to provide standardization in observations so that different dyads and samples can be compared, 2) to increase understanding of common patterns in interaction, 3) to use structured observations as a basis upon which to intervene. Several of these tools are listed below.

- **Ainsworth's Strange Situation.** A highly validated and reliable laboratory situation consisting of observing parent and child through two separations and reunions. Valid for children from 12 through 20 months although it has also been used extensively with children through four years of age. This tool has an exclusive coding system and true validity is based on coders being extensively trained in the three primary attachment patterns. Many clinicians use a separation and reunion situation for looking at parent-child interaction. This can be very helpful and clinically useful information may be obtained but this is not the same as Ainsworth's Strange Situation which follows a very structured protocol and coding system. (Ainsworth, Blehar, Waters, & Wall. 1978).

- **Assessment of Home Environment.** A 45-item checklist rating emotional and verbal responsivity of mother, avoidance of restriction and punishment, organization of physical and temporal environment, provision of appropriate play materials, maternal involvement with child and opportunities for variety in daily stimulation. The Home Inventory is used for children from birth-to-3 years of age. It has been criticized as having a middle-class bias, and has had limited effectiveness in discriminating subtle differences in a relationship. (Caldwell)

- **Parent Behavior Progression.** A home observation tool with Form 1 for children birth to 9 months of age and Form 2 for children 9 through 36 months of age. Measures 6 levels of parent behaviors including the parent enjoying the infant, the sensitive observation of the infant and response to the infant, whether the interaction is mutually satisfying, and whether the parent provides appropriate developmental activities. The Parent Behavior Progression can be helpful in sensitizing observers to developmental issues within the interaction. Bromwich has also outlined intervention strategies based on her assessment tool. (Bromwich, R. 1978).

- **Nursing Child Assessment Scales.** The Nursing Child Assessment Scales are structured observations of parent-child interaction during specific situations: a feeding session and a teaching situation. The feeding situation is used to observe dyads where the child is birth to one year of age while the teaching situation is used to observe children birth to three years of age. In the feeding situation the mother is asked to feed the child as she normally would and to let the observer know when she is finished. In the teaching situation, the mother is asked to teach the child a developmental task slightly above the child's present level.

Each Nursing Child Assessment Scales look at the mother's behavior and also the child's behavior, thus integrating a transactional approach into the tool. The parent is rated on sensitivity to the child's cues, response to distress, social-emotional growth fostering and cognitive growth fostering. The infant is rated on clarity of cues and responsiveness to parent. While the scales were designed for home observation they can also be used in other settings. They can be very helpful in alerting observers to qualities in the interaction and can be used as a basis for intervention techniques. (Barnard, K. 1978).

Attachment - Separation - Individuation (A-S-I). The A-S-I is a tool for observing interaction in dyads in which the child is birth to 36 months. Observations are conducted in naturalistic settings and a profile is obtained for both the parent and child in five major areas: sensory cueing, contact, organization perception of identify and other people. Behaviors looked for are divided into 7 different phases corresponding with the development of attachment and separation-individuation. Thus, the profiles discriminate behaviors which are appropriate at particular developmental phases based on attachment-separation-individuation theory. (Foley & Hobin, 1981). (Mahler, Pine, & Bergman. 1975).

ASSESSMENT CONSIDERATIONS

As in any other domain of child development, assessment of parent-child interaction should be embedded in a transdisciplinary model. While a psychologist, nurse, or educator may have primary responsibility for intervening in the interaction, other team members have important observations and contributions to make both in the assessment and intervention. For instance, a speech therapist may have astute observations about turn-taking in the interaction, the communicative context and the amount of reciprocity. In a similar way, a physical therapist may note how positioning can either enhance or limit a child's ability to respond to the parent.

Sometimes interactions between parent and child can be painful experiences. If one observes an interaction relationship going awry, the observer needs to focus on the transactional framework presented in this chapter. Neither the child nor the parent are totally responsible and neither person's difficulties should be identified, with the exclusion of the other's problems. Interaction is a complex two way process that is unique to that particular pair. No child would be quite the same with another parent and no parent quite the same with another child.

The assessment process involves; 1) detailed observations and 2) interviews with parents. Interviews are conducted through structured but open-ended questions to the parents, questions that allow parents to express their observations and needs openly. This is a continual process that commences with the families' initial contact with the program and continues throughout their participation. Initially parents are asked about their observations and concerns. Areas included in the process are outlined in the previous section of this chapter "Determinants of the Interaction." Interviews can be conducted by any or all of the assessment members. However, it is suggested that initially one person be designated as the major contact with the family. After the family is involved in the intervention program, other staff members may take a more active role

in the process of assessment. The person(s) whose responsibility it is to perform these assessments must be a sensitive and skilled interviewer. This involves making parents feel comfortable and feel that their opinions are valued. Further, it involves delineating the fine line between obtaining information needed to help in the intervention planning process; e.g., how parents feel about the child's disability, and not over-stepping the bounds of the intervention program to delve into other matters not in the realm of program services; e.g., financial planning, marital problems.

It is the parent(s) who determine the areas of need and concern. It is the interviewer who helps them to clarify the needs, articulate those needs, and further define the needs. For parents who are less able to function as the "generator" of suggestions at a given point in time, the interviewer may assist them to become active participants by listening emphatically, understanding their feelings, instilling hope and noticing positive aspects of the situation. This process may free parents to become more involved in the decision making and intervention planning process. Beyond this, the interviewer seeks the parents' opinions, obtains the information parents wish to present and then assists them to clarify and elaborate. Finally, the interviewer summarizes and ensures that she/he has understood the parents' concerns.

In order to develop intervention strategies to support the parent-child relationship, a specific observational assessment of the partnership is necessary. This assessment reflects the contribution of the child, the contribution of the parent and how the dyad functions. Overlaid on this process is an appreciation of the developmental stages of the relationship that provide a context for the interactional changes over time. These developmental stages or adaptations are included in *Supporting Parent-Child Interaction: A Guide for Early Intervention Personnel*, by Hanson and Krentz. (1986).

Observations can be made informally during play, caretaking activities; e.g., changing a diaper or in more "formal" situations, (as described in the NCAST scales of a feeding or teaching situation). The assessment team should be sensitive to the needs and wants of the family in conducting the observation and should have an established rapport with the family. "The Interaction Between the Parent-Child" and "Determinants of the Interaction" sections provide some guidance for the observation.

Cultural Differences

Some cultural differences exist in the ways in which infants and their caregivers relate and these are probably due to both biological and environmental factors. (For a fuller discussion of this issue, please refer to "Cultural Differences in Caregiver-Child Interaction: Implication for Assessment and Intervention" by Carol Westby, Ph.D.)

Biologically based differences include level of activity, state regulation and motor precocity. African-American infants have been found to walk at an earlier age than Caucasian and Native American babies and have also been found to show more extreme state changes than Caucasian or Puerto Rican infants. Environmentally-based differences include the role of extended family or community members as caregivers, the kinds of activities engaged in and the pace of the activities.

Many culturally-based environmental differences are rooted in the psychological and sociological views of children. These include the understanding of the task of socialization, the capacities which children are seen to have and their perceived developmental level. African-American mothers have been found to value independence and tend to respond less frequently to infants because of fears of "spoiling." Cultures that believe a child has more intentionally of behavior may either punish more or model

things more because of their beliefs in the child's capacities.

What appears most important in evaluating parent-child interaction is to be sensitive to cultural differences and to refrain from imposing a single model of interaction on other groups. A relevant question is how a particular mother sees her child in the context of her own culture. Inquiries about her expectations and wishes for the child, her attribution of responsibility to the child and how these impact her characteristic style are important. It is also important to remember that while particular cultural groups treat children in different ways, each dyad is unique and can vary widely even within cultural groups.

IMPLICATIONS FOR INTERVENTION

It is beyond the scope of the information outlined in this chapter to discuss intervention techniques for parent-child interaction, however, a few underlying tenets should be mentioned.

In interviewing with any parent and child, it is important to form a partnership with the parent so that both the professional and the parent are engaged in the mutual task of making their relationship with their child more rewarding. This partnership can be developed by eliciting the parents' observation of the interaction, inquiring about how they feel about the relationship and understanding the special difficulties they might have. The staff working with parents and children have been impressed by the fact that parents have often made wonderful adaptations that help their child to relate to them or to better accomplish a task. Sometimes these adaptations can look maladaptive, thus it is important to know why a parent does things a certain way before making a judgment about it. An example of this is a parent who knows that she must limit her vocalizations to her neurologically sensitive baby when feeding him. While she seems quiet and somewhat removed to some observers, she has found a way of changing her natural inclinations to facilitate her child's weight gain and stability. Being sensitive to the parent's understanding of the child will also foster the partnership of parent and professional.

A good interventionist can also use the transactional framework for helping the parent to feel less blame and guilt for problems in the interaction (blame may be self directed by the parent or directed at the child). If the child's limitations and their impact on the relationship is explained to the parent, a vicious cycle of blame can be alleviated and energy can be spent coping with the actual problem.

One must always keep in mind the sensitivity of the relationship and begin with what the parent already understands.

Specific interventions that can be helpful include: 1) modeling with a staff member experimenting with interventions 2) reviewing videotapes of the interaction with the parent to elicit their understanding in a less pressured situation than when they are actually feeding or trying to get the child to perform and 3) parent discussions in parent groups of their relationships with their children, the rewards of satisfying interaction and adaptations they feel they've made.

Training Activities

Strategy #1

Purpose: To observe and respond to a parent-child interaction.

Materials: Videotape of a parent-child interaction, approximately 10 minutes in length.

