

1: Change & Continuity Over Time: Islam | Researchomatic

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Print Caregivers who work well together are likely to share common, though not identical philosophy and practices. They probably have similar styles of communications and beliefs about how important it is to be attentive and responsive to children. Click here to learn more. They can decide quickly who will go outside with which group of children, who will sit with the children who are eating, and who will put the other children to sleep. Setting up a system of primary caregiving establishes an environment in which meaningful and lasting relationships can develop between caregivers and children as well as between caregivers and families. These relationships rest on satisfying relationships within the caregiving team, which call to mind the principle of continuity of care. It can take different forms. Children and caregivers can remain together in the same room in a mixed-age group in which children who enter as infants gradually become the big kids. Maybe one caregiver moves with a group of children. Even moving a cluster of children to the next age group rather than moving children individually contributes to some continuity of care. Keeping children and caregivers together for three years has several benefits. Close relationships between children and their primary caregivers can flourish. The child, who says goodbye to the ones she loves every morning when they leave her at the center, does not have to say goodbye to the person who has helped her to adjust to life in child care. Losing primary children can also be remarkably tough on teachers. It is unrealistic to expect caregivers to give children up to the group next door without feeling sad and perhaps a bit critical or at least concerned. Besides connecting to their primary caregivers, children relate in special ways to other children who share their primary caregiver. A group of 2-year-olds returned from a walk when one of them began to wail. She knew him well enough to jump right in. Moreover, she knew the routine. Her caregiver had used those words with her often enough. Like this child, with continuity of care, children and caregivers know the culture of their classroom well. Instead, programs move children from room to room as they reach developmental milestones, such as beginning to walk. Some centers even move children daily to maintain caregiver-to-child licensing standard ratios. Although this approach may make sense from an administrative point of view, it certainly does not make sense for children, families or caregivers. Administrative concerns stemming from a scarcity of resources can be a stumbling block to continuity of care, and so is staff turnover. People are not interchangeable. Even when a fine person is hired to replace someone who leaves the center, relationships need to be established anew. Caregivers leave their jobs for many reasons. Better compensation, and benefits, increased educational opportunities, and public awareness of the important job that infant and toddler caregivers do are crucial if caregivers are to remain in their positions. However, the quality of care for infants and toddlers will not rise automatically after these goals are achieved. In fact, time for caregivers to communicate with each other, a team approach to caregiving, primary caregiving, and continuity of care are not magic bullets. There is no simple path to high-quality care for young children, although knowledge about infants, toddlers, families, and ourselves can help show us caregivers the way. Quality is something to work at together, learning not only from what others have written about infants and toddlers but also with conversations with each other, trying new ideas, evaluating ten carefully, and always defining and redefining for ourselves what high-quality infant and toddlers care can be. Excerpted from Theilheimer, R. Molding to the children: Primary caregiving and continuity of care. *Zero to Three*, 26, 3.

2: Change and continuity in infancy (edition) | Open Library

Change and Continuity in Infancy. By Jerome Kagan. Read preview. Excerpt. The illusion that we can specify in time or location the beginning of an idea or major.

