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AN EXPLORATION OF INFANT AND TODDLER CHILD CARE CONSULTATION:
A MULTIPLE CASE STUDY

by

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ABSTRACT

AN EXPLORATION OF INFANT AND TODDLER CHILD CARE CONSULTATION: A MULTIPLE CASE STUDY

Christine Marie John
Old Dominion University, 2015
Director: Dr. Angela Eckhoff

This qualitative, multiple case study was an exploration of the professional development (PD) experience of consultation as it occurred within infant and toddler child care settings. Consultation is dependent upon the establishment of a relationship between the consultant and the consultee and offers opportunities for professional growth and enhanced quality child care. This researcher followed four infant and toddler child care consultants working with child care centers through a quality enhancement PD program in a Mid-Atlantic state. Within each of the four participating centers, a member of the administration and one infant and/or toddler caregiver along with their consultant contributed their consultation experience to the larger study. Families of the infant and toddlers in care were also invited to contribute their expectations of infant and toddler child care.

Through the use of interviews, observations, and collection of program artifacts, key themes emerged as: Opportunities for relationship building and professional growth, and enhanced environmental qualities. This study contributes to the infant and toddler child care literature focusing on the PD experience from the various perspectives of the stakeholders. Findings suggest that infant and toddler PD program participation should be voluntary with clearly explained roles for participants, allow time for collaboration between all participants, and invite family members to contribute to PD and program enhancement efforts.

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This is dedicated to family, friends, and the relationships I neglected to cultivate and nurture on this journey. This is all I have to offer you.

In honor of those not here to celebrate, I dedicate this to you. On this journey I lost all of my grandparents and I know they would have been proud. Without the hard work they instilled in my parents, I would not have made it this far.

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Every teacher I’ve ever had must also be recognized as one who has contributed to my success. Some directly, others indirectly, but all played a part in delivering me to this final destination. My first and most influential teachers are my parents, Andrew and

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CHAPTER I

INTRODUCTION

According to the U.S. Census Bureau, over 12 million children are in an organized child care arrangement (Laughlin, 2013). Over 50% of children under the age of three are under the care of a non-relative for the majority of the day (Davis & Connelly, 2005; Green, Peterson & Lewis, 2006; Mulligan, Brimhall & West, 2005). Infants and toddlers make up a large portion of the child care population with 27.5% of infants under the age of one year and 37.2% of children between the ages of one and two years in attendance on a regular basis (Laughlin, 2013). In 2002, 38% of infants and toddlers spent more than 35 hours a week in non-parental child care and 17% spent between 15 and 34 hours (Kreader, Ferguson, & Lawrence, 2005).

With such large numbers of young children spending so much time in out of home care, it is imperative that their caregivers receive professional development (PD) that supports the needs of the caregiver and promotes optimal development in the children. Parents have indicated quality as one of the top three most important aspects of child care (Child Care Workforce Study, 2005). The quality of care that children receive in the early years is a contributing factor to children's social, emotional, cognitive, physical and language development (Shrivers, 2005).

Quality Child Care for Infants and Toddlers

Providing adequate care that is responsive and sensitive promotes secure attachment in the relationship young children share with non-familial caregivers in child care settings (Bowlby, 2007; Hale-Jinks, Knopf, & Kemple, 2006). This relationship is predicated upon the positive experiences and interactions between the children and

caregivers. When children build trust in their caregiver, they are confident and secure enough to venture away from their caregiver to explore and learn from their environment.

Children who receive responsiveness and sensitivity from their caregivers in child care are less likely to exhibit behavior problems, and have higher cognitive and language skills regardless of socioeconomic status (Burchinal, Vandergrift, Pianta, & Mashburn, 2010; Clarke-Stewart, Vandell, Burchinal, O'Brien, & McCartney, 2002). Healthy, "secure" attachments are formed when the child experiences responsive care that is sensitive, acknowledges the individual needs, moods, and communications of the child, and when those needs are promptly and appropriately met (de Schipper, Tavecchio, Van IJzendoorn, 2008; Sroufe, 1985). The constructs of responsiveness and sensitivity are grounded in the theory of attachment.

Children attending higher quality child care that includes a stimulating and responsive environment experience many benefits (Burchinal, Peisner-Feinberg, Bryant, & Clifford, 2000; Clarke-Stewart, Vandell, Burchinal, O'Brien, & McCartney, 2002; Helburn, 1995, NICHD, 2000). One significant benefit includes higher cognitive and language development as measured by the Peabody Picture Vocabulary Test-Revised, Form L (Dunn & Dunn, 1981). These children also showed an increase in social competence as measured by the Peer Play Scale developed by Howes (1980). Specifically, they were found to have higher social skills, be more cooperative, and fewer behavior problems as preschoolers when high quality was provided in the child care setting (Helburn, 1995). The High/Scope Perry Preschool Project reported that exposure to high-quality programming before school results in fewer arrests, higher graduation rates, and post secondary school attendance (Schweinhart & Weikart, 1997). In the

report, *Forging a New Framework for Professional Development*, Ochshorn (2011) also notes additional benefits of quality early learning environments include increased high school and college graduation rates.

Quality child care can serve as a buffer from the stressful experience of being cared for outside the home. The chemical known as cortisol is present in a brain under stress and can interrupt brain growth and development (de Schipper, Riksen-Walraven, Geurts, & de Weerth, 2009; Groeneveld, Vermeer, van Ijzendoorn, & Linting, 2010; Vermeer et al., 2010; Watamura, Kryzer, & Robertson, 2009). In a study of 35 toddlers, it was reported that 71% showed an increase in cortisol levels during the child care day indicating child care as a stressful experience (Watamura, Donzella, Alwin, & Gunnar, 2003). Over 30% of the study infants experienced a rise in stress levels throughout the progression of the day in child care when compared to the same children spending the day at home (Groeneveld, Vermeer, van Ijzendoorn & Linting, 2010).

Birth to three is a time of rapid brain growth and development for all children (Zeanah & Zeanah, 2009). The earliest years of life are the most critical, “fundamental learning building blocks” (p.3, Ochshorn, 2011). Key elements of quality care that support that growth and development include adequate health and safety practices, knowledgeable and responsive caregivers, and engaging environments (Garland & Rasmussen, 2010). Layzer and Goodson (2006) define child care quality as “the aspects of the environment and children’s experiences that nurture child development” (p. 558). Parental definitions of quality child care mirror those reported in research. Elements such as a welcoming environment, developmentally appropriate learning activities, health and safety procedures, and educationally qualified staff with a continuity of caregivers over

time are considered desirable child care center traits by parents (Ceglowski & Davis, 2004; Harrist, Thompson, & Norris, 2007; Paulsell, Nogales, & Cohen, 2003).

Similar to parental definitions of quality, research identifies three major types of quality in child care known as structural, process, and global quality (Hestenes et al., 2007). Structural quality refers to aspects that have been cited in research regarding staffing, ratio and group size. The interactions shared between the caregiver and the children in care constitute the process quality. Global quality encompasses the physical environment, including the materials and activities available to the children.

Structural Quality

Structural quality refers to features of child care that are often regulated by local and state agencies, such as adult-child ratios, classroom or group size, caregiver qualifications, and years of experience (Harrist et al., 2007; Kontos, Howes, & Galinsky, 1996; Peisner-Feinberg & Yazejian, 2010; Thomason & LaParo, 2012). Stakeholders, such as parents, policy makers, social service providers, owners, directors, and child caregivers, have also recognized a connection between quality child care and the education level of the staff (Harrist, Thompson, and Norris, 2007). Structural quality is often determined and/or regulated by institutions of higher education, state licensing departments or national accreditation agencies, such as Child Care Aware. Measuring this type of quality is often collected through self-report demographic surveys or interviews with the caregiver (Adams & Buell, 2002; Walker, 2002; Weaver, 2002).

Process Quality

Stakeholders have identified communication, rapport, and caregiver practices as essential features of quality (Harrist et al., 2007). Process quality is described within the

literature as adult-child interactions and caregiver practices (Arnett, 1989; Kontos et al., 1996; Peisner-Feinberg & Yazejian, 2010; Thomason & La Paro, 2009). Process quality has been measured largely by the Caregiver Interaction Scale (CIS; Arnett, 1989) which measures attentiveness and responsiveness of adult-child interactions through sensitivity, harshness and detachment (Raikes et al., 2005); Ontai, Hinrichs, Beard, & Wilcox, 2002). The quality of the interactions between child and caregiver helps promote secure secondary attachments and optimal development (Thomason & La Paro, 2009).

Global Quality

Global quality characteristics account for features of the environment and classroom activities that stimulate child development (Ceglowski & Bacigalupa, 2002; Hestenes et al., 2007; Kontos et al., 1996). Global quality can be measured by rating scales targeting early learning environments. The Infant/Toddler Environment Rating Scale – Revised, (ITERS-R; Harms, Cryer, & Clifford, 2003) is one such tool and is widely used in research to capture the level of quality as provided in classrooms with children under the age of 30 months (Ontai et al., 2002; Raikes et al., 2005; Weaver, 2002). The ITERS-R measures health and safety practices, interactions between adult and children, and the activities and materials in the child care classroom.

Longitudinal, multi-state studies have shown that early childhood educators are not providing care that is responsive and sensitive to the unique and individual needs of infants and toddlers (NICHD, 2000). In large scale studies, infant and toddler care is consistently rated significantly less positive than that of their preschool counterpart (Ghazvini & Mullis, 2002; NICHD, 2000; Howes et al., 2008; Helburn, 1995; NICHD, 2000; Phillipsen, Burchinal, Howes, & Cryer, 1997; Whitebook, Howes, & Phillips,

1990). The Cost, Quality, and Child Outcomes (CQO) is a large-scale study across four states and reported that 40% of infant and toddler child care was found to be less than adequate and may even be harmful to children (Helburn, 1995). This study was the largest study of child care conducted in the mid-1990s. Together the NICHD and CQO studies are the largest, longest child care studies to date. Results from these collaborative works has influenced child care programs and state licensing agencies to raise the quality of child care available to young children (Glantz & Layzer, 2000).

Of those caregivers participating in the National Institute of Child Health and Human Development (NICHD) Study of Early Child Care (1996), only eight percent of the caregivers were rated as highly sensitive. The NICHD study began in 1991 and is the largest, longitudinal study of child development in various, unassigned types of child care including child care centers, non-familial homes and familial homes. Phillipsen, Burchinal, Howes, and Cryer (1997) and Albers, Riksen-Walraven, and de Weerth (2007) also found the sensitivity of infant and toddler care to be inadequate. Ghazvini and Mullis (2002) reported that only 9% of the child care centers serving infants and toddlers were providing “good” quality care, according to the Infant/Toddler Rating Scale (ITERS: Harms, 1990), which measures environmental and interactional quality. Thus, the challenge of providing high quality early learning environments for infants and toddlers needs to be addressed.

Problem Statement

Improving the knowledge, skills, and disposition of infant and toddler caregivers through PD is a common strategy utilized to enhance the quality of child care for our youngest children (Ackerman, 2008). PD is often designed and executed from the state

level with little to no input from the actual caregivers working with children (Gable, 2003). Hill (2007) reports that the content and delivery of PD are influenced primarily by the provider of PD; leaving the needs of the caregivers as a secondary consideration. Adult learning theory posits that recipients of PD must play an active role in their participation for an enhanced learning experience (Dunst & Raab, 2010; Landry, Swank, Smith, Assel, and Gunnewig, 2006).

Dunst and Raab (2010) conducted a study of early childhood educators' perspectives of contrasting types of PD including short, one to three hour conference presentations, workshops lasting between four and six hours or between 10 and 14 hours, and intensive weeklong trainings either off or on-site. A majority of the 255 participants from 26 states cited on-site PD as the most useful method of training to influence a change in caregiver behavior (Dunst & Raab, 2010). Consultation programs can provide caregivers with opportunities for relevant feedback and meaningful collaboration, as well as support in their current role as an infant and toddler caregiver. PD can offer caregivers a pathway toward the high quality of child care infants and toddlers need for optimal development (Fuligni, Howes, Lara-Cinisomo, & Karoly, 2009). Unfortunately, some of those experiences are not meeting the needs of the infant and toddler child care educator community (Helterbran & Fennimore, 2004).

When exploring consultant classroom activities Dinnebeil, McInerney, and Hale (2006) found that the consultants were less likely to engage in adult conversation and feedback. In fact, through classroom observations, observers found between 58 and 86 % of the observation, consultants were interacting with children instead of the adult (Dinnebeil, McInerney, & Hale, 2006). The self-report journals provided by the five

participating consultants are consistent with the findings of the observers, though they also documented spending a significant amount of time collaborating with the caregivers.

Professional development strategies are not likely to change until the professional needs of infant and toddler caregivers are recognized and the effective strategies that impact those services are studied and determined. Professional development is a valuable investment that must be used effectively. Without knowledge that PD is useful and helpful by its recipients, it may be viewed as a waste of time (Helterbran & Fennimore, 2004). In many states, infant and toddler caregivers are participating in consultation services. Traditionally, PD efforts target child development; however, it should also include the perspective of the caregivers as well (Shpancer, et al., 2008). Research identifying consultation practices for infant and toddler consultants is vital to the establishment of effective PD programs for infant and toddler caregivers. The impact and perspective of infant and toddler PD consultation is understudied, underexplored and necessary in order to develop effective infant and toddler PD programs that improve caregiver behavior and produce a positive effect on child care quality (Helterbran & Fennimore, 2004; Ochshorn, 2011).

Purpose of the Study

This study explored the consultation relationship between the recipients and providers of PD as it is developed during the consultation process. In this research, the on-site stakeholders consisted of the infant and toddler child care staff (director and caregivers) and the consultant. The perspective of additional stakeholders, the families of the infants and toddlers in child care, were also be included as their voices are largely absent from the existing literature in this area. By choosing this focus, this study provided

a unique, in-depth view of the PD process caregivers experience as they attempt to enhance the quality of that care, from the unique perspective of those who work to enhance the quality of infant and toddler child care.

Overview of the Methodology

A systematic exploration of PD is needed in order to gain an understanding of the consultation process as experienced by the infant and toddler administrators and caregivers, as well as the consultant. A qualitative, multiple case study design was employed to understand the role and impact of consultation for infant and toddler caregivers. In an effort to develop a descriptive account of the experiences and expectations of the stakeholders, in-depth, semi-structured interviews, formal and informal observations, and the collection of program artifacts were utilized (Powell & Stremmel, 1989).

Research Foci

This case study was be guided by several research questions to gain an understanding of the expectations and experiences of stakeholders participating in an infant and toddler consultation program. The consultation experienced is designed to improve the quality of child care and by presenting the following questions, this study helped determine the impacts consultation participation has on the quality of child care received by infants and toddlers. The research questions were as follows:

1. To what extent are site stakeholders' (center director, infant and toddler caregivers) expectations of infant and toddler consultation participation similar to infant and toddler consultants' expectations of program participation?

2. In what ways are site stakeholders' expectations of infant and toddler consultation being fulfilled during the course of participation?
3. To what extent do family expectations of infant and toddler care reflect the services provided through infant and toddler consultation?
4. In what ways is participating classrooms' quality of care affected by infant and toddler consultation?

Conceptual Framework for Professional Development

Child care centers often turn to PD activities to increase the responsiveness and sensitivity of their staff. Improving caregiver behaviors and practices are vital for the enhancement of the quality of care infants and toddlers receive in child care settings. Howes and Tsao (2012) introduce a conceptual framework of PD in early childhood that promotes and supports positive relationships between a child and their caregiver and upon which this study is based. Caregivers who experience a respectful, positive relationship can begin to understand how they themselves can provide the sensitive, responsive care infants and toddlers need for optimal development.

