Evidence-Based Practice in Infant and Early Childhood Psychology
Barbara A. Mowder
To my parents, David and Janice Hogue,
and
My children, Melissa and Meredith Mowder

Florence Rubinson
To my husband, Irwin,
and
Our children, Haley and Michael

Anastasia E. Yasik
To my parents, Stanley and Elizabeth Yasik,
and
My niece, Katie Yasik
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Preface

This book, Evidence-Based Practice in Infant and Early Childhood Psychology, represents the first comprehensive presentation of evidence-based practice in infant and early childhood psychology. To appreciate the relevance of this text, some historical notes might prove useful. Widerstrom, Mowder, and Sandall (1991) published the first practice-oriented book on at-risk newborns and infants and those with disabilities. That book, At-risk and Handicapped Newborns and Infants: Development, Assessment, and Intervention, integrated a variety of professional perspectives (e.g., early childhood education, early childhood special education, nursing, occupational therapy, psychology) with implications for assessment and intervention.

The Widerstrom et al. (1991) book was based on prior journal publications (e.g., Mowder, Widerstrom, & Sandall, 1989) establishing the need for multidisciplinary services for young children and their families. Indeed, prior to that book, Widerstrom and Mowder, while teaching at University of Colorado at Denver (UCD), secured the first federally funded grants (1986–1989) integrating early childhood education, early childhood special education, nursing, and school psychology training. Thus, for the first time, the needs of young children and their families were broadly articulated in terms of suggested infant and early childhood practice and training.

Subsequently to the Widerstrom et al. (1991) book and integrated training at UCD, a few additional books related to meeting the needs of young children and their families were written (e.g., Widerstrom, Mowder, & Sandall, 1997), including a book exclusively devoted to early childhood personnel preparation (Bricker & Widerstrom, 1996). Collectively, these books and related publications helped establish the relevance of psychology, especially school psychology (Mowder, 1996), in early childhood practice. Subsequently, Foley and Mowder (2000) argued for and outlined doctoral level training for school psychologists working with infants, young children, and their families and Foley and Hochman (2006) produced a book exclusively focused on mental health issues with infants and young children, entitled Mental Health in Early Intervention: Achieving Unity in Principles and Practice.
In contrast to the previous infant and early childhood books, *Evidence-Based Practice in Infant and Early Childhood Psychology* takes a distinct position of embracing science as the foundation of practice, integrating contemporary research, and offering evidence-based practice implications. To be sure, some areas of early childhood practice possess a more comprehensive evidence-base than other areas. Regardless, this book represents contemporary knowledge regarding infant and early childhood psychology (in many chapters the term *early childhood* is used to refer to both developmental time periods), presented in conjunction with multicultural and diversity issues, training implications, and ethical concerns. These themes are woven through each of the chapters, written primarily by professionals with considerable research and practice experience and expertise. The range of experience blends to provide a comprehensive presentation of early childhood practice.

A few words on terminology will assist the reader. First, this book is designed for professionals in training or currently working with infants, toddlers, and young children. As such, authors refer to professionals using various terms including *clinician, practitioner,* and *psychologist.* These variations are not meant to confuse, but rather they reflect authors’ preferences and perspectives. Similarly, throughout the chapters authors use terms such as *infants,* *young children,* and *youngsters.* Unless otherwise specified, these terms refer to young children generally between birth and early elementary school age.

The coeditors would like to recognize individuals who assisted in the completion of this work. Barbara Mowder and Anastasia Yasik appreciate the varied contributions from the Pace University Psychology Department graduate students, faculty, and staff. Florence Rubinson particularly notes the contributions of Dana Freed, Erika Levavi, Amy Sandigorsky, Marissa Schneider, and Issac Silberstein. The coeditors also extend heartfelt appreciation to the many authors contributing to this book; their expertise, attention to detail, and prompt response to comments helped in making this book exceptional.

