Specialized and updated training on supporting advanced technologies for early childhood education and care professionals and graduates

MODULE I.1

Introduction to the Concept of Early Intervention and Intervention in Different Contexts

Professor:

Dra. María del Camino Escolar Llamazares
Departments of Education Sciences
University of Burgos

e-EarlyCare-T

"Specialized and updated training on supporting advanced technologies for early childhood education and care professionals and graduates", e-EarlyCare-T, reference 2021-1-ES01-KA220-SCH-000032661, is co-financed by the European Union's Erasmus+ programme, line KA220 Strategic Partnerships Scholar associations. The content of the publication is the sole responsibility of the authors. Neither the European Commission nor the Spanish Service for the Internationalization of Education (SEPIE) is responsible for the use that may be made of the information disseminated herein."

Table of Contents

I. INTRODUCTION **5**

II. OBJETIVES **5**

III. THEME-SPECIFIC CONTENT **6**

1. THE CONCEPT OF EARLY STIMULATION **6**

1.1. CHILD DEVELOPMENT **6**

1.2. DEVELOPMENTAL DISORDERS **7**

2. OBJECTIVES OF EARLY STIMULATION **7**

3. APPLICATION OF EARLY STIMULATION IN INTERDISCIPLINARY CONTEXTS (FIELDS OF ACTION) **8**

3.1. INTERVENTION LEVELS **8**

3.1.1. Primary Prevention in Early Care 8

3.1.2. Secondary Prevention in Early Care 9

3.1.2.2. Diagnosis 10

3.1.3 Tertiary Prevention 11

3.2. MAIN AREAS OF ACTION **12**

3.2.1. Child Development and Early Care Centers (CDIAT) 12

3.2.1.1. Primary and Secondary Prevention 12

3.2.1.2. Tertiary Prevention 12

3.2.2. Health Services 14

3.2.3. Social services 16

3.2.4. Educational services 16

4. TARGET GROUP OF EARLY CHILD CARE 17

5. CONCLUSIONS 18

RESUME 19

GLOSSARY 20

BIBLIOGRAPHY 21

BASIC BIBLIOGRAPHY MODULE 23

RESOURCES 23

BY NC SA

I. Introduction

Child development is a dynamic, complex process, based on biological, psychological and social development. The first years of life are a critical stage, in which perceptual, motor, cognitive, linguistic, affective and social skills are shaped. These skills will enable balanced interaction with the environment (Gómez Artiga y Viguer Seguí, 2007; Grupo de Atención Temprana-GAT, 2005).

Early Care (EC), based on the scientific principles of Paediatrics, Neurology, Psychology, Psychiatry, Pedagogy, Physiotherapy, Linguistics, etc., aims to offer children with deficits or who are at risk a set of optimizing and compensating actions. These actions will facilitate proper maturation in all areas and will allow children to reach the highest level of personal development and social integration. In this sense, Early Intervention is part of a comprehensive process whose objective is the harmonious development of children integrated into their environment. (GAT, 2005; Serra Desfilis, 2007).

We know that the first years of life are crucial for proper biological, psychological and social development (Alonso, 1997; San Salvador, 1998). Hence, the importance of understanding development at this stage, especially when there are signs of congenital, metabolic, maturational or other disorders or possible risk of them. In fact, early care and intervention improves the chances of biopsychosocial development. It is essential to work from a multidisciplinary perspective, with the belief that children with any type of deficit can develop a useful life and integrate into society (Candel, 2005; Pons, 2007; Robles-Bello & Sánchez-Teruel, 2013)

Since TA is based on prevention, we can relate it to primary, secondary and tertiary prevention (which will be analyzed in depth in the following sections):

- **Primary prevention** in EC acts on subjects at "high risk" of suffering from a deficit, even though they have not yet shown symptoms or have not been diagnosed. These &are universal measures, aimed at the entire population to protect health.

- **Secondary prevention**, acts to avoid what may cause the appearance of a disorder or deficit, reducing its progression and duration or mitigating its effects. The ultimate goal is reducing a disease in the population. EC attempts to detect diseases, disorders or risk situations early (Robles-Bello and Sánchez-Teruel, 2013).

- **Tertiary prevention** aims to reduce the incidence of chronic disabilities in a population, trying to minimize disability caused by disease. EC directs its actions to minimize the consequences of a deficit or disease once diagnosed. In addition, it tries to reduce the consequences of children’s metabolic, neurological, genetic or developmental disorders or pathologies (Robles-Bello and Sánchez-Teruel, 2013).

Consequently, EC is an effective strategy for preventing or compensating for the effects of any type of deficit (developmental, biological or social) early in a child's life. (Robles-Bello & Sánchez-Teruel, 2013).

II. Objetives

Understand the general characteristics of early care and its application to different fields of action, as well as to different groups.

III. Theme-specific content

1. THE CONCEPT OF EARLY STIMULATION

According to the White Paper on Early Intervention (Group of Early Intervention-GAT, 2005, p. 14): *Early Attention is understood as the set of interventions aimed at the child population aged 0-6, the family and the environment, which aim to respond as soon as possible to the temporary or permanent needs presented by children with disorders in their development or who are at risk of developing them. These interventions, which must consider the child as a whole, must be planned by a team of professionals with an interdisciplinary or transdisciplinary orientation.* (Robles-Bello & Sánchez-Teruel, 2013).

In the 1990s, the current concept of Early Intervention emerged, agreed by different professionals and reflected in the work of GAT (2005). This work is a reference for all sectors involved in EC: associations, professionals, institutions, researchers and family members, among others (Gómez Artiga & Viguer Seguí, 2007; Robles-Bello & Sánchez-Teruel, 2013).

According to Candel (2005), EC should not be understood as a treatment aimed at children, but as a series of actions aimed at children, the family and the community in general. Given the cerebral plasticity of the nervous system (GAT, 2005), the maturation process of the brain does not end with birth, but continues to develop for a while, and is also susceptible to modification (Gútiez, 2005; Robles-Bello & Sánchez-Teruel, 2013).

1.1. CHILD DEVELOPMENT

Child development in early years is characterized by the progressive acquisition of such important functions as postural control, movement autonomy, communication, verbal language, and social interaction. This development is linked to the maturation process of the nervous system, already initiated in utero, and to emotional and mental organization. It requires adequate genetic structure and satisfaction of the basic human needs at a biological and psycho-affective level. (GAT, 2005; Serra Desfilis, 2007).

Child development is the result of the interaction between genetic factors and environmental factors:

- **The genetic base**, specific to each person, establishes their own development capacities and so far, impossible to modify.

- **Environmental factors** modulate and even determine the possibility of expression or latency of some of the genetic characteristics. These factors are *biological, psychological and social*: A) *Biological environmental factors*: maintenance of homeostasis, health status, absence of factors of aggression to the Nervous System (NS)... Necessary conditions for adequate maturation. B) *Environmental factors of a psychological and social order*: children’s interaction with their environment, emotional bonds, the perception of everything around them (people, images, sounds, movement...). These conditions, which are basic needs of human beings, are decisive in emotional development, communicative functions, adaptive behaviors and in attitudes towards learning (GAT, 2005; Serra Desfilis, 2007).