Activity:

1. The training group should view the videotape of a parent-child interaction. (Participants can be assigned to focus especially on either the parent's or the child's contribution to the interaction prior to viewing the videotape).

2. After viewing the videotape, conduct small discussion groups (about 5 members each, with child and parent focus mixed in the group) should be formed. Discuss the following questions for about 20 minutes:

   a. Who initiated the interaction?
   b. What was the partner's response?
   c. What specific engagement cues was noted?
   d. What specific disengagement cues were noted?
   e. What was the effectual tone of the relationship?
   f. What was the timing and pace of the relationship?
   g. How would you begin to intervene in this partnership?
   h. What intervention strategies would you use?

3. Reconvene the group into a large session and discuss these same questions. Facilitate the discussion and emphasize the contributions of each partner in determining the interaction.

Time: 45-50 minutes.

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Crosscultural Issues in Assessment

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California's diverse ethnic population is reflected in early intervention programs throughout the state. These programs are struggling with the answers to some very difficult questions: How do we assess the limited English speaking child? How do we recruit and hire bilingual/bicultural staff? What are the best practices in serving families?

The purpose of this chapter is to provide basic guidelines for working with families from various cultures. The intent is not to present the "Ten Easy Steps to Serving Families from Various Cultures," because there are no easy answers to be given. The object of the information presented is to stimulate thinking and discussion, generate ideas and lead to better services for children and families.

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INTRODUCTION TO CROSSCULTURAL ISSUES

Immigration is drastically changing the ethnic composition of California. Demographic figures of California dramatically demonstrate this phenomenon: (Assembly Office of Research, State of California, 1986).

In 1970, California's population was:

Non-Hispanic White:	78%
Black:	7%
Hispanic:	12%
Asian:	3%

In 1985, California's population was:

Non-Hispanic White:	63%
Black:	8%
Hispanic:	21%
Asian:	8%

Projections for 2000 are:

Non-Hispanic White:	53%
Black:	8%
Hispanic:	27%
Asian:	12%

This immigration trend will have an impact on the public school system: 14% of the children entering kindergarten in 1985 were classified as "limited English proficient"(LEP). Statewide, 13% of the total school enrollment were classified as LEP. (Assembly Office of Research, State of California, 1986). This cultural/ethnic diversity will be reflected in early intervention programs.

Early childhood practitioners need to learn about the culture of the families they serve, adapt assessment and programming strategies to meet the unique needs of various cultures, and meet the language needs of these children and families. Webster defines cross (adj.) as "involving mutual interchange." "Crosscultural" is the mutual interchange between cultures.

DEFINITION OF POPULATION

This chapter focuses on the "culturally and linguistically different young child with special needs and their families." A "culturally and linguistically different child" is a child whose primary language is a language other than English and whose cultural background is other than middle-class American. A "young child with special needs" is a child younger than five years of age, who has been diagnosed as having a

handicapping condition, or who is at risk for developing a handicapping condition due to psychosocial or medical factors. A culturally and linguistically different young child with special needs is a child under five years of age, whose primary language is a language other than English, whose culture background is other than middle-class American, and who has been identified as having a handicapping condition or is at risk for developing a handicapping condition due to psychosocial or medical risks.

SENSITIVITY/RESPECT FOR CULTURE

It is recommended that early intervention teams discuss their personal values and attitudes towards people of different culture groups. The program and assessment philosophy should include a statement on how children and families from other cultures will be served.

Staff inservice training should include discussions on the unique aspects of the various cultures represented in the program, and the impact of the culture on the assessment, Individual Educational Plan (IEP) and intervention strategies.

Although it is important and helpful to learn the traditional beliefs of a different culture group, these beliefs should not be generalized to all people of one culture. There must be a sensitivity to differences within each culture and to individual family needs. Ethnic groups come to the United States from different countries. Hispanics from Mexico are unique from Hispanics from El Salvador, Chinese from Hong Kong are different from Chinese from Cambodia.

It is important to know the status of the family when they came to the United States. Did the family come from a refugee camp? Did they come as an intact family with financial resources? Education? Vocational skills that are needed/desired in the United States? This information will obviously impact the family's ability to "provide for themselves" in the United States.

WORKING WITH FAMILIES

We must remember that although families differ according to their beliefs, customs and needs, all families served have one experience in common—the birth of a child with special needs. An ecological model of service delivery should be used when working with families — the child and family must be considered in the context of their individual uniquenesses, level of the family's acculturation, and the attitudes and beliefs of the community in which they reside. (See Chapter 1, Foundations of a Family Approach to Early Childhood Assessment.)

It is important to learn the traditional cultural values and beliefs of the family,

although we must be careful not to generalize these beliefs to all members of a cultural group. Examples of cultural values and beliefs to consider are:

Impact of a child with a handicap on the family. Traditionally, what are the cultural beliefs concerning the birth of a child with special needs? What supports are available for the family within the context of their culture?

Child rearing practices. Is the family routine child-centered or adult-centered? What are the family beliefs regarding toileting? feeding? discipline?

Roles of family members. Traditionally, who is the primary caregiver and decision maker? (mother? father? grandparent?) Is the caregiver and decision-maker the same person?

Importance of education. Do the cultural groups view institutional education as important? What are the family goals for their children? Do parents actively participate in their child's education, or do they "give" their child to the schools as the authority to educate?

There must be a willingness to be sensitive to beliefs of the family, to work with these beliefs without denying them. Families may give reasons to explain the handicapping condition that is difficult to understand or be accepted by other cultures. Procedures may be tried to help the child. For instance, some Catholic families light a candle and say a prayer to ask for God or a saint to help an individual. Some families may take their child to an acupuncturist for help. Professionals must be sensitive to and understanding of these practices.

What supports are available to the family? Do relatives or friends from the native country live nearby? If family and friends aren't available, what other support systems are available?

ASSESSMENT

Trust and Open Communication

It is important to develop trust and open communication with the family. This can be accomplished by listening to the family's questions, concerns and comments. If the family observes that you care about their child, are wanting to help their child and respect their wishes and concerns, you will have the basis for trusting relationship in which to work, even if you do not speak their language.

Language for Assessment

Best practices, legislation, (Title VI of the Civil Rights Act of 1964, P.L. 94-142) and court decisions (*Diania vs. State Board of Education*, 1970) mandate that assessment be carried out in the child's primary language. Bilingual assessment best practice is to use a professional who is bicultural/ bilingual. If a bicultural/bilingual professional is not on the staff, community members can be hired as "paraprofessionals." The role of the bicultural/bilingual paraprofessional is to assist other staff members in learning about different cultures, acting as the primary contact person with families and carrying out the assessment under professional supervision and guidance. If bicultural/bilingual staff members are not available, an interpreter should be used. When choosing an interpreter, it is important to consider the following qualifications:

- Proficient in English and the non-English language
- Knowledge of grammar, slang and idiomatic expressions
- Extensive vocabulary and memory skills
- Understanding of the families cultural nuances
- Ability to work with people
- Willingness to advocate for family
- Understanding of the service being provided.

It is important for the interpreter and family to develop a trusting relationship. Families must trust the interpreter before they will share confidences.

It is also important for the interpreter and English speaking staff to develop a trusting relationship. The interpreter must be able to trust that the staff will help the meeting run smoothly, keep eye contact with and foster a relationship with the parents, pause frequently to allow for interpretation and plan adequate time for the meeting. Staff must trust that the interpreter will interpret what has been said, ask if the message isn't clear and interpret all comments and questions from the parents.

Best Practices

Best practices for the assessment of linguistically and culturally different young children with special needs are similar to the assessment best practices for all young children.

- The assessment plan must be written with and signed by the parents, in the language of the family.
- The parent is an active member of the assessment team.
- The assessment team includes at least one member who speaks the child/family's language and understands their culture. (This team member could be a bilingual paraprofessional or interpreter).
- More than one assessment tool should be used.
- The child should be observed over a period of time, in different settings (home, center, playground).
- Informal observation, as well as formal assessment tools, should be used.
- Information from all agencies who serve or have served the child should be gathered and incorporated.
- The assessment report and recommendations are clearly written in language that the parent can understand (jargon is not used; if used, it is defined). The report should be written in the language of the family. The report is reviewed with the family by the bilingual team member.

Family Interview

During the family interview, in addition to the usual information gathered about the child and family, it is important to learn:

- What country is the family from?
- How long have they been in the U.S.?
- Why did they come to the U.S.?
- Are they refugees?
- What language is spoken in the home?
- What language is spoken in the community?
- Are family members living in the United States? Where? In the same community?
- What vocational skills and/or educational training do family members have?

Decision Maker

The decision maker in the family must be identified. This member should be involved in the assessment process. Don't assume it is the mother. In some cultures the father or grandmother is the decision maker.

Language of Instruction

The assessment process should explore the language of instruction, as well as educational goals.

Formal Assessment Measures

Formal assessment measures should be used with caution. Most tests are standardized on middle-class American children. The test items and language may be biased against a culturally and linguistically different child. An interpretation of a question into a language other than English may alter the meaning of the question. If a test is given in a language other than English, the assessment report must state this and caution that test results may have been effected.

IEP PROCESS

The IEP process can be intimidating to the most sophisticated families. When a family does not speak English, these processes can become a confusing nightmare. It is important that the experience is positive and meaningful for all families in programs.

It is important to consider the family view of education. In some cultures; i.e., Asian and Hispanic, many parents give the responsibility for education to the teacher. Parents do not tell the teacher what to teach. It may be difficult for these parents to make suggestions about what they would like their child's goals to be. (Leung, 1985)

If the family isn't involved, the reason may be cultural based or limited transportation, time or child care prevent them from coming. If this is the case, staff must work with the parents to find ways to be involved in the program.