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PART I

FOUNDATIONS OF PRACTICE
Providing psychological services to infants, toddlers, and young children is complex, demanding a wide-ranging and integrative set of knowledge and skills. The early childhood psychologist (throughout this chapter, the term is meant to include infant and early childhood practice) draws from knowledge bases recognized as essential to the professional practice of psychology (Commission on Accreditation, 2007). These bases include, for instance, biological, cognitive, affective and social aspects of behavior, human development, individual differences, developmental psychopathology, and social–cultural impacts on family and society. In addition, early childhood work requires a deep and fluent knowledge of child development, developmental disabilities, and family functioning. Those who work on a daily basis with very young children utilize a flexible and creative repertoire of applied skills in assessment and intervention (e.g., engaging in play such as hide-and-seek, building block towers, coaching mothers in interactive reading). Early childhood psychologists usually are experts in preschool curriculum as well as the informal curriculum of home and family caregiving; more specifically, they apply evidence-based practice to support the efforts of parents, caregivers, and teachers in assuring the best possible outcomes for infants and young children.

Who are early childhood psychologists? What is distinctive and unique about working with very young children? What type of training and experiences best prepare psychologists for early childhood practice? What evidence is available to guide the selection of assessment, consultation, and intervention approaches and help train and support parents and teachers in applying best practices? Addressing these inquiries is the focus and purpose of this text dedicated to the practice of early childhood psychology; this chapter provides an overview of the issues that frame our work.
AN INTEGRATIVE SPECIALIZATION WITHIN APPLIED PSYCHOLOGY

The divisional structure of the American Psychological Association (APA) was established to recognize unique areas of practice and research. There is one current division dedicated to child psychology (i.e., Division 53: Clinical Child and Adolescent Psychology) but no subspecialty of infant and early childhood psychology. Instead, psychologists working with children and families are served by the three major applied practice divisions of clinical, counseling, and school psychology, and the additional practice divisions devoted to intellectual and developmental disabilities, family psychology, and pediatric psychology. Other divisions represent research and policy efforts addressing children’s issues, such as developmental and educational psychology, community psychology, and child and family policy. (See Table 1.1 for a listing of relevant divisions.) These multiple focus areas are representative of the integrative nature of early childhood work, encompassing knowledge bases, skill sets, and policy across various aspects of psychology research and practice. The significant array of divisions that touch on psychological practice with infants, toddlers, and young children also illustrates the difficulty in identifying early childhood psychologists as distinct, since the nature of the work also cuts across practice areas.

A subspecialty of psychological practice with young children was presented in Barnett’s (1986) review of training and practice needs of school psychologists working within preschool settings. Barnett’s article was published just as the Education for All Handicapped Children Act was amended

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as P.L. 99-457, in 1986, mandating free and appropriate special education services for students with disabilities be extended downward to preschool (ages 3–5), with incentives for states to also serve infants and toddlers with disabilities. The passage of P.L. 99-457 spurred a movement to train, or retrain, school psychologists to perform assessments and design interventions within preschool special education and infant and toddler early intervention programs (McLinden & Prasse, 1991). Refinements of a practice label, such as “applied developmental psychologist” or “developmental school psychologist,” were offered by Bagnato and Neisworth (1991) to underline the heavy influences of developmental principles and ecological perspectives to this practice specialty.

Within the early intervention arena, a broader role of infant and preschooler mental health specialist gained recognition. Weatherston (2000) describes infant mental health specialists as ascribing to a set of core beliefs and clinical strategies, rather than belonging to a particular discipline. She notes that practitioners who utilize relationship-based approaches to working with families with young children are infant mental health specialists, including, for instance, early childhood educators, nurses, psychiatrists, physical and occupational therapists, and social workers as well as psychologists.

**Practice Settings**

Early childhood psychologists are employed in a diversity of settings, including preschool special education and infant early intervention programs (Bagnato & Neisworth, 1991; Barnett, 1986; Widerstrom, Mowder, & Willis, 1989). The psychologist’s contributions to preschool special education and early intervention programs continue to be highlighted through research on roles and collaborative efforts (Rubinson, Sweeny, Mowder, & Sossin, 2003) and by policy and position statements offered by organizations such as the National Association of School Psychologists (NASP, 2003). Additional service settings may include child trauma centers, foster care agencies, and Head Start, as well as hospitals, medical clinics, and social services.