Nature versus nurture Although developmental change runs parallel with chronological age, [30] age itself cannot cause development. Environmental factors affecting development may include both diet and disease exposure, as well as social, emotional, and cognitive experiences. Plasticity of this type can occur throughout the lifespan and may involve many kinds of behavior, including some emotional reactions. Genetic-environmental correlations are circumstances in which genetic factors make certain experiences more likely to occur. In all of these cases, it becomes difficult to know whether child characteristics were shaped by genetic factors, by experiences, or by a combination of the two. What relevant aspects of the individual change over a period of time? What are the rate and speed of development? What are the mechanisms of development? What aspects of experience and heredity cause developmental change? Are there typical individual differences in the relevant developmental changes? Are there population differences in this aspect of development for example, differences in the development of boys and of girls? Empirical research that attempts to answer these questions may follow a number of patterns. Initially, observational research in naturalistic conditions may be needed to develop a narrative describing and defining an aspect of developmental change, such as changes in reflex reactions in the first year. Such studies examine the characteristics of children at different ages. Some child development studies examine the effects of experience or heredity by comparing characteristics of different groups of children in a necessarily non-randomized design. Child development stages Milestones are changes in specific physical and mental abilities such as walking and understanding language that mark the end of one developmental period and the beginning of another. Studies of the accomplishment of many developmental tasks have established typical chronological ages associated with developmental milestones. However, there is considerable variation in the achievement of milestones, even between children with developmental trajectories within the typical range. Some milestones are more variable than others; for example, receptive speech indicators do not show much variation among children with typical hearing, but expressive speech milestones can be quite variable. Prevention of and early intervention in developmental delay are significant topics in the study of child development. Increased knowledge of age-specific milestones allows parents and others to keep track of appropriate development. Here are descriptions of the development of a number of physical and mental characteristics. Speed and pattern[edit] The speed of physical growth is rapid in the months after birth, then slows, so birth weight is doubled in the first four months, tripled by age 12 months, but not quadrupled until 24 months. At birth, head size is already relatively near to that of an adult, but the lower parts of the body are much smaller than adult size. In the course of development, then, the head grows relatively little, and torso and limbs undergo a great deal of growth. However, genetic factors can produce the maximum growth only if environmental conditions are adequate. Some of these differences are due to family genetic factors, others to environmental factors, but at some points in development they may be strongly influenced by individual differences in reproductive maturation. Motor[edit] A child learning to walk Abilities for physical movement change through childhood from the largely reflexive unlearned, involuntary movement patterns of the young infant to the highly skilled voluntary movements characteristic of later childhood and adolescence. Definition[edit] "Motor learning refers to the increasing spatial and temporal accuracy of movements with practice". Speed and pattern[edit] The speed of motor development is rapid in early life, as many of the reflexes of the newborn alter or disappear within the first year, and slows later. Like physical growth, motor development shows predictable patterns of cephalocaudal head to foot and proximodistal torso to extremities development, with movements at the head and in the more central areas coming under control before those of the lower part of the body or the hands and feet. The dorsolateral frontal cortex is responsible for strategic processing. The parietal cortex is important in controlling perceptual-motor integration and the basal ganglia and supplementary motor cortex are responsible for motor sequences. Intra-limb correlations, like the strong relationship and distance between

hip and knee joints, were studied and proved to affect the way an infant will walk. There are also bigger genetic factors like the tendency to use the left or right side of the body more, predicting the dominant hand early. Sample t-tests proved that there was a significant difference between both sides at 18 weeks for girls and the right side was considered to be more dominant Piek et al. Some factors, like the fact that boys tend to have larger and longer arms are biological constraints that we cannot control, yet have an influence for example, on when an infant will reach sufficiently. Overall, there are sociological factors and genetic factors that influence motor development. This is significant in motor development because the hind portion of the frontal lobe is known to control motor functions. This form of development is known as "Portional Development" and explains why motor functions develop relatively quickly during typical childhood development, while logic, which is controlled by the middle and front portions of the frontal lobe, usually will not develop until late childhood and early adolescence. Skilled voluntary movements such as passing objects from hand to hand develop as a result of practice and learning. Infants with smaller, slimmer, and more maturely proportionated infants tended to belly crawl and crawl earlier than the infants with larger builds. Infants with more motor experience have been shown to belly crawl and crawl sooner. Not all infants go through the stages of belly crawling. However, those who skip the stage of belly crawling are not as proficient in their ability to crawl on their hands and knees. Atypical motor development such as persistent primitive reflexis beyond 4â€”6 months or delayed walking may be an indication of developmental delays or conditions such as autism , cerebral palsy , or down syndrome. Children with disabilities[edit] Children with Down syndrome or Developmental coordination disorder are late to reach major motor skills milestones. A few examples of these milestones are sucking, grasping, rolling, sitting up and walking, talking. Children with Down syndrome sometimes have heart problems, frequent ear infections , hypotonia , or undeveloped muscle mass. This syndrome is caused by atypical chromosomal development. Along with Down syndrome, children can also be diagnosed with a learning disability. Learning Disabilities include disabilities in any of the areas related to language, reading, and mathematics. These principals allow him or her to make sense of their environment and learn upon previous experience by using motor skills such as grasping or crawling. There are some population differences in motor development, with girls showing some advantages in small muscle usage, including articulation of sounds with lips and tongue.

