E

EARLY INTERVENTION

Early intervention (EI) is best seen as a system of multidisciplinary services designed to support those family interactions that enhance optimal development of children ages birth to three years. The benefits of such a system include remediating existing developmental difficulties, preventing the future effect of these difficulties, alleviating potential delays, limiting the development of additional handicaps, and promoting improved family functioning. These goals are accomplished by providing a wide array of therapeutic and developmental services for children, coupled with instruction and support for families. EI serves children with difficulties deriving from established disabilities (Down syndrome, autism, visual/aural impairments, etc), as well as environmental risks (disadvantaged families, maltreating parents, low-birth-weight child).

The history of EI is closely tied to federal legislation for special education services. With the passage of Public Law 94–142, Public Law 99–457, and subsequent legislation, and the implementation of the Individuals With Disabilities Education Act (IDEA), educators were made more aware of the special needs of infants, toddlers, and their families. Part C of IDEA (Program for Infants and Toddlers with Disabilities) is a federal grant program that aids in establishing and overseeing a comprehensive program of EI services for children birth to 36 months of age. Each individual state is responsible for creating a comprehensive early intervention system. One part of this system is the establishment of a comprehensive Child Find System. This system is a continuous process planned to locate, identify, and refer young children with disabilities to intervention services. The system also includes activities to increase public awareness of available services, and screening and evaluation of eligible children.

Originally, all programs were child-centered, with parents only playing peripheral roles. First the child was assessed for specific handicapping conditions, and then assigned to a multidisciplinary team of service providers including, but not limited to educators, social service personnel, speech and language clinicians, occupational and physical therapists, psychologists, and nurses. The parents were responsible for keeping all appointments and for continuing remediation programs within the home. Positive outcomes were seen as the extent to which parents learned and carried out the intervention activities that they were taught.

As a greater understanding was developed between families and service providers, it was realized that the needs of young children could only be truly appreciated in the context of their families. The focus of EI then shifted from the child as a single entity to the child within the family and the family within a total social context. Children's development is now viewed as being closely related to the environment within which the child is developing, namely, the family. As the family influences the development of the child, so does the child shape the development and dynamics of the family. Present models of EI are family-centered with emphasis on the family's strengths rather than deficits.

Cultural traditions play a very strong role in all family interactions; therefore, this role cannot be ignored within the context of the EI program. Cultural views of disabilities are extremely varied, and the parents' view of what constitutes an area that is acceptable for change and what is not can be difficult to understand before first considering cultural views. For example, within the rigid hierarchical structure of some societies, the deference that is paid to experts can easily be mistaken for trust. Parents may acquiesce to the recommendations of experts within the context of the conference, but may not follow through with activities that are dissonant with their cultural beliefs. By understanding the cultural background of the child's family, EI professionals can better design programs that will be helpful and acceptable to both child and family.

From a service provision standpoint, early intervention seeks to integrate a large range of services within a variety of settings and coordinates those services in a way that conflicts are minimized between service providers. Children experiencing difficulties because of poor parent–child interactions may be best helped through a clinic-based system; while children dealing with more environmental difficulties, such as poverty, may be best served by a community-based program. Hospital-based programs usually supervise interventions for children born with severe handicapping conditions. Home-based programs help parents and children through professional visits to the family's home environment.

Programming and services for each individual child are created on a developmental basis. Whether a child is an infant or a toddler, the services are based on the child's developmental needs rather than age level. Services for the family are also based on need rather than age level of the child.

The effectiveness of early intervention programs is a difficult question to answer. According to policy makers and individual parents, a quick consensus can be reached that early intervention does make a difference. Any of these stakeholders can cite particular instances where services have made a world of difference for the families and children involved. From a scientific standpoint, the answer becomes a little less clear. Significant methodological difficulties in many studies that sought to answer this question only pose additional questions. Most studies were completed when early intervention services were first instituted. Children receiving the "new" intervention services were compared to children receiving no services whatever, creating a huge positive effect for the new EI services. While subsequent studies have been mainly focused on one particular area of disability (i.e., hearing impaired), making global conclusion difficult, aggregated results have shown overwhelmingly that EI does make a difference in children's lives.

Early intervention has been seen as the best hope for the future of children facing challenging handicaps to learning. EI programs work with children in the context of their family rather than as a separate entity that needs adjustment, thus helping the family as well as the child. While programs vary greatly in the delivery of services, all programs integrate a variety of professionals in the task of improving the lives of at-risk children and their families. Through EI, the devastating effects of handicapping, or potentially handicapping situations, can be addressed.

—Martha Carlton

See also Autism Spectrum Disorders; Head Start

Point Versus Counterpoint: Early Intervention

The case for:

- It targets environmentally vulnerable children.
- It is most promising when programs are based upon structured curriculum and target parents as well as children.
- The focus is on the needs of the entire family.
- It is based in local communities.
- Various agencies successfully plan and coordinate supports and services together.
- It prevents declines in intellectual development for children with developmental delays.

- It may reduce family stress.
- It often lessens the necessity for special education services later in the child's educational future.

The case against:

- Gains made with developmentally delayed children tend to be limited.
- Service providers are more child-centered and find it difficult to work with and through families.
- Most programs do not meet the needs of historically underrepresented populations.
- There is often a lack of coordination of services.
- Some treatments are extremely expensive and time intensive.
- Some well-known therapeutic practices (such as sensory integration and patterning) have not proved to be effective in valid research studies.
- Multiple services often are not integrated and cause conflict or confusion for families.
- Programs focused on case management and parent education were not effective in improving the developmental outcomes of low-income children.

For further information see:

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REFERENCES AND FURTHER READING

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EATING DISORDERS

Eating disorders are emotional problems characterized by an obsession with food and weight. These disorders start with a preoccupation with food and weight and then escalate into an emotional dysfunction that is characterized by an obsession with food and weight. This obsession first involves secrecy, where the person with the eating disorder tries to hide the problem by possibly avoiding social situations involving food and may eat alone in order to hide the quantity of food eaten. The obsession also involves control. People with eating disorders may feel that they have no control over their life, so they gain control through restriction *of* food. However, this control is short lived because they then lose control *to* food (http://www.nationaleatingdisorders.org). These disorders can result in death if not taken seriously. Eating disorders fit into three categories: anorexia nervosa, bulimia nervosa, and binge eating.

ANOREXIA NERVOSA

Anorexia nervosa is the most serious and life-threatening eating disorder, with an estimated mortality rate of 10%, and affects approximately 1% of all females. The onset of this disorder is usually in adolescence. According to the *Diagnostic and Statistical Manual, Fourth Edition-Text Revision (DSM-IV-TR)* (American Psychiatric Association, 2000), anorexia nervosa is diagnosed if the following characteristics are present:

- A refusal to maintain minimal normal body weight for age
- An intense fear of gaining weight or becoming fat
- Feeling fat even when obviously underweight
- Amenorrhea (i.e., cessation of the menstrual cycle)

The *DSM-IV-TR* distinguishes between two subtypes of anorexia nervosa: the restricting type and the binge eating-purging type. Individuals diagnosed with anorexia nervosa-restricted type limit and/or avoid eating foods (e.g., foods containing fat) and may exercise excessively to lose weight. Those diagnosed with the binge eating-purging type exhibit the same bingeing and purging behaviors as bulimics; they consume