One consistent theme of early childhood services is mental health consultation (Donahue, Falk, & Provot, 2000). Indeed, early research (e.g., Piotrowski, Collins, Knitzer, & Robinson, 1994) documented mental health consultation as a high priority for Head Start programs. Currently, Federal Head Start regulations (U.S. Office of Health & Human Services, 2007) require each program to have a mental health professional available, providing consultation regarding child behavior and mental health, promoting health and wellness, and assisting in securing services for children with disabilities or atypical behaviors. These mental health professionals could be psychologists, as well as social workers, counselors, or other behavioral specialists.
Donahue and colleagues (2000) offer an interesting historical reflection on involvement by psychologists as Head Start mental health consultants. Subsequent to the documented need for early childhood mental health consultation, the APA called on members to volunteer their services to Head Start programs. Many practitioners responded, but few had the requisite knowledge and training in early childhood issues and appropriate consultative practices. Thus, this early practice initiative essentially failed to meet the needs of children, families, and staff in Head Start programs. A sense of urgency followed the sobering recognition that specific skills are necessary for working in early childhood settings. In other words, many psychologists attempted to utilize skills in working with older children (e.g., elementary school aged, adolescents) as well as adults and apply those psychological services to young children and their families.

The early, and continuing, need for psychological services is clearly illustrated by the unsettling preschool expulsion statistics. Using data drawn from the most recent National Prekindergarten Study, Gilliam (2008) found that 10% of prekindergarten teachers reported making at least one dismissal within a 12-month period. The resulting rate of expulsion (i.e., 6.7 per 1,000) is more than three times greater than the rate for students enrolled in kindergarten through 12th grade. The majority of expulsions were due to challenging behavior, which Gilliam (2005; 2008) believes can be addressed effectively through mental health consultation.

As health care has expanded to encompass a wide range of mental health services, the role of the psychologist in health care settings has also expanded (Brown, 2004). Traditionally, applied developmental psychologists offered diagnostic services for young children with intellectual or developmental disabilities (e.g., mental retardation, autism spectrum disorders) or in providing follow-up services and supports for medically fragile children (e.g., premature infants) (Minde, 2000; Thurman, Gottwald, Cornwell, & Korteland, 1997). Currently, psychologists play a pivotal role in family interviewing (Seligman, 2000), conducting observations of children and parent–child interactions (Benham, 2000; Brassard & Boehm, 2007), and administering developmental assessment measures (Brassard & Boehm, 2007; Finello, 2005; Gilliam & Mayes, 2000). Kaplan-Sanoff, Lerner, and Bernard (2000) articulate a model for utilizing developmental specialists within pediatric care settings to help assess developmental progress and provide assistance to parents in managing behavioral concerns. The developmental specialist role might be filled by a number of professionals with training in development, family systems, and assessment, such as psychologists but also including nurses, social workers, and other mental health professionals.

Finally, services for children who have experienced significant trauma (e.g., exposure to violence, placement in foster care due to abuse or neglect)
rely heavily on the contributions of psychologists and other mental health professionals specializing in early childhood (Banerjee & Castro, 2005; Donahue et al., 2000; Gimpel & Holland, 2003; Scheeringa & Gaensbauer, 2000). These children and families, seen in settings such as clinics, therapeutic nurseries, or specialized early intervention programs, receive developmentally appropriate mental health interventions. Few other psychological service areas or practice settings involve such a high degree of skill integration, knowledge, and collaboration involving physical and mental health assessment of young children, intervention within family systems, and the design of comprehensive family-based treatment services.

Although early childhood psychologists may be employed in many settings (e.g., agencies, community programs, hospitals, medical offices, schools), the actual delivery of services often occurs within young children’s natural settings (e.g., child care, home, preschool classroom) rather than psychologists’ private offices. Harden and Lythcott (2005) even use the term kitchen therapy to convey the intimacy and flexibility needed to meet the needs of young children and their families.