3: When It Comes to Infant-Toddler Care and Development, It's All About the Relationships

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In addition to the general quality of care for infants and toddlers, discrete practices may influence the development of infants and toddlers. One practice that is currently attracting substantial interest is the provision of continuity of caregivers for young children. Continuity of caregivers means that infants and toddlers remain with the same teachers during a significant part, if not all, of their first years in a program. Continuity of Caregiver Traditionally, young children in center-based child care programs have a series of different caregivers during the first three years of life. Many programs move children more often, from class to class, teacher to teacher, as soon as they attain certain developmental milestones, such as crawling or walking. Some programs may move children on a daily basis to meet ratio or other staffing requirements. This practice is often used to ensure efficient use of program resources by keeping classes full and enrolling infants, for whom there is more child care demand. The rationale for continuity of caregiver is similar to that for assigning primary caregivers to very young children. Primary caregivers take major responsibility for meeting the care and educational needs of a small group of children, within a larger group. Both practices, continuity of caregiver and primary caregiver, are intended to create a consistent personal relationship between a child and a teacher. In these practices primary caregiver and continuity of caregiver, transitions between teachers are minimized because transitions are seen as being stressful for the child and adults and wasteful in terms of learning time. When a child is moved to a new caregiver, recommended practice suggests that strategies be used to ease transitions. For example, children can visit their new class and teacher before moving, or their new teacher can visit them a few times so that they can get to know one another. Theory and Research The current professional recommendation of continuity of caregiver for infants and toddlers is based on conclusions drawn from child development theory and from limited research findings. Theoretically, issues regarding the development of secure maternal attachment are considered paramount for infants and toddlers Ainsworth et al. Secure maternal relationships are associated with more positive child outcomes, especially with regard to social-emotional development e. Howes and Hamilton found that with multiple changes in caregivers, toddlers are less likely to relate to a new caregiver based on her own behavior but rather re-create the quality of the relationship with a previous caregiver. Likewise, little is known about the extent to which continuity of caregiver is practiced, although reports of survey research conducted by Cryer et al. Implementing Continuity of Caregiver When the practice of continuity of caregiver is implemented in child care centers, various strategies are used. For example, the amount of time that children remain with the same teacher might vary, with some having the same teacher through the first and second years, and others having the same teacher for a shorter but extended period e. Keeping children with the same teacher is more likely when multiage groups are used, because having a birthday or reaching developmental milestones does not force a change in class. Continuity of caregiver, however, is also used with same-age groupings. Teachers and their children may use the same physical space through their years together, or they may move from one classroom to another. In classes with multiple teachers, all teachers and children might move together, while in another setting, a subgroup of children might move with only one of the teachers. Thus, even within this practice continuity of caregivers, there can be substantial variation. Yet the major requirement for providing continuity of caregiver is met. To offer continuity of care for infants and toddlers, center staff might want to consider the following suggestions: Avoid taking new children only in the youngest group; this practice forces moving children up one at a time and separates them from the teacher to whom they are attached. Recruit new children to fill in at upper age levels when it is more appropriate to have more children per adult. Reward staff for longevity with the program. If a staff member leaves, overlap staff so that children are never left with strangers. Conclusion Although positive child development effects may be associated with the practice of continuity of caregiver, it is certainly possible that there are also negative effects associated with the practice.