Consultation is designed to provide a positive relationship between the consultant and consultee. Based on models of mental health and school-based consultation, Buysse and Wesley (2004) emphasize a more specific framework for consultation that will also be utilized for the current study. Three components are important to the consultation process: problem solving with the consultee to identify challenges to providing quality care, encouraging and supporting the consultee in the implementation of newly learned behaviors, and coaching the consultee by providing new information and strategies through training within the context of the infant and toddler child care setting. While it

should be recognized that consultation should be customized for each setting, Buysse and Wesley (2004) suggest certain elements be present in the consultation experience.

Effective consultation must be based on the development of a relationship between both the consultant and the consultee (Buysse & Wesley, 2004). A relationship based on trust and respect where participants can openly discuss goals, strategies, and roles is vital to a successful partnership. The process of consultation begins by establishing the reason for consultation and determining the level of commitment on the part of the consultee (Buysse & Wesley, 2004). Once a relationship has been established, observations and assessments can help the consultant identify strengths of the consultee, as well as, challenges which then leads to the collaborative creation of goals. Together, the consultant and consultee indicate strategies for goal attainment. The consultant supports and encourages the consultee as those selected strategies are implemented. All parties in the relationship should evaluate the outcome of the goals and determine if additional supports or knowledge is necessary for successful implementation. The consultant and the consultee should openly discuss the newly acquired skills and areas needing further assistance (Buysse & Wesley, 2004).

Delimitations of the Study

The current study draws its participants from child care centers already participating in an infant and toddler child care consultation program in the southeastern region of a Mid-Atlantic state. The consultation program is conducted over a minimum of a five month period, thus that is the timeframe of the current study. When consultation services extended beyond this minimal time frame, so did the study. Family child care providers serve infants and toddlers and are part of the child care consultation program;

however, only child care centers served as participants under study. Family child care consultation is typically conducted with one caregiver who also serves as business owner and director. In the state of this study, they are not required to be regulated and the training requirements for those who are regulated are quite minimal in comparison to centers. While this population is valuable to the infant and toddler community, they are not part of the current study.

Children with disabilities may be enrolled in participating centers, however, inclusion consultation and consultation for individual children and families are not examined. While infant and toddler consultants may offer technical assistance to caregivers in regards to enrolled children with disabilities, as the quality of the program depends on the experiences and opportunities for all children, it is not the focus of this study.

Researchers found that early care educators implemented better practices when those practices had an obvious positive effect on the behavior and academic gains of the children (Mashburn, Downer, Hamre, Justice & Pianta, 2010; Onchwari & Keengwe, 2010; Wagner & French, 2010). Caregivers have described the PD experiences as a waste of time, whereas on the other hand, caregivers who experienced a change in their children, gained a higher level of competence and were therefore motivated by their own feelings of success (Helterbren & Fennimore, 2004; Wagner & French, 2010). While studies saw a change in child behavior as a result of consultation, in an effort to illustrate the experience of the participating adults receiving PD, this study did not explore child outcomes.

Significance of the Study

Wagner and French (2010) state the importance of designing PD activities and experiences in ways that empower teachers. The context in which PD is offered should support an optimal level of learning through choice and within a sense of community. Early childhood research regarding preschool aged children (3-5 years) and their caregivers abounds in the literature. Studies focusing on child care for infants and toddlers are scarce and those caregivers commonly have fewer prospects and opportunities to participate in continued PD (Ochshorn, 2011; Thomason & LaParo, 2009). Researchers are calling for more research that identifies the specific characteristics of effective PD (Dunst & Raab, 2010). This study will contribute to the limited body of literature featuring the PD of infant and toddler caregivers and the relationship established through on-site consultation experience. The unique perspectives of site stakeholders will be illuminated through this exploratory quest to understand the infant and toddler consultation process and its impact on the quality of child care received by children less than three years of age.

Definition of Terms

Caregiver. Caregiver is a term used to describe the adult who cares for the elderly, or a parent or other family member caring for a young child. In the child care setting, the term caregiver refers to the non-familial adult providing care for children in the absence of the family. Teacher is a term commonly used but to distinguish that children under the age of three need care more than teaching, this term seems more appropriate and will be used to describe the adult responsible for her classroom of children. The term teacher will not be changed if a participant chooses to use it.

Infant and Toddler. It is recognized that what constitutes an infant or toddler varies within the literature and amongst various agencies. According to quality measurement tools used within this study, an infant is a child under the age of 12 months and a child between 12 and 36 months is considered a toddler. For the purposes of this study, these definitions will be used.

Professional Development. Professional development has been defined by various entities within the field of early childhood. The National Professional Development Center on Inclusion (NPDCI; 2008) defines PD as “facilitated teaching and learning experiences that are transactional and designed to support the acquisition of professional knowledge, skills, and dispositions as well as the application of this knowledge into practice” (p. 3). The National Association for the Education of Young Children (NAEYC) and National Association of Child Care Resource and Referral Agencies (NACCRA) state that PD incorporates a combination of education, training, and technical assistance (2011).

Consultation. Consultation is a method of increasing the knowledge and skills of employees in many fields. The definition of the term is as unique as the field utilizing the strategy. Consultation in the field of early childhood typically occurs between an outside expert or specialist and the caregiver working directly with young children. It is a collaborative process in which the consultant conducts an assessment, and ideally, together with the consultee, identifies areas for growth and determines strategies for improvement (NAEYC and NACCRA, 2011). It is this process under which this study is based.

Chapter Summary

Research has shown that while infants and toddlers can benefit from high quality child care, many settings are not equipped to provide that level of care (Helburn, 1995). Increasing the knowledge and skills of infant and toddler caregivers is a method often used to enhance the level of quality in infant and toddler classrooms. The conceptual frameworks for PD and consultation were used as a basis for this exploration of study. Caregivers need to experience a relationship that is positive in nature in order to support the physically demanding and highly emotional needs of infants and toddlers. On-site consultation is a common strategy employed to enhance the quality of early care and childhood education. Utilizing relationship-building strategies within the consultation process models the behaviors caregivers need to become highly effective caregivers.

The following chapter summarizes past and current literature regarding the PD of the infant and toddler workforce. The methodological strategies, population of participants, data collection and the analytic approach that were utilized to conduct the study have been described in Chapter 3. Chapter 4 reveals results to the four posed research questions based on data that was collected from the participants during the study. The final chapter provides a discussion and implications of the current study and offers recommendations for future research.

CHAPTER II

Literature Review

Professional development is one highly sought remedy to increase the low quality of care that infants and toddlers receive in child care settings (Fontaine, Torre, Grafwallner, & Underhill, 2006; Helburn, 1995). In order to be effective, PD must meet the needs of the population of the workforce receiving and providing child care, provide appropriate, relevant and meaningful content, and approach the PD activities with input from the caregivers (Buysse, Winton, Rous, 2009). Professional development activities should include support and encouragement, as well as, opportunities for problem solving, teaching and coaching.

The purpose of this qualitative multiple case study is to explore the experiences and expectations of stakeholders as they participate in a quality enhancement consultation program for infant and toddler child care. The specific strategies utilized by participating consultants are also explored, as well as, the impact that experience has on the quality of the infant and toddler child care classroom. Given the scarcity of this subject within the research literature, this study adds to the current body of PD literature through its focus on the infant and toddler workforce. This chapter serves as a review of the literature regarding specific PD strategies used to enhance the quality of infant and toddler child care.

Purpose of the Literature Review

Professional development is commonly experienced by caregivers working in child care settings. The literature regarding this practice will be highlighted within this review of the literature in an effort to display the various strategies and forms utilized to

increase the knowledge base and enhance the skill level of the infant and toddler child care workforce. The voices of child care staff will also be illuminated. Professional development strategies are illustrated according to the conceptual framework of PD and consultation. Perspectives of PD and quality child care as held by the stakeholders, including the child care staff and families of infants and toddlers, and the providers of PD are also explored.

This study and literature review will be guided by the following exploratory questions:

1. To what extent are site stakeholders' (center director, infant and toddler caregivers) expectations of infant and toddler consultation participation similar to infant and toddler consultants' expectations of program participation?
2. In what ways are site stakeholders' expectations of infant and toddler consultation being fulfilled during the course of participation?
3. To what extent do family expectations of infant and toddler care reflect the services provided through infant and toddler consultation?
4. In what ways is participating classrooms' quality of care affected by infant and toddler consultation?

After further explanation of the guiding conceptual framework for this study and literature review, the characteristics of the learners and providers of PD will be discussed. Recognizing those who are most affected by this topic will put the information presented in the most accurate perspective. The content and approaches to PD share the topics and types of activities that typically occur in child care settings. Finally, elements of effective PD are discussed within the context of early care and education.

Conceptual Framework for Professional Development

The conceptual framework for professional development guiding this literature review is one proposed by Howes and Tsao (2012). The central tenant of this framework acknowledges the role of a didactic, supportive relationship between caregivers and professional development providers in the caregivers' implementation of sensitivity and responsiveness to their infants and toddlers in child care. Because the relationship formed between the child and the adult is vital to the development of the child, the adult must facilitate a positive relationship conducive to sharing that experience.

Additionally, a professional development framework developed by Buysse, Winton, and Rous (2009) for the National Professional Development Center on Inclusion, NPDCI, requires PD to consider the characteristics of the learners and caregivers, the content provided, and the approaches to PD be taken into account as well. These two conceptual frameworks will be used as a foundation to draw conclusions from the research presented. The framework authored by Howes and Tsao (2012) suggests that caregivers need to experience a respectful, sensitive relationship in order to promote positive infant and toddler development.

The frameworks described above draw attention to the population of the workforce that provides PD. The child care staff and the families of young children need to be considered in the development of professional learning experiences. Content typically covered through PD includes topics such as child development, adult – child interactions, emergent literacy, health and safety, and developmentally appropriate activities. There are several approaches to PD and the most common delivery methods are formalized training, one-time workshops, and on-site training.

Characteristics of the Learners and Providers

According to the frameworks of PD, the diverse characteristics and needs of the learners and the providers must be addressed in PD activities. Race, education, experience, financial stability, mental capacity, and culture of the child care staff, infant and toddler families, and the providers of PD are characteristics that can impact and influence the provision and outcome of PD (Buysse, Winton, & Rous, 2009). The providers of PD are also described in the following sections to view their work in child care from their perspective. This section will describe not only the recipients and providers of PD, but the expectations of the families of the children in care are also considered.

Child Care Work Force

The infant and toddler workforce generally consists of women between the ages of 18 and 65, averaging at about 43 years of age (Whitebook & Sakai, 2003) and have acquired anywhere from very little to high degrees of education and education can range from General Education Diplomas to advanced degrees in related fields. At the center or school level, quality of infant and toddler can be affected by educational and experiential requirements, limited compensation and turnover rates amongst caregivers. Education and experience varies widely, compensation and benefits are limited and turnover remains high among this population. On average, caregivers are predominantly female, are of Caucasian decent with a small percentage reporting second jobs and having received public assistance at one time in their lives (Nicholson, 2011; Whitebook & Sakai, 2003).

Requirements. By many state standards, the educational and experiential requirements of caregivers working in child care are varied and limited (NCCIC, 2008). According to the National Child Care Information and Technical Assistance Center (NCCIC; 2008) out of the 50 states and DC, 33 states have no minimum early care and education preservice qualification or training requirements beyond a high school degree or equivalent. In the US, four states have instituted training requirements upon being hired while 13 have requirements ranging from earning a CDA or two years of vocational coursework, to 90 hours of training and three years of experience. Currently, states require anywhere from zero to 30 hours of annual ongoing clock hours. California and Hawaii have no additional training hours required. It is possible that infant and toddler child care is consistently rated as low due to minimal or non-existent training and qualification requirements (Helburn, 1995; Shpancer, et al., 2008). In a report on the preparation of the early childhood workforce, Early and Winton (2001) note 62% of the lead teachers working in child care centers have no training within the field.

When asked their opinion regarding education and training, caregivers and administrators have expressed its importance (Gable & Haliburton, 2003). However, a more recent study revealed that 49 caregivers who participated in an interview seeking their view of working in child care did not impulsively indicate education or training as a method to improve the quality of child care (Shpancer et al., 2008). A potential reason for not specifying a need for more education may include prior PD experiences that were not relevant to their role in child care. Additionally, it is possible that without follow up support, some PD activities are not found to be effective by the caregivers.

Caregiver Turnover. In addition to low education and limited levels of experience, caregivers are not incentivized through monetary measures to stay in the field. On the contrary, they receive low wages and little, to no health care benefits or vacation. Whitebook and Sakai (2003) found that caregivers who left the field to work in other occupations between 1996 and 2000 were making on average over \$4.00/hour more than their former caregiver colleagues who decided to remain working with young children.

Whitebook and Sakai (2003) describe three types of turnover at the job, position, and occupation levels. Caregivers who leave a child care center to work in another child care center is known as job turnover. Caregivers experiencing positional turnover have taken on a new role within the center, moving from one classroom to another, upgrading to a management position, or perhaps to work in the kitchen, or provide transportation. Turnover at the occupational level describes the actions of a caregiver who chooses to leave the field of early childhood to pursue work unrelated to young children. Each of these types of turnover means that young children will have to adjust to a new caregiver. They will have to learn the rules of the new caregiver, develop a relationship based on those rules, and learn to trust and find security in the new stranger in their lives (Whitebook & Sakai, 2003).

Turnover rates are highest in lower quality settings and often low quality settings can influence an increase in “caregiver burnout” and turnover (Whitebook, Howes, & Phillips, 1998). Centers with higher turnover rates were also found to provide less developmentally appropriate activities and lower sensitive interactions (Whitebook, et al., 1990). Caregivers state that lack of support from coworkers and administration is one

path to burnout (Shpancer, et al., 2008). Studies have reported turnover rates higher than 30%, sometimes approaching 40% in child care settings (Manlove, 1993; Whitebook, Howes, & Phillips, 1990). Job growth between 2003 and 2008 was anticipated to experience an influx of 33-39% new hires in child care compared to 15% in other fields (Levine, 2001).

Child care centers with higher quality care experience lower turnover rates (Helburn, 1995). Children attending those higher quality centers also experience better outcomes in social, language and math skills, positive self-concepts, and a positive attitude in child care (Helburn, 1995). Infants and toddlers are at risk of not forming secure attachments with their caregivers in the face of a turnover crisis in child care (Hale-Jinks, Knopf, & Kemple, 2012).

Manlove (1993) conducted a study exploring factors of burnout among 188 child care workers in licensed centers and found those teachers with higher education and more opportunities for ongoing training experienced burnout at lower rates. In a report addressing caregiver turnover, Hale-Jinks, et al., (2006) equate job stress and dissatisfaction with high turnover rates. Caregivers reporting they work in an environment where they feel they are supported in their role experience less stress and job dissatisfaction (Whitebook & Sakai, 2003).

The rates at which caregivers are leaving the field speaks volumes and even then, are often only heard by the children they leave behind (Hale-Jinks, et. al, 2006). When caregivers are prepared for the challenging work encompassed by working with infants and toddlers, they are less likely to leave their position (Hale-Jinks, et al, 2006). With a workforce that suffers high turnover rates, stressful work environments, and minimal

requirements to increase their level of education, efforts to compensate, educate, and support caregivers are needed (Bobzien, 2008; Branscomb & Ethridge, 2010; Fontaine, et al., 2006; Hale-Jinks, et al., 2006). Enhancement projects that include effective PD and supports for staff can have positive effects on child care centers (Fontaine, et al., 2006).