Estimating the Number of Early Childhood Psychologists

Estimating how many psychologists specialize in early childhood services is difficult. This challenge is partially due to the diverse nature of settings in which early childhood psychologists might be employed as well as the lack of standard reporting of personnel data across settings. However, statistics are available for personnel working within the infant, toddler, and preschool special education programs.

Data collected during the fall of 2001 for the Individuals with Disabilities Education Act (IDEA) Report to Congress counted 1,691 psychologists providing services to infants, toddlers, and their families (U.S. Department of Education, 2004). Similar statistics for psychologists working within the preschool special education programs are not reported in the IDEA Reports to Congress, as these preschool specialists are folded into the data for total numbers of psychologists (29,628) serving children ages 3–21 in special education programs (U.S. Department of Education, 2005). However, a 2003 survey of school psychologists in New York State (Rubinson et al., 2003) did reveal that approximately 26% of the respondents are involved at some level with early childhood services; apparently, this proportion is consistent with prior reports in the literature. By employing a 25% estimate to the 2005 IDEA count of psychologists, possibly 7,500 psychologists are serving young children with special education needs.

As of 2007, Head Start operated 18,875 program centers, each of which required a mental health consultant (Administration for Children and
Families, 2007). Since there are various professionals (e.g., psychologists, social workers) filling these mental health roles, the specific number of Head Start psychologists is unclear. Further, statistical reports on the numbers of psychologists working in settings such as community agencies, foster care, or medical settings are not readily available. Thus, a quantitative portrait of early childhood psychologists is far from complete or finished.

**UNIQUE ASPECTS OF PRACTICE**

Although working with infants, toddlers, and young children in any setting requires core foundation knowledge, early childhood practice typically is founded on unique values and skills. For example, values such as (1) appreciation of principles of development to guide programs; (2) recognition of the primacy of parents and family relationships; (3) provision of culturally congruent and respectful services; (4) utilization of collaborative, team-based models; and (5) reliance on evidence-based approaches to design and evaluate interventions permeate the early intervention and infant mental health literature (Bagnato & Neisworth, 1991; Foley & Mowder, 2000; Thurman et al., 1997; Weatherston, 2005) and are the foundation for policy and position statements influencing early childhood practice (Division for Early Childhood [DEC], 2007; NASP, 2003). A deep appreciation of these foundation values leads to models for service delivery that respect the needs of young children and their families, within their cultural context, involving collaboration within and among early childhood providers.

**DISTINCTIVE DEVELOPMENTALLY APPROPRIATE PRACTICE**

The daily routines, learning opportunities, and systems to promote health and well-being for young children are designed in concert with contemporary understanding of child development and learning. The National Association for the Education of Young Children (NAEYC) has promulgated a set of guidelines for early childhood programs (Bredekamp & Copple, 1997) that articulate developmentally appropriate practice standards for curriculum design and delivery, assessment, and family involvement which respect the developmental stages, learning styles, and relationship needs of infants, toddlers, and preschool-age children. An extension of those standards for educating children with disabilities, issued by the DEC (2007) of the Council for Exceptional Children (CEC), offers additional guidance in designing learning environments, assessments, and program evaluations that recognize individual differences within a developmentally appropriate framework. For the early childhood psychologist, developmentally appropriate practices might involve conducting assessments utilizing play with toys, respecting
children’s need for naps and snacks, and keeping parents in close proximity. Developmentally appropriate practices also guide consultation; for example, recommendations regarding the selection of early literacy activities and measures for monitoring the progress of at-risk learners might be addressed.

EARLY CHILDHOOD PSYCHOLOGY INVOLVES WORKING WITH FAMILIES

The primacy of the family in young children’s lives is one of the core values encompassing all work with infants, toddlers, and preschoolers. Contributors to early childhood services have approached the topic of family influence and interventions from a variety of theoretical frameworks, including, for instance, family systems theory (Cornwall & Korteland, 1997; Seligman & Darling, 2007), parent–child interactions and family dynamics (Mowder, 1997b; Sameroff, 2004), family needs and resources (Erickson & Kurz-Riemer, 1999; Trivette, Dunst, & Deal, 1997), and developmental impacts of family variables (Crockenberg & Leerkes, 2000). Cornwall and Korteland, borrowing from family therapy literature, describe the “family as a system and context for early intervention” (1997, p. 93). At a practical level, this means that families are present at, participate in, and may be the subjects of assessment; their priorities and goals for services for their children are significant; and interventions are designed to incorporate and/or target parents and/or the family. Within early childhood intervention, the term family-centered services is often used to describe a strengths-based approach wherein families are viewed as partners and collaborators in problem solving to produce positive outcomes for their children (Brown & Conroy, 1997; Seligman & Darling, 2007).