For example, if a child spends several years with a teacher who interacts negatively with the child, undesirable outcomes would be likely. At this time, the actual effects associated with the practice are based only on theoretical assumption and limited research. Center staff may require more compelling evidence that a practice is truly a better option before undertaking the substantial modifications that are required in making a significant change. This project has been funded at least in part with Federal funds from the U. The content of this publication does not necessarily reflect the views or policies of the U. Department of Education, nor does mention of trade names, commercial products, or organizations imply endorsement by the U. ERIC Digests are in the public domain and may be freely reproduced. For More Information Ainsworth, M. A psychological study of the Strange Situation. Quality of center child care and infant cognitive and language development. *Child Development*, 67 2 , Mother-child interactions, attachment and emergent literacy: *Child Development*, 59 5 , Continuity of caregiver for infants and toddlers in center-based child care: Report on a survey of center practices. *Early Childhood Research Quarterly*, 15 4 , Caregiver stability and day care. *Developmental Psychology*, 16 1 , Child care patterns of infants and toddlers. Continuity of care for infants and toddlers. *Early Development and Care*, , Relation to infant-parent and day-care characteristics. *Child Development*, 61 3 , Cost, quality, and child outcomes in child care centers. University of Colorado at Denver. Mothers and child care teachers. *Child Development*, 63 4 , The changing experience of child care: *Early Childhood Research Quarterly*, 8 1 , The influence of attachment pattern on developmental changes in peer interaction from the toddler to the preschool period. *Child Development*, 57 2 , The development of communicative competence of securely and insecurely attached children in interactions with their mothers. *Journal of Psycholinguistic Research*, 26 1 , Continuity of adaptation in the second year: The relationship between quality of attachment and later competence. *Child Development*, 49 3 , Characteristics of infant child care: Factors contributing to positive caregiving. *Early Childhood Research Quarterly*, 11 3 , Relationship duration in infant care: Time with a high-ability teacher and infant-teacher attachment. *Early Childhood Research Quarterly*, 8 3 , Maternal sensitivity and patterns of infant-mother attachment. *Child Development*, 59 4 , Attachment, intelligence and language: *Social Development*, 4 2 , Child care teachers and the quality of care in America. Child Care Employee Project. Author, Title or Subject:

4: Continuity And Discontinuity In Development - Developmental Psychology - IResearchNet

Change and continuity in infancy by Jerome Kagan, , Wiley edition, in English.

He apparently had not appointed anyone to succeed him, and the result was confusion and an unclear line of succession—a fact that ultimately created significant divisions in Islam, whose effects remain today. The earliest stage of growth of Islam came during the time of the first four rulers, called the orthodox caliphs. A major change occurred, however, as Islam spread outside Arabia. From an early, deliberate simplicity, Islam would now become more urbane and complex. Thesis Statement Islam has always modified itself according to the contemporary challenges of the world successfully without losing its fundamental beliefs. Discussion Islam arose at a time seventh century C. The Byzantine Empire, ruling from Constantinople, had fought repeatedly with the Persian Empire, and both were weakened by the effort. Areas theoretically controlled by the Byzantine emperor, such as regions of northern Africa, were far away from the capital. Aslan, Modern life presents great challenges to traditional Islam. Industrial work schedules make daily prayer and other religious practices difficult; women are demanding total equality with men and complete independence; and individualism is weakening family ties and social responsibility. Islam is being pulled in many directions. Soon after its beginnings, Islam became and remained a world power for about eight hundred years. Islamic cities were centers of civilized living. During this period, Islamic strength contrasted with the general weakness of western Europe: Ruling from Constantinople, the Byzantine emperors continued the Eastern Roman Empire in weakened form. Islam continued to spread and consolidate eastward, as far as Indonesia and the Philippines, but after that its expansion slowed. Dirks, Toward the end of the fifteenth century the pendulum of power swung in the opposite direction. While Islam became fairly settled in its territory, western Europe began to expand its control. These explorations changed the patterns of trade. Before then, trade was conducted primarily by land routes, which were frequently controlled by Muslim rulers. Now journeys could be made by ship, a form of travel that greatly enlarged the opportunity for travelers to influence others. These journeys were just the beginning of powerful waves of expansion by European traders, soldiers, political figures, and Christian missionaries. Coupled with circumnavigation were the growth of scientific understanding

5: Continuity of Caregiver for Infants and Toddlers

As one of the premier rare book sites on the Internet, Alibris has thousands of rare books, first editions, and signed books available. With one of the largest book inventories in the world, find the book you are looking for. To help, we provided some of our favorites. With an active marketplace of.