Providers of Professional Development

Buyse, Winton, & Rous (2009) report that most providers of consultation and technical assistance hold at least a bachelor's degree and have experience working in the field of early care and education. Rarely do they have formal education nor experience providing technical assistance (Buyse, Winton, & Rous, 2009; Dunst & Raab, 2010). Early childhood special education (ECSE) consultation is often used as a basis for other entities engaging in practices similar to this line of work. In a study seeking to gather information regarding the need for training and support for those who provide professional development, consultants participating in focus groups described their roles as multidimensional and not well defined (Nelson, Lindeman, Stroup-Rentier, 2011). ECSE professionals report that on a daily basis they are responsible for multiple major tasks, including but not limited to teaching children and their teachers, assessing the early care and education environment, collaborating with members of the community, coaching, supporting and encouraging consultees (Nelson, Lindeman, Stroup-Rentier, 2011).

Knapp-Philo et al. (2004) state the importance of employing competent trainers. Consultants also need a support system to develop competencies in their role and for their own reflections and discussion of challenges and successes. Comprehensive orientation can provide trainers with an in-depth understanding of the philosophy, content, and

purpose of the consultation process. ECSE consultants reported in a focus group that new knowledge is not necessarily a barrier to implementation, but the lack of a clear definition of and support for their role and no opportunity to practice those skills in a safe environment may be viewed as a barrier to effective consultation (Nelson, 2011).

Consultants with previous training in early childhood may be able to connect their work with children to developmental norms; however, consultants with education backgrounds may not have the adequate preparation to work effectively with adults (Wesley & Buysse, 2004). Focus group ECSE consultant participants reported that their own training and support is important to help them perform their job (Nelson, Lindeman, Stroup-Rentier, 2011). Dinnebeil, McInerney, and Hale (2006) conducted a study in an attempt to document the tasks and activities of ECSE consultants. They found that the itinerant ECSE consultants with the least experience but had completed a preparation program targeting their consultative role, spent the most time in a consultative role in comparison to other ECSE consultants who engaged in interaction with the children during their visits.

Families of Infants and Toddlers

Parents define quality child care as having a welcoming environment, providing developmentally appropriate learning activities, following appropriate health and safety procedures, and employing educationally qualified staff with a continuity of caregivers over time (Ceglowski & Davis, 2004; Harrist, Thompson, & Norris, 2007; Paulsell, Nogales, & Cohen, 2003). Liu, Yeung, and Farmer (2001) found that a large percentage (88%) of their parents participating in surveys about their ideas about day care services in Australia believed that improving the professionalism of their staff was a necessary

component of out of home child care. All parents held the expectation that their child should receive care that promotes academic achievement as well as other areas of child development (Liu, Yeung, & Farmer, 2001).

Though the families do not typically receive nor provide PD, they are a consumer of the child care program and as such indirectly benefit from such services by way of quality as provided by their child's caregivers. It is vital to recognize the values and expectations of the families of children in care because children develop within the context of the relationship they share with the family and their voices should be considered throughout the context of the PD experience.

Research has shown that parents and early educators have similar values in providing care for young children both placing high values on health, safety, and interactions in the early child care classroom (Cryer & Burchinal, 1997). When trained observers and parents were asked to rate infant and toddler classrooms using the ITERS, the 724 participating parents rated the classrooms as having high quality and the 228 trained observers rated them as low quality (Cryer & Burchinal, 1997). This overestimation of quality by the parents suggests that research is needed to understand infant and toddler child care from the perspective of the parent. It is vital that in infant and toddler care, families are considered as an integral source of information in order to facilitate consistent care.

Improving the professional qualifications of the staff can help caregivers educate parents about quality care and meet their expectations while also meeting the needs of children. Families reported the early childhood settings should meet the individual needs of children, but it is difficult for them to identify high quality (Cryer & Burchinal, 1997).

Parents from the United States also indicated that the child care program serves as a source for family education and support (Carlson & Stenmalm-Sjoblom, 1989). Materials such as books and storytime were deemed important, as well as the opportunity for self-selected activities, rote counting and stimulating physical environments. Creative materials and open ended play, like puppets, music instruments, and gross motor equipment, multicultural and writing activities were not. In fact, sedentary activities, such as coloring and computers, were rated as having higher values. Parents also identify language assistance, problem solving, and compliance with adults as an important part of early childhood programs (Carlson & Stenmalm-Sjoblom, 1989). It is possible that families place unrealistic expectations and values on aspects of care that lie outside the responsibilities normally held by child care staff.

Families must be part of the community of learners within the child care milieu (Ochshorn, 2011). Infants and toddlers develop within the context of relationships and their first relationships are usually with family members. As direct consumers of early care and education, families of infant and toddlers needs should be considered when designing the PD of their infant and toddler caregivers (Hill, 2007). PD programs may need to assist child care staff in meeting those expressed needs of the child's family and educate families on elements of quality that promote optimal child development.

Content of Professional Development

Buyse, Winton, and Rous (2009) agree with Hill (2007) that PD activities should focus on specific subject matter, align with instructional goals, curriculum materials, and professional practice. Change in caregiver behavior is likely when the content of the PD has been designed to meet the specific needs of the caregiver (Thornton, Crim, &

Hawkins, 2009). PD activities and content should be meaningful and relevant to the learner and taught within the specific context for which content has been designed.

Math, language literacy, family engagement, nutritional and physical activity, inclusion practices are examples of content covered during various PD activities within the literature (Lyn, Evers, Davis, Maalouf, & Griffin, 2014; Powell & Diamond, 2013; Rudd, Lambers, Satterwhite & Smith, 2009). Professional development opportunities must address the differing levels of knowledge caregivers possess (McNerney et al., 2006; Rudd, Lambert, Satterwhite, & Smith, 2009; Thornton, Crim, & Hawkins, 2009).

Thornton, Crim, and Hawkins (2009) conducted a study exploring teachers' understanding of math concepts and practices, as well as the impact of the coaching experience. Surveys were provided to 126 prekindergarten teachers before and after voluntarily participating in a two year coaching program with a focus on mathematical content. The teachers reported an increase of their mathematical knowledge and implemented more developmentally appropriate teaching strategies, such as hands on activities in lieu of worksheets. The PD techniques utilized by coaches were individually developed and content was differentiated based on the needs of the teachers and the children in the classroom (Thornton, Crim, & Hawkins, 2009).

Similarly, Rudd, Lambert, Satterwhite and Smith (2009) also examined the impact of math use through workshops combined with a coaching component. Through observation, they found larger increases in the use of math mediated language when workshops were enhanced by individualized coaching experiences. Lyn, Evers, Davis, Maalouf, and Griffin (2014) explored the barriers and supports to implementing new nutrition and physical activities. Through semi-structured interviews with 22 child care

center directors, they recognized the need for providers of PD to prioritize the needs of the recipients in order to provide adequate support for staff modifying current practices.

Professional development experiences that intend to improve quality may fail to meet the expectations of the attendees. Caregivers may be required to accrue training hours and PD experiences but acquiring knowledge and implementing new practices and behaviors is optional (Hill, 2007). Research has shown that when content is developed and delivered to a specified population, larger gains are observed when compared with PD experiences generically created and conducted (Lyn, Evers, Davis, Maalouf, & Griffin, 2014; Rudd, Lambers, Satterwhite & Smith, 2009)

Approaches to Professional Development

Studies show that professional growth and development can be influenced by the caregiver, the PD context and delivery, and the environment of the caregiver (Wagner, 2010). Buysse et al., (2009) identify PD as a facilitation of “learning opportunities....those that result in college credit or degrees as well as those that generally are less intensive and do not yield credits or degrees, those that occur largely through formal coursework, and those that are more informal and situated in practice” (p.238). Maxwell, Feild, and Clifford (2006) define training as “the professional development experience that takes place outside the formal education system” (p.29).

Based on research regarding parenting behaviors, De Schipper, Riksen-Walraven, and Geurts (2007) identify multiple determinants that influence caregiver sensitivity and responsiveness with infants and toddlers in child care settings. Formalized training, workshop training, and participation in on-site training emerge as strategies cited in literature which increase the responsive and sensitive care infants and toddlers need from

caregivers to form healthy attachments (Ackerman, 2008; Burchinal, Cryer, Clifford, & Howes, 2003; Buysse et al., 2009; Dunst & Raab, 2010; Zaslow & Martinez-Beck, 2006).

Opportunities to build and form mutual relationships with the facilitator of PD within the context of the child care setting can be a factor that promotes the application of new knowledge and implementation of new skills. The following section addresses each of the aforementioned approaches to PD through the lens of the conceptual framework of professional development guiding this study.

Formalized Training

College course work and specialized training are professional development methods that can be categorized as formalized training. They are often grouped together in literature and have been defined as ranging from some college to a graduate degree, specialized training in child development through vocational experiences, or certification from an accrediting agency (Clarke-Stewart et al., 2002). Research has shown participation in formalized training can be associated with an increase in quality of early care programs (Arnett, 1989; Burchinal et al., 2002; Cassidy, Buell, Pugh-Hoese & Russell, 1995; Clarke-Stewart et al., 2002; Gable & Haliburton, 2002; Raikes et al., 2005; Torquati, Raikes, & Huddleston-Casas, 2007). According to the environmental rating scales developed by Harms and colleagues, degreed caregivers of preschoolers, infants and toddlers who reportedly attended no trainings scored higher on global quality measures than the caregiver who had some training but no formal education beyond high school (Burchinal et al., 2002).

Raikes, Raikes, and Wilcox, (2005) found high education levels were strongly related to global and process quality of non-familial child caregivers. However, it has

been documented that caregivers providing child care in their home have lower levels of education than that of center caregivers (Rusby, 2002). Weaver (2002) reported that caregivers who had earned a CDA or ran an accredited program provided “good” quality care according to the environmental rating scales, in comparison with caregivers who reported various levels of training and provided care that was less than “good.” On the contrary research conducted by Campbell et al., (2005) found that formalized training did not serve as a contributor of quality child care for infants and toddlers. In a study of 128 caregivers providing child care in their home, Koh & Neuman (2009) offered a literacy course to one group and the course and coaching to a second group. A third group served as the control for the study and only participated in trainings they arranged on their own. Through an assessment of teacher knowledge and observations of the environment, they found no significant difference between the performance of the control group and the coursework only group (Koh and Neuman, 2009). Improving quality requires PD to address the knowledge and skills of a caregiver; however, in this study those needs were not met by providing a course without the supports of follow up coaching.

Torquati, Raikes, & Huddleston-Casas (2007) found that education (CDA or child development coursework) can be linked to higher global quality for preschoolers, but those links were found to be true for infant and toddler caregivers. In fact, Torquati et al (2007) found no associations between level of education and process quality for either age group which directly contrasts other researchers findings (Burchinal et al, 2002; Clarke-Stewart et al., 2002; Doherty, Forer, Lero, Goelman & LaGrange, 2006; Raikes et al., 2005; Walker, 2002; Weaver, 2002).

Formalized training is obtained through college coursework and other forms of specialized training. Research shows that knowledge can be increased through this method of PD; however, the delivery of knowledge is provided within the walls of adult-sized classrooms and out of context of the child care environment and lacks opportunity for true application. This challenges the caregiver to apply information learned outside the class setting to implement new strategies in their own classroom with their young children.

Formalized training offers the potential for a relationship building component but lacks the support, guidance and feedback critical to successful implementation of new skills (Koh & Neuman, 2009). When support is provided during formalized training, individualization, problem solving, coaching and modeling can be missing components due to predetermined curriculums set by directing agencies or entities.

Workshop Training

Workshop style trainings are the most widely used method for PD and can lead caregivers toward high quality (Bruder, 2009; Burchinal et al., 2002). Workshop or “one shot” trainings are offered by various agencies, center directors, early childhood education specialists, etc and are valued by facilitators and recipients alike (Burchinal, et al., 2002; Kontos, et al., 1996). Caregivers can choose topics and may attend the same sessions repeatedly.

Training can have a positive effect on the child care environment as well as the interaction between the caregivers and children (Burchinal et al., 2002; Kontos et al., 1996). Kontos et al, (1996) investigated the effects training had on quality as provided by caregivers working in their home. While improvements were made, they were only

marginally so on the environment and sensitivity provided to the children in care. This study utilized a comparison group but one may question if they were matched appropriately. The caregivers who participated in the study were enrolled in a training program and sought training. The comparison group was not in the training program and it is not clear how much, if they received any training within their community. The caregivers participating in the program clearly had the access, resources and motivation to seek PD (Kontos, et al., 1996).

Caregivers who did not have a formal degree but reported they attended workshops within the community were also shown to have slightly higher quality than their non attending counterparts (Raikes et al., 2005). However, literature reveals negative consequences of using training as the only source of PD in an effort to improve quality for infants and toddlers. Caregiver sensitivity was shown to decrease in child care centers and homes of caregivers when training was the only PD activity attended (Adams & Buell, 2002; Koh & Neuman, 2009; Kontos et al., 1996). Fiene (2002) also reported a decrease in global quality of infant caregivers in center based care after receiving training. As a result of a qualitative research study of military child care centers, Ackerman (2008) found that one caregiver believed that large group, workshop style trainings did not allow for individualization of the PD of caregivers.

Workshops may be designed by providers of PD or prescribed by a particular curriculum for the early care and education workforce. Trainers can attempt to make the learning meaningful and relevant to the needs of the individuals in attendance; however, it is often provided out of context. The caregivers can learn new information and may

practice applying their skill in a theoretical setting or role play but many caregivers are unable to apply their new knowledge or skills in their own setting.

Opportunities for feedback and support may be possible during workshops but are most likely non-existent or at best limited given the one shot method typically used. The information is also presented out of context and doesn't allow for personalization of the information as much as trainings that occur over time or on-site. Some recipients of PD may have choice in their attendance; however that freedom also means they can seek the same topics, thereby not necessarily extending their learning experience. Most training requirements simply require that early childhood staff accrue a minimal number of hours each year, but learning and applying the new material in their setting is optional (Hill, 2007).

On-site Training

Research suggests that on-site training with a coach, mentor, or consultant is the most effective delivery method of PD (Dunst & Raab, 2010; Koh & Neuman, 2009; Ochwari & Keengwe, 2010; Powell & Diamond, 2013). While workshop training is often the primary method of PD (Bruder, et al., 2009), on-site training is rated as the most useful by early childhood practitioners (Dunst & Raab, 2010). On-site training can be individualized, content and context specific, and can provide the encouragement support needed for caregivers to fulfill their role (Domitrovich, Gest, Gill, Jones, DeRousie, 2009; Thornton, et al., 2009; Wagner & French, 2010). On-site experiences are designed in part largely through collaborative efforts between the child care staff and consultant (Koh & Neuman, 2009). Opportunities exist within on-site training for problem solving,

teaching and coaching. PD that is ongoing plays a vital role in supporting the needs of caregivers as they face various challenges in their field (Helterban & Fennimore, 2004).

Several researchers have studied caregivers' quality improvement after experiencing an on-site training component coupled with an additional form of PD (Adams & Buell, 2002; Campbell & Milbourne, 2005; Koh & Neuman, 2009; Rudd, Lambert, Satterwhite, & Smith, 2009). Koh and Neuman (2009) investigated family child caregivers attending a 3 credit course coupled with 32 weeks of ongoing visits from a mentor and compared them with a group of caregivers who only attended the course. Other researchers conducted a study of caregivers receiving on-site training and workshop training (Adams & Buell, 2002; Campbell & Milbourne, 2005). The comparison group in each of the studies only received training. While the studies yielded positive gains in caregiver sensitivity towards children, it is important to recognize Koh and Neuman (2009) conducted their investigation with family caregivers and utilized a different measure of process quality. Campbell and Milbourne (2005) worked strictly with center based caregivers while Adams and Buell (2002) worked in both settings.