In early childhood, the nervous system is in a stage of maturation and notable plasticity. Because it is maturing, there is greater vulnerability to adverse environmental conditions and harms. Therefore, anything affecting the acquisition of the first developmental milestones can endanger subsequent development. However, plasticity also

BY NC SA

gives the Nervous System greater capacity for recovery and organic and functional reorganization, which decreases in later years (GAT, 2005; Serra Desfilis, 2007).

The progression of children with alterations in their development will depend to a large extent on the date of detection and the point when Early Intervention begins. The shorter the stimulus deprivation time, the better the brain plasticity and the shorter the delay. In this process, family involvement is crucial for affective and emotional interaction, as well as for effective treatments (GAT, 2005; Serra Desfilis, 2007).

1.2. DEVELOPMENTAL DISORDERS

Development is the dynamic process of interaction between the organism and the environment that results in the organic and functional maturation of the nervous system, the development of psychological function and structuring personality. Developmental disorder is a significant deviation from the normal course of development resulting from health or relationship events that compromise biological, psychological or social development. Some developmental delays can be compensated for or neutralized spontaneously, and it is often the intervention that determines the transience of the disorder (GAT, 2005; Serra Desfilis, 2007).

The main risks are biological and social. Children who, during pre, peri or postnatal periods, or during early development, have been subjected to situations that could affect their maturation process, such as prematurity, low birth weight or anoxia at birth, are considered to be at biological risk. Children at *Psychosocial risk* are those who live in unfavorable social conditions, such as lack of care or inadequate interactions with parents and family, mistreatment, neglect, or abuse, which can affect their maturation (GAT, 2005; Serra Desfilis, 2007).

2. OBJECTIVES OF EARLY STIMULATION

The main objective of EC is to promote children and their family’s development and well-being, enabling their integration into the family, school and social environment, as well as personal autonomy (Candel, 2005). Consequently, it works on areas such as cognitive, autonomy, language or communication, and motor skills (Federación Estatal de Asociaciones de Profesionales de Atención Temprana –FEAPAPT-, 2008; GAT, 2005; Robles-Bello & Sánchez-Teruel, 2013).

Early Attention must reach all children who present any type of disorder or alteration in their development, be it physical, mental or sensory, or who are in a situation of biological or social risk. All actions and interventions in early care must consider not only the child, but also the family and their environment (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007; Serra Desfilis, 2007; Viger Seguí & Gómez Artiga, 2007).

he following set of objectives specific to Early Intervention emerges from this framework: 1. Reduce the effects of a deficiency or deficit on the overall development of the child; 2. Optimize, as much as possible, the course of the child's development; 3. Introduce any required compensation mechanisms, eliminate barriers and adapt to specific needs; 4. Avoid or reduce the appearance of secondary or associated effects or deficits produced by a high-risk disorder or situation; 5. Meet the needs and requirements of the family and the environment the child lives in; 6. Consider the child as an active subject of the intervention (GAT, 2005).

3. APPLICATION OF EARLY STIMULATION IN INTERDISCIPLINARY CONTEXTS (FIELDS OF ACTION)

When planning the intervention, the point in the child's development and their needs must be considered in all areas, not only the deficit or disability that may present. In Early Intervention, the child must be considered as a whole, taking into account intrapersonal, biological, psychosocial and educational aspects specific to each individual, as well as the interpersonal aspects related to their own environment, family, school, culture and social context (GAT, 2005; iger Seguí & Gómez Artiga, 2007).

Consequently, intervention covers a set of actions aimed at the population from 0 to 6 years old, but also at the family and the community. There are numerous scientific disciplines that support the theoretical basis of EC, such as Neurology, Developmental and Learning Psychology, Pediatrics, Psychiatry, Pedagogy, Physiotherapy, Speech Therapy, among others (De Linares & Rodríguez, 2004; Robles-Bello & Sánchez-Teruel, 2013; Viger Seguí & Gómez Artiga, 2007).

The effectiveness of EC programs is based on the earliness of the intervention, which depends on early diagnosis of problems. This diagnosis allows children to start work early, and the earlier, the more effective that work will be, since the ability to assimilate and integrate new experiences is much greater in early stages of development (Pérez-López & Brito, 2004). The disciplines on which EC is based provide children—suffering from deficits or at risk of suffering from deficits—with a set of organized and planned actions that facilitate their maturation in all areas, allowing them to reach the highest level of development and social integration (Quirós, 2009; Robles-Bello & Sánchez-Teruel, 2013).

The main objectives of intervention are: preventive measures, early detection, and intervention focused on maximum development of physical, mental and social faculties in diagnosed children (Robles-Bello & Sánchez-Teruel, 2013).

3.1. INTERVENTION LEVELS

The biopsychosocial model of Early Intervention leads to the need to establish relationships with the programs and services that act in the context of children and their families. There are three levels on which this collaboration should be based (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007): primary, secondary and tertiary prevention in EC.

3.1.1. Primary Prevention in Early Care

Primary prevention in health are the actions and health protection aimed at the well-being of children and their families. They are universal measures for the entire population, including rights such as health care, maternity leave and fostering or adoption. At this level Early Intervention is responsible for identifying and communicating to social institutions, circumstances that may be relevant to creating norms or universal rights in the promotion and protection of child development. A primary prevention measure of Early Intervention is that it is universal, free, and early (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007).

Primary prevention of child development disorders aims to prevent conditions that can lead to deficiencies or disorders in child development. The competent services in these actions are primarily Health, Social Services and Education (GAT, 2005, 2011):

- Health services are responsible for: family planning programs, care of pregnant women, maternal and child health, detection of metabolic disorders and vaccinations, information on risk factors and their prevention, primary pediatric care and hospital and healthcare actions in general. Pediatric services in Primary Care—used by the entire child

CC BY NC SA

population from birth to 14 or 18 years of age—are important in the prevention of developmental disorders. Child Mental Health services are important in primary prevention, collaborating with health and family planning teams in maternal and child programs, to avoid high-risk situations. (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007; Serra Desfilis, 2007; Viger Seguí & Gómez Artiga, 2007).

- *Social services are responsible for:* interventions aimed at preventing situations of social risk and child abuse. Social Services activity is part of the task of caring for the family. Social Services also intervene in the prevention of child developmental disorders, through programs aimed at high-risk groups due to social conditions, such as teenage mothers, or migrant populations, etc. (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007; Serra Desfilis, 2007; Viger Seguí & Gómez Artiga, 2007).

- *Educational services are responsible for:* actions to support the child and the family from Infant schools. These schools do essential work in the prevention of developmental disorders for high-risk populations. They offer a stable and stimulating environment to a sector of the child population that often suffers from adverse conditions in the family (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007; Serra Desfilis, 2007; Viger Seguí & Gómez Artiga, 2007).