To assist in making the IEP process meaningful, programs should:

- Explain the procedure to families beforehand—who will be present, what will be discussed and the purpose.
- Assist the family in planning beforehand for the meeting.
- Keep the meeting as simple as possible, don't use jargon, don't *read* reports.
- Schedule enough time for the IEP, considering the time needed for translation.
- Arrange for an interpreter at the beginning of the IEP process. The interpreter should be involved in all aspects of the IEP process (notification of meeting, assisting parents in planning, actual meeting and follow up). Allow the family to bring their own interpreter (someone they trust).

LINKING THE ASSESSMENT TO INTERVENTION

The assessment report and IEP must be in the language of the family. The determination of language of instruction should be a major outcome of the assessment process. It is important to integrate the child's special education and language needs into a well-rounded program. Intervention goals should include activities to develop a positive self concept and understanding of culture. When planning activities consider the following and how they may be incorporated into the planned educational strategies.

- What foods are eaten in the home?
- What toys are used in the home?
- What furniture, clothes, cooking utensils, etc. are familiar or similar to the cultural group?
- What are familiar animals and plants?
- What local stores sell materials that are familiar to the cultural group?
- What are some cultural stories or games?

Parents should be utilized as important team members in the planning of the intervention activities. Parents may be able to cook foods or teach the staff songs that are traditional in their culture.

The early intervention program should be flexible and be able to meet the individual cultural needs of various groups. For example, an early intervention program in East Los Angeles serves a largely poor Hispanic population. Most of the mothers do not work. Extended family and neighbors are involved in the care of the children. To meet the needs of this population, the following policies were set: Siblings under school age are bussed into the center with the enrolled child and family member and are incorporated into the program, an "open door policy" exists where all family members are invited to the center (advance notice is not required) and during public school vacations activities are planned for older children (often making them classroom helpers).

Community resources may assist in meeting the needs of families by providing staff training, assisting in planning the program, or providing interpretation/translation services. Examples of community resources are:

- Bilingual unit of the local public education agency
- Agencies or local organizations that employ bilingual/bicultural staff (ie. Mental Health, Chinatown Service Center)
- Local church
- Political leaders in the community
- Ethnic organizations

Training Activities

NOTE: It is important to balance self awarenss activities (Strategy #4) with cultural specific activities. Participate need to reflect on their own beliefs and values, as well as learn information about specific cultures.

Strategy #1

Purpose: Cultural Awareness

Materials: Panel of 3-4 professionals from various ethnic backgrounds.

Activity:

1. Ask the panel to answer a pre-arranged set of questions; plan three questions plus a back-up if time goes quickly.

   Examples of questions:

   a. Acknowledging the fact that not all members of a cultural group are similar in their beliefs and practices, are there communalities in the cultural group being represented that would be important for an early interventionist to be aware of?

   b. What are the child rearing practices of the cultural group you are represented?

   c What is the impact of child with special needs, a child who is ill, or the death of a child on the family in culture group you represent?

   d. How does cultural group requested view or utilize assistance from public agencies (e.g., schools, medical practitioners, social services)?

   e. How has your program been adapted or modified to meet the needs of the population served?

Time: Allow approximately one hour of discussion (total). Plan for at least 30 minutes of question and answer time at the end of the panel discussion.

Strategy #2

Purpose: Cultural Awareness

Materials: Panel of 3-4 parents, representing various ethnic backgrounds. (Remember parents often need reimbursement to help for transportation and child care in order to participate.)

Activity:

1. Have each parent respond to three to four prearranged questions.

2. Follow with at least 30 minutes of questions and answer time. It is recommended that the parents be bilingual if the audience is English speaking, to help the discussion flow freely. If interpreters are used, allow time for the interpretation to occur.

   Examples of questions:

   a. Acknowledging the fact that not all members of a cultural group are similar in their beliefs and practices, are there communalities in the cultural group you are representing that would be important for an early interventionist to be aware of?

   b. What are the child rearing practices of the culture group you are representing?

   c. What is the impact of child with special needs, a child who is ill, or the death of a child on the family in your culture?

   d. How does each cultural group view or utilize assistance from public agencies (e.g., schools, medical practitioners, social services)?

   e. What would *YOU* like the audience (early interventionists) to know before they work with your child and family?

Time: Allow approximately one hour of discussion (total). Plan for at least 30 minutes of question and answer time at the end of the panel discussion.

Strategy #3

Purpose: Cultural Awareness

Materials: None

Activity:

1. Ask the group to envision that their family has recently relocated to Japan (or another foreign country). Their child is in need of a developmental assessment. What would they want the assessment team to know about *THEIR* (participant's) *FAMILY* culture? Allow the group a few minutes to think about the question, than have them exchange ideas with their neighbor.

2. After approximately 10 minutes (or more if time allows) of discussion, ask for some responses back to the large group.

3. After you have solicited a few responses, ask the large group "Is the information you want shared about your family culture representative of *ALL* Americans?"

Time: Total: 30 minutes

Strategy #4

Purpose: Self-awareness

Materials: None

Activity:

1. Ask participants to think about the following questions:

   a. What cultural group do you identify with?
   b. What is one positive benefit you have received as a result of being a member of this cultural group?
   c. What is one negative impact you have felt as a result of being a member of this cultural group?

2. Ask participants to discuss their responses in small groups.

3. In the large group, discuss what happened in small group.

(This activity is based on the belief that everyone must come to terms with their own culture to be able to be sensitive to another culture. Often times white, middle-class Americans feel "culture-less." It is important to recognize that all people have a culture that impacts on beliefs, values and family practices).

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Leung, Brian. (March, 1985). *Working with Asian families inservice.* Unpublished paper presented at inservice given at Centro de Ninos y Padres, California State University, Los Angeles.

Annotated Bibliography

Advisory Committee on Child Development Programs. (October, 1985). *Second language learning by young children.* Sacramento, CA: California Department of Education.

This report contains reprints of six presentations from the "Second Language Learning by Young Children" conference held in Fresno April, 1985. Each presentation is research based and offers practical approaches to working with young children who are learning two languages. Child Development Programs Advisory Committee recommendations for child care are also included.

Bilingual Bicultural Education Office, California State Department of Education. (1984). *Handbook for teaching Cantonese-speaking students.* Sacramento, CA: California Department of Education.

This book was written for school personnel to help them better serve Cantonese-speaking students. Major topics that are covered are: general background information (immigration history, educational background, sociocultural factors), specific information regarding the Cantonese language and appropriate program options.

Bilingual Bicultural Education Office, California State Department of Education. (1983). *Handbook for teaching Korean-speaking students.* Sacramento, CA: California Department of Education.

This book was written for school personnel to help them better serve Korean-speaking students. Major topics that are covered are: general background information (immigration history, educational background, sociocultural factors), specific information regarding the Korean language and appropriate program options.

Bilingual Bicultural Education Office, California State Department of Education. (1983). *Handbook for teaching Vietnamese-speaking students.* Sacramento, CA: California Department of Education.

This book was written for school personnel to help them better serve Vietnamese-speaking students. Major topics that are covered are: general background information (immigration history, educational background, sociocultural factors), specific information regarding the Vietnamese language and appropriate program options.

California State Department of Education. (1982). *Basic principles for the education of language-minority students: An overview.* Sacramento, CA: California State Dept. of Ed. Publication Sales.

This booklet provides an overview of the education of language-minority students. Included are discussions on the historical development of education for these students, theoretical principles of learning two languages and implications for instruction.

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This Council for Exceptional Children booklet provides an overview of the bilingual special education field. The five chapters cover the topics of demography, testing, cognitive development in mildly handicapped bilingual children, language and curriculum development, and teacher education programs.

da Silva, G. (1984). Awareness of Hispanic cultural issues in the health care setting. *Children's Health Care, 13*, 1, 4-10.
This article explains the health-related traditions, values, and beliefs held by various Hispanic groups. A number of culture-specific diseases and treatment modes are discussed.

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This book provides information in the areas of communication assessment, bilingualism and the effects of second language learning on the phonological, semantic and syntactic-morphological system. Information on testing concepts and various assessment approaches are presented.

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This booklet is written for special educators, providing hints on how to actively involve Hispanic families in an early intervention program.

Omark, D. R., & Erickson, J. G., (Eds.) (1983). *Bilingual exceptional child.* San Diego, CA: College-Hill Press, Inc.
This book provides a comprehensive overveiw of the topic "bilingual exceptional children." The book is divided into three major sections: Concepts in Education of the Bilingual Exceptional Child (basic issues), Exceptionalities in Bilingual Populations (particular exceptionalities within various cultural groups) and National Issues and Model Programs (national organizations, alternative models, program evaluation).

Special ideas for education handicapped children and youth: Successful visits to bicultural homes. Los Angeles: Regional Resource Center West
This pamphlet emphasis the differences between middle class American values and the values of other cultural groups (ie, independence). Hints on how to recognize and consider these values when working with families from other cultural backgrounds are provided.

Westby, C. & Rouse, G. (1985). Culture in education and the instruction of language learning-disabled students. *Topics in Language Disorders*, 5, 4, 15-28.
This article discusses cultural traditions and values (ie. use of time, group versus individual) and their impact on educational performance. A culturally sensitive program for language learning-disabled bicultural children is outlined.