Changes may occur within an individual across the life span, and there may be between-person differences in such intraindividual change. The description and explanation of intraindividual change involves the concepts of developmental continuity and discontinuity, whereas the description and explanation of interindividual differences in intraindividual change involves the concepts of stability and instability. In regard to continuity and discontinuity, descriptions or explanations of development can involve quantitative or qualitative changes. Descriptively, quantitative changes involve differences in how much or how many of something exists. For example, in adolescence, quantitative changes occur in such areas as height and weight since there is an adolescent growth spurt, and these changes are often interpreted as resulting from quantitative increases in the production of growth-stimulating hormones. In turn, descriptive qualitative changes involve differences in what exists, in what sort of phenomenon is present. Explanations of development also can vary in regard to whether one accounts for change by positing quantitative changes e. In other words, it is possible to offer an explanatory discontinuous interpretation of development involving either quantitative or qualitative change. The point is that on the basis of adherence to a particular theory of development e. Thus, virtually any statement about the character of intraindividual development involves, explicitly or implicitly, taking a position in regard to three dimensions of change: In essence, then, one may have descriptive quantitative discontinuity coupled with explanatory qualitative continuity, or descriptive qualitative continuity coupled with explanatory quantitative discontinuity, and so forth. For example, a feature of personality e. It may be represented or depicted isomorphically at two different temporal points e. However, more of this qualitatively invariant phenomenon may exist at time 2 e. Moreover, both descriptive quantitative discontinuity and descriptive qualitative continuity may be explained by the same ideas, such as by continuous explanatory principles. For example, smiling may be assumed to be released across life by biogenetically based physiological mechanisms. For instance, smiling may be assumed to be biogenetically released in early infancy and mediated by cognitively and socially textured processes across subsequent developmental periods. Indeed, if different explanations are, in fact, invoked, they may involve statements that constitute either quantitatively or qualitatively altered processes. In short, the particular couplings that one posits as involved in human life will depend on the substantive domain of development one is studying e. That is, any particular description or explanation of intraindividual change is the result of a particular theoretical view of development. The Contributions Of Heinz Werner Heinz Werner believed that considerable confusion existed among human developmentalists over the continuity-discontinuity issue and that at the crux of this confusion was a lack of understanding about two different aspects of change i. He argued that these two aspects of change must always be considered in discussions of descriptive and explanatory continuity-discontinuity. However, Werner explained the superordinate conceptual importance of the qualitative-quantitative dimension of change. Quantitative Change In regard to the quantitative aspect of development, we have noted that there is change in a feature of development in regard to how much of something exists. Quantitative change is an alteration in the amount, frequency, magnitude, or amplitude of a developmental variable or process. He weighed pounds when he was measured at 8, 9, 10, 11, and 12; but he weighed pounds when he was measured at Thus, a quantitative change occurred in how much weight existed between the times of measurement occurring at ages 12 and 13 years. By gaining 5 pounds per year, the child gradually goes from to pounds between his 8th and 13th years. With gradual quantitative changes, the rate of change stays the sameâ€”is continuousâ€” from one measurement time to the next. This is quantitative continuity. Thus, quantitative change may be abrupt. In measuring this change, there is a gap between one point in the measurement curve and another; that is, a curve representing the different measurements is not smooth but has an abrupt change in its direction. The occurrence of an abrupt change is quantitative discontinuity. Qualitative Change The second