Research reveals that caregivers showed an increase in observed quality according to the ITERS-R after developing a professional relationship with an educational consultant (Fiene, 2002; Ontai et al., 2002). Both researchers, Fiene (2002) and Ontai et al (2002) found that caregivers receiving between four and nine months of monitoring and assistance were more likely to improve their interactions and environmental quality scores (Ontai et al., 2002). Researchers Ontai et al., (2002) began a study of a PD program that included goal creation with monthly reviews, and team implementation of those goals, including training focused on child development and curriculum

development improving the knowledge base of the staff (Ontai et al, 2002). Fiene (2002) utilized a randomized design to conduct in comparison to the study conducted by Ontai et al (2002) who used a sample of convenience. Randomized design is a stronger method of research because it can “best identify the components of professional preparation that are necessary and sufficient for promoting children’s development and learning” (Welch-Ross, Wolf, Moorehouse, & Rathgeb, 2006).

Campbell and Milbourne (2005) studied the effects of a PD program that combined training with onsite consultation that included written goals. The researchers found an increase in the overall quality of care provided in the classrooms participating in the study; however, the improvements were primarily environmental. Douglass and colleague (2012) found that director participation and engagement was a clear indicator of who sustained positive changes during an on-site strengthening families PD initiative. Dunst and Raab (2010) gathered caregiver perspective of different types of training and they rated on-site training as the most effective. Caregivers reported the most salient characteristics of PD included participation in activities that mirrored real-world experiences and an opportunity to practice new skills complete with feedback under the guidance of a consultant (Dunst & Raab, 2010).

On-site training has the potential for continuous, on-going practice of implementing new strategies and skills as well as revisiting and reflecting on current skills and knowledge. In successful consultation programs, the new knowledge and skills have been individually and collaboratively prescribed to a caregiver and a specific set of children. Professional development activities with support built in is clearly indicated as a need by caregivers in child care settings (Nelson, et al., 2011; Wagner & French, 2010).

While caregivers may not always have a choice to participate, on-site training offers the capability for the facilitator of PD to provide individualized feedback and support.

Early childhood educators find the intensity of on-site training is more useful than intermittent conference attendance or workshops (Dunst & Raab, 2010). In a self report evaluation, they also determined they gained the most positive changes in their practices and abilities after the on-site experience. Rudd, Lambert, Satterwhite, and Smith (2009) also found that a workshop session coupled with on-site sessions with a coach resulted in a 56% increase in math mediated language use which was 39% higher than workshop attendance alone.

During the early years of life, children are dependent upon the adults in their lives to provide education and opportunities for learning. For adults who have an established set of experiences, values and beliefs, learning that occurs naturally and within the setting of the content, in this case the early childhood classroom, may be viewed as more accessible, practical, and applicable. Learning is a risk that requires one to accept vulnerability and expose the possibility of mistakes. PD that incorporates on-site experiences can be seen as a safe environment for making such mistakes and benefitting from the new knowledge that may follow.

Providers and recipients of PD opportunities need to consider the approach to professional development based on the needs of the recipients. Formalized training, workshop training and on-site training are commonly used remedies for low quality but the most effective methods address key adult learning strategies (Fontaine, et al., 2006). On-site training opportunities such as coaching, mentoring, and consultation that facilitated collaboration are effective strategies/methods that allow caregivers

opportunities to gain knowledge and practice their skill under the guidance of a professional or with the support of a peer (Bruder, Mogro-Wilson, Stayton, Smith, & Dietrich, 2009; Hill, 2007).

Elements of Effective Professional Development

Through semi-structured, open ended focus groups, researchers found that consultants view PD as effective when respect, trust, open communication, and efforts used to establish equality among participants is present (Nelson, Lindeman, & Stroup-Rentier, 2011). Core components of PD opportunities shall include collaboration and professional discussion amongst fellow colleagues, dynamic hands-on learning activities, reflection and feedback sessions, and content that is research based (Shepard, 2007). Volunteer participation, support and collaboration, individualized content, as well as opportunities for reflection and feedback are valued components of professional development illustrated in PD literature (Buysse and Wesley, 2004; Dunst & Raab, 2010).

Volunteer Participation

The degree of choice appointed to caregiver for PD participation can impact the effectiveness of the experience (Wagner & French, 2010). Helterbren and Fennimore (2004) propose that early childhood professionals should “take an active, self-directed, daily hand in their own learning” (p. 270). Caregivers who were required to participate in an on-going training and consultation professional development program were reportedly resentful, viewed the training as uninteresting and a waste of time (Wagner & French, 2010). Reluctant caregivers reported the consultation experience had no impact on their classroom practices. Thornton, Crim, and Hawkins (2009) investigated the impact of a

coaching program on prekindergarten teachers' comprehension of math content and practice. The researchers reported statistically significant increases in teachers' use of three of the five mathematical contents studied creating more engaging activities and decreased their use of worksheets in the classroom (Thornton, Crim, & Hawkins, 2009). It may be that teachers who choose their PD have positive outcomes because they are intrinsically motivated to learn and apply new knowledge.

Support

The level of support received by providers and recipients of PD has been cited in research as a critical element to successful implementation (Domitrovich, Gest, Gill, Jones, & DeRousie, 2009; Nelson, Lindeman, & Stroup-Rentier, 2011; Powell & Stremmel, 1989; Wagner & French, 2010). Through PD activities, caregivers should not only learn new information, but gain the ability to apply this new knowledge into their current work setting (Nelson, Lindeman, Stroup-Rentier, 2011). This level of support is recognized as a need for recipients and providers of PD alike.

Caregivers. Caregivers have reported a variance of support in the area of professional growth ranging from a total lack of support from their supervisor (Wagner & French, 2010) to full support from the administrative staff (Ackerman, 2008; Douglass & Klerman, 2012). Child care staff describes their experience working at a new center as being forced to “sink or swim” and they are “thrown” into the classroom with neither preparation nor support from the administration (Nicholson & Reifel, 2011).

Caregivers who perceived their work environment to be supportive were more likely to implement new practices within their child care setting (Ackerman, 2008; Douglass & Klerman, 2012). Ackerman (2008) reported that when management joined in

debrief meetings with their consultant and caregivers, the meetings were more likely to take place and the management team was able to support the work of the caregivers better. Douglass and Klerman (2012) and Knapp-Philo (2004) also found that added engagement from the director resulted in a link between training and implementation practices. Professional development activities that include peer support within the context of a child care center not only allow the caregivers to build relationships with their co-workers, but they can also contribute to a community of learners while making sense of their own teaching practices (Wagner & French, 2010).

Consultants. Nelson, Lindeman, and Stroup-Rentier (2011) conducted focus groups with 34 ECSE consultants in order to gain an understanding of their perceived training and support needs. Consultants suggested that their role is multidimensional and there is a need for more training on specific consultation strategies such as collaboration and leadership as this role differs from their previous role as caregiver (Nelson, et al., 2011). The study participants also commented that their PD experience was primarily knowledge based with no practice or modeling component. Similar to elements provided in on-site training, they reported that consultant behavior change was limited with no coaching or supportive mentor to facilitate the transfer of knowledge to practice.

Dinnebeil, McInerney, and Hale (2009) found that on average, the consultants in their study spent over half of their consultant time primarily interacting with children instead of providing technical assistance to the teacher. Focus groups reveal that consultants felt caregivers expected them to spend a majority of their time with children (Nelson, et al., 2011). Additional support may provide the necessary construct

consultants need in order to provide more focused services for the participating caregivers.

Collaboration

Collaborative efforts can affect change in caregiver behavior and provide a forum for several teachers or professionals to work together towards a common goal by sharing practices, successes, and failures (Morrow et al., 2003). Research has indicated that adults learn most effectively when they become actively engaged in the content, when the learning occurs within authentic contexts, and it contains opportunities for collaboration, problem solving and the practice of specific skills (Dunst & Raab, 2010; Landry, Swank, Smith, Assel, & Gunnewig, 2006). Early Childhood Special Educators report the element of collaboration is often overlooked or missed entirely when working with caregivers of children with disabilities (Nelson, et al., 2011).

Helterbren and Fennimore (2004) report that caregivers should first take action research in their own classrooms, then collaborate with providers of PD to design activities to alleviate the challenges presented by the classroom. Teachers whose training included collaboration as part of their literacy PD were more likely to have children who demonstrated cognitive gains that carried into the kindergarten years (Landry et al, 2006). According to consultants, successful collaboration can be characterized as having some of the following features: respect for all participants, open communication between consultant and consultee, equality of participating team members, and an opportunity for building a positive working relationship (Nelson, Lindeman, & Stroup-Rentier, 2011). Specifically setting goals and instituting accountability with an on-site consultant can increase the probability that the caregiver will attempt to try out new skills and teaching

strategies. When caregivers are involved in the creation of those goals, they are more intrinsically motivated to support those efforts. Those who reported a lack of engagement and collaboration indicated that they would like to have more influence over the program goals (Wagner, & French, 2010). When consultants and caregivers collaborated to determine their focus for the duration of their time together, participation predicted an increase in the language development of the children (Mashburn et al., 2010).

Individualization

“The variety of the staff development approaches that the teachers in this project rated as effective suggests that there are many ways to begin, or to continue, the change process” (Morrow et al., 2003, p. 22). Practicality of its use in the classroom must also be taken into account when considering a PD program (Morrow et al., 2003). When meaningful activities are employed as part of a positive, supportive relationship, caregivers are able to interact warmly and sensitively (Howes & Tsao, 2012). Caregivers reported that effective strategies included techniques that could be used in real time within their classroom on a daily basis (Douglass & Klerman, 2012). The caregiver’s ability to take part in meaningful applications of new knowledge was linked to positive learner benefits (Dunst & Raab, 2010).

Douglass and Klerman (2012) conducted a multiple case study on the influence a PD program focusing on strengthening families had in four child care programs. Through observations, semi-structured interviews and document review, the providers of PD discovered specific barriers to implementing change and were able to focus on those barriers within the context of the child care center. Caregivers reported that participation

in role plays helped them better understand their own assumptions and also provided an increased competency to perform required duties (Douglass & Klerman, 2012).

Feedback

Feedback is an important feature of the consultation process and can impact the quality of PD experience (Dunst & Raab, 2010; Mashburn et al., 2010; Nelson, Lindeman, & Stroup-Rentier, 2011; Powell & Diamond, 2013). Military child care training specialists reported that providing specific feedback to infant and toddler caregivers was an effective way to enhance their knowledge and skill levels (Ackerman, 2008). Mashburn et al., (2010) conducted a study of 134 prekindergarten teachers participating in web based PD designed to improve language and literacy development as well as the interactions between teacher and child. On average, the teachers spent 19 hours consulting via videoconference regarding teaching practices and setting future goals. The researchers report a significant positive association between the number of hours a teacher spent consulting and receiving feedback with the receptive language development of the children. Hsieh, Hemmeter, McCollum, and Ostrosky (2009) employed a single subject consultation program for six weeks with a coaching component. With immediate feedback, caregivers were supported in their efforts to enhance the emergent literacy practices for preschoolers.

Conclusion

Studies have targeted various audiences and stakeholders such as the perspectives of caregiver and consultant (Ackerman, 2008; Dunst & Raab, 2010), solely caregivers (Berthelson & Brownlee, 2007; Hsieh, 2009) or directors (Lyn, Evers, Davis, Maalouf, & Griffin, 2014), or consultants (Dinnebeil, et al., 2009; Nelson, 2011), or families utilizing

child care services (Knoche, et al., 2006; Liu, Yeung, and Farmer, 2001). Largely absent is the voice of the infant and toddler caregiver and families of infants and toddlers.

As reported in this literature review, the infant and toddler workforce is undereducated and undercompensated. As a consequence, infant and toddler child care offers quality that is often rated as inadequate and potentially harmful (Helburn, 1995). Skills and knowledge regarding implementation of quality child care is sorely needed for caregivers of children between birth and three years of age. There is a paucity of infant and toddler research about how to acquire it (Campbell & Milbourne, 2002; Hestenes et al., 2007; Thomason & La Paro, 2009). Even more elusive is translating the research and theories that do exist into policy and more importantly into practice (Fukkink & Lont, 2007; Wesley & Buysse, 2010; Zaslow & Martinez-Beck, 2006). Given the low levels of quality child care that has been proven in many infant and toddler classrooms (Helburn, 1995), it is critical to conduct further research on improving the PD system employed by child care programs (Ackerman, 2008; Early et al., 2007).

Understanding the individual characteristics of the caregiver can serve as a guide for directors or consultants providing technical assistance for infant and toddler care. The development of professional training opportunities must be created with the articulated needs of caregivers (Nicholson & Reifel, 2011). Nicholson and Reifel also point out the need for training to be based within the context of the individual caregivers' center or classroom as it plays a vital part of their learning their role as caregiver. Implementing developmentally appropriate practices requires that caregivers have resources, support, and time for reflection and feedback (Nelson, Lindeman, & Stroup-Rentier, 2011).

A PD curriculum that is individualized allows the caregiver to apply new knowledge and skills in an environment that the material was specifically created for. When guidance and feedback are components of the PD process, the caregiver learns respectful interactions, is free to take risks and make mistakes without fear. Ultimately, the caregiver becomes the student, and it is the student's role to learn from the experience and apply the new knowledge in their own environment. The effective PD provider is able to model this relationship and transform it into a learning experience for the caregiver.

Chapter Summary

The current study explores the expectations and implications of infant and toddler consultation as experienced by the infant toddler staff and families, as well as the consultant providing the PD activities. This literature review reveals that a vast majority of research has focused on preschool children and providers of PD. Research from the perspective of the caregiver exists in only a minority of studies. Infant and toddler research is also limited and the voice of the infant and toddler caregiver is scarce.

Making PD accessible, effective, and replicable is where researchers' focus should target (Ochshorn, 2011). This study aims to explore a professional development consultation process capturing the perspective of the stakeholders. Effective consultation designed to enhance the quality of care provided to infants and toddlers in child care should allow the caregiver to determine the level of participation, provide support from a facilitator of PD as well as peer and administrative support.

Professional development is one avenue to increase the level of knowledge, skills, and practices of educators (Fontaine, 2006). The precise mode of delivery of PD that

leads to increased quality in child care settings is understudied and largely undetermined (Kontos et al., 1996). Caregivers are interested in a wide variety of PD activities and must find a method that best meets their needs and those of their children (Lanigan, 2011; Rusby, 2002).

Research has shown a positive correlation between caregivers who spent more time participating in consultation and children's language development (Mashburn, et al., 2010). There are several plausible reasons that may account for its success. Consultation is an on-going PD activity that is individualized for its participants and occurs over time. In most cases, one or several, familiar facilitators guide caregivers through various activities that lead to new knowledge and teacher practices. Consultants often work alongside their consultee offering feedback as they practice a new skill and provide time for reflective dialogue and feedback to discuss successes and challenges (Mashburn, et al., 2010). Through this parallel process, the relationship that is developed between the consultant and caregiver not only demonstrates effective practice, but also models positive, respectful interactions (Douglass & Klerman, 2012).

Evidence shows that workshop style trainings that are offered one time are not as effective as ongoing efforts of education and training (Weaver, 2002). Training should be tied to specific goals and outcomes (Campbell & Milbourne, 2005). Gable and Haliburton (2003) report several barriers to caregivers receiving adequate PD. Inconvenient scheduling was reported as the most important reason for not attending training. Cost, transportation, and time are additional challenges cited by caregivers receiving PD opportunities (Gable & Haliburton, 2003; Rusby, 2002). On-site training can alleviate many of the reported barriers for caregivers.