3.1.2. Secondary Prevention in Early Care

Secondary prevention in health is based on the early detection of diseases, disorders, or high-risk situations. It is implemented through special programs aimed at groups identified as being at risk, such as premature infants born at less than 32 weeks or less than 1,500 grams; family units with adolescent pregnancies under 18 years of age, at risk of relational dysfunction; family units with pregnancies from the age of 35, with risk of chromosomal abnormalities; children with spastic tetraplegia and risk of hip dislocation (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007).

3.1.2.1. Detection

Detecting possible alterations in child development is a fundamental aspect of Early Intervention insofar as it enables community action mechanisms to be implemented. The sooner detection is achieved, the greater the assurance of preventing additional pathologies, achieving functional improvements, and enabling more adaptive adjustment for children and their environment (GAT, 2005; Serra Desfilis, 2007).

Early detection of disorders in child development is essential for diagnosis and therapeutic care. Early detection is essential to influence a stage in which the plasticity of the nervous system is at its heigh, and the therapeutic possibilities demonstrate greatest efficacy. Children's developmental disorders need to be detected at the point the first telltale signs appear (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007; Serra Desfilis, 2007).

In the detection of developmental disorders or risk situations we can consider various stages and agents (GAT, 2005):

a) Prenatal Stage Obstetrics Services. Secondary prevention of child development disorders should start in Obstetrics services, with care for pregnant women by health professionals (obstetricians and midwives). These professionals are responsible for detecting risk situations and providing information, support, and guidance for mothers-to-be (GAT, 2005; Gómez Artiga GAT, 2005 Viguer Seguí, 2007; Serra Desfilis, 2007).

CC BY NC SA

b) Perinatal stage Neonatology Services. Children at high risk of presenting deficiencies, disorders or alterations in development due to certain genetic conditions and adverse situations in the biological or organic sphere receive care in Neonatology units or services: intrauterine infections, low weight, hypoxia, cerebral hemorrhages, postnatal infections. When there are signs compatible with a developmental disorder, appropriate therapeutic measures are put in place, always tailored to the child's situation (GAT, 2005; Gómez Artiga GAT, 2005 Viguer Seguí, 2007; Serra Desfilis, 2007).

c) Postnatal stage Pediatric Services. The pediatric team is the main agent of early detection through regular visits to the child in the first years of life and healthy child control programs. **Direct observation** of children and information provided by parents allows confirmation of normal child development or suspected deviation from it. This level of detection is essential, since children with serious developmental problems often have a history of pre- or perinatal pathology and there are often specific follow-up programs that they should attend. Detection in these cases should be within the framework of regular pediatric consultation (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007; Serra Desfilis, 2007; Saiz Manzanares & Escolar-Llamazares, 2013; Saiz Manzanares et al., 2019; Sarriá Sanchez, 2010).

d) Educational services. Nursery school, teachers and educators are important agents of detection. At this stage, problems can be seen in the basic abilities and behaviors for learning: motor skills, socialization, language, attentional and perceptive difficulties and cognitive or emotional limitations, which have not been detected previously. The conditions of the Nursery School and the interactions that occur in the school context, differ from those in the family environment, and reveal the presence of deviations in the developmental process, imbalances in children’s psycho-affective development or alterations in behavior. These deviations can easily go unnoticed by parents and by health personnel and may not detected until the child accesses the educational context (GAT, 2005; Gómez Artiga GAT, 2005 Viguer Seguí, 2007; Serra Desfilis, 2007).

When teachers detect a possible disorder, they communicate their concern to the family. Based on the data provided by the school and family environment, coordinated observation and *action guidelines* should be established, along with referral to a pediatrician and the Early Care Center. The goal is to establish a complete diagnosis and initiate appropriate therapeutic intervention (GAT, 2005; Sarriá Sánchez & Brioso Díez, 2010; Saiz Manzanares & Escolar-Llamazares, 2013; Saiz Manzanares et al., 2019; Sarriá Sanchez, 2010).

e) The family environment. The family environment is an important means of detection, since it is often the parents, in daily interaction in their natural context, who notice deviations between their child's and other children’s behavior. Greater care and information for parents would facilitate early detection of developmental disorders (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007; Serra Desfilis, 2007).

f) Social Services. Due to their relationship with families with psycho-social problems and with the community in general, they are in a very good position to detect social risk factors in child development, such as situations of very low family income, teenage mothers, drug addiction, social marginalization of the family etc. (GAT, 2005).

3.1.2.2. Diagnosis

Diagnosis consists of finding evidence of an alteration in development, as well as the knowledge of its causes, allowing the beginning of appropriate therapeutic intervention. Given the suspicion of a disorder in child development, it is essential to propose a broad diagnosis, which considers different areas and levels. The problem in most cases is not

cc by nc sa

confined to a single aspect. It usually affects different areas and has a multifactorial origin: interaction of genetic factors, health aspects, psycho-affective care and environmental conditions in general (GAT, 2005; Viger Seguí & Gómez Artiga, 2007).

Diagnosis in Early Intervention must address the biological, psychological, social and educational fields, requiring collaboration of professionals from various disciplines: medicine, psychology, pedagogy and social sciences.

iagnosis of developmental disorders considers three diagnostic levels: functional, syndromic and etiological:

1.) Functional diagnosis. Qualitatively and quantitatively determine disorders or dysfunctions. It constitutes the basic information for understanding the child's problems, considering family interaction and that of their cultural environment, their capacities and the possibility of developing them. A functional diagnosis is essential for producing intervention objectives and strategies.

2.) Syndromic diagnosis. This is a set of signs and symptoms that define a certain pathological entity. The identification of a syndrome allows us to determine the structures (neurological, psychic or social) responsible for the disorder and provides guidance on its etiology. Syndromic diagnosis guides us towards the areas where we need more nformation to establish the etiological diagnosis. It also helps to establish whether it is a stable, transitory or evolutionary pathology, with a predominantly organic or environmental basis.

3.) Etiological diagnosis reports on the causes—of a biological or psycho-social nature—of the functional disorders or of the identified syndrome (GAT, 2005; Viger Seguí and Gómez Artiga, 2007).

In all cases, an attempt is made to establish the etiology of the different disorders identified, always considering their probable multifactorial nature. It is a broad approach that considers biological, psychological, educational and environmental aspects in general (GAT, 2005).

One important issue in Early Intervention is the communication of diagnostic information to parents in a risk situation, or in the probable presence of a developmental disorder in their child. This information produces an emotional shock in the parents, with anxiety and anguish, fear, feelings of rejection, and denial. It can often start family arguments. Care is needed throughout this process of giving information and how it is done. Good information makes it easier for the family to understand and assimilate the reality of their child and to adapt their environment to the child's needs (GAT, 2005; iger Seguí & Gómez Artiga, 2007).