Linking Assessment to Program Planning

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A critical consideration in assessment is how the assessment will address program planning issues. Assessment becomes an isolated activity unless the assessment team links the assessment information to intervention efforts. The purpose of this chapter is to explore the role that program planning can play in each stage of the assessment process: the assessment planning phase, the assessment itself, the integration of the information gathered in the assessment, and finally, in the dissemination of the information to the family, professionals and other agencies.

About the author: Ann Carr's background includes being a speech and language specialist in infant and preschool programs. Her interests include team assessment, training and human resource development, and family/professional relationships. When this chapter was originally written, Ann was the Director of Training and Consultation for the Accreditation Council on Services for People with Developmental Disabilities.

INTRODUCTION

Linking assessment to program planning begins with the initial stage of the team assessment process. The assessment team can gather relevant information by:

1. A careful team planning process
2. Gathering qualitative information about the child and family, in addition to quantitative information
3. Effective communication of results to those people, programs, and agencies that may be involved with the child and family in intervention efforts

An initial team assessment can be viewed as the first phase of the intervention effort. For many families, it is the first time that a relationship is formed with the professional community or program staff. It may be the first time that the family will synthesize information from many sources in order to address family concerns, answer questions about their child's condition and provide guidance in future intervention efforts. A tone is set for future parent and professional collaboration.

An effective assessment process can also assist the team members in thinking through which intervention strategies, environments and materials can be of assistance to families in addressing their children's needs. The team assessment provides a format for the family, other caregivers, and relevant professionals to exchange and synthesize information so that one picture of the whole child emerges.

Team assessments can be conducted for one or several reasons. Each of these purposes have implications for intervention:

- Eligibility
  Which program(s) will benefit the child and family?

- To determine diagnosis
  What is the child's diagnosis, so that a program can be designed to meet the child's unique needs.

- Program planning
  What teaching strategies and modifications to the environment will assist the child and family? What are the families concerns, priorities and resources?

- Program evaluation
  How effective was this program in assisting the child and family?

PREPLANNING PROCESS

Team assessment preplanning begins with gathering information from a key resource, the family. Information that may be relevant to intervention includes:

- Family's concerns
- What the child does well
- Their child's favorite toys, activities, people

Initial information, such as this, then can begin shaping the assessment process in order to address future intervention efforts. In addition, information and concerns should be gathered from other sources.

- Pediatrician
- Referring professional
- Previous assessment reports
- Professionals who are currently working with the child and family, such as the preschool teacher

The child's teacher, if the child is receiving intervention services, is another key resource in assuring the assessment can be linked to early intervention services. Information that can be gathered from the teacher, either by interview or as a participating member of the assessment team include:

- Teacher's concerns
- Child's strengths
- Child's interaction with peers
- Child's learning style
- Classroom curricula
- Present and future skills that the teacher/intervention team are targeting
- Child's favorite toys, activities, people

From the information gathered from the above sources, the assessment team can then formulate the assessment questions that will be addressed during the team assessment. The assessment questions provide the focus for the assessment.

Next, the assessment team determines team membership, based on the targeted questions. The family's membership on the team as well as a member from the intervention team, such as the teacher, assures linkage to program planning efforts.

The assessment team discusses which skills, activities, environments need to be observed in the assessment. Team roles and responsibilities should be addressed and agreed upon:

- Role of the family during the assessment
- Role of the the intervention team during the assessment process
- Roles of each team member in gathering the information to address the assessment questions
- Formal and informal assessment measures to be used (e.g., selection of criterion referenced scales that match the curriculum employed by the intervention team).

THE ASSESSMENT

During the assessment, the team will discover family and child information that is useful for answering assessment questions and planning the content and process of intervention. Too often, assessments focus on child content information only (What can the child do/not do?). Expanding the focus to include process information for both the family and child will help assure that the assessment information can be linked to program planning efforts.

To observe content information, it may be helpful to answer "what" type questions. For example:

- What tasks/skills are mastered and not mastered?
- What underlying constructs of development are mastered and not mastered?
- What skills does the child need to learn next in order to answer parent and intervention program concerns.
- What are the families strengths and capabilities? (Please refer to Chapter 1 "Foundations for a Family Approach to Early Childhood Assessment" for additional information)
- Are the families concerns, needs, and aspirations clarified?
- What sources of support and resources for meeting needs and achieving projects can the family identify? (Please refer to Chapter 1 "Foundations for a Family Approach to Early Childhood Assessment" for additional information)
- What additional information does the family and intervention program want in order to address concerns?
- Any other content information that would be helpful in answering the assessment questions?

In order to investigate process information, it is helpful to answer "how" questions. Ecology considerations will assist the team in arriving at a picture of the total child within the context of the family and community.

Parent-child interactions, child-peer interactions, family schedule, parent goals and concerns, cultural influences and best environment impact must be addressed.

- How does the parent and child deal with successes and frustrations that the child encounters?
- How do parents and children read each others' cues?
- How does turn taking in the communication interchanges between parent and child happen?

  (reciprocity considerations)
  (Refer to "Foundations for Understanding Parent-Child Interaction" for additional information)
- How does the child learn from other children?
- How does the child initiate and respond to interaction with other peers?
- How does the child and siblings play and interact with each other?
- How will the family's daily routine influence intervention choices (program and activities).

- How can parental goals and concerns be best addressed?
- How can the staff empower the family to become more competent in mobilizing resources to meet its needs and achieve desired goals? (Dunst, Trivette, Deal, 1988.)
- How can resources in the family's community be mobilized to assist in addressing family needs?
- How can the family's strengths be utilized?
- How does the child's previous experience with the presented task/situation impact on the performance?
- How does the family's value system impact on the assessment information that is being gathered?
- How does the standardization of the tests impact on the interpretation of the results?
- How does the ethnic/culture background of the child and family have an impact on the observed behavior and recommendations?
- How does the environments in which the child functions support the child's growth in abilities? (e.g., daycare, preschool, home).
- How could the environments be strengthened?

Teaching and learning considerations assist the team in observing how the child processes information and is critical to planning implementation strategies.

- How does the child approach/explore the materials and people?
- Which materials/people does the child enjoy the most?
- Which materials/people does the child least enjoy? Why?
- How does the adult's pacing affect the child's performance?
- How does the child's responsivity time affect the pacing of the interaction?
- Which modalities (visual/auditory/kinesthetic) does the child utilize to learn information the best?
- How does the child use the feedback from his performance?
- How does the child use information from other people— adults, peers?
- Which prompting systems help child? (modeling, physical prompting, verbal prompting, partial physical prompting)
- How does the child comprehend the tasks from the materials? Are any prompts, supports needed?
- How quickly does the child learn from the parent?
- How quickly does the child learn from the assessment team member
- How does the child complete tasks?
- How did the child's state and attention span affect his/her performance?
- How does positioning affect the child's performance?
- How does the child respond to different reinforcements (verbal, physical, touch, reward)?

It is difficult to obtain all of the above information in one assessment session. The child's performance is affected by location (home, new situation), time of day, length of testing session and people present. In addition, there is a large body of information that needs to be collected. Thus, in order to get an accurate picture it is very helpful to have multiple observations, varying the mentioned factors (e.g., time of day, location). Also, the assessment questions may focus the team's attention on certain factors. The following is an example of one assessment task that can answer "what" and "how" questions.

Situation: *A CHILD IS ABLE TO STACK THREE ONE-INCH CUBES.*

What questions can you answer?

What: This skill is mastered between 13 months and 21 months (Bayley).
What: Child understands the concept of "putting one on top of another."
How: Child performed activity, after the assessor demonstrated.
How: Child uses right hand to place blocks, left hand to secure pile.
How: Right hand exhibited slight tremors when attempting to place block.
How: Child is persistent – the blocks fell three times, child tried again until successfully completed the task the fourth try.
How: Parent verbally encouraged the child to try again.
How: After the child completed the task, she looked at the assessor and smiled.

INTEGRATION OF ASSESSMENT INFORMATION

Family feedback

The concluding activity of the assessment session is a brief feedback session with the family. In this session, a discussion of the findings gives everyone a sense of closure to the assessment experience. It also provides a crucial link to "what happens next."

Purpose of Feedback Session

Parents need immediate feedback regarding the results and recommendations from the assessment. If the team is conducting multiple observations, then a brief summary is provided at the conclusion of each session. The purposes of the feedback session are:

- Provide closure to family.
- Answer questions.
- Ask questions. (Was this typical behavior today? Were you surprised by anything you saw?)
- Provide brief summary of strengths and needs.
- Make simple suggestions for home. (A couple key suggestions will give parents a concrete step toward addressing concerns).
- Clarify next steps (another assessment, IEP, etc.)

Timing Issue

A crucial consideration in providing the feedback is timing. Consider the amount of information that is given in the initial feedback session. The team needs to balance the need to provide enough information to give the total picture, but not so much detail so as to overwhelm the parent. Important information should not be withheld for a later session.

Team Roles

The team needs to decide the role of the team members in providing the feedback (is one person a spokesperson for the team or does each team member report their findings?) Refer to Assessment Results in the Chapter 2 , "Foundation for a Family Approach to Early Childhood Assessment."

Team Observations

A second key activity in integrating assessment information is a team discussion of the assessment findings. This is the time when different perspectives and pieces of information can be synthesized into forming one total picture of the child. Relationships between assessment data will emerge. This also is a very fruitful time for team members own personal development, since their perspectives will be enriched by one another's views. Team discussions should include a discussion of observations and the formulation of team recommendations.

Models for discussion

- Each team member reports by discipline or developmental domain, other team members contribute additional observations from their perspective.
- Each assessment question is answered by total team.
- Team develops an alternative model.