Providing adequate PD guidance can help teachers act in developmentally appropriate ways (Thornton, Crim, & Hawkins, 2009). Caregivers who perceived their PD efforts to be supported by the center are more likely to sustain change (Ackerman, 2008) and provide more sensitive caregiving (Manlove et al., 2008). Effective PD should meet the individual needs of caregivers, while addressing content, experience specific information, and strategies to promote higher quality care practices (Campbell & Milbourne, 2005).

Policies must reflect what we know about making progress in the quality of care for infants and toddlers. Most states have a minimum of training hours required by caregivers but simply increasing the education and knowledge levels of individuals may not be enough to implement and sustain the changes that are necessary to provide high quality child care for infants and toddlers (Ackerman, 2008). “We argue that high-quality PD involves the complex interplay between knowledge and practice” (Koh & Neuman, 2009, p. 557). Simply increasing one aspect will not replace the need to provide caregivers with the many tools they need to successfully provide high quality care for infants and toddlers (Early et al, 2007). Koh and Neuman (2009) found that simply offering a course was not enough to impact the structural and process literacy practices of family caregivers, however, the combination of a course and a coach made significant difference in the level of positive caregiving and sensitivity to children provided.

The next chapter describes the research design and methods used for data collection and analysis. A thick, rich description of each case and its participants are represented to provide a deeper understanding of the context in which this study took place. Sampling strategies, trustworthiness and methodological limitations have also

been presented. The final two chapters outline the results of the study and provide a discussion of those results and implications for further studies.

CHAPTER III

METHODOLOGY

The first chapter described the background of the problem that is poor quality child care for infants and toddlers and the lack of literature focusing on PD for their caregivers. Chapter Two explored literature that reported effective strategies as a means to enhance the quality of that care through PD. This chapter discusses the multiple case study research method used in this study to build an understanding of the expectations and experiences of participants taking part in PD through the use of on-site consultation. The research design, sample and population of each case under study are described within this chapter. Data collection procedures, strategies for trustworthiness and the data analysis plan are also be discussed in detail. A discussion of methodological limitations concludes this chapter and provides information about how I plan to reduce the impact of threats to the research design. The following chapters provide the results and a discussion of this exploratory study.

Research Design

This study was planned to understand the consultation process as it is experienced by infant and toddler caregivers and consultants and case study methodology is the best fit as the study sought to explore phenomena that cannot be manipulated (Yin, 1994; 2009). Case studies allow researchers to develop an understanding of the case from the multiple perspectives of the participants and their activities as they occur in the natural setting (Edwards, 2001; Stake, 2006). Utilizing this method for this study provided an opportunity to understand the PD consultation process in infant and toddler child care from the vantage point of the stakeholders.

Stake refers to the population of participants and the phenomenon to be studied as the “quintain” (Stake, 2006). In this multiple case study, the quintain is the consultation process as experienced by the participants in the context of infant and toddler child care. The actions, behaviors, and interactions of infant and toddler families, center staff and consultants were observed and described using thick descriptions under this method of study (Merriam, 1988; Patton, 2002). According to Yin (1994), the case study as a research method embraces an all-encompassing system – not a data collection strategy or design feature alone, but a comprehensive research strategy.

Utilizing a qualitative multiple case study design for this study has allowed me to identify the PD expectations and experiences of infant and toddler child care center staff and infant and toddler consultants situated in multiple child care settings (Patton, 2002; Yin, 1994). Two to three cases are necessary for replication purposes and developing a pattern among the cases while selecting between four and six cases provides enough evidence to demonstrate a contradiction between cases (Yin, 1994). Qualitative case studies are not meant to be representative or even generalizable (Stake, 2006). This research design, however, has afforded me the opportunity to perceive the expectations and the process of the infant and toddler child care PD experience across several cases which is valuable and necessary to build a rich understanding of the consultation process as it occurred with caregivers of infants and toddlers in child care (Stake, 2006).

The information under study often reveals itself in time and is ever evolving throughout the life of the study. The researcher often plays an interactive role as the data is shared by participants. Case studies have been extensively utilized within the social sciences, such as education, and the benefits of conducting such research are numerous

(Yin, 1994). This research design allows for a deep understanding and insight into the expectations of PD programs aimed at infant and toddler child care stakeholders (Ryan & Lobman, 2007). The qualitative case study provides not only a wealth of information about a few cases, but also offers an in-depth view of a phenomenon with careful attention to detail within a specific context while quantitative research offers a breadth information using predetermined categories and standardized data collection techniques (Patton, 2002).

Hays and Singh (2012) state that social constructivism is the belief that there is no universal truth as there are many realities that exist. Social constructivists seek to gain an understanding of a phenomenon through observation and interaction with their subjects. It is also valuable to the researcher to learn how the subjects gain an understanding of the phenomenon as well (Hays & Singh, 2012). The epistemology of the relationship is that knowledge is co-constructed between the center and consultant which offers an ontological lens to the study. In this study, I observed the relationship between the consultant and consultee and documented to what extent that is occurring. Through an axiological view, an emphasis on the values of the caregiver and consultant within the context of the child care setting was respected. As the researcher intending to learn the experience of the participants, I remained out of the way and silent throughout the observations. At each visit, I also asked participants if they wanted to share additional information about their consultation experience. Each participant was notified of the date of the observation before it was to occur. Questions regarding the study and comments regarding the observation were sought before and after each interview and observation. Center participants were provided with materials from me to support their work with

infants and toddlers within the child care setting at each site visit. Consultants were provided with a small gift card for their participation during the first interview and a larger gift card at the culmination of the study.

In this multiple case study, four child care centers participating in an infant and toddler consultation program have been explored. Each case is bounded by the child care site and consisted of four stakeholder groups: the director of a child care center, the infant or toddler caregiver (also known as staff member), families of infants and toddlers, and the infant and toddler consultant.

Research Foci

The relationship established between the consultant and the caregivers is an essential element to the effectiveness of the PD process (Domitrovich, et al., 2009). Domitrovich et al, (2009) noted many researchers assess the collaboration experience and goal alignment of PD from the perspectives of both the caregiver and consultant. Exploratory questions were developed to guide this study in an effort to understand the dynamic relationship between the consultant and the caregiver and the impact that relationship may have on the quality of care provided to infants and toddlers in the child care setting.

The first exploratory question, “To what extent are site stakeholders expectations of infant and toddler consultation participation similar to infant and toddler consultants’ expectations of program participation?” was developed to help me understand the expectations and goals of the on-site participants receiving PD and compare stated expectations with those of the consultant designing and providing the consultation experience. Determining whether the goals and expectations match reveals the intended

outcome of participants and ultimately, should lead to a more cohesive experience for all participants. An additional question, “In what ways are site stakeholders’ expectations of infant and toddler consultation being fulfilled during the course of participation?” allowed for a closer examination of highlights or challenges of the consultation process.

Parents are an important population to explore because they are an invaluable piece of child development, as well as, the child care environment. As a researcher, it would be a missed opportunity if their stated expectations of those services as they are the consumer of child care were not taken into consideration. To that end, an exploratory question guiding this research study included, “To what extent are family expectations of infant and toddler services similar to the services provided through infant and toddler consultation?” In an effort to address a final question, “In what ways is participating classrooms’ quality of care affected by infant and toddler consultation?” data were collected to uncover any implications participation has on the quality of care as provided by the caregiver.

Role of the Researcher

This exploration into infant and toddler consultation was born out of a personal and professional curiosity. I began my early childhood career as a toddler caregiver and was constantly on a quest to learn more about the field and how to improve my classroom practices. Nine years after I began my journey as a toddler caregiver, an opportunity arose for me to switch gears from infant and toddler caregiver to infant and toddler consultant. The journey has been full of lessons learned, resources, information and experiences. As I now provide consultation to infant and toddler caregivers, I wonder what it must be like on the receiving end. In my tenure as a caregiver, I did not have

access to a consultant and I believe I could have benefited from such an experience. I am not so naïve to think that perhaps, I would not want a consultant disrupting my classroom and critiquing my practice. It has been my experience that consultation may not always be welcomed, as it is often requested by the director and not the individual caregiver.

Through this case study, I explored the perspectives of the consultation participants in hopes to gain a new understanding of the process from the outside looking in. I am a parent and have been on both sides of the consultation “fence.” I currently work as an infant and toddler consultant for the consultation program under study and I firmly believe all perspectives are necessary to get a full view of the process. My own two children attended child care as infants and toddlers. Though my children are no longer in child care, I recognize the family perspective is vital to the growth of infants and toddlers. The participating consultants were also my co-workers. As a consultant, it was important that I recognized my own opinions and biases toward the process. Biases and assumptions were bracketed through various means to maintain the integrity and robustness of this study. Through reflective journaling and a research team, it was my aim to address the challenges of those biases and assumptions due to my intimate connection to the quintain (Hays & Singh, 2012; Patton, 2002).

Reflective journaling assisted me in the maintenance of honesty and authenticity through frequent self-reflective entries and reviewing of past entries. Field notes were completed after every interview and trip to the field for observations. Thoughts, fears, expectations, opinions and assumptions about the experiences of the participants were documented and used to guide me through the data collection process. The act of reflexivity provided me an opportunity to analyze my own thoughts, as well as those of

the participants, which was vital in reporting the results and illuminating the voices of the participants.

Research Team

A research team was assembled to help me bracket my assumptions and code interviews. The team consisted of experts with a doctorate in early childhood education also mothers to young and middle aged children, an elementary school teacher and mother of a middle school child, and a member of the United States Navy who is also the mother of three young children. The research team participated in mock interviews, assisted in coding interviews and focus groups and worked to establish inter coder agreement. The team members were also utilized as a sounding board for decision making during the life of the study. When working with human subjects it is common for the unexpected and one must be prepared for on the spot changes and adaptations. Several meetings were conducted to determine the most appropriate path when teacher turnover occurred on multiple occasions at one location. Interview questions were continually reviewed to ensure the information being sought would contribute to the research questions posed.

It is critical to recognize the role of the researcher and the plan to address the possibility of biases and assumptions. Maintaining accuracy in the identification of the expectations and experiences of participants will be less of a challenge using these strategies. Reflective journaling, peer debriefing and research team meetings aided in the development of a precise understanding of those experiences.

Participants and Sample

Participants for the current study were recruited from a larger population of consultants and child care staff already participating in an infant and toddler consultation program. The Program, as it will be known, is part of a national initiative devoted to enhancing the quality of care provided for children under the age of three. In this Mid-Atlantic State, there are 15 consultants providing services to approximately 120 child care centers offering out of home care for infants and toddlers during the 2014-2015 year. Funding for this consultation program has been made available through the U.S. Department of Health and Human Services.

Quality improvement, quality enhancement, and quality assurance is provided to infant and toddler caregivers through training, technical assistance and on-site consultation. The Program is available to caregivers who work in a variety of settings including public and private child-care centers, religious exempt centers, and family day homes. Each full-time consultant carries a caseload of approximately eight child care centers and is required to spend a minimum 40 hours and five months providing technical assistance and on-site consultation.

Through participation in the Program, the infant and toddler child care environment is assessed for quality and together with the director and caregiver(s), the infant and toddler consultant drafts a plan for quality improvement. The plan includes the specific elements that will be enhanced and provides a variety of strategies used by all participants in order to achieve that goal. The plan outlines those accountable, identifies needed resources and provides a timeline for each strategy to be completed. The plan also provides an opportunity for the participants to indicate whether or not the goals were

met.

Qualitative multiple case study is situational and permits the researcher to explore a complex, multifaceted entity and its constituents. Each case has subsections that require further exploration and examination to gain a deeper understanding of the experiential knowledge of the quintain (Stake, 2006). This case study collected data from four populations or subsections: directors, infant and toddler child care staff (referred to as caregivers), families of infants and toddlers, and the consultants providing technical assistance targeting infant and toddler development and care.

In order to fully achieve the benefits of a multiple case study, setting a minimum goal is realistic and appropriate (Patton, 2002). In order to understand the depth of the case, I spent a considerable amount of time collecting data to this end. Stake (2006) recommends collecting data from anywhere between four and ten cases. Qualitative data is ever emerging and must remain flexible for the life of the study. A total of four child care centers agreed to participate and share their consultation experience.

Sampling Techniques

A combination of sampling techniques was utilized to achieve information saturation. Through purposive sampling, I sought to examine the average child care center serving infant and toddler families to identify the consultation expectations, experiences, and any impacts of participation (Hays & Singh, 2012; Patton, 2002). Because this sample was meant to be illustrative, a balance of infant and toddler consultants representing the various urban and suburban regions of this Mid-Atlantic state were among those recruited. In order to create information-rich cases, snowball sampling followed the original sampling procedure (Patton, 2002). When a consultant

indicating participation interest was identified, the consultant then recruited the center and center staff. The center staff assisted in recruiting family participation with encouragement and support from me. The actual procedures followed for each step are described in the following paragraphs.

Consultants providing consultation PD services received an email describing the proposed study followed by a phone call to identify the consultant's interest and intent to participate. When a desire was acknowledged, I arranged a meeting to discuss the details of the study and obtained their signature on the letter of informed consent (Appendix B). Consultants providing infant and toddler technical assistance through consultation then notified participating centers of my intent to explore the expectations and experiences of the consultation process. An interest letter (Appendix C) was provided to the consultant to share with the infant and toddler center staff to gain knowledge of their interest level. When the director expressed an interest in learning more about the center's participation, the director gave the consultant permission for me to contact them directly. The consultant then shared a contact name and information.

Upon receiving contact information, I contacted each child care center director who expressed a desire to participate in the study by phone to schedule an informal visit to the center at a time that was mutually convenient to further discuss the study and establish rapport with the staff. I emailed the letter of consent to those who requested it in advance of this visit to give them time to understand study participation and develop questions for our first meeting. At this initial meeting, I presented the informed consent letter (Appendix D) and described the study in detail, explaining each participant's role and responsibilities. Each participant was given an opportunity to ask questions for

clarification before they agreed to participate by signing the informed consent letter.

Subsequently, at every visit, each participant was provided additional opportunities to ask questions about the study or their participation.

Families were recruited by me and center staff through an interest letter (Appendix E). This letter was provided to directors in advance of sharing it with parents to seek their input and/or suggestions. Either I or the directors provided hard copies for each family with a child less than 36 months of age enrolled. Where possible, I distributed the interest letter to family members directly, late in the afternoon when parents normally picked up their child. I collected contact information (name, phone number, email, most available time for participation) on-site and verbally represented the study to the families to gain their interest in participating in the study. A date, time and location for the focus group was determined with input from the director. Families who expressed a desire to participate were contacted and informed of the meeting date, time and location. When possible, interested families received the informed letter of consent prior to the focus group. Upon the day of the focus group, they received two hard copies to read and sign. One was returned to me and they kept the remaining copy. Emails and text messaging was also used to remind families of their focus group scheduled date and time.

Due to the busy nature of raising a family and working (hence the need for child care), recruiting of families was not as successful as I would have hoped. In the centers where no parents expressed an interest, despite the multiple recruiting attempts, a parent telephone interview was solicited with one parent instead. The chosen parent was determined by the director or caregiver and contacted by me to establish the best time to

conduct the interview. One case was unable to even locate one parent willing to participate in an interview neither over the phone nor in person.

Participants

The ultimate number of cases was guided by the number of participating consultants and child care centers. In each of the four participating cases data was collected from a minimum of one director and one caregiver, and the consultant. In three of the four cases, data was collected from one family member of an infant/toddler. See Table 1 for a matrix by case illustrating the participants from each case. A description of each participant follows the table.