The information about the diagnosis of a disorder should always be accompanied by information for the family about therapeutic, social, educational, and economic resources, among other things. Similarly, it is important that parents know how to access resources, as well as the existence of support groups. It is vital to ensure coordination between professionals and institutions and offer support throughout the referral process (GAT, 2005; Serra Desfilis, 2007; Viger Seguí and Gómez Artiga, 2007).

3.1.3 Tertiary Prevention

Tertiary prevention in health, corresponds to actions aimed at remedying situations of biopsychosocial crisis. Examples are the birth of a child with a disability or the appearance of a developmental disorder. EC is responsible for activating a reorganization process, working with children, families, and the environment in which they live. The complexity of

BY NC SA

these situations requires the intervention of a multidisciplinary team (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007).

Tertiary prevention in Early Intervention groups all the activities directed towards children and their environment to improve their developmental conditions. It addresses children, their families, and their environment. It aims to mitigate or overcome developmental disorders or dysfunctions, prevent secondary disorders, and modify risk factors in the child's immediate environment (GAT, 2005; Serra Desfilis, 2007; Viger Seguí & Gómez Artiga, 2007.)

Another fundamental objective of intervention is to ensure that the family knows and understands their child's reality, their abilities, and their limitations. In this way, families can act as agents who improve children's development, modifying their environment to their physical, mental, and social needs, ensuring their well-being, and facilitating their social integration. Intervention needs global, interdisciplinary planning, considering children's abilities and difficulties in the different areas of development and their history and developmental processes. It must also consider the possibilities and needs of the other family members along with the resources available and knowledge and action in the social environment (GAT, 2005; Serra Desfilis, 2007; Viger Seguí & Gómez Artiga, 2007).

3.2. MAIN AREAS OF ACTION

3.2.1. Child Development and Early Care Centers (CDIAT)

CDIATs are autonomous services whose objective is to care for children aged 0-6 who have or are at risk of developmental disorde. Its main objective is to provide the care required by all children who present disorders or dysfunctions in their development, or who are in a situation of biological, psychological, or social risk. The CDIAT model mainly covers the care of children with various pathologies or dysfunctions in their development (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007).

The CDIAT team will be multi-professional, interdisciplinary and holistically oriented, considering that interventions cover *intrapersonal*, biological, psychological, social, and educational aspects that are specific to each individual, along with *interpersonal aspects* related to their own environment, such as family, school and culture. The team will be made up of specialists in Early Intervention from the medical, psychological, educational, and social fields (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007; Viger Seguí & Gómez Artiga, 2007).

3.2.1.1. Primary and Secondary Prevention

The functions of a CDIAT include awareness, prevention, and detection. The Early Intervention Center will collaborate with institutions, patient groups and other professionals in the development of awareness programs for the general population in prevention aspects related to child development (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007; Viger Seguí & Gómez Artiga, 2007).

3.2.1.2. Tertiary Prevention

Interventions will be planned and programmed individually, considering the needs and possibilities of each child in each area of development, the situation, and the possibilities of their family and those of the school environment. The program must include the timing of the objectives, the methodological modality and the evaluation of the proposed objectives or the result of the application of the program. Intervention at the Early Intervention Center begins when a request is received from the family or from any other

BY NC SA

professional or institution. This intervention consists of different moments: initial assessment, therapeutic intervention, follow-up and control, and referral (GAT, 2005; Gómez Artiga Viguer Seguí, 2007; Viger Seguí & Gómez Artiga, 2007):

A) Initial Assessment Process. This involves a comprehensive, in-depth study of the child's development, their individual and family history, and their environment. This requires the collaboration of professionals from different disciplines, as well as the collaboration and coordination of the institutions that originated the case. There are four steps in the initial assessment: 1) Collection of information, 2) Evaluation of the child and their environment, 3) Create diagnostic hypotheses and intervention plan and 4) Return interview with the family (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007; Viger Seguí & Gómez Artiga, 2007).

A1). Information collection. Proper collection of information is the most important element of the diagnostic process and is the instrument that guides the subsequent steps in the evaluation process. Information is gathered through reception, *systematic collection of information,* and the contributions of other professionals (Saiz Manzanares, & Escolar-Llamazares, 2013; Saiz Manzanares et al., 2019; Sarriá Sanchez, 2010).

1.1. Reception is the first contact with the family, in which the professional listens to and collects parents' concerns, memories, projects, expectations, and difficulties about their child. This welcome interview, in addition to being an important initial assessment tool, establishes the first guidelines for the design of the intervention (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007; Serra Desfilis, 2007; Viger Seguí & Gómez Artiga, 2007).

1.2. Systematic collection of information. Based on the information from the reception interview, this is the collection of data that the family has not spontaneously provided, but which necessary for proper understanding of the child's development and point in their development, as well as possible causes of the alteration (GAT, 2005; Saiz Manzanares & Escolar-Llamazares, 2013; Saiz Manzanares et al., 2019; Sarriá Sanchez, 2010).

1.3. Information from other professionals. Information is obtained from other professionals—such as pediatricians, school psychologists, educators, social workers, etc.—through written reports or interviews. The data will be organized into a common history (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007; Serra Desfilis, 2007; Viger Seguí & Gómez Artiga, 2007).

A2). Assessment of the child and their environment. There are various instruments for assessing children and their environments which are used differently for each child, based on the initial hypotheses based on their history: – Observation of spontaneous and reactive behavior to certain presented situations and stimuli; - Relationship with parents and the professional performing the evaluation; – Relationship with other children and with the educator when the child is in school; – Physical examination and neurological and functional assessment of the child; – Standardized tests; – Observation at home; – Complementary exams, specialized consultations. These techniques provide information on the child's general and specific functioning at a physical and emotional level. This information will indicate the possible limitations and deficits presented by the child, along with their abilities and potential (GAT, 2005; Gómez Artiga and Viguer Seguí, 2007; Saiz Manzanares and Escolar-Llamazares, 2013; Saiz Manzanares et al., 2019; Sarria Sanchez, 2010).

A3). Development of diagnostic hypotheses and intervention plan. Once the information collection stage has concluded, each professional will provide the data and conclusions from their evaluations in order to jointly establish—taking into account all the bio-psycho-social factors—diagnoses or diagnostic hypotheses on three levels: functional,

syndromic and etiological. The needs of the child and the family, and existing resources in the community will be established. It is important to establish action priorities, and possible short-, medium- and long-term forecasts. The objectives of the therapeutic intervention will be specified, prioritized, and timed, determining the professional or professionals who will be responsible for each part (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007; Serra Desfilis, 2007; Viger Seguí & Gómez Artiga, 2007).

A4). Return interview. In the return interview we offer the parents the diagnostic information prepared by the team, using appropriate language they can understand. This information should allow them to understand their child's situation, possible future prospects, and the therapeutic means the center can provide (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007; Serra Desfilis, 2007; Viger Seguí & Gómez Artiga, 2007).