aspect of change that Werner specifies is the qualitative one. Here we are primarily concerned not with how much of something exists but with what exists—what kind or type of thing exists. Thus, we are concerned with whether or not a new quality has come to characterize an organism, whether something new has emerged in development. When we are considering qualitative change we are dealing with epigenesis, or emergence. In distinguishing between quantitative and qualitative aspects of change, Werner highlights a core conception of the organismic position. Some of the types of changes that comprise development are emergent changes. These are changes in what exists rather than in how much of something exists. Something new comes about in development, and because it is new—because it is qualitatively different from what went before—it cannot be reduced to what went before. Hence, if at time 1 we can be represented by 10 oranges and at time 2 we can be represented by a motorcycle, we cannot reduce our time 2 motorcycle status to our time 1 orange status. To take another example, before puberty a person may be characterized as being in part composed of several drives—for example, a hunger drive, a thirst drive, a drive to avoid pain, and perhaps a curiosity drive. With puberty, however, a new drive emerges or, at least, emerges in a mature form—the sex drive. The emergence of this new drive is an instance of qualitative discontinuity. The sex drive cannot be reduced to hunger and thirst drives, for instance. Hence, qualitative changes are by their very nature discontinuous. A qualitative, emergent, epigenetic change is always an instance of discontinuity. Moreover, not only is an emergent change an irreducible change, but it is a change characterized by gappiness. As indicated above, developmental gappiness occurs when there is a lack of an intermediate level between earlier and later levels of development. It should be clear that gappiness must also be a part of an emergent change. The presence of an intermediate step between what exists at time 1 and the new quality that emerges at time 2 would suggest that the new quality at time 2 could be reduced through reference to the intermediate step. Since we have just seen that an emergent change is defined in terms of its developmental irreducibility to what went before, it is clear that gappiness must also be a characteristic of any emergence. Thus, to quote Heinz Werner: It seems that discontinuity in terms of qualitative changes can be best defined by two characteristics: Quantitative discontinuity on the other hand, appears to be sufficiently defined by the second characteristic. Identity and the life-cycle. *Psychological Issues*, 1, 18—Prenatal roots of instinctive behavior. Concepts and theories of human development 3rd. Intellectual evolution from adolescence to adulthood. *Human Development*, 15, 1—The concept of development from a comparative and organismic point of view. University of Minnesota Press.

6: Child development - Wikipedia

Change and continuity in infancy. New York: Wiley, p. [Department of Psychology, Harvard University, Cambridge, MA] the research summarized in *Change and*.