Table 1

Stakeholder Descriptions by Case

Case I: Many Hearts

Category	Consultant	Director	Caregiver
Gender	F	F	F
Age range	56-64	36-55	18-35
Race/Ethnicity	B	W	B
Household composition	M	DIVORCED	S
Ed. Level	MASTER'S	MASTER'S	ASSOCIATE'S
Yrs ECE	BLANK	23	4.5
Yrs Center	BLANK	4 MONTHS	4.5
Position	CONSULTANT	DIRECTOR	INFANTS
Years in position	6	4 MONTHS	5 MONTHS
Years with IT	22	4 MONTHS	4.5
Employ status	FT	FT	PT
Benefits:	Health, dental, life insurance, paid leave	PAID LEAVE	NONE

Case II: My Child Care

Category	Consultant	Director	Caregiver 3
Gender	F	F	F
Age range	36-55	18-35	18-35
Race/Ethnicity	OTHER	OTHER	W
Household composition	M	S	DIVORCED
Ed. Level	MASTER'S	CERTIFICATION	SOME COLLEGE
Yrs ECE	16	5	BLANK
Yrs Center	5.5	1.5	1 MONTH
Position	CONSULTANT	DIRECTOR/OWNER	INFANT LEAD TEACHER
Years in position	5.5	5	2
Years with IT	16	5	10
Employ status	FT	FT	FT
Benefits:	health, dental, life, paid leave (sick, annual, and volunteer), short and long- term disability, matched funding retirement fund	BLANK	BLANK

Case III: Jumping Jacks

Category	Consultant	Director	Caregiver
Gender	F	F	F
Age range	36-55	56-65	18-35
Race/Ethnicity	W	W	W
Household composition	M	M	S
Ed. Level	MASTER'S	MASTER'S	ASSOCIATE'S
Yrs ECE	20+	37	12
Yrs Center	N/A	1.5	1
Position	CONSULTANT	EXECUTIVE DIRECTOR	TWO YEAR OLD TEACHER
Years in position	2.5	1.5	10
Years with IT	4	20	BLANK
Employ status	FT	FT	FT
Benefits:	Paid leave, health, dental, life, retirement, FMLA, disability	Paid leave (3 weeks), sick & personal leave, health, dental	Paid leave (3 weeks), sick leave, dental

Case IV: The Play Yard

Category	Consultant	Director	Caregiver
Gender	F	F	F
Age range	36-55	36-55	18-35
Race/Ethnicity	W	B	B
Household composition	M	M	SEPARATED
Ed. Level	MASTER'S	BACHELOR'S	SOME COLLEGE
Yrs ECE	35	12+	7
Yrs Center	BLANK	1.5	2
Position	CONSULTANT	DIRECTOR	LEAD INFANT TEACHER & MANAGER
Years in position	1	1	1.5
Years with IT	1	1.5	BLANK
Employ status	FT	FT	FT
Benefits:	health, dental, life insurance, paid leave	Paid time off	BLANK

Case Descriptions

With over six months of data collection gathered, I was afforded the opportunity to interview and observe the infant and toddler consultants working with directors and caregiving staff of children attending child care. I also had the good fortune to meet and learn the expectations of that child care from the families who send their infant and/or toddler to child care in their absence. Within the next few paragraphs, I will share not only what I learned through program documents and interview, but some of what I have learned by experienced and observed with the study participants during my visits to the child care centers. After I provide a description of each case and before the participants are introduced, I will provide a short vignette describing my initial visit at each site to illustrate my personal experiences as I gained access to the participating centers.

Case I: Many Hearts

Many Hearts is a licensed child care center in a rural part of the state with a capacity to care for 30 children between birth and 36 months of age in three classrooms. Prior to consultation services, Many Hearts had not participated in any other type of program consultation. Currently they serve all types of children, including those from low income families. According to the Consultant Activity Summary, over 6 months and a total of 40 hours of technical assistance was provided within the course of 16 on-site visits. Half of those visits self-reported group care as the topic covered during the visit. One quarter of the visits were dedicated to learning and development. Just under six training hours were provided and the content of those trainings included group care and health and safety.

Due to unforeseen circumstances, three consultants provided training and technical assistance to the caregivers of Many Hearts. Darlene had provided 70% of the total hours of on-site visits before additional consultants were called in to complete those services. Study participation began after 53% of the 40 hours were conducted. During the single observation I was able to attend, the infants were engaged in floor time, diaper changing and meal time. Darlene, the study consultant participant, provided board books and fleece socks, offered to provide laminating services and plastic bags. She spent a majority of that 60 minute observation talking with a caregiver recently employed, whom she had not yet met. A total of nine primary interactions were noted during this observation and three of those interactions were goal oriented discussions. Discussion topics included feedback on environmental changes and resources. It was observed that she also spent a considerable amount of time sitting on the floor interacting with children on four separate occasions.

Experiences from the field

I am greeted with a smile by the director upon my first visit as she is expecting me. She explains that she has met me before at trainings she has attended in the past when she worked in another facility. The consultant arrives moments after I arrive and we are escorted to the infant classroom to begin the observation of the consultation process. The director volunteers the use of her office for the staff interviews and we set up a time to conduct them once the observation is complete.

Upon entering the infant classroom, the staff quickly introduces themselves and I explain my study and why and how long I will be observing the classroom. My explanation is simply that I am learning about professional development in action and

that I will be recording the activities primarily carried out by the consultant. I find a corner of the classroom to sit on the floor where mobile infants do not typically play since it is just below the infant supplies storage area. From here, I can see the whole room including areas for routine care (diaper changing) and play (the sleeping space is behind a wall and was not used during the observation). There are two caregivers present, one of whom is a participant in the study. The second is a caregiver who is relatively new to the center.

The participating teacher, Krystal, is greeted by her infant and toddler consultant, Darlene. She has brought some infant board books for the classroom and fleece socks for Krystal. The consultant spends just over an hour in the classroom. By this observation date, she has already spent over 20 hours with this center providing consultation.

Selina. Selina is the full-time director of Many Hearts and as of February 2015, has been in that position for less than one year. The director is new to the center and was brought in after the commencement of program participation. She found this center in her latest job search and was happy to be participating in the quality enhancement services as she reported not much infant and toddler experience. Her early childhood education experience is more than 20 years but that experience did not include infants and toddlers. She is younger than her consultant, reporting her age between 36 and 55. She has a Master's Degree and has accrued paid leave from her employer.

Selina's journey to the field of early childhood didn't begin as early as other participants. She found herself working with infants and toddler when she applied for and became the new program director at Many Hearts. During her college years, she was required to provide community service and because she knew she enjoyed working with

children she volunteered with a head start program. Thus, she changed her major and has been working with young children since that time. On the contrary to most of the other participants, the director of Many Hearts became a recipient of infant and toddler consultation because the center was already participating when she was hired.

Krystal. Krystal, the infant caregiver is the youngest of the trio, sharing that she is between 18 and 35 years of age. She currently holds an Associate's Degree and has less than five years' experience in early childhood, all of it working part-time with infants and toddlers. She began working at Many Hearts as she had worked there previously under different management. The current director expressed an interest in having her return to work with infants and Krystal was unsure but once she got into it she began enjoying the work. She had no real previous experience working with such young children. She explains,

It was a different experience but it really brought me a little closer to learning and understanding how kids learn and engage in different things (Interview, July 22, 2015).

She joined Many Hearts less than a year ago and was already employed when the current director was hired. Work benefits are not afforded to her in her position. Krystal's passion for young children began when she started babysitting. She enjoyed watching them learn and grow and took pleasure in "being part of their life so young and teaching them milestones" (Interview, January 22, 2015). Prior to working at Many Hearts as an infant caregiver, Krystal had worked with young and older toddlers. When she learned about the infant caregiver position at Many Hearts, she was not sure but soon found herself enjoying the work. She found the position brought her "closer to learning and

understanding how kids learn and engage in different things” (Interview, January 22, 2015).

This caregiver of Many Hearts began working with the infant and toddler consultant because the infant program was new and she recognized that knowledge in working with infants would be needed to help the center. She shared that she looked forward to learning how to do an infant program and what is expected of her as an infant caregiver.

Patricia. Patricia has a ten month old enrolled in Many Hearts Child Care Center. She is married and between 18 and 35 years of age. She identifies as Black or African American and has earned an advanced degree. Her daughter has been enrolled in her current child situation for over eight months.

Darlene. Darlene has been an infant and toddler consultant for over five years and has worked with this population for over 20. She is between 56 and 64 years of age and has earned a Master’s Degree. From her full-time employment as a consultant, she benefits from health, dental, and life insurance and has accrued paid leave from her employer.

Darlene knew from a young age that she wanted to be a teacher as that was often her role in her childhood play. She started as a teacher’s assistant and quickly observed that some teachers were good and others were not. She knew she would need to go to school in order to be effective in her role.

When asked, “What lead you towards working with infants and toddlers?” Darlene reminisced about her work with preschoolers. When she switched agencies, she noted that their focus was with infants and toddlers and she expressed an interest in

learning more about them as opportunities became available. She was fascinated in their differences from older children and enjoyed learning about “their needs, what was important to them and the caregivers that worked with them” (Interview, July 3, 2015).

Many Hearts became a recipient of infant and toddler child care consultation when the new owner shared she would be purchasing the center. She understood that it was going to need some work and wanted the assistance of the consultant. The pair met a short time later to discuss how the center was going and began their relationship at that time.

She was working for an agency and transitioned to an infant and toddler consultant when the position became available. She previously worked in a preschool and had an opportunity to shift to working with the infant and toddler population when her agency’s focus moved towards younger children. She finds the work interesting because it is so very different from working with preschoolers. She finds learning about their needs and what is important to them fascinating.

In the case of Many Hearts, none of the participants are categorized in the same age bracket. Their levels of experience with infants and toddlers vary wildly amongst them and while the consultant and caregiver identify as Black, the director is White. They each have differing household compositions as well. The director and consultant have earned a Master’s and the caregiver an associate’s. The benefits of each participant also vary across the three.

Case II: My Child Care

My Child Care has two classrooms caring for less than 20 children under three years of age. The center serves children who are migrant, homeless or in foster care,

those from a low income family, as well as children with diagnosed disabilities. The director reports that the center has participated in a professional consultation relationship prior to June of 2014 when they began working with the on-site infant and toddler consultation program. They have had a child care health consultant, mental health consultant, and worked with early intervention.

Eliza accrued 55 hours providing training and technical assistance to My Child Care, the largest number of hours among the four participating child care centers. During the 24 visits, she reported that most of the technical assistance was provided in the areas of group care, learning and development and health and safety. She also provided nine hours of training within that 11 month time period on social and emotional growth, group care, learning and development, and health and safety. This center's study participation began after 37 hours or 67% of on-site visits had already occurred. Due to staff turnover, the consultant extended her service hours to work with the newly hired staff.

Experiences from the field

I arrived at this center just before the consultant and was greeted by the director. She was welcoming and I reminded her about the topic of my study and extended my sincere appreciation for her center's participation. We arranged to meet after the observation for the initial interview. The consultant reported that the center chose to participate in an effort to create a place of excellence and she has high expectation of her staff. She also desired training hours.

The consultant for My Child Care, Eliza, escorted me down the hall to the classroom of toddlers. The children were engaged in a circle time activity with their teacher and the consultant I sat back to observe. The caregiver providing this circle time

was an original participant but because she was no longer employed at this facility on my next visit, her interview has been eliminated from the study. The infant teacher became the focus and I learned that while she had little employment history at My Child Care, she had over ten years early childhood experience. She spent some of that time working directly with infants and toddlers.

A total of three 60 minute observations were conducted with Eliza at My Child Care. Due to multiple instances of turnover, each observation was with a different caregiver. The final observation is the participating teacher whom provided interview information for this case study. Over the course of the three visits, the infants and toddlers were engaged in meal time, floor time, reading books, and naptime.

A majority of Eliza's time was split between interacting with the three caregivers and the children in attendance. Across all three visits, a total of 22 primary interactions were between the consultant and the caregiver while 21 of those interactions were between consultant and child. The content of those interactions were interacting with children followed closely by talking with the caregivers. The nature of most of her consultant activities were interacting with children. Eliza modeled and encouraged language while sitting on the floor with the infants and toddlers of My Child Care. She provided feedback to the caregivers regarding a variety of topics such as child development and literacy. She also spent time sharing her own family stories with the caregiver.

Ronnica. Ronnica is the full-time director and owner of My Child Care. She has held that position for almost two years but has five years early childhood experience. During the interview, Ronnica shared a personal story that happened to her own child

while attending child care. She felt that due to lack of caring and properly keeping the children healthy and safe, she needed to begin caring for children in her own home. She did some research and took classes to ensure that she was up to date on things she didn't know. She cared for children in her own home before purchasing and opening My Child Care.

Lauren. Lauren is between 18 and 35, has worked with infants for less than five years and has earned college credits. She has been the full-time infant teacher at My Child Care for less than one year. She has over ten years experience working in child care as it has been her passion since she was nine. With over ten years experience working in child care, Lauren claims that her passion for working with young children began when she was babysitting at the young age of nine. Her last employment was with infants and she applied for jobs where an infant caregiver was needed. She acquired this position upon relocating to the area and applying for the position. She did not indicate any benefits received as a condition of her employment.

Eliza. Eliza is between the ages of 36 and 55 and has been an infant and toddler consultant for over five years. She has a Master's Degree and has been in the field of early childhood for over 15 years, all of which included working with infants and toddlers. Her employment qualifies her to receive health, dental and life insurance as well as sick, annual and volunteer leave. She also qualifies for short and long-term disability and a matched funding retirement fund.

Eliza, the consultant for My Child Care, shared that her interest in infants and toddlers, specifically in their social and emotional well-being is part of what drew her to the infant and toddler consultation program. She shared her excitement that in this

position, she will get to focus solely on infants and toddlers. My Child Care was chosen Eliza recognized the director's desire to create a center of excellence and high expectations. She also wanted to be able to provide hours of professional development for her staff.

In the case of My Child Care, the director/owner and caregiver share the same age bracket while the consultant is older than the two. The racial identification of the trio varies as does the household composition. The director and caregiver each have less than ten years' experience with infants and toddlers while the consultant has over 15. All participants are considered full-time employees but the staff of My Child Care did not share any benefits as a result of that employment.

Case III: Jumping Jacks

Jumping Jacks has one toddler classroom serving children from diverse backgrounds. Children in low income families and those diagnosed with a disability are currently among the children receiving child care services. They are located downtown in a major city and have previously participated in consultation services dedicated to enhancing the quality of care provided by the center.

Jumping Jacks benefited from Georgia's consultation services for over ten months. She spent 48 hours on-site providing technical assistance in all of the reportable areas. Study observations began only after 11 hours of service had occurred. Of the 22 total visits, ten of those visits were devoted to group care and learning, followed by leadership and management for eight visits, and social and emotional growth for seven. Seven hours of training were conducted by Georgia and the content of those trainings

included social and emotional growth, group care, learning and development, health and safety, and literacy.

During the three 60 minute observations spent with Georgia at Jumping Jacks, the toddlers were engaged in group time, outdoor and gross motor play, and free play. All visits were conducted with the same lead teacher, Katherine, although she had an alternate assistant teacher for the second visit.

Georgia's primary interactions were conducted with children. Those count totals amount to 16 instances of that primary interaction which followed closely by the assistant teacher with 14 and the participating study caregiver with 13. Her time with children was spent providing supervision and guidance. She modeled language while sitting at their level and interacting playfully. She also encouraged caregiver-child interaction. She provided technical assistance to teachers regarding child development and family communication.

Experiences from the field

After making several attempts to locate an appropriate parking spot, I then had to find the front door. Once inside, I was escorted to the director's office and conducted the interview for the director in the director's office. She was solicited by the child care administration to help the center determine what is most important for all children and the infant and toddler aspect of that, helping those teachers grow professionally in their ability to really engage with two year olds, expand language and help them to learn new methods of teaching through play (Donna, Interview, January 12, 2015).