B) Therapeutic Intervention. The intervention groups together all the activities aimed at the child and their environment to improve their development conditions. Action areas and the type of intervention will be established based on the child's age, characteristics and needs, the type and degree of disorder, the family, the team itself and possible collaboration with other community resources. The intervention will be planned and programmed globally and individually, with specific guidelines tailored to each child's needs and those of each family in each of the areas of development. The program must include timescales of the objectives, as well as evaluation and how to achieve them (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007; Serra Desfilis, 2007; Viger Seguí & Gómez Artiga, 2007).

C) Evaluation and Monitoring. The evaluation must cover all aspects of the intervention and can be considered in two phases: a) Continuous evaluation, which will allow the program to be adjusted to needs and modified as required; b) Final evaluation, which determines if the objectives set at the beginning of the intervention have been met and that serves to specify whether it is considered complete or if a referral has to be made (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007; Serra Desfilis, 2007; Viger Seguí & Gómez Artiga, 2007).

D) Derivation. The care period of a child in an Early Intervention service ends when they no longer need this Service or, for reasons of age or skills, must continue with care from another source. In both cases, the family has the right to receive information orally and a written report summarizing the child's progress and current situation, as well as the needs that are considered accurate (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007; Serra Desfilis, 2007; Viger Seguí & Gómez Artiga, 2007).

3.2.2. Health Services

a). Obstetric Services. The preventive work of these professionals, basically in primary prevention, is through: Detection and diagnosis of risk factors prior to pregnancy; Care for pregnant women at high biological, psychological or social risk; Childbirth preparation consultations where the future parents are given information about the normal development of the child, as well as about possible warning signs; Detection of possible situations of risk in childbirth and appropriate care; In the case of prenatal diagnosis of deficiency, parents—especially mothers—need preventive psychological care from the beginning, due to potential effects on the mother-child bond (GAT, 2005; Serra Desfilis, 2007; Viger Seguí & Gómez Artiga, 2007).

b). Neonatology Services. In the perinatal environment, we often find children at high risk of presenting deficiencies, based on their immaturity, low birth weight or other hereditary or pre-perinatal factors. Between 10 and 12% of newborns go through a "neo-natal care unit", and between 3% and 5% of newborns are considered to be at psycho-

BY NC SA

neurosensorial risk. This reality makes Neonatology services an important tool for primary prevention. They also do important secondary prevention work by detecting and diagnosing pathological conditions, already established at birth, that are associated with developmental disorders (GAT, 2005; Serra Desfilis, 2007; Viger Seguí & Gómez Artiga, 2007).

c). Pediatrics in Primary Care. These are healthcare professionals who have regular contact with children and their families and are a point of reference for parents. Pediatricians are essential in order to properly detect and refer children for diagnosis, follow-up and to intervention centers. Primary prevention in Pediatrics is through the health controls of the healthy child program. *Detection* is child health examinations, applying objective screening methods and observation methods to detect warning signs of developmental disorders. Observation data offered by the family should be assessed and given particular importance (GAT, 2005; Serra Desfilis, 2007; Saiz Manzanares & Escolar-Llamazares, 2013; Saiz Manzanares et al., 2019; Sarriá Sanchez, 2010).

d). Neuropediatric Services. Neuropadiatrics services intervene in Early Care in various areas: • They act together with Neonatal Unit professionals in terms of detection, diagnosis and therapeutic care required by at-risk newborns; • They participate in development monitoring programs as part of the team caring for children considered to be at high bio-psycho-social risk; • They detect warning signs and diagnose neurological disorders; Neuropediatricians establish functional, syndromic and etiological diagnoses of children with disorders in their development and specifically in organic-based processes (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007; Serra Desfilis, 2007).

e). Children's Rehabilitation Services. Rehabilitation services in Spain have been linked to three types of experiences: 1. Hospital experience, predominated by physical therapeutic actions and treatment of "acute pathologies"; 2. Experience from social services, through personalized programs to respond to the needs of social integration and autonomy of people with disabilities (network of INSERSO Base Centers); 3. Experience from the patient-support-group movement that produced specialized centers for comprehensive, intensive treatment for certain pathologies. For children aged 0 to 6, the teams at the base centers have been a very important part of promoting the Early Stimulation and Early Care programs. Specific patient-support-group centers have often taken the place of centers for the care of children with disabilities, especially from early childhood (GAT, 2005; Serra Desfilis, 2007).

f). Mental Health Services. Professionals in Child Mental Health units are involved at all levels of Early Care. General primary prevention measures from Child Mental Health include: • Coordination and development of programs with other health, educational, social and judicial services; • Collaboration in preventive programs for the detection of psychological risk factors; • Participation in training and coordination programs with other primary care professionals.

Therapeutic intervention in child Mental Health units covers various basic modes of action: • Direct intervention with children individually or in small groups, in cases of severe early psychopathology, basically psychosis, autism, developmental disharmonies... ;• Family interventions in order to make it easier for them to understand children’s disorders, difficulties and the importance of adapting the family environment to their needs; • Coordination activities with other related services and professionals (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007; Serra Desfilis, 2007; Viger Seguí & Gómez Artiga, 2007).

CC BY NC SA

3.2.3. Social services

Considering the importance of the social context and the surrounding conditions in the existence of a deficit in development or in the risk that it may occur, social services have a role and a responsibility both in prevention programs and in detection, diagnosis, and intervention. Social services and their professionals intervene at all levels of primary care. Their action in Early Care is vitally important and is carried out through the promotion of families' social welfare and through prevention and intervention programs (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007).

a). Promotion of the social welfare of families. Early Intervention has contributed to recognizing how important factors such as the following are for child development: affective dedication; economic sufficiency; job stability; stability of family relationships; participation in social networks; and consistency of educational styles. The protection of the first relationships between parents and children must be a social priority. This means a need for more thorough measures that, based on respect for cultural diversity, encourage, train, and help parents in what they do and allow them to balance work and family life (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007; Serra Desfilis, 2007; Viger Seguí & Gómez Artiga, 2007).

b). Prevention programs. Primary prevention can be carried out through interventions (individual or group support) aimed at contexts previously defined as "with social difficulty/risk" as well as through community projects aimed at promoting well-being and comprehensive health in early childhood. Based on social risk indicators, secondary prevention programs aim to detect family situations and environmental and social factors that may influence the appearance of disorders in children's development or put it in at risk (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007).

c). Early intervention programs in the psychosocial field. The objectives of these programs are: a. the reconstruction and reorganization of the family of origin; b. the protection and accompaniment of transits when there is a dissolution of family ties or the constitution of new ones; c. family reintegration, foster care or adoption; d. protection and accompaniment of institutionalized children without other options or family references; and e. Early treatment of any developmental disorder that can be detected (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007).