EFFECTIVE SERVICES BUILD ON CULTURAL AND SYSTEM CONTEXTS

Appreciating the family context requires sensitivity to families’ cultural milieu, which includes factors such as language, ethnic heritage and tradition, neighborhood, and ways of thinking about and behaving toward children. One of the first steps toward professionals’ cultural sensitivity is self-examination of one’s own cultural experiences and beliefs. Self-examination usually leads to an appreciation of the impact of culture on families, spurring consequent practice modifications (Brassard & Boehm, 2007; Erickson & Kurz-Riemer, 1999).

For example, a thorough understanding of how linguistic and cultural diversity affect the assessment of young learners is a critical competency for early childhood psychologists. The process of self-examination is highlighted in Brassard and Boehm’s (2007) frank analysis of myths about language and
cognitive skill acquisition in young non-native English-language learners. Such myths include beliefs that English language learning is endangered by use of another language while bilingualism interferes with cognitive development, and misperceptions that conversational skills represent English language mastery, or that expected differences in acquisition of English for second-language learners (e.g., word-finding problems or articulation difficulty) are signs of communication disorders. Brassard and Boehm also offer research-based guidelines for screening and assessment of culturally and linguistically diverse preschoolers, including, for instance, a decision-making tree for examining primary language proficiency and need for further communication or cognitive assessment, and guidelines for selecting and training interpreters and paraprofessionals.

Working from research bases drawn from cultural beliefs about the nature of children and child-rearing practices, Iglesias and Quinn (1997) weave cultural perspectives into guidelines for competent service provision within early intervention programs. For example, cultural groups have different belief systems about the degree to which infants are viewed as willful or innocent, or to which extended families share responsibility for raising young children. Awareness of cultural perspectives on child development and behavior should then lead to culturally appropriate early intervention practices, such as involving extended family in treatment sessions or setting goals for child behaviors that are congruent with family expectations for infant development.

**EARLY CHILDHOOD SERVICES PROVIDED BY TEAMS**

Using a multidisciplinary approach for assessment of children with disabilities is a cornerstone of special education law, as the original special education law, P.L. 94–142 (1975), and subsequent revisions continue requiring that eligibility for services is based on a multifaceted, multidisciplinary evaluation. Models for effective assessment in early childhood intervention programs have evolved beyond multidisciplinary approaches to interdisciplinary and transdisciplinary models (McLean & Crais, 2004). For example, members of a multidisciplinary team each offer a specific area of expertise, but do not necessarily work together to provide integrated services. Unfortunately, this model may lead to duplication of efforts (e.g., gathering background information), leading to service fragmentation and/or omission of some service components; medical services are often based on a multidisciplinary model. In contrast, the interdisciplinary team offers individual assessments and interventions, but meets together to share information and plan programs (e.g., the Individualized Education Plan [IEP] team model for special education services). The highest level of team integration is afforded
by the transdisciplinary model, where members jointly plan and conduct assessments, offering services that are targeted to improve child functioning across several domains. Parents are considered part of the transdisciplinary team and, therefore, are integrated in planning, delivering, and evaluating services.

For transdisciplinary teams to work effectively, McLean and Crais (2000) suggest a number of guidelines. For example, they emphasize learning about team members’ disciplines as well as supporting team members by integrating their professional expertise through role “release” and sharing service delivery tasks. Not surprisingly, this model requires a significant level of communication and trust among team members. The transdisciplinary model is consistent with Weatherston’s (2005) reflections on infant mental health practice. She notes that relationship-based approaches involve the parent–child relationship as well as relationships among many individuals, such as practitioners, family members, and supervisors.