Recommendations are made based on the family's strengths, needs, sources of support or resources

- Address family goals/concerns/needs.
- Consider how the team's recommendations will strengthen and not supplant the family's sources of support and resources. (Promote the use of informal support as the principle way of meeting needs. Dunst, Trivette, Deal, 1988.)
- Promote a sense of cooperation and joint responsibility for meeting needs. (Dunst, Trivette, Deal, 1988.)
- Promote the family's immediate success in mobilizing resources. (Dunst, Trivette, Deal, 1988.)
- Promote the family members ability to see themselves as an active change agent responsible for behavioral change. (Dunst, Trivette, Deal, 1988.)
- Consider recommendations for activities that can be incorporated into daily routines.
- Consider the family's culture when making recommendations for programming.

Team recommendations should address assessment questions/focus and be consistent with program curriculum

- Review intervention team questions/concerns and insure recommendations address them.

- Review referring professional or agency questions/concerns and insure that they are addressed.
- Review and consider any other assessment team questions that were generated.

Consider the community service delivery system
- Know what resource/services are available in the family's community.
- Make realistic recommendations.
- Avoid recommending levels of service for another agency.
- Keep in mind the least restrictive alternative for child and family.

Plans for follow up of recommendations
- Determine team members' roles in following up on the recommendations.

TEAM REPORT

The final step of the assessment is writing the team report and disseminating it to all appropriate parties. Several suggestions which will enhance the report's applicability to program planning efforts include:

- Determine a report coordinator (the person who will be responsible for editing and disseminating the report). The report coordinator will check for consistency and make sure the report reflects the team discussion.
- Determine the audience (family, school district, receiving program, pediatrician).
- Write the report so that the information is easily understood.
- Organize the report so that information is easily retrieved.
  Have assessment purpose reflected in the report organization. Determine report length (long enough to include pertinent information but not voluminous so that it won't be read).

Include a summary statement highlighting the assessment questions and major findings. Possible report formats:

a) Behavioral domain format; e.g., gross motor, language, etc.
b) Assessment question format
c) Other format determined by team
   (See Appendix A, B, and C for sample observational reports from the Early Childhood Special Education Assessment Institute (a PDIPP training), which reflects different report formats.)

Some additional recommendations for reporting assessment observations so that it will be useful for program planning include:

- State parent concerns and response to the concerns.
- Be specific in what you report (e.g., if a child has a five-word vocabulary, report the five words.)
- Report a child's strengths as well as needs.
- Report developmental levels in each domain rather than just an overall score.
- Report behaviors that describe the child's level of development.
- Make reports readable to parents and others professionals— describe terms, define jargon.

- Report on learning style, effects of using teaching strategies during assessment, timing and presentation of materials, learning from peers, learning from adults.
- Report observations and conclusions from informal assessment techniques. (e.g., play observation).

Recommendations for Program Planning Strategies include:

- Intervention recommendations should address families' goals and priorities.
- Recommend activities that link different skills together; e.g., an activity that has a child positioned in a certain way to decrease muscle tone, while participating in a language activity.
- Suggest strategies that help the child's weaknesses by using his/her strengths.
- Look at the underlying construct or underlying concept of a developmental task. Target those concepts through a number of suggested activities.
- Plan activities that can easily be incorporated into the family's daily routine. Consider the family's time, resources, and interests when planning the activities.
- Goals should be formulated considering the developmental level, functional appropriateness and age appropriateness.
- Activities should be consistent with the philosophy of the intervention program. For example, behaviorally based activities may not be appropriate for a developmentally based program.
- Write goals and activities that are culturally relevant.
- Suggest activities that are consistent with the child's learning style, and the parent and child's interaction style.
- Consider what services should be provided to support and build on the family's strengths, and address the family's needs related to enhancing their child's development.
- Consider the least restrictive alternative for the child and family, and what services could support the child in that setting.

The dissemination of the assessment report should include:

- Sending the report to appropriate people. A follow-up call after the report is sent can clarify points or encourage discussion of questions.
- Consider sending a summary of report (maybe summary section of report) to those less involved. Include a cover letter.
- Review the final report with the parents. Ask parents if plans should be made for a discussion with siblings, and extended family members or other significant people in the family's life.

(Refer to Communication of Results in Chapter 2, "Foundations for a Family Approach to Early Childhood Assessment," for additional information.)

Training Activities

Strategy #1

Purpose: To distinguish the difference between content (what) and process (how) observations, both of which are essential for program planning.

Materials: Five-minute video of assessor presenting one or two tasks to a young child.

Activity:

1. Present a brief lecturette on the "what" (content) and "how" (process) question framework.
2. Show a five-minute video of an assessor presenting one or two tasks to a young child. Divide the audience into two groups. Have one group look for information that would be helpful for the content of intervention ("what" questions), the second group look for process intervention information ("how" questions.) Discuss the observations, and record the information on a chart pad.
3. Ask each group to share their information in a large group discussion.

Time: Total activity time: 30-45 minutes

Strategy #2

Purpose: To distinguish the difference between content (what) and process (how) observations.

Materials: Video of twins completing same task. (The videotape *Cognitive Assessment of Infants*, by Ulrey & Rogers has a twins vignette)

Activity:

1. Present a brief lecturette on the "what" and "how" question frame work.
2. Show a video of twin's completing the same task. After viewing the video have the group discuss the quality (how) of the twin's responses.

Time: 30-45 minutes

Strategy #3

Purpose: To compare/contrast assessment report format or styles.

Materials: Two to three sample assessment reports, each organized in a different manner. (Three different assessment reports are located in Appendix A, B, C).

Activity:

Option 1

1. Distribute the reports to the audience for their review. After everyone has read the assessment reports in Appendices A, B, or C, have each assessment team discuss the following questions.

Option 2

1. Divide the audience into two or three groups. Have each group review one report, answering the discussion questions listed below.

2. Bring the group back together, and compare the different reports. (Facilitators should be available to guide the discussion through each question. Facilitators should make sure that the time is divided for a thorough discussion of each question. (Sometimes it is the tendency of groups to focus on question 3.)

3. After the team has completed the discussion of the questions, then the discussion can cover the following points. It is again very helpful to have a facilitator be available for this discussion.
   a. Which elements of the discussed reports can be used in your program setting?
   b. What should your team report look like?
   c. What steps does your team need to take in order to implement this team report in your program setting?

Discussion Questions:

1. What is the purpose of the report?
2. What are the strengths of the report?
3. What are the weaknesses of the report?
4. Does the report outline WHAT the child can do and HOW the child does it?
5. How is this reported?
6. Is the report understandable to parents and professionals from varying backgrounds?
7. Does the report link the assessment data to program planning?

Time: 30-45 minutes

Strategy 4

Purpose: To evaluate team efforts in linking assessment to program planning through the report.

Materials: Handout 1: LINKING ASSESSMENT TO PROGRAM PLANNING REPORT Checklist. A team assessment report written by the team completing this activity.

Activity:

1. Each member individually completes the checklist.
2. Team members compare responses, discussing their reasoning for each response.
3. Discuss strengths/concerns and possible changes for report.

- *or* -

1. As a team, members discuss and respond to checklist.
2. Discuss strengths/concerns and possible changes for report.

Time: 45-60 minutes

Handout 1

LINKING ASSESSMENT TO PROGRAM PLANNING REPORT CHECKLIST

Review your team report and check the appropriate column for each question.

Does the report:

☐ yes	☐ no	1. State the purpose of assessment – who was present?
☐ yes	☐ no	2. Include concerns and a response to stated concerns of: a. parents b. referring agency/professional c. assessment team
☐ yes	☐ no	3. Report developmental levels for each behavioral domain rather than only an overall developmental level.
☐ yes	☐ no	4. Convey the underlying contructs of development that are mastered.
☐ yes	☐ no	5. Report specific findings (e.g., if the child has a five word vocabulary, report the five words).
☐ yes	☐ no	6. Report findings that are understandable to parents and professionals.
☐ yes	☐ no	7. Report cultural factors that are important for intervention or affected the child's performance.
☐ yes	☐ no	8. Describe the child's learning style.
☐ yes	☐ no	9. Describe the child's strengths.
☐ yes	☐ no	10. Describe the child's needs.
☐ yes	☐ no	11. Report what materials/people motivate the child.
☐ yes	☐ no	12. Look at what the child brings to an interaction and what the parent brings to the interaction.
☐ yes	☐ no	13. Comment on the positioning of the child's body and materials that guides optimal performance.
☐ yes	☐ no	14. Include activities that can be easily incorporated into the daily routine and take into account the family's time, resources, and interests.
☐ yes	☐ no	15. State who will receive copies of the report.

Appendix A
OBSERVATIONAL REPORT #1

Name: David
Date of Birth:
Age as of 6/30/86: 3 years

I. ASSESSMENT TEAM:
Maria F., Mother
Martin K., Psychologist
Patty S., Speech & Language Therapist
Michael B., Speech & Language Therapist
Amy H., Education Specialist
Barbara B., Pediatrician
Gordon U., Special Education Resource Network Facilitator
Classroom Teacher

II. REFERRAL INFORMATION:
Ms. F. volunteered to participate in the Preschool Assessment practicum to obtain general information regarding David's development as well as to provide preschool assessment experience to the team.

III. BACKGROUND INFORMATION:
By parent report, pregnancy and developmental history were unremarkable. David has had recurrent episodes of otitis media. His hearing was evaluated three weeks prior to this evaluation and found to be within normal limits, according to Ms. F.

David lives with his mother and has no siblings. He has attended Tri-City Childcare Center for the past ten months, Monday through Friday, 6:45 a.m. 4:00 p.m. There are extended family members living in the area which include the mother's sister and brother-in-law and their three children.