3.2.4. Educational services

School is an important milestone in the process of children's integration and socialization, very significantly in those with developmental problems. Early childhood education is particularly important since the first years of life are key to children's harmonious physical and psychological development, as well as for the formation of their intellectual faculties and development of their personality. Education at these ages has a marked preventive and compensatory character, due to the importance of early intervention in avoiding problems in development both in the general population and especially in children who have special educational needs. Early childhood education establishes a series of general objectives in order for children to develop skills such as: knowing their own body, relating to others through different forms of expression and communication, acquiring a certain autonomy in their usual activities, and observing and exploring their environment, family, and social surroundings (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007; Serra Desfilis, 2007; Viger Seguí & Gómez Artiga, 2007).

a). Primary prevention. It is important to highlight educational character as a mediator and facilitator of subsequent learning during this school period. Early childhood education should contribute to children's emotional, physical, social, and moral development (GAT,

 CC BY NC SA

2005; Gómez Artiga & Viguer Seguí, 2007; Serra Desfilis, 2007; Viger Seguí & Gómez Artiga, 2007).

b). Secondary Prevention. The detection of children's possible special educational needs while they are infants is one of classroom-teachers' functions, in collaboration with psychopedagogical teams. These teams will be in charge of assessing children's needs, as well as issues related to their schooling, curricular adaptations, and any technical aids they may need (GAT, 2005; Serra Desfilis, 2007; Viger Seguí & Gómez Artiga, 2007).

c). Tertiary Prevention. Within this stage of early childhood education, schooling for students with special educational needs should begin in a context that is as normal as possible in order to support and encourage development and the learning process. This means that, in practice, these students should be in ordinary schools. This means the curriculum being adapted to the needs of each student, leaving schooling in special education units or centers for situations where students need significant or extreme adaptations to the ordinary curriculum, as well as personal and material measures that are not common in ordinary schools (GAT, 2005; Serra Desfilis, 2007; Viger Seguí & Gómez Artiga, 2007).

4. TARGET GROUP OF EARLY CHILD CARE

EC is aimed at all children between zero and six years of age who show some type of deficiency and includes those children with at high biological, psychological, or social risk that may affect their development (Gútiez, 2005; Robles-Bello & Sánchez-Teruel, 2013).

The first group (*biological risk*) refers to children who suffer from documented alterations or disabilities (disorders in motor, cognitive, language, sensory, generalized development, behavioral, emotional, somatic expression, evolutionary disorders, etc.) The second group (*psychological risk*) refers to children who, during their pre, peri or postnatal period or during early development, have been subjected to situations that could alter their maturational process, such as prematurity, low weight, or anoxia at birth (GAT, 2005; Robles-Bello & Sánchez-Teruel, 2013).

Finally, children at *psychosocial risk* are those who live in unfavorable social conditions, such as lack of care, inadequate interactions with their parents and family, mistreatment, neglect, or abuse, which can alter their maturation process (GAT, 2011; Pineapple, 2007). Sometimes, these children's parents may exhibit attitudes that EC programs are responsible for reducing or modifying behaviors such as anxiety or lack of skills to take on responsibilities and meet their children's special needs. And so, we try to improve the development of the infant or, at least, ensure that there is no negative influence on their development (GAT, 2005; Gómez Artiga & Viguer Seguí, 2007; Robles-Bello & Sánchez-Teruel, 2013).

Currently, there are specific, agreed-upon, common diagnostic criteria within EC which allow epidemiological studies to be performed, research to be designed, preventive measures to be taken, forms of action to be contracted, and a common language to be established among the professionals involved in EC from the different disciplines. This is the Diagnostic Organization for Early Care (ODAT) (FEAPAT, 2004, 2008) which, based on previous international classifications, allows us to identify not only developmental disorders or difficulties, but also the etiological factors that cause them. whether biological, psychological and/or social (GAT, 2005; Robles-Bello & Sánchez-Teruel, 2013).

This classification system is organized into a series of axes that have been modeled to contain the lists of different aspects of a biological, psychological, and social nature, and also includes the continuum represented by detection, diagnosis and treatment.

BY NC SA

The structure has three levels:

The first level describes the risk factors for developmental disorders in the different contexts, the child, the family, and the environment. It includes:

1. Biological risk factors.

2. Family risk factors.

3. Environmental risk factors.

The second level describes the type of disorders or dysfunctions that can be diagnosed in the child in interactions with the family and with the characteristics of the environment. It includes:

1. Developmental disorders.

2. Family.

3. Environment.

The third level includes the resources distributed in three axes referring to the child, the family and the environment. Treatment is carried out in Child Development and Early Care Centers, which in Andalusia are called Early Child Care Centers, which respond to this community need for a resource that promotes activities related to upbringing, education and socialization in all levels of prevention, although each service or sector will participate to varying levels and with varying responsibilities (Robles-Bello & Sánchez-Teruel, 2013; Serra Desfilis, 2007; Viger Seguí & Gómez Artiga, 2007).

5. CONCLUSIONS

There has been great progress made in the development of programs aimed at children, parents, and the community in matters of prevention, detection, treatment and information on EC. This progress is especially thanks to the parent groups for affected children and professionals from various fields who took care to investigate and get involved in the progress of these actions (Robles-Bello & Sánchez-Teruel, 2013; Serra Desfilis, 2007; Viger Seguí & Gómez Artiga, 2007).

According to the White Paper on Early Intervention (GAT, 2000, 2005, 2011), in its different editions, research is a necessity for the development of intervention programs. Research in the field of psychology of early childhood care will serve to increase knowledge about the characteristics of different disabilities and developmental disorders, their repercussions on family dynamics, and sources of stress, as well as to evaluate what intervention modalities are most effective. However, research in this clinical area of intervention in childhood is still to be done in Spain. For a long time, EC research has focused almost exclusively on demonstrating the efficacy of any intervention versus no intervention. Currently, there is a need to demonstrate which specific intervention approaches are most effective, which particular aspects of each form of intervention lead to better outcomes for children, which program features are most effective, and what child and family characteristics contribute to the best results (Robles-Bello & Sánchez-Teruel, 2013; Serra Desfilis, 2007; Viger Seguí & Gómez Artiga, 2007).

In this regard, it is essential to have interdisciplinary research that allows medium and long-term follow-up of children's development, the results of which are communicated to the services and intervention programs that initially meet the needs of children and their

BY NC SA

families in order to be able to assess the real impact of these resources and to promote improvements in the quality of all services (Robles-Bello & Sánchez-Teruel, 2013; Serra Desfilis, 2007; Viger Seguí & Gómez Artiga, 2007).

Evaluation of EC intervention programs has two objectives: understanding, on the one hand, children's capacities, and abilities and, on the other, how families live and organize themselves. With this knowledge, it will be possible to provide the most appropriate individual treatment program for each child within a family (Meisels & Shonkoff, 2000; Robles-Bello & Sánchez-Teruel, 2011, 2013).