EVIDENCE-BASED PRACTICE GUIDES SERVICE DELIVERY

The call for evidence guiding psychological services is not new, and is based on a long tradition of psychotherapy research informing practice (e.g., Garfield & Bergin, 1978). In fact, volumes (e.g., Jacobson, Foxx, & Mullick, 2005) have been written to help practitioners differentiate evidence-based treatments for individuals with developmental disabilities (e.g., autism) from fads and gimmicks. Nonetheless, emphasis on evidence-based interventions was accelerated by the passage of federal initiatives (e.g., No Child Left Behind [NCLB], 2002) to improve educational outcomes. The requirement that instructional choices are based on scientific evidence, helped encourage a growing body of intervention research. For early childhood psychologists, these options included, for example, family-based interventions (Kumpfer & Alvarado, 2003), family-school intervention partnerships (Bates, 2005), and mental health prevention programs (Beckwith, 2000; Durlak & Wells, 1997). In fact, practitioners now learn about effective practices from many sources, such as journals devoted to evidence-based outcomes (e.g., Early Childhood Services: An Interdisciplinary Journal of Effectiveness), databases (e.g., the National Registry of Evidence-Based Programs and Practices [www.nrepp.samhsa.gov]), the What Works Clearinghouse (www.whatworks.ed.gov) maintained by the U.S. Department of Education’s Institute of Education Sciences, and the Florida Center for Reading Research (www.fcrr.org), which has reviews of prekindergarten literacy programs.

The growing database of effective programs for young children ultimately aids the selection of specific programs and interventions. Interventions, however, need to be tailored specifically for infants and young children.
and appropriate for local schools and agencies. Beyond selection and implementation, program evaluation and accountability is essential for developmentally appropriate practice (DEC, 2007). Gilliam and Leiter’s (2003) article on designing early childhood program evaluations provides a valuable road map. For example, they recommend that programs build a logic model to map how each service component is connected to program goals, and to identify both proximal (short-term and direct) and distal (long-term and less direct) outcomes desired as a result of program efforts. The components of a program evaluation may focus on implementation (also called process study or formative evaluation), attainment of targeted outcomes, or more scientifically rigorous investigations that link outcomes directly to program components (e.g., through use of control or comparison groups). Thus, programs can complete the circle of evidence-based practice, by starting with program design based on selection of the most effective interventions available to fit program goals and cultural contexts, moving to monitoring of implementation processes, then assessing attainment of desired outcomes, and finally closing the loop by making modifications of program goals, interventions, or processes based on evaluation data.

RECOMMENDATIONS FOR TRAINING

As infant and early childhood psychology has grown, there have been increasing calls for training incorporating early childhood values, knowledge, and skills. As early as the 1970s, leaders in infant mental health services (e.g., Selma Fraiberg), formulated guidelines for professional training. The major components of such training, as described by Weatherston (2005), included (1) building a knowledge base in infant development; (2) developing skills for practice in observation, assessment, and interventions; (3) processing experiences with teachers and mentors; and (4) working on individual practice issues through reflective supervision.

Shortly after the preschool and infant early intervention special education laws were passed, McLinden and Prasse (1991) articulated the need for training of preservice school psychologists to prepare for roles with very young children, while advising that established professionals retool some of their skills and approaches to better serve young children. McLinden and Prasse addressed differences in training and practice for skill sets associated with early childhood assessment and intervention, family supports, and case management and team collaboration. Foley and Mowder (2000) offered perspectives on the distinctive processes for learning essential skills for practice with infants, young children, and families. In particular, they highlight how observations and practicum experiences help trainees internalize transactional views of child development, as well as understand
relationships between families and early childhood practitioners. Although the training they describe is somewhat specific to school psychology, Foley and Mowder recognize that hybrid programs in clinical–school psychology may also provide the platform for early childhood skills.