Hamilton This study reports relations between infant Ainsworth Strange Situation classifications, negative life events, and Adolescent Attachment Interview classifications. Chi-square analyses indicate that negative life events are significantly related to change in attachment classification. There were no differences between adolescents reared in conventional or nonconventional families in the distribution of adolescent attachment security, the experience of negative life events, or the continuity of attachment from infancy through adolescence. It extends our understanding of attachment by exploring continuity beyond childhood in adolescents who have been reared in both conventional and nonconventional family contexts. By studying attachment in this group we can examine how attachment functions within a broader definition of family and family life. The FLS families at the beginning of the project were evenly distributed across five major lifestyles: The project is currently directed by Thomas S. This is one of three long-term longitudinal studies assessing infant attachment. General Introduction," for an overall view of study design, measures, and supporting references. Generally it is assumed that attachment should remain stable over time. Various models may account for this stability. Bowlby proposed that infants in their development of attachment relationships also form internal working models of themselves and the social world. Although change in this internal working model is possible, over the course of early childhood the internal working model becomes less flexible and consciously accessible and so may be less susceptible to change. These two models are difficult to isolate in the real world and are not directly tested in the current study. However, the study does examine environmental circumstances that might support or disrupt attachment continuity. In this study, these factors are more likely to occur in the families with nonconventional lifestyles. Although potential risk factors associated with nonconventional lifestyles did not seem to influence initial infant attachment security, these potential risks may have a greater impact on the continuity of attachment over time. Nonetheless, changes in family circumstances occurred at a much higher rate in nonconventional families than would be expected in more traditional families with young children. Throughout their early childhoods, children in the nonconventional families experienced more frequent changes in family composition. These patterns of instability in family configuration persisted throughout childhood. Financial stresses were also more prevalent in nonconventional families; overall household income was lower and less predictable than that found in conventional families. Elevated life stresses and changes in family circumstances may pose challenges for children as they develop. Although no differences due to family lifestyle were found in early childhood across a variety of cognitive, physical, or socioemotional outcomes in the FLS Project Weisner, some differences did begin to emerge as children entered school. This study examines the continuity of attachment from infancy through adolescence in a sample of families many of whom were actively experimenting with family lifestyles and social roles. This study also examines the influence of negative life events by using the common events identified by Waters, Hamilton, and Welnfield as well as extended maternal-child separations and parental drug use. These two events have particular relevance to this sample. Some of the communal families featured periods of maternal-child separation as part of their structure. Parental drug use has been more frequent among the nonconventional parents and does seem to have some negative effect on child outcomes. The adolescent follow-up of these families was primarily based on mailed questionnaires and surveys. Limited resources were available to conduct the in-depth interviews required for the administration of the Adult Attachment Interview AAI, therefore, a subsample of the FLS adolescents was selected. Three strategies for subsampling were considered: The third strategy was used to ensure that the less frequently occurring insecure classifications were represented adequately in the analyses. Families were contacted by mail as part of the larger follow up of FLS families that was in progress. Forty-nine adolescents within the full FLS sample had insecure infant attachment classifications. Twenty-nine of those adolescents were inaccessible because of family relocation outside of the project location. Twenty adolescents with insecure infant

attachment classifications 6 with resistant classifications and 14 with avoidant classifications were targeted for inclusion in the current study. Two families were not located. Twelve adolescents with avoidant infant attachment classifications and 6 adolescents with resistant infant attachment classifications were included in the final subsample. Twelve adolescents with secure infant attachment classifications were also included. In contacting the adolescents with secure attachment histories, four adolescents initially identified for inclusion in the subsample were subsequently excluded and replaced. In two of these families the adolescent was attending college outside of the geographical area, one family declined to participate, and the fourth family and adolescent, although agreeable, proved difficult to schedule. Although in the full sample there was no association between family lifestyle group and infant attachment classification, in the subsample infant insecurity in the subsample was significantly associated with conventional lifestyles. At the adolescent follow-up, family organization included 14 two-parent married couples including one lesbian couple and two stepparent families, 15 single parents including two fathers and one communal group both biological parents, now divorced, and with new partners were present in the household. Reliability was initially established through pilot samples and careful and systematic training of raters. Reliability was assessed periodically throughout the data collection and differences were resolved by consensus see Bernstein et al. The negative life events were those identified in Waters et al. Two additional negative life events were included because of the particular nature of this sample: Results did not differ from those conducted with the full sample. The full case history of each adolescent was reviewed and the presence of each discrete negative life event was noted. The presence or absence of negative life events was unambiguous and all coding was done by the author. All interviews were audiotaped and later transcribed for analysis. The author, trained by Mary Main and Erik Hesse, scored the transcripts in accordance with the procedures developed by Main and Goldwyn. The second rater was trained by the author; in all cases the scores of the more experienced rater were used. Nine adolescents were classified as secure and 21 as insecure 13 Dismissing and 8 Preoccupied. No adolescent received a primary Unresolved classification. Table 1 contains the crosstabulation of infant and adolescent attachment classification. Sixteen of the adolescents classified as insecure in infancy were also classified as insecure in adolescence. Seven adolescents remained secure.

7: Formats and Editions of Change and continuity in infancy [www.enganchecubano.com]

The continuity of attachment security from infancy into young adulthood was consistently moderated by OXTR genetic variation. Infant attachment security predicted the security of adults' general and romantic attachment representations only for individuals with the OXTR G/G genotype.