Evaluations of EC programs in Spain have sought to determine how EC works in terms of the number of early care child development centers, working professionals, children served, form of referral and type of subsidy. They have not really proven the effectiveness of attending an EC program. Therefore, it would be extremely meaningful to understand how effective they are based on progress made in the development of children who are undergoing surgery (GAT, 2011; Robles-Bello & Sánchez-Teruel, 2013).

Similarly, there still needs to be better coordination between the different agents involved in EC treatmentEC, and better coordination between the different administrations involved (Robles-Bello & Sánchez-Teruel, 2013).

Resume

Early Attention (EA) aims to offer children with deficits or at risk of suffering from them a set of optimizing and compensatory actions that facilitate their proper maturation in all areas and that allows them to reach the highest level of personal development and of social integration (GAT, 2005; Serra Desfilis, 2007).

Child development in the early years is characterized by the progressive acquisition of functions as important as postural control, movement autonomy, communication, verbal language, and social interaction. This evolution is linked to the maturation process of the nervous system and to the emotional and mental organization. It requires an adequate genetic structure and the satisfaction of the basic requirements for the human being at a biological and psycho-affective level (GAT, 2005; Serra Desfilis, 2007). Development is the dynamic process of interaction between the organism and the environment that results in the organic and functional maturation of the nervous system, the development of mental functions, and the structuring of the personality.

A developmental disorder is considered a significant deviation from the course of development, because of health or relationship events that compromise biological, psychological, and social evolution. Some developmental delays can be spontaneously compensated or neutralized, often being the intervention that determines the transience of the disorder (GAT, 2005; Serra Desfilis, 2007).

The main objective of EA is to promote the development and well-being of the child and his family, enabling his integration into the family, school, and social environment, as well as his personal autonomy (Candel, 2005). Consequently, areas such as cognitive, autonomy, language or communication, and motor skills are worked on, in addition to advising, guiding, and intervening individually and/or in groups for families who have a child with a disability or at risk of suffering from it (State Federation of Associations of Early Care Professionals -FEAPAPT-, 2008; GAT, 2005; Robles-Bello and Sánchez-Teruel, 2013).

When planning the intervention, the evolutionary moment and the needs of the child must be considered in all areas and not only the deficit or disability that they may present.

 BY NC SA

In Early Care, the child must be considered as a whole, considering the intrapersonal, biological, psychosocial and educational aspects, specific to each individual, and the interpersonal, related to their own environment, family, school, culture and social context (GAT, 2005; Viger Seguí and Gómez Artiga, 2007).

Consequently, a set of actions aimed at the population from 0 to 6 years of age, but also at the family and the community are contemplated. There are numerous scientific disciplines that support the theoretical basis of AT, such as Neurology, Developmental and Learning Psychology, Pediatrics, Psychiatry, Pedagogy, Physiotherapy, Speech Therapy, etc. (De Linares and Rodríguez, 2004; Robles-Bello and Sánchez-Teruel, 2013; Viger Seguí & Gómez Artiga, 2007).

Given that TA is largely based on prevention, we can relate it to primary, secondary, and tertiary prevention: - Primary prevention in TA acts on subjects at "high risk" of suffering from a deficiency, even if they have not yet shown symptoms or have not been diagnosed. These are universal measures, aimed at the entire population and with the intention of protecting health. - Secondary prevention acts to avoid what may lead to the appearance of a disorder or deficit, reducing its evolution and duration or mitigating its effects, all with the goal of reducing a disease in the population. In EA, an attempt is made to detect diseases, disorders, or risk situations early (Robles-Bello & Sánchez-Teruel, 2013). - Tertiary prevention aims to reduce the incidence of chronic disabilities in a population, trying to minimize the disability caused by a disease. In TA, he directs his actions to minimize the consequences and sequelae of a deficit or disease, once diagnosed. An attempt is made to alleviate the consequences derived from metabolic, neurological, genetic or evolutionary disorders or pathologies of the child (Robles-Bello and Sánchez-Teruel, 2013).

The main areas of action are the Child Development and Early Care Centers (CDIAT), Health Services, Social Services and Educational Services.

The great progress produced in the development of programs aimed at both children, parents, and the community in matters of prevention, detection, treatment or information on EA should be noted. (Robles-Bello and Sánchez-Teruel, 2013; Serra Desfilis, 2007; Viger Seguí and Gómez Artiga, 2007). However, it is important to point out the importance of interdisciplinary research that allows for medium- and long-term follow-up of the child's development, the results of which are known by the services and intervention programs that initially met the needs of the child and/or their family in order to assess the real repercussions of these resources, as well as to promote improvements in the quality of all services (Robles-Bello and Sánchez-Teruel, 2013; Serra Desfilis, 2007; Viger Seguí and Gómez Artiga, 2007).

Glossary

Primary prevention: They are the set of health activities aimed mainly at the general population, aimed at preventing the onset or appearance of a disease. Its objective is to reduce the incidence of the disease.

Secondary prevention: It consists of detecting and applying treatment to diseases in very early stages. The intervention takes place at the beginning of the disease, its main objective being to prevent or delay its development.

Tertiary prevention: Seeks to reduce the degree of disability, sequelae, and premature death, in the event that recovery from the state prior to the disease has not been achieved.

BY NC SA

Genetic Basis: Genetics is the study of heredity, the process in which a parent passes certain genes to his offspring.

Environmental factors: Each one of the elements of the environment that act directly on the living being (or at least on a phase of its life cycle). Environment is synonymous with natural surroundings but not with environment.

Biological risk: Possible exposure to microorganisms that may cause disease.

Risk of a social nature: Social risk is understood as the possibility that a person suffers damage that originates from a social cause. This means that the social risk depends on the conditions of the environment that surrounds the individual.

Direct observation: Systematic, valid, and reliable record of behaviors or overt behaviors. Through this technique the researcher can observe and collect data through his own observation.

Bibliography

Alonso, J. M. (1997). Early attention. In S. Alonso and D. Casado (Eds.). *Achievements on Disability in Spain* (p. 45-67). Madrid: Royal Board of Prevention and Care for People with Disabilities.

Anguera Arginaga, M. T. (2005). La observación. In C. Moreno Rosset (Ed.), *Evaluación psicológica. Concepto, proceso & aplicación en las áreas del desarrollo & de la inteligencia* (pp. 225–291). UNED & Sanz & Torres.

Candel, I (2005). Elaboración de un programa de Atención Temprana [Elaboration of a program of early intervention]. *Electronic Journal of Research in Educational Psychology, 3*(3), 151-192.

Costa, M., & López, E. (1986). Salud Comunitaria. Barcelona: Martínez-Roca.

De Linares, C. & Rodríguez, T. (2004). Bases de la atención familiar en la Atención Temprana. En J. Pérez- López, & A. G. Brito (Eds.), *Manual de Atención Temprana. Psicología*. Madrid: Pirámide.

Escorcia Mora, Claudia Tatiana, & García Rodríguez (2019) *Prácticas de atención temprana centradas en la familia & en entornos naturales*. Madrid: UNED.