I then found the toddler classroom and observed the consultant and caregivers in action. After the first hour, she found an empty space in the building for us to discuss her

experiences and expectations. The toddler caregiver shared that she was unaware that she would be receiving on-site infant and toddler consultation.

It was something our boss set up and I think maybe that's why at first we were like, 'What?' We were taken aback, 'What's going on.' I know it took a little time but we adapted and I think that if it has been brought to us we would have thought, 'What are we doing wrong?' Not that we we're doing it wrong, it was something that was going to help us (Katherine, Interview, May 18, 2015).

She was very accommodating and open towards me. She spoke freely during the interview and felt comfortable enough to share the previous statement with me. I understood that she felt reserved about having a consultant and was concerned that she might not be doing all that she should for her children. On our first visit, she professed to be "perfectionist." She worried that her best was not good enough for her superiors and the consultant. On a second visit, it was apparent to me that I was also a source of anxiety as she continually checked in with me to see if I had any comments or suggestions for her classroom. She also felt the need to explain certain practices or changes in routines as they occurred. I reassured her that my observation was primarily focused on the activities of the consultant and I welcomed the opportunity for her to comment or ask questions before I left each visit. By the final observation, she seemed a bit more relaxed and less concerned with my presence.

Donna. Donna has been the director for Jumping Jacks for almost two years. She reports 37 years of experience working with young children, 20 of that included infants and toddlers. With over 30 years early childhood experience, she has held various positions such as PD provider, early childhood environment designer, and has worked

with children with disabilities. Benefits offered through her employer include paid sick and personal leave as well as health and dental insurance.

Donna's story is similar to those already shared. She, too, began working with children at a young age serving as a babysitter. She knew she wanted to work with children and decided to go to school to figure out how to make this her career. After taking courses in high school and college she served in many positions of her early childhood career. She operated a home child care center, worked in child care referral programs, directed a small church preschool, taught children and even learned about the Reggio approach by attending a research tour. As children in her center had unmet needs, she decided to work towards a master's degree in special education. She's also spent ten year in the public school setting.

Most recently, she's been an in early childhood special education at a college and also held the position of head of PD. She expressed a desire to work in a child care center serving children of diverse needs and backgrounds. She was solicited to become the director of Jumping Jacks and hopes to help the teachers grow professionally.

The director of Jumping Jacks, Donna, requested infant and toddler consultation because the mentor program they previously participated in focused primarily on preschool-aged children. She wanted her staff to be able to "define what is most appropriate for the toddler class" (Interview, January 12, 2015).

Katherine. The toddler caregiver, Katherine, is the youngest of this group with only between 18 and 35 years of age. Ten of her twelve years of experience in the field of early childhood have been with toddlers. Her entry to the early childhood field has been told my many. She was once considered the neighborhood babysitter, a nanny, and

then a child caregiver in a licensed facility while she attended school at night. She has since earned her associate's degree and is very happy working with toddlers. She has only been at her current center for just over a year. In this full-time position, she receives paid personal and sick leave and dental insurance.

Like Lauren at My Child Care, Katherine also babysat for children in her neighborhood. She also worked in an infant nursery and was a private nanny until she entered college. As she attended college working towards her associate's degree, she worked in a child care center with older toddlers and young preschoolers.

Katherine confessed that she and her co-teacher were unaware of their participation until the infant and toddler consultant came to visit the classroom. In one of her two interviews, she shared that she thinks it was something her boss initiated. They hadn't been briefed beforehand and therefore they were taken aback and unclear as to why the consultant was visiting.

Monique. Monique has three young children, two of whom are under three. She is married and is between the age of 18 and 35. She currently serves as a toddler caregiver in child care.

Georgia. Georgia is the full-time infant and toddler consultant for Jumping Jacks and is between 36 and 55 years old. Though she has held that position for less than five years, she currently has over 20 years of early childhood education experience. She holds a Master's Degree and through her employer, has earned paid leave, dental, health, and life insurance, qualifies for Family Leave Medical Act and disability.

Georgia's entrance to the field of early childhood was far from typical. She began her undergraduate degree work studying international relations and was unhappy with her

path. She decided to pursue a master's degree in early childhood education because she had a passion for working in high poverty areas. After working for years at a community college in the early childhood special education department, Georgia was approached by her current supervisor at a conference about the infant and toddler consultant position. She later applied and was hired.

Georgia chose Jumping Jacks as one of her twelve child care programs to receive consultation services because of its unique persona. The center is located in a major city and serves a diverse population, including families of low income and those with children who have been diagnosed with disabilities. She recognized that the staff is more knowledgeable in comparison to other centers in the area.

While the three center participants from Jumping Jacks all identify as White, they are each from varying age brackets. The caregiver is the youngest under 35, the director is over 56, and the consultant's age is between the two. Likewise, their experience also varies according to the same pattern. The caregiver has the least experience with over ten years, the consultant with over 20 and the director over 35 years. Each member has reported earning a degree. The director and consultant have a Master's and the caregiver has her Associate's. Each member also received paid leave and dental insurance. The director and consultant also receive additional insurances (health) and the consultant also qualifies for life and disability insurance, retirement, and Families Medical Leave Act (FMLA).

Case IV: The Play Yard

The Play Yard is a child care center with a licensed capacity for two classrooms caring for 40 children under three years old. The infants and toddlers in attendance come

from diverse backgrounds. The director reported they currently have children learning English as second language are diagnosed with a disability, are from low income, migrant or homeless families. They have received consultation services prior to the infant and toddler consultation program; however, it was targeted for the preschool classrooms with children over three years old.

During the course of ten months, Kayla provided over 45 hours of on-site training and technical assistance to the caregivers of The Play Yard. The center agreed to participate in the current case study after 18.5 hours had been provided. Within the 23 visits, Kayla spent the majority of those visits covering learning and development and leadership and management practices. Just over six training hours were dedicated to the topics of understanding ITERS-R, social and emotional growth and learning and development.

Over the course of my three visits to the Play Yard, the infants enjoyed a variety of experiences such as free play, literacy activities, and mealtime. Kayla's primary consultant activities were spent interacting with the infants. Sitting on the floor playing, talking, singing and reading with infants make up the content of those interactions. She also spent a considerable amount of time talking with the caregivers. On several occasions she solicited questions from the caregivers regarding quality child care and offers technical assistance on display, health and safety practices, and room arrangement.

Experiences from the field

My first visit to this center did not include an observation as it did in the other cases. I met with the director and to infant teacher, Marty to collect signatures on the informed consent documents and conducted the initial interviews for both participants. I

interviewed the director in her office which doubles as the front entrance of the child care building. She commented that a goal she possesses is to have multiple centers featuring high quality learning and believes that on-site consultation will help push them in that direction.

The interview with the caregiver occurred in the infant classroom while two the other staff and infants were present. Marty, the infant caregiver, has been in this position for a number of years and hopes to get the classroom running smoothly without her so that she can “properly train” additional staff members. These interviews were unique because the participants were still responsible for their primary duties as we talked. We were interrupted several times by children, parents, or other staff members. One infant began taking his first steps and of course we paused to celebrate. Another child, of school age, was disruptive on the bus ride to the center so he became the responsibility of the director during the interview. Both the director and caregiver were willing to continue the interview despite my offer to post pone the event. Though they spoke openly and freely, we did have the benefit of privacy. Subsequent visits to the program were rather uneventful. They occurred in the late afternoon as opposed to the other centers where morning observations took place.

Shameka. The full-time director, Shameka, is also between the ages of 36 and 55 and has earned her Bachelor’s degree. She has acquired over ten years of early childhood education experience with less than two of those years with infants and toddlers. Shameka, the director, inherited her child care program over ten years ago. She explained that the staff did the best they could but the quality of the center had not been maintained. Her benefits include paid time off.

Shameka began her child care experience because she was at church and was asked to volunteer in that capacity. She was eventually hired and then acquired her own child care center through a family member who no longer wished to run The Play Yard. Shameka received a recommendation from her toddler and preschool mentor to seek out the services offered by the infant and toddler consultation program. She stated that one of her goals was a high quality center and is willing to take advantage of any program offering to provide guidance to that end.

Marty. Like the other caregivers in this study, Marty is between the ages of 18 and 35 and is the youngest of the trio. She has earned some college credits, over five years in the field of early childhood, two of which are at The Play Yard. She began working with young children as a volunteer, later worked in a licensed facility, then for cared for children in her own home. She was eventually hired to work with the infants and toddlers in a newly formed child care center. Her experience as the full-time lead infant teacher measures less than two years.

Marty has always enjoyed children and studying how their minds work. She believes that there is no better way to study their mind than to work with them. In her initial interview, Marty shared that though she's had child care experience prior to her current role, she began this position as a volunteer, helping out family who owned the business. Her previous work experience includes licensed child care and operating a child care in her home.

Marty and Kelly. Marty and Kelly each have a toddler enrolled in The Play Yard. They each only have the one toddler and are also between 18 and 35. Each of these women are also a relative of the owner & director, Shameka, of The Play Yard.

Kayla. Kayla provides consultation for the director and caregivers of The Play Yard has been in this full-time position for less than five years but she has been in the early childhood field for over 30. The majority of her experience has not been with infants and toddlers. She has a Master's degree and is between 36 and 55 years of age. With her position, she is afforded health, dental and life insurance as well as paid leave.

Through the time spent with younger family members, Kayla began to realize "how much I enjoyed being with them" (Interview, June 10, 2015). While still in high school, she knew she wanted a job where she could help. She shared, "being with children was healing" (Interview, June 10, 2015). Because she experienced a "tumultuous childhood" she believes that lead her to be sensitive to the needs of children. Kayla has been a director of a child care center and decided it was time for her to grow professionally when she found out about the infant and toddler consultation program. In her role as director, she missed having direct contact with the children and believed that this new position was going to be a good fit for her.

Kayla began her relationship on a professional visit to the center prior to offering consultation services. While there, she met the staff and learned they were already trying to make positive changes within the center. They also had previous experience with a mentor for their older toddlers and preschoolers, but the mentor did not provide services to the infant classroom. Because that relationship existed, Kayla offered her services and they willingly accepted.

Each of the participants from The Play Yard have less than five years' experience working in their current position and experience with infants and toddlers. They each work full-time and have varying levels of degrees as well as years of experience in the

field of ECE. The benefits offered by their employer also vary greatly amongst the three. The director and consultant are one age bracket older than the caregiver. The caregiver and director identify as Black and the consultant identifies as White.

Summary of Participants

Research has shown the average child care provider is a 43 year old, woman of Caucasian descent (Whitebook & Sakai, 2003). Consistent with research, most of the participants in this study are between 18 and 55 years of age (n=10) and half identify as White (n=6). The remaining two participants are categorized as over 56 and identify as Black (n=4) or Other (n=2). In contrast to research by Whitebook and Sakai (2003) that shows caregivers are not likely to receive benefits as a condition of their employment, half of the study participants do, in fact, receive some form of paid leave and insurance benefits (n=6). Two caregivers reported only receiving paid leave; one reported no benefits and three chose to leave that information blank on the demographic survey.

Measures

The unique strength of the case study is its capacity to handle a range of evidence (Yin, 1994). Several measures were utilized to construct an understanding of the expectations, experiences, and changes the consultation process has on infant and toddler caregivers and their settings. Stake (2006) states that the most meaningful data collection are gathered through direct and indirect observational methods. Open ended, semi-structured interviews, observations, focus groups, and field notes were used to document the expectations and experiences of the stakeholders. A demographic survey providing background information of the participants was collected before the first in-depth, semi-structured interviews took place. The demographic survey can be found under Appendix

F. Formal and informal observations and program artifacts were also collected for data analysis in a quest to understand the quintain under study. Table 2 illustrates the measures and describes their significance to the study.

Table 2

Measurement Tool Matrix

Research Questions	Measurement	Significance
To what extent are stakeholders' and consultants' expectations of consultation participation similar?	Semi-structured Interview	Identify the expectations of each center's participation and determine match within each case
In what ways are stakeholders' expectations of consultation fulfilled?	Semi-structured Interview Consultant Visit Observation Form	Determine match of expectations met within rendered consultation services
To what extent do family expectations of infant and toddler care reflect the services provided through consultation?	Focus Group or Semi-structured interview	Identify family expectations of infant and toddler child care services
In what ways is participating classrooms' quality of care affected by infant and toddler consultation?	Program Artifacts <i>Infant/Toddler Environment Rating Scale - Revised</i>	Additional data to identify consultation strategies and their possible relation to quality enhancement

Semi-Structured Interviews

In-depth, semi-structured interview protocols and scripts were developed and adapted based on research (eg. Brown, Knoche, Edwards, Sheridan, 2009). The two phases of interviews can be found in Appendices G and H. The semi-structured interview format allows researchers the opportunity to further explore the phenomenon under study with additional, relevant questions (Merriam, 1988). Stake (2006) recommends that

interview questions be centered around the quintain, not the individual participating in the interview. Consultation work, especially with those who work with young children is based on the relationship shared between consultant and consultee.

Merriam (1988) proposes that different types of questions are often used in qualitative studies ranging from fact to opinion to gather different kinds of informational data. Good interviews will have questions regarding behavior and experiences, perception and opinion seeking, feeling and knowledge gathering, as well as background and demographic information (Merriam, 1988; Yin, 2009). The following Tables 3 and 4 serve as blueprints for the consultant and center staff interview protocols designed for this study.

Table 3

Consultant Interview Protocol Blueprint

Question type	Consultation Period	Post Consultation Period
Background/Demographic	1	1
Behavior & Experience	3	2
Opinion & Perception	4	4
Knowledge	1	0
Feeling	1	2
Total	10	9

Table 4

Center Staff Interview Protocol Blueprint

Question type	Consultation Period	Post Consultation Period
Background/Demographic	2	1
Behavioral & Experience	2	0
Opinion & Perception	3	5
Knowledge	2	1
Feeling	0	2
Total	9	9

Questions inquiring participant experience, prior PD and current expectations were part of the interview protocol to gain a better understanding of the individual as it provides a unique perception of the relationship developed during the consultation process. Additional questions sought information regarding their current PD experiences and preferences. The final interview consisted of questions regarding their personal experience as they reflected upon the consultation process recently experienced.

Focus Groups

Focus groups were planned with family members to elicit their expectations of the care their infant and/or toddler receives in a child care setting. The Focus Group protocol is located in Appendix I. Families identified elements of high quality care for their infant and toddler in an effort to determine if the consultation program of PD does in fact prepare caregivers to meet family expectations. As mentioned earlier, when a group of parents were not available to participate, individual parents were sought for an interview. This focus group protocol was designed for either method available. After the focus group protocol was developed, it was piloted with the parent member of my research team. Feedback was provided and questions were altered to ensure terminology was understood and that the questions elicited data to inform the research question regarding parent expectations of infant and toddler child care. The final blueprint for the Focus Group Protocol is listed in the table below.

Table 5

Focus Group Protocol Blueprint

Question type	
Background & Demographic	1
Behavioral & Experience	3
Opinion & Perception	2
Knowledge	1
Feeling	2
Total	9

While focus groups were the aim of the parent portion of the study, they were unavailable/unable to recruit from three of the four participating child care centers. Though the first child care center was able to locate two parents, it was noted during that session that one parent dominated the conversation. My efforts to elicit responses from the quieter participants were overshadowed by the actual words or ideas of the more vocal participant. When the quieter participant, Parent 2 was asked a question directly, it was clear that the ideas were extensions of those previously expressed. Therefore, it was advantageous that the other centers were unable to produce more than one parent participant.