Spanish is the primary language spoken in the home. David had multiple babysitters before attending the Tri-City Childcare Center. Some of his babysitters spoke English and others spoke Spanish.

IV. PROCEDURAL INFORMATION
Assessment procedures included:
- Teacher interview
- Parent interview
- Play observation
- Structured play observation
- Parent-child separation and reunion observation

The assessment was video and audio tape recorded for later viewing by the team and a copy was to be made for the teacher's and parent's use.

During the parent interview Ms. F. asked the following questions:
1. Is David doing things that other children his age can do?
2. What can I do when David cries because he wants something I can not give him?
3. How do I get David to be potty trained?

V. RESPONSE TO QUESTION 1: Is David doing things that other children his age can do?

Learning Style

David demonstrated the use of familiar objects appropriately with a plate and spoon and crayon and paper. He used objects symbolically in play with a peg as a food object which he placed toward his mouth. He imitated words and actions produced by an adult. He was able to demonstrate object permanence in which he acknowledged that the object did not disappear even when he was not able to see it. Imitation skills were seen as a strength.

David was able to draw a line with crayon and paper. He often did not stop after completing the line and continued to draw in a repetitive manner. David was able to successfully string one bead. When presented with another bead, he was unable to move the bead down the string in order to fit another bead on the string. While David showed interest in the bead task, he attended to it for a brief time and showed little variation in how he manipulated and explored the task.

David utilizes people in helping him find solutions for problem solving. He frequently utilizes a trial-and-error approach to solving tasks. For example, a doll that was connected to a stick which was covered by a cone can be seen by pushing the stick up the cone. David did not immediately conceptualize that he needed to push the stick up to make the doll reappear. However, he used a trial and error approach by pulling the doll's head upward and was able to do the task with motor prompting. His interest in surroundings and use of people to help him solve problems are seen as significant strengths.

Based on informal observations, David is doing things that represent the 2 years to 2 1/2 year level of development.

Recommendation: David should be referred to the local educational agency for a more comprehensive assessment of his cognitive, linguistic and social emotional skills.

Communication

David's understanding of language in the context of play situations and conversation was stronger than his use of language expressively (speech). He demonstrated understanding of simple directions and questions in English; e.g., "Sit down," "Look for the juice," "What is it?" "Are you thirsty?" "Where's the dog?" During the parent separation observation, his mother told him she was leaving to go to the doctor. Upon her return, he gestured to her (by pointing his finger into his leg) to ask if she had been given a shot. This type of association of meanings from conversation was noted in both Spanish and English.

During play, David's expressive communication attempts consisted primarily of single words and gestures, consistent with parent and teacher report. He occasionally spoke in phrases; e.g., "I want cookie," "No puedo," (I can't). He used speech much more frequently when the adult modeled short simple statements while talking with him. He named toys and animals sometimes in English and other times in Spanish. Strengths were seen in his spontaneous interest in communicating an idea and his use of nonverbal language; e.g., gesture to express relationships. For example, when seeing the picture of a rabbit on a crayon he was holding he said, "a rara". The adults sitting with him did not understand what he was saying until he turned the crayon over

and showed them the rabbit. Another time, he pointed to the animals and the farmhouse and motioned that they should go together and proceeded putting the animals into the farmhouse as he said "casa". Thus, David demonstrated that he had the knowledge of the objects and their relationships or in the previous example, the knowledge of the rabbit and the fact that his listeners did not understand him. David did not have the language (words) to express these ideas and relationships verbally.

Ms. F. reported that she would like David to learn to speak both Spanish and English. When working with him she used Spanish and English interchangeably. According to teacher report, he understands classroom directions adequately in English.

David 's communication skills were below what would be expected of a 3 year old child. Learning English as a second language and changes in the language used by caretakers may be a significant factor to his language delay. In addition, his behavioral tendency to be dependent upon adult assistance and having needs met through attention getting and pointing causes independent use of speech to be less motivating to him.

Recommendation

1. It was suggested to Ms. F. that she use Spanish when speaking to David at home, since this is the language she is most comfortable with and with which she will be able to provide the best language models. Use of English only at the child care center was recommended in order to provide consistency of language learning in this environment. The goal is to provide consistent language modeling while keeping the two languages separate, so as to decrease confusion and facilitate development of a stable language base.

2. To help David to talk more, it was recommended that when he indicates a want or need through gesture that the word be said for him. He does not need to be required to say the word exactly before he gets what he wants everytime, but do encourage him and praise him when he attempts to say the word. When David says a word, expand upon this briefly; e.g., if David said "cow" say "Yes! The cow says moo!"

VI. RESPONSE TO QUESTION 2: What can I do when David cries because he wants something I cannot give him?

Observation and Findings

David was very responsive to the play environment and the examiners. He demonstrated curiosity and exploratory behavior, but short attention span and distractibility inhibited his use of one toy purposefully and independently. With demonstration and modeling, David was able to imitate and demonstrate symbolic play (the use of an object to represent a real object, e.g. pushing a block and making car sounds)for increased periods of time. David demonstrated a strong need to control each situation and tended not to consistently follow directions. He was more cooperative when directions were provided in an animated and playful manner. When the environment was unstructured, his activity level escalated, his need for independence increased and he was less able to self-regulate his behavior or respond to re-direction by either the examiner or his mother.

When David was interacting with his mother, it was quite apparent that Ms. F. had a warm, affectionate relationship with her son. She consistently encouraged him to do his

best and to be good. However, many of her comments were not direct. When David wanted his way, he immediately resorted to temper tantrums and it appeared that his mother, in wanting to keep David happy, was unclear as to how to set limits for her son.

Recommendations

1. When directions are given to David they need to be simple, clear and in one language. It is advisable that Spanish be spoken within the home environment and that English be spoken within the school environment.

2. The child care program environment should be structured with a limited amount of visual distractions.

3. It will be important that a consistent pattern of limit setting be developed both in the home and school so that David can learn to:
   a. control his behavior
   b. obey and respect authority
   c. be responsive to adult directions

4. It is recommended that Ms. F. participate in a parent support group to aide her in developing skills for managing David's behavior. Ms. F. expressed interest in joining a support group.

VII. RESPONSE TO QUESTION 3: How do I get David to be potty trained?

Toilet Training

By parental history, David wears diapers both day and night (and at the program). At home, he will indicate discomfort about a bowel movement in his diapers to the point that he wants a shower after an initial cleaning. Ms. F. indicated that she tried to get him to go in his potty at home. For example, she will read books to him while he is sitting there. She told us that he will not go in the potty and then usually soils his diapers within a short time. She indicated her frustration and is seeking further directions in this area.

His teacher states that he wears a diaper all day at school and "doesn't tell her when he has to use the bathroom." Within the classroom setting, this is the expectation for all children. There is no set time for all children for toileting, but they are taken to the bathroom when they indicate a need. There has been no trial of "habit training"; i.e., taking him to the bathroom on a prescheduled regular basis with positive reinforcement.

Recommendations

1. There should be consistency between home and school on setting up a habit training schedule with positive reinforcements and modeling. Ms. F. and his teacher should note when David does go to the bathroom. When a pattern is recognized; e.g. every morning between 10:00-10:30, he should be taken to the toilet during these times.

An example of positive reinforcements and modeling: From our observations, we know that David will imitate an activity – particularly with puppets in a positive play setting. As a suggestion, there are "toilet training dolls" in the toy stores that have their own potty and will urinate in them. This could serve as a model for David. Also, there are books such as "All by Myself" illustrating toileting in simple details and pictures, appropriate for a very young child. This is also available in local toy or book stores.

2. There should be consideration of David's observed abilities in the cognitive and communication areas when setting up a program. For instance, David is using mostly single words in Spanish and English. At this time, he does not express his need to go to the bathroom.

3. David's observed temperament should be considered when establishing a toileting routine. The section on "limit setting" outlines some of the observed characteristics which carry over to toileting.

4. Ms. F. should have as much support and feedback as possible, in order for this to be a successful, positive experience.

VIII. CONCLUSION

David is a warm, appealing and energetic boy who demonstrated many skills at the 2-3 year level in the areas noted in our observations. Specific recommendations concerning language, cognition, limit setting and toilet training are discussed in the body of this report.

The team enjoyed working with David and Ms. F. who were cooperative, interested and friendly. The team appreciated Ms. F.'s and the Tri-City Care Center's collaboration.

A general consideration was discussed with Ms. F. and his teacher concerning future developmental screening to monitor his progress and to evaluate his future program needs.

Appendix B

OBSERVATIONAL REPORT #2

NAME: Robert C.
CHRONOLOGICAL AGE: 28 months
DATE OF OBSERVATION: 8/9/90

ASSESSMENT TEAM
Ms C - Grandparent
Joe C - Educational Specialist
Jennifer R - Child Development Specialist/Motor Therapist
Pam T - Social Worker
Riannon - Classroom Teacher

REASON FOR REFERRAL
Robert's Grandmother volunteered to assist in the team training and wanted more information about Robert's communicative abilities. The purpose of the assessment was as a learning experience for all participants. A portion of this observation was videotaped as a teaching tool for the team members.

BACKGROUND INFORMATION
Robert lives with his Grandmother (Ms C) and extended family. According to the Developmental Summary of 2/90, Robert was prenatally exposed to a multiplicity of drugs and his mother has schizophrenia and is residing in a supervised home. His family is very involved with Robert's development and is interested in information regarding his speech.