Federación Estatal de Asociaciones de Profesionales de Atención Temprana (FEAPAT) (2004). *Organización Diagnóstica para la Atención Temprana. Manual de Instrucciones*. Madrid: Real Patronato sobre Discapacidad.

Federación Estatal de Asociaciones de Profesionales de Atención Temprana (FEAPAT) (2008). Organización Diagnóstica para la Atención Temprana. Manual de Instrucciones. Madrid: Real Patronato sobre Discapacidad. GAT (2011). La realidad actual de la Atención Temprana en España. [The current reality in the early intervention in Spain] Madrid: Real Patronato de la Discapacidad.

Gómez Artiga, A., Viguer Seguí P., & Cantero López, M.J. (2013). *Intervención temprana desarrollo óptimo de 0 a 6 años.* Pirámide.

Gómez Artiga, A., & Viguer Seguí, P. (2007). Aproximación al estudio de la Intervención Temprana: antecedentes, orígenes y evolución histórica. In A. Gómez Artiga, P.

Viguer Seguí, & M. J. Cantero López (Eds.), *Intervención Temprana. Desarrollo óptimo de 0 a 6 aos* (pp. 21–35). Ediciones Pirámide.

Gútiez, P. (Ed.) (2005). Atención Temprana: prevención, detección e intervención en el desarrollo (0- 6 años) y sus alteraciones. [Early intervention: prevention, detection and intervention in the development (0- 6 years) and their disorders] Madrid: Editorial Complutense.

Grupo de Atención Temprana (GAT) (2005).. Libro Blanco de la Atención Temprana. In *Real Patronato sobre Discapacidad.* Real Patronato sobre Discapacidad.

Grupo de Atención Temprana (GAT) (2005). Libro Blanco de la Atención Temprana. In *Real Patronato sobre Discapacidad.* Real Patronato sobre Discapacidad.

Quirós, V. (2009). Nuevo modelo para la atención tem- prana en Andalucía: directrices y desafíos. Revista Iberoamericana de Educación, 48, 1-8

Pérez-López, J. y Brito, A. G. (2004). Manual de Atención Temprana. Madrid: Pirámide.

Pina, J. (2007). Análisis de un modelo de seguimiento en Atención Temprana. Tesis doctoral. Universidad Complutense de Madrid.

Pons, A. (2007). Atención Temprana en Andalucía, Vox Paediatrica, 15, 26-29.

Polonio-López, B., Castellanos Ortega, M.C., & Viana Moldes, I. (2008). Terapia Ocupacional en la Infancia: Teoría y Práctica. Madrid: Panamericana.

San Salvador, J. (1998). Estimulación Precoz. Barcelona: CEAC.

Sáiz, M.C. Aplicación y Validación de un programa de desarrollo socio-cognitivo en niños con deprivación socio-ambiental. Tesis Doctoral. Valladolid: Secretariado de publicaciones e intercambio científico de la Universidad de Valladolid [Microficha]. [Disponible en el repositorio institucional de la Universidad de Burgos con autorización de la Universidad de Valladolid.

Saiz Manzanares, M. C., & Escolar-Llamazares, M. C. (2013). *Observación Sistemática e Investigación en Contextos Educativos*. Servicio de Publicaciones e Imagen Institucional de la Universidad de Burgos.

Saiz Manzanares, M. C., Escolar Llamazares, M. C., & Rodríguez Medina, J. (2019). *Investigación cualitativa. Aplicación de métodos mixtos y de técnicas de minería de datos*. Servicio de Publicaciones e Imagen Institucional Universidad de Burgos.

Sarriá Sanchez, E. (2010). La observación. In S. Fontes de Gracia, C. García-Gallego, L. Quintanilla Cobián, R. Rodríguez Fernández, P. Rubio de Lemus, & E. Sarriá Sánchez (Eds.), *Fundamentos de investigación en Psicología* (pp. 311–352). Universidad Nacional de Educación a Distancia.

Sarriá Sánchez, E., & Brioso Díez, Á. (2010). Metodología observacional. In M. J. Navas Ara (Ed.), *Métodos, diseños y técnicas de investigación psicológica* (pp. 439–482). Universidad Nacional de Educación a Distancia.

Serra Desfilis, E. (2007). Una visión de la Intervención Temprana desde la orientación del ciclo vital. In A. Gómez Artiga, P. Viguer Seguí, & M. J. Cantero Lòpez (Eds.), *Intervención Temprana. Desarrollo óptimo de 0 a 6 aos* (pp. 53–69).

Viger Seguí, P., & Gómez Artiga, A. (2007). La Intervención Temprana desde las diferentes escuelas psicológicas. In A. Gómez Artiga, P. Viguer Seguí, & M. J. Cantero López (Eds.), *Intervención Temprana. Desarrollo óptimo de 0 a 6 años* (pp. 3–750). Ediciones Pirámide.

Basic bibliography Module

Anguera Arginaga, M. T. (2005). La observación. In C. Moreno Rosset (Ed.), *Evaluación psicológica. Concepto, proceso y aplicación en las áreas del desarrollo y de la inteligencia* (pp. 225–291). UNED y Sanz y Torres.

Federación Estatal de Asociaciones de Profesionales de Atención Temprana (FEAPAT) (2008). Organización Diagnóstica para la Atención Temprana. Manual de Instrucciones. Madrid: Real Patronato sobre Discapacidad. GAT (2011). La realidad actual de la Atención Temprana en España. [The current reality in the early intervention in Spain] Madrid: Real Patronato de la Discapacidad.

Federación Estatal de Asociaciones de Profesionales de Atención Temprana (FEAPAT) (2008). Organización Diagnóstica para la Atención Temprana. Manual de Instrucciones. Madrid: Real Patronato sobre Discapacidad. GAT (2011). La realidad actual de la Atención Temprana en España. [The current reality in the early intervention in Spain] Madrid: Real Patronato de la Discapacidad

Sáiz, M.C. Aplicación y Validación de un programa de desarrollo socio-cognitivo en niños con deprivación socio-ambiental. Tesis Doctoral. Valladolid: Secretariado de publicaciones e intercambio científico de la Universidad de Valladolid [Microficha]. [Disponible en el repositorio institucional de la Universidad de Burgos con autorización de la Universidad de Valladolid.

Viger Seguí, P., & Gómez Artiga, A. (2007). La Intervención Temprana desde las diferentes escuelas psicológicas. In A. Gómez Artiga, P. Viguer Seguí, & M. J. Cantero López (Eds.), *Intervención Temprana. Desarrollo óptimo de 0 a 6 años* (pp. 3–750). Ediciones Pirámide.

Resources

- The Educator. Partnerships in Early Intervention. July 2016: http://icevi.org/wp-content/uploads/2017/11/The_Educator_2016_July_Partnerships_in_Early_Intervention_Vol_XXX_Issue_1-1.pdf