Formal and Informal Observations

Formal and informal observations are data collection methods used to strengthen the information learned from semi-structured interviews (Yin, 1984). Merriam (1998) states elements likely to be present during an observation that need to be recorded include the setting, participants, activities and interactions, frequency and duration, and additional subtle factors (Merriam, 1988).

Consultant Visit Observation Form. The Consultant Visit Observation Form (Appendix K) was adapted from Dinnebiel, McInerney, and Hale's (2006) Classroom Visit Observation Form for use with infant and toddler itinerant or intervention consultants. Using this form, consultant behaviors and activities were identified at five minute intervals for a period no less than 60 minutes. Through naturalistic and persistent observations of the consultant within the child care setting, the researcher took descriptive and reflective field notes during and following the observation, documenting strategies and activities utilized by the consultant and those experienced by the caregiver.

The researcher acting as an observer, identified the stage of the consultation process and recorded specific behaviors and activities exhibited by the consultant during the on-site visit (Dinnebiel, McInerney, & Hale, 2009). The researcher remained passive and unobtrusive during the observations and ended every visit by asking participants (director, caregiver(s) and/or consultant) if they wish to add or seek any additional information regarding the observation or participation in the study (Merriam, 1988).

Field Notes. Field notes were recorded during interviews, focus groups, and observations. The Field Notes Form, located in Appendix L, was created to assist in contributing to the individual data collection experience. Additional information such as details from the field, interviewer/observer or participant comments, and reflective summary were captured during and immediately following the experience as necessary.

Infant and Toddler Environment Rating Scale - Revised. The change in classroom quality was assessed through formal observation. *The Infant/Toddler Environment Rating Scale – Revised* (ITERS – R; Harms, Cryer, & Clifford, 2006) is a tool to measure the level of child care quality for children under 30 months of age. The

ITERS – R was developed at Frank Porter Graham Child Development Institute and consists of 39 items organized into seven subscales. Each of the seven subscales contains a number of items as identified in parenthesis. The subscales include Space and Furnishings (5; environment), Personal Care Routines (6; health and safety), Language and Listening (3; language and literacy), Activities (10; access to developmentally appropriate materials), Interactions (4; sensitivity and responsiveness), Program Structure (4; class schedule and discipline), and Parents and Staff (7; program policies and professional development). Each of the items is measured using a rating scale from one (inadequate) to seven (excellent).

The predictive validity, indicator reliability and item reliability of the ITERS – R has been well established (Harms, Cryer, & Clifford, 2006). Indicator reliability found an agreement on 91.65% of the 467 indicators within the 39 items. Item reliability was found to be 85% across the 39 items. Overall, the scale has a level of consistency with Cronbach's alpha of .93. Reliability of this tool is maintained through inter-rater reliability. Inter-rater reliability is calculated every ten observations and must be maintained at 80%. This quantitative data will be used in conjunction with qualitative evidence as a basis for the results of the participating cases (Yin, 1994).

Program Artifacts

Program artifacts, from the center and its' environment, also supplemented the scores of the ITERS-R to capture specific, qualitative changes in quality that have occurred during the consultation process that are not illustrated through the ITERS-R. Table 6 identifies individual documents and describes the source and purpose of each program artifact. Each center receiving consultation services created goals along with the

help of their consultant and documents strategies for goal attainment. Artifacts will include the quality improvement plan or goals, as well as the strategies, resources and materials documented by the consultant as a strategy to increase quality for the infants and toddlers in care.

Table 6

Program Artifacts

Measure	Purpose	Source
Program Profile	Provides demographic information about the participating center	Consultant
Consultant Activity Form	Calculates the total on-site hours, including training, topics covered during visits	Consultant
Quality Improvement Plan	Documents the number and type of goals for quality enhancement	Consultant
Pre/Post ITERS-R Results	Indicates the level of quality before and after consultation services	Consultant

The demographic survey identified the stakeholders giving the researcher the ability to appropriately compare within and across cases. Interviews and focus groups illuminated the PD experience of each stakeholder allowing the researcher to view consultation process from their perspective. The served as evidence of the expressed views of the stakeholders and were an additional lens into the complex task of building a relationship with a consultant in an effort to impact quality in infant and toddler child care. Interviews and documents aid the researcher in understanding a relationship in which the researcher is not a part, to see what cannot be seen (Stake, 2006). The artifacts have been combined with a quantitative description of the level of quality as observed by

the ITERS-R measurement tool. Together, these various measurement strategies provided a saturation of data that enabled me to accurately represent the perspective of each stakeholder and the impact of the consultation process on the infant and toddler child care environment (Strauss & Corbin, 1998).

Data Collection Procedures

Qualitative case study researchers focus their attention on building a relationship connection between the ordinary experiences of its participants and the “disciplines of knowledge” (Stake, 2006; p. 10). In this study, establishing a relationship of trust enabled me access to reliable, consistent data collection. In order to capture the expectations and experiences of participants during and after consultation participation, the collection of data occurred over time throughout the duration of consultation services.

Consultation Period

The infant and toddler consultant conducted a formal observation before the consultation process began to determine the level of quality as provided by the infant and/or toddler child care environment. The consultants spent approximately three to four hours in the classroom using the ITERS-R as a pre-assessment measurement tool. The final product contains a numerical value determining the level of quality, as well as a qualitative summary of strengths and recommendations for the individual classroom of infants and/or toddlers. The consultants of the four case study centers had also completed anywhere between 25 and 70 % of the total on-site visit hours. In at least once, over 90% of the required 40 hours had been completed. Three of the four consultants provided 15 or more hours beyond the minimal requirement.

Collecting signatures on the informed consent form from the participating consultants began the data collection process. A mutual time and location was designated to explain the study, collect signatures on the informed consent, complete the demographic surveys, and conduct the first interviews and observations. Though recruitment began in late October of 2014, it was not completed until early February 2015. After interest was expressed, consultants were briefed on recruitment strategies for their centers and ultimately chose which centers would be approached for participation. When they located an interested center, contact information was shared with me so that I could contact the director to provide information about the study and answer any questions they had about participation. Locating interested centers took consultants approximately 4-6 weeks. Center recruitment took place during the winter months of December, January and February. Winter weather, vacations, and holidays may have extended the length of time centers needed to process the information provided and ultimately express an interest in participation.

When permission to contact the center had been received, the director was contacted via phone to introduce myself and explain the purpose of the study as well as the responsibilities and risks of participation. Once it was determined that the director was willing to participate, I asked that they identify and seek interest from the caregiver they choose as long as they are currently caring for infants or toddlers and working with the infant and toddler consultant. A mutually convenient time to meet was established and scheduled. During this first meeting, informed consent was collected, demographic surveys were completed, initial interviews were conducted and in some cases, the initial observation also took place.

During the initial interviews, I collected the demographic survey from all of the participants, consultant, director, and caregiver of classrooms serving children birth through 36 months. Demographic data has been illustrated in a case matrix/table format for easy reading and understanding and overview of each quintain. Research tells us that the infant and toddler workforce has many challenges to providing quality. Collecting demographic helps the researcher draw connections from the research to the population under current study.

Member checking opportunities were utilized during each on site observation visit and also occurred following each interview. Participants were approached at the end of each visit for an opportunity to ask questions or provide an explanation or clarity of the visit. Member checking was conducted on two occasions for each participant following the interview process. Summaries and interpretations of the interviews were created by me and shared with participants for accuracy and clarity. Member checking for the initial interview took place immediately before the second interview. I re-read the questions followed by the participants' responses, providing ample wait time for the participant to agree, amend, or clarify my interpretation. In most cases, the participant accepted my summary. There were only a few occasions where the participant added extra details and on no occasions did the participant change their response. Member checking for the final interview was provided to the participant via email. A summary of their response was attached and they were provided an opportunity to review, amend, and affirm their responses as they deemed appropriate. Again, no participants amended the summary.

All interviews were recorded on a tape or digital recorder and a cell phone for backup. They were all transcribed and coded by me. Members of the research team were responsible for coding at least 25% of the interviews. Research team members coded three initial interviews, three final interviews and one parent interview to provide a variety. Collapsed codebooks were created through the use of categories and finally reduced into themes. Participant quotes were also coded from participant responses illustrating each stakeholder's perspective of their consultation experience. Final codebooks were also shared with research team members to ensure robustness, accuracy and clarity.

The technical assistance and strategies for enhancing the quality of care available to the infants and toddlers is developed based on the results of the formal observation as part of the infant and toddler consultation program. This document is referred to as the Quality Improvement Plan (QIP). The Quality Improvement Plan (QIP) is established to address the items on the ITERS-R scale that are in need of improvement. The QIP is usually developed very early on as it records not only goals for improvement, but strategies that will be implemented by the consultant and center staff in an effort to enhance the quality of child care for infants and toddlers. This document is also updated by center staff and consultant as needed and should be reviewed at least once a month. This program artifact was collected from the consultant for analysis.

An informal observation of the consultant and infant and toddler caregiver was determined according to the schedule of the consultant and caregiver. The duration of the observation was planned to be a minimum of one hour, or less as prescribed by the actual consultation process. The Consultant Visit Observation Form and field notes were used to

record the consultant strategies and behaviors of the consultation dyad. A total of three observations were planned for the duration of the consultation period of data collection using the Consultant Visit Observation Form. Three observations of each case occurred with the exception of one case, in which only one observation was possible.

Supplementary program artifacts that have been updated or changed were planned to be collected during the second and third observations, however they were often not available at the time and were collected during the post consultation period.

Family members with a child enrolled in a participating classroom were be asked to complete a short, demographic survey, identical to the one completed by center staff and consultant participants. All families in attendance received three children's board books appropriate for infants and toddlers. They also received resources regarding infant and toddler development.

All focus groups and interviews were be facilitated by me. They were recorded using the same digital recorder and cell phone, transcribed and coded by me. Due to the lack of parent participation, two of the planned focus groups became individual parent interviews using the same focus group protocol. Similar to the codebooks created for the individual interviews, the focus group/interview responses were also coded. One parent interview was coded by a research team member. Categories, themes and quotes were utilized to illuminate the expectations families possess about the quality and type of care they desire for their infant and/or toddlers.

Post-Consultation Period

When the child care center and consultant determined the services were complete (with no less than five months and at least 40 hours of infant and toddler consultation) the

ITERS – R was conducted by an outside consultant contracted by the program’s infant and toddler consultant to determine a quantitative change in quality. The consultant shared those results with me for data analysis. Additional artifacts collected during this time include the Consultant Activities Summary, the center’s Program Profile,

Additional program artifacts collected during this final phase of data collection include the Program Profile, Consultant Activities Summary. The Program Profile provides demographic child care center data. The Consultant Activities Summary reports the number of consultation visits and on site PD hours afforded caregivers and directors.

A visual of the two periods of data collection, as well as the measurement tool and the targeted participant for each type of data collection that occurred during this study can be found in Table 7. As noted in the chart, data collection was collected by me. I also conducted all interviews, focus groups and informal observations. Formal observations were conducted by a consultant and program artifacts were generated documents produced by study participants.

Table 7

Data Collection Matrix

Date Timeline	Data Source	Data Collector	Measurement Tool
Consultation Period	Director, Caregiver, Consultant, & Family	Researcher	Demographic survey
	Director, Caregiver, & Consultant	Researcher	Initial Interview
	Caregiver & Consultant	Researcher	First Observation
	Caregiver & Consultant	Researcher	Second Observation
	Family Member(s)	Researcher	Focus Groups/Interviews
	Caregiver & Consultant	Researcher	Final Observation
Post Consultation Period	Director, Caregiver, & Consultant	Researcher	Post Consultation Interview
	Consultant	Consultant	Program Artifacts (Program Profile, Quality Improvement Plan, Consultant Activities Report)
	Classroom/Environmental	Consultant & Assessor	Pre/Post ITERS – R scores

Analytic Approach

Data collection and analysis occurred simultaneously throughout the life of the study to identify patterns of expectations and experiences expressed by stakeholder participants and observed by the researcher (Hays & Singh, 2012; Patton, 2002).

Demographic surveys, interviews and focus groups, researcher observations, field notes and program artifacts were analyzed to produce study results. Qualitative investigation requires careful attention to language and reflection of emergent patterns. In the sections that follow, I will provide an overview of each type of data collection strategy and the analysis method utilized to understand the consultation experience of the study participants.

Demographic Surveys

Demographic surveys were collected with all participants at the outset of the study in an effort to gain background information that I might not have accessed during the interview process or observations. Saldana (2013) states that attribute codes provide descriptive participant characteristics and is particularly appropriate for case studies and those with multiple participants and sites utilizing data such as interview transcripts, field notes, and documents (Merriam, 1998; Stake, 1995). Survey data was illustrated at the beginning of this chapter in Table 1. The table contains information on each of the participants, such as years of experience, highest level of education, and employment benefits.

Interviews and Focus Groups

Interviews were conducted on two separate occasions with each of the center participants. The initial interview was conducted soon after informed consent was

obtained and the second interview was held after consultation services ended. Focus groups were conducted with consenting family members at various times during the data collection phase based on availability of the participating family member. Within-case displays were used to reveal patterns among the individual cases. Yin's (2009) cross-case analysis synthesis is especially relevant when more than one case study is under exploration as is the situation for the current study. The case displays assisted me in identifying similarities and/or differences between the cases (Hays & Singh, 2012). The use of this analysis method helped me establish more robust results than studies exploring only one case (Yin, 2009).

Observations

Formal and informal observations took place several times throughout the course of this case study. Formal observations were conducted by the consultant before and an outside consultant, not employed by the PD program, after consultation services were provided. A quantitative and qualitative summary report was generated by the observer as a result of those observations. Quality scores were calculated to represent the level of care the infants and toddlers were receiving at the time of the observed classroom.

Informal observations were conducted on three separate occasions and analyzed by me. In order to derive scientific meaning from the observations, the counting method was used to analyze the data collected from the adapted Consultant Visit Observation Form (Merriam, 1988). In order to accurately reflect the behaviors of the consultation process, calculating the frequency of certain practices is not only helpful, but necessary. This technique lead credence to the responses indicated by participants and reduced researcher bias with a concrete, quantifiable approach.

Field Notes

During each of visit to the field, notes were taken using this form to capture the environment beyond that of the Consultant Visit Observation Form or the interview protocol (Merriam, 1988). The field notes served to supplement data gained from interviews, focus groups, and observations. Qualitative case study is an exploration within a boundary. With the aid of field notes, I was better able to understand the context under which the consultation process took place and provided a clearer representation of the participants' experiences.

Program Artifacts

Program artifacts were vital to the illustration of each case and their experience in the consultation process (Hays & Singh, 2012, p. 314; Patton, 2002). The artifacts were utilized to strengthen and in some cases, clarify data collected throughout the consultation experience. The Quality Improvement Plan described the written goals and documented various strategies used by the center staff and consultant in an effort to enhance the quality of care provided for infants and toddlers. This document was used to record the successful accomplishment of the goals set by staff and their consultant. The Consultant Activities Summary Form recorded data entered by the consultant on a monthly basis. On-site trainings and content topics were identified for each visit the consultant made to their center.

Qualitative Data Sources

All audio recordings of interviews and focus groups were transcribed in their entirety following the by coding of the data occurred in cycles as recommended by

Saldana (2013). The data was then reduced to categories which aided in the recognition of patterns and prevalent themes across the interviews conducted within each case.

Coding Structure

Descriptive coding was the first coding approach utilized and resulted in one word or short phrase codes that were used to describe participants' responses that occurred in 20% of the transcripts from the first set of interviews (Saldana, 2013). One of researchers' primary case study goals is to allow readers to visualize the researchers' experience and descriptive coding is a process that can lead to that outcome. Saldana (2013) reports this method of coding suitable for qualitative studies exploring physical environments