ASSESSMENT TOOLS
1. Parent (Grandmother) Interview
2. Teacher Interview
3. Classroom Observation
4. Playground Observation
5. Play Assessment

PARENT INTERVIEW
Language and communication are reportedly Ms C's (Robert's Grandmother) main concern at this time. Robert's speech consists primarily of single words and occasional 2 word phrases; he can reportedly name parts of the body on request (eyes, ears, nose, mouth, arms, legs) and names many familiar objects and foods. According to Ms C, speech is easily understood when he is naming an object. However, he has adapted words for certain things ("ma" for milk) that only his family understands. Robert reportedly has difficulty making his needs known verbally and will point or pull an adult's hand in an effort to communicate. At times he will babble. According to Ms C, Robert enjoys music and sings several songs (Alphabet song, Old MacDonald) however the words are difficult to understand.

Robert has reportedly shown some behavioral changes in the past 6 months and, although this is not a major concern of Ms C's at this time, it was an area of some discussion. Robert reportedly has periods of irritability and both day program staff and grandmother report "occasional" bad days where Robert has more difficulty with task completion, and non-compliance and when tantrums are more likely to occur. He has

reportedly begun screaming tantrums at home which occur less than once a week and are the result of Robert not having his way. Although Robert generally sleeps well, Ms C reports that once every 3-4 weeks he wakes up screaming unconsolingly and that it can take up to an hour to calm him.

Ms C shared much information regarding Robert's abilities at home. He has reportedly developed many self help skills including getting himself food from the refrigerator, opening doors, and answering the telephone; he is able to independently turn on the TV and will turn it off when finished.

Robert's Grandmother spoke lovingly and openly of Robert and of her concerns regarding his language development. It is apparent that she is commited to assisting Robert in any way that she can.

LANGUAGE OBSERVATION
We noted that Robert seemed to have functional receptive language at or near his chronological age. He was not always compliant in following directions, but we believe other factors might have come into play in the noncompliance (see summary). His expressive language fell into two categories: imitative and spontaneous.

Imitative - Robert could imitate sounds and one word phrases fairly easily. This was especially true when the words were associated with an activity he was involved in. He said "Hello mama" while playing with a toy telephone. He said "Hello" to the children in [illegible] group when the instructor said their name first. He imitated approximately 25-30 words during our 2-hour observation. Robert also imitated some two word phrases. The phrases included more juice, new car, and hello mama. It took Robert a longer time to imitate the two word phrase, and the phrases were spoken in a non-flowing style.

Spontaneous - Robert also had some one and two word spontaneous phrases. When he saw a new car outside in the playground he said "car." He said "no" appropriately a number of times. He made car noises when he played with a toy car. He said "fine" when asked "how are you?"

Robert's articulation seemed at or near age appropriate levels. We heard the "s" and "t" sounds when he said a friends name, "Setei." He also used the blend "sh" when playing.

PLAY OBSERVATION
In Robert's play a number of cognitive milestones were observed in the way he used toys and played with others. He did not demonstrate purposeful trial and error strategies. Instead he primarily interacted with objects as they entered his environment. Robert used common toys appropriately such as a toy phone, a car and a riding toy. Pretend play was not seen during today's observation nor was the combining of toys functionally. Robert's social play primarily consists of solitary (playing by himself) and parallel play (playing next to another child) with occasional associative play for short periods of time. Associative play skills include rolling a car between himself and another child as well as sharing the seat of a riding toy car.

Robert's play strategies included free movement about his environment primarily walking although at times he crawled in the classroom. He enjoys more gross play rather than fine play. For example, he demonstrated a preference for cars, pull toys,

and riding toys. Robert was able to place blocks into a container and dump them out. He also placed large pegs in a peg board. Poking and pointing were seen. An inferior scissors pinch was noted when he was eating his snack.

SUMMARY

Robert's language was predominantly triggered by the object or adult he was interacting with. He seemed to have difficulty in coming up with words or phrases spontaneously. A delay in time from the teacher saying a word and Robert's imitation was noted. This was not always true and he did sometimes come out with a spontaneous words or phrases. We found his play level to be substantially below the level of his skills in the motor, cognitive, and receptive language areas. We also found from our parent interview that Robert has excellent self help skills and learns functional, motivating skills quickly.

RECOMMENDATIONS

1. Robert's program encourage development of play skills in the areas of using common toys appropriately and beginning pretend play.
2. Robert be given ample time to respond to questions and naming activities.
3. Robert be encouraged to work on one task at a time for longer periods of time.
4. If Robert's sleep problem and "good and bad" days continue further evaluation for possible neurological involvement may be indicated.

Appendix C
OBSERVATION REPORT #3

Name: Becky P. Chronological Age: 35 months
Date of Birth:
Date of Observation: 6/28/85
Site: Agency for Infant Development (AID)

ASSESSMENT TEAM

Pamm S., Special Educ. Coord., Head Start
Holly B., Speech Pathologist, Head Start
Brian L., Clinical Psychologist, Head Start
Bitsy S., Teacher on Special Assignment, Contra Costa County Schools

REASON FOR REFERRAL

Becky's parents volunteered to assist in the team training and wanted more information about Becky's cognitive and communicative abilities. The purpose of the assessment was as a learning experience for all participants. The observation was video and audio taped to be used as a teaching tool for the team members.

BACKGROUND INFORMATION

Becky is a 35-month-old girl with a diagnosis of cerebral palsy; spastic quadriplegia, born preterm at 28 weeks gestational age with a birth weight of 3 lbs. 5 oz. She had significant medical history at birth and was hospitalized for 4 months.

Becky lives with both of her parents; she is the fifth of six children. She is currently enrolled in the Agency for Infant Development where she receives occupational therapy and early intervention services. She also receives services through the Regional Center, California Children's Services, Kaiser (physical therapy and medical services), and the Elks Club (speech therapy).

A summary of AID's records were reviewed by the team prior to observation.

PARENT INFORMATION

Becky's mother described her as a happy child with a fun sense of humor. She stated that Becky had good relationships with her siblings and was especially motivated by her 8 week old baby sister. Mother reported that Becky loves school, enjoys riding the bus, attending the church nursery and socializes well with her peers and siblings.

Becky has been using an adaptive wheel chair for the past year. She rolls to get around and does some scooting. She usually reaches with her left hand first, but is now starting to use her right hand as well. It was reported that Becky's movements became more fluid when she was involved with her new baby sister; i.e., stroking her.

In the cognitive area, her mother reported that Becky discriminates between two objects, likes working with colors and numbers, and discriminates between two pictures. She enjoys stories and music. She understands the concepts in/out, up/down, and over. She knows the following body parts: feet, knees, eyes, ears, nose, mouth, chin, hair, head, hands, fingers, toes. She likes pop-up toys, bells, and balloons.

In the language area, Becky can say approximately 15 words. She communicates through eye contact, gestures and single words and will try to imitate new words. It was reported that a communication board was attempted using discrimination of two pictures, but this was discontinued because it was reported that Becky became bored with the activity.

The mother spoke freely about her daughter's strengths and needs. She provided a detailed description of Becky's behaviors and skills. She was knowledgeable about her daughter's development and hoped that this observation would give her additional insight into her daughter's cognitive and language abilities.

OBSERVATIONS

This observation took place in a small room at the Agency for Infant Development by the Assessment Team and parent. Becky's younger sister was brought in during the last 20 minutes of the assessment. Because other assessments were occurring at the same time, a number of auditory distractions existed during the observation. The observation plan was to observe the parent and child interacting in play, structured tasks facilitated by members of the assessment team, and child/baby interactions.

Becky and her mother had a very warm and close relationship. The mother served as a vital and supportive interpreter for Becky's verbal and non-verbal communication. Becky's mother was surprised at some of the skills demonstrated. Becky was very engaging and separated easily from the mother. The mother employed teaching techniques that optimally allowed for success and learning by orienting Becky to the task and providing cues to increase success.

The observation session began by having Becky and her mother play together. Mother began the play with a bean bag game during which Becky demonstrated the ability to anticipate and appropriately expressed the concepts of up, down and more.

While playing with the Jack-in-the-Box and the pop-up toys, mother was asked to demonstrate B.P.'s understanding of colors, numbers and object identification. B.P. identified red, blue, and green and pointed to the nose on the Jack-in-the-Box. When presented with the pop-up toy she was able to indicate the one that was "all gone."

At this point the team facilitator asked the mother to allow Becky to play freely with the telephone. Becky recognized the use of the phone and said 'hi'.

Next, Becky as moved to her chair and selected cognitive items were attempted from the *Hawaii Early Learning Profile and the Preschool Language Scale*. These included object constancy (hiding keys under cover), using tools to get a toy (pulling string to get the dog), object displacement (hiding a ball in a cup and then leaving the ball under a towel), a two piece formboard (circle and square), color discrimination with blocks, identifying animals by sound and name, body parts on a doll and a person, and use of a

crayon and markers. Becky's mother was encouraged to make suggestions regarding modification of the administration of these items.

During this phase of the observation she demonstrated color recognition, object identification by name, object displacement using one screen, identification of body parts.

Becky was a socially responsive child. She warmed up after initial contact with the examiner, responded to verbal and facial expression and seemed to enjoy playful interactions. On occasion she would lower her head, possibly indicating fatigue or lack of interest. Becky used head movement to indicate yes/no. She also used eye contact with people and objects as well as purposeful hand movements to respond to tasks.

At the end of the session Becky's sister was brought into the room. Becky was placed on the floor near her. Becky became more interested and rolled over much faster than she had previously. When the baby cried Becky appeared to be concerned. She seemed to enjoy helping the mother feed the baby.