In addressing retraining, Mowder, Goliger, Sossin, and Rubinson (2003) surveyed school psychologists across New York State (NYS) regarding their early childhood roles and training needs. Of the 812 surveys completed, 27% indicated they worked with the infant, toddler, or preschool population. The most frequently endorsed training needs were approaches to intervention (83%), followed by assessment skills (80%), diagnosis of disabilities (66%), and pharmacology issues with young children (64%). Although the least frequently endorsed topics were collaboration with other early childhood professionals and multicultural issues, they nonetheless were identified as needed by one-third of the early childhood psychologists responding to this survey. Workshop formats were the most commonly preferred format, followed by graduate courses; an institute format was less popular, but still endorsed by over 30% of the early childhood respondents.

An extension of this survey reached 1,019 licensed doctoral psychologists in NYS (Gallagher, Mowder, Sossin, & Rubinson, 2006). In terms of percentages, fewer licensed psychologists (i.e., 19%) provide services to young children and their families compared to school psychologists. Of licensed psychologists indicating early childhood practice, the highest percentage (47%) were clinical psychologists, followed by school psychologists (19%), with the percentages of other licensed respondents (e.g., counseling, developmental, educational psychology) accounting for a combined total of approximately 15%. According to the respondents, the primary pathway to infant and early childhood knowledge and skills was gained through reading and on-the-job experiences. The ranking of training needs was similar to school psychologists, with information about assessment, interventions, and pharmacology among the highest continuing education priorities, and workshop formats preferred.

The continuing education priority topics revealed by the surveys of both NYS school psychologists (Mowder et al., 2003) and licensed doctoral psychologists (Gallagher et al., 2006) lend themselves to the workshop formats both groups preferred. However, such formats appear unlikely suited to the particular demands of either reflective practice and supervision articulated by Weatherston (2005) or building relationships with families (Foley & Mowder, 2000; Zeannah, Larrieu, & Zeannah, 2000). In fact, these two elements of early childhood practice are highlighted in Delahoueke’s (2005) reflections on retraining to work with infants and young children. For example, she combined postgraduate coursework with over 200 hours of continuing education; however, the opportunity for reflective supervision, gained as a member of a multidisciplinary clinical services team, was the most helpful in
fully appreciating the integrative nature of the work and the primacy of familial relationships.

Moving away from the discipline of psychology, Zeanah et al. (2000) offer training guidelines for infant mental health specialists. They outline a comprehensive curriculum, including (1) knowledge of infant development, developmental psychopathology, infant mental health and developmental disorders; (2) applied skills in assessment, intervention, and prevention skills; and (3) professional skills related to relationships with clients (families), interdisciplinary collaboration, and legal and ethical issues. Zeanah et al. promote this training for all professionals in the infant mental health field, encompassing child welfare officials (e.g., child protection workers, judges), child care providers (e.g., day care center directors), medical professionals (e.g., psychiatrists, nurses, pediatricians, nutritionists), educators (preschool teachers), special education personnel (e.g., child development specialists, physical, occupational, and speech therapists) as well as traditional mental health professionals (e.g., counselors, psychiatrists, psychologists, social workers). Recently, a group of early childhood professionals developed the California Infant/Preschool/Family Training Guidelines (Finello & Poulsen, 2005), which recommend a tiered program of training with a higher level of preparation for infant mental health professionals (e.g., psychologists, child development specialists, social workers) and core early childhood skills and competencies for service providers in other disciplines (e.g., day care providers, physical therapists).

MODELS FOR CONCEPTUALIZING INFANT AND EARLY CHILDHOOD ISSUES

Early childhood psychologists draw on various models for conceptualizing, organizing, and delivering services. Some of the models with the greatest influence on early childhood psychology practice include the (1) medical model; (2) mental health model; (3) development, disability, and psychopathology models; (4) learning theory and behavior change models; and (5) early educational models for typical as well as those children with disabilities. These models rely on the rich history of psychology, education, and applied mental health practice, and are woven together into distinctive ways of thinking, relating, and assisting others that characterize the specialty practice area of infant and early childhood psychology.

MEDICAL MODEL

The linear processes of diagnosing, prescribing treatment, and suggesting prognoses and outcome form the essence of the medical model. This model