This is despite the fact that about half of children under age three regularly receive child care from someone other than a parent. And we know from research that high-quality care beginning from birth can improve developmental outcomes for children and help close gaps in educational achievement. A recent research brief written jointly by members of the Network of Infant Toddler Researchers and the Quality Initiatives Research and Evaluation Consortium, focuses on practices that child care centers can adopt in order to develop and support caring relationships between young children and their caregivers. Receiving sensitive, responsive caregiving is linked to positive cognitive and behavioral outcomes later in life, including for babies deemed at-risk based on early neurodevelopmental screening. Research also suggests that babies who experience a close, secure attachment to their caregivers are more likely to have the confidence necessary to explore their surroundings and gain experiences that aid future learning. The research brief focuses specifically on two relationship-based care practices that child care centers should make a priority: Primary caregiving is the act of having one teacher bear the primary responsibility of caring for a small group of three to four children within a larger group setting. Under this model, rather than having a rotating set of caregivers throughout the week, children receive the majority of their care from just one adult, allowing for the formation of close, secure attachments between child and adult. The primary caregiver is responsible for feeding, diapering, and helping children get to sleep at least 75 percent of the time. The primary caregiver also serves as the main point-of-contact with the parents of his or her small group of kids, allowing for trusting relationships to develop between parent and caregiver as well. In order to enable children to receive the majority of their care from the same adult, child care centers organize staff schedules in ways that prioritize primary caregiving. For example, primary caregivers are sure to begin the week with their small group of children in order to provide an easier transition from the weekend. On the fifth day, a designated secondary caregiver takes over, ensuring that children do not experience a change in caregivers on any one day. Studies show that young children who experience multiple caregivers or child care settings in the course of a day are more likely to have behavioral problems. Closely related to the idea of primary caregiving is the second relationship-based practice covered in the brief: Continuity of care is the practice of keeping young children and their caregivers together for an extended period of time, ideally up to 36 months of age. This differs from the traditional practice of moving a child to a new caregiver and classroom once he or she has a birthday. Under a continuity of care model, children have the same caregiver from infancy all the way to age three. Once the children reach age three, the caregiver loops back to the infant room and starts again with a new group of children. Just as in primary caregiving, the emphasis is on having a consistent caregiver with whom young children can form a long-lasting, secure attachment, as opposed to a rotating cast of adults who provide care. Research suggests that children who change caregivers before 24 months of age are likely to be less securely attached and more aggressive compared to children who experienced a consistent caregiver. Both primary caregiving and the importance of continuity of care are referenced in the Early Head Start Performance Standards. But while research backs the importance of primary caregiving and continuity of care in child care settings, studies suggest that few centers currently implement these practices. There are a few reasons for this. It can be difficult for child care centers to provide children with the same caregiver from infancy to 36 months of age when employee turnover is often high. There can also be staff resistance to the idea of changing routines and procedures that have been in place for many years. The brief points out that implementing relationship-based care practices is not something that is done once and then forgotten about. Rather, increasing focus on the quality of the caregiver-child relationship is a continual process that requires updates to professional development, policies, and procedures in order to communicate to parents and staff the importance of shifting towards a model that values continuity of care. States can incentivize relationship-based care practices by

implementing lower child to staff ratios at higher levels of their QRIS or providing other supports to programs that choose to implement ratios lower than state regulations. States can choose to increase subsidy rates to centers offering lower child to staff ratios. These extra funds could enable center directors to increase worker compensation, possibly leading to lower rates of staff turnover. There is also a need for continual professional development for center directors and staff about best practices for implementing relationship-based care practices. Science increasingly tells us this is also true for infants and toddlers.

8: Primary Caregiving and Continuity of Care – ZERO TO THREE

Abstract. Although change is as common as continuity in morphological or psychological development, the psychologist is particularly friendly to the latter idea and assumes, unless shown otherwise, that the psychological structures formed by early experience remain untransformed.

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