At the close of the session (while Becky's mother was feeding the baby) Becky was read the story of "The Three Bears." During the story Becky demonstrated understanding of the story and anticipation for what would be coming next.

Discussion of the observation session with the mother and the A.I.D. Occupational Therapist indicated that the skills demonstrated during the observation were representative of Becky's skills.

SUMMARY

Becky is a 35-month-old girl with cerebral palsy, who was observed for 1 and 1/2 hours as a part of the practicum training experience to better understand her cognitive and language skills. Becky was observed to have demonstrated the following skills: object constancy (finding an object under a screen), color identification and discrimination, concepts of opposites: i.e., up/down, knowledge of body parts, anticipation of events, sequencing of stories, identification of a circle, pulling a string horizontally to obtain a toy, followed on part commands and identified animals.

Object constancy, identifying colors, identification of circle, and pulling a string to obtain a toy are among the skills one would expect of a 17-19 month old child. These behaviors were clearly demonstrated during the observation and can be considered Becky's minimum level of cognitive functioning by this team. Other behaviors observed indicate higher cognitive levels, for example: identification of body parts (3 parts — 19-22 month, 6 parts — 22-24 months), understanding personal pronouns, some action verbs and adjectives; i.e., "Give it to me," 20-24 months, listens to stories (27-30 months), matches primary colors (29-33 months). Becky also was observed to have the following skills indicative of her understanding of language at close to her chronological age (3 years): can understand thousands of words, identifies objects by their use, understands some common opposites, understands some prepositions, like stories about herself, stays with an activity for 8-9 minutes, matches/sorts by color, shape, size, follows one part commands. The observers felt that Becky's anticipation of the story line in the "Three Bears" demonstrated more sophisticated sequencing skills than could be assessed in Becky's play.

Becky's primary means of communication is gestural; i.e., head nodding, pointing. She is exhibiting behaviors necessary to begin verbal communication; i.e., mouthing words, imitating sounds.

Becky responded well socially, separated well from her mother and persevered throughout the observation session. She attends well auditorily and this would suggest to be an appropriate modality for teaching.

In the post interview Becky's mother indicated how well Becky responds to music and this too could be used as a promising teaching technique.

RECOMMENDATIONS

Following the observation there was a debriefing discussion between the team, Becky's mother and the AID Occupational Therapist. The following joint recommendations were discussed.

1. B.P. could benefit from additional adaptive toys to assist her in developing increased control over her environment and to facilitate her ability to communicate with others.

   The group felt that toys like *Simon* might be fun for Becky and also help to develop responses to visual and auditory kinds of cues that might be preparation for using computer assisted communication/learning. Becky's mother indicated that the family is building a computer fund and that they intend to purchase a computer to meet the needs of the family. The parents had been curious about whether there were ways that Becky could benefit. It was recommended that the family look into the Radio Shack Color Computer, for example, which has a preschool notebook in which the child touches squares, pictures, etc. in response to cues on the screen. Other 'input' devices such as joysticks were also discussed. Becky's mother indicated that she was aware of a computer resource book. The team also referred Becky's mother to the Center for Independent Living in Berkeley, Easter Seal Rehabilitation Center and United Cerebral Palsy to see if they might have some ideas about adaptive equipment of toys for Becky.

2. Becky should continue to be encouraged to vocalize more for herself to foster increased verbal communication, coupled with other gestural and assisted communication systems.

Ways to use songs and music to increase vocalization were discussed. Becky's mother noted that the speech therapist has been working on similar goals and that Becky has begun to respond using "Adorable Dora."

3. Becky's mother should continue her techniques of 'error free learning' in playing with Becky and perhaps help Becky's siblings use the same techniques.

The group discussed the way Becky's mother identifies the choices and provides an additional cue; i.e., is this the apple or is this the APPLE, or putting the correct one slightly closer. It was recommended that this was an excellent way to begin working on concepts but that as Becky began to learn some of the concepts that the extra cues be dropped.

Some of the concepts that might be explored are: 1) seriation (ordering things, i.e., big/little), 2) classification tasks; i.e., same and different or finding all the red things in a group of two or three things, 3) sequencing (the order of events could be done through telling stories and seeing if Becky can anticipate what will come next or by discussing TV programs to work on what happened first, second, etc.).

4) We encouraged parent(s) and family to continue working with B.P. and to continue to share their successes with future staff working with her.

(Our thanks to all the staff and particularly Becky and her mom for being so open and helpful during our learning experience.)

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Bagnato, S. (1981). Developmental scales and developmental curricula: Forging a linkage for early intervention. *Topics in Early Childhood Special Education, 1*, 2, 1-8.

Davis, J. (1982). *Educational programming and curriculum development.* Unpublished manuscript.

Dunst, C. J., Trivette, C. M., Deal, A. G. (1988). *Enabling and empowering families: principles and guidelines for practice.* Cambridge, MA: Brookline Books.

Annotated Bibliography

Bailey, D.B. and Wolely, N. (1989). *Assessing infants and preschoolers with handicaps.* Columbus: Merrill Publishing Co.

This text addresses issues, considerations, and procedures in assessing infants and preschoolers with handicaps. The focus of this text is assessment for the purpose of intervention program planning. The book addresses fundamental issues and considerations in assessment (test, observations, informal assessments), specialized assessment issues (environment, screening, unique considerations in assessing young children), and assessment within the context of key curricula/ development domains (cognitive development, motor skills, social interaction skills, play skills, self-care skills).

Bagnato, S. J., Neisworth, J. T. & Munson, S.M. (1989). *Linking developmental assessment and early intervention.* Curriculum-Based prescriptions (2nd ed.) Frederick, MD: Aspen Publishers, Inc.

The purpose of this book is to demonstrate "how to use curriculum-based materials as 'best practices' to match the spirit and letter of P.L. 99-457 (team approach, multidimensional assessment, family focus, program prescriptions, and handicap adaptations)." An annotated list of developmental scales and curricula as well as numerous forms are provided.

Beckman, P. J., Robinson, C. C., Jackson, B., & Rosenberg, S. A. Translating developmental findings into teaching strategies for young handicapped children. *Journal of the Division for Early Childhood, 10, 1,* 45-52.

This article covers important teaching principles that interventionists should keep in mind when recommending intervention strategies and activities. These principles include 1) responsivity to the child's cues, 2) appropriate language input, 3) enhancing active involvement in the environment, 4) activities that are a developmental match.

Cook, R.E., Tessier, A., & Armbruster, U.B. (1987). *Adapting early childhood curricula for children with special needs,* (2nd Ed.) Columbus: Merrill Publishing Company.

This text provides a comprehensive overview of the field of early childhood special education. Active family participation, child development assessment, and curricula are linked together into comprehensive programming. Numerous practical assessment and programming strategies are included.

DuBose, R. and Kelly, J. (May, 1981). *Curricula and instruction for young handicapped children: A guideline for selection and evaluation.* Western States Technical Assistance Resource.

This excellent article reviews the theoretical foundations that underlie the curricula that are available in the field (diagnostic-prescriptive, piagetian, and behavioral). Guidelines are proposed for the selection of curricula. The foundations that were outlined are important to remember when making recommendations for programming in assessment reports. The curriculum list is somewhat dated (1981).

Dunst, C. J., Trivette, C. M., Deal, A. G. (1988). Enabling and empowering families: Principles and guidelines for practice. Cambridge, MA: Brookline Books.

This book provides a model and specific guidelines for gathering family focused assessment information to assure family focused intervention strategies. It is extremely helpful for early intervention practitioners who are interested in shifting from a child focused to a family focused service delivery model.

Hanson, M. J. (1982). Issues in designing intervention approaches from developmental theory and research. In D. D. Bricker (Ed.) *Intervention with at-risk and handicapped infants: From research to application.* Baltimore, MD: University Park Press.

This article gives an excellent overview of the research that addresses the recipient of early intervention services, how early intervention services should be conceptualized and designed, and what should be included in early intervention efforts. This article includes discussion of what assessments are currently telling us and what assessments need to do next.

Vincent, L. J., Laten, S., Salisbury, C, Brown, R, and Baumgart, D. (1981). Family involvement in the educational processes of severely handicapped students: state of the art and directions for the future. In B. Wilcox and R. York (eds.). *Quality education services for the severely handicapped: the federal perspective.* U.S. Department of Education, Division of Innovation and Development.

This article reviews the current and historical perspectives on family involvement in programs for children with disabilities, including assumptions held by parents and professionals about their roles in the educational process and the needs of these families. Recommendations for models of active family involvement are made in five areas: assessment, programming, determining progress, making program decisions, and evaluating program success.

Willoughby-Herb, S. J. (1983). Selecting relevant curricular objectives. *Topics in early childhood special education,* 2, 4, 9-14.

This article provides useful guidelines for selecting curriculum objectives, involving a sequence of three steps: 1) evaluating and adapting the assessment and curricular content to include all areas of development as well as qualitative indicators of child performance; 2) relating the child's learning and behavioral characteristics to selection of objectives; and 3) relating the demands of the child's social environment to the curriculum. Examination of the child's learning and behavioral style and information regarding the child's social environment must all be incorporated into the selection and prioritization of a child's goals and objectives.

Wolery, M. R. (1983). Evaluating curricula: purposes and strategies. *Topics in early childhood special education,* 2, (4), 15-24.

As the number of developmental curricula expand, there is a need to evaluate these curriculum in terms of: 1) their applicability to the project; 2) how well they are implemented; and 3) their effectiveness in promoting children's progress. These three evaluation purposes, as well as corresponding evaluation questions and strategies are outlined in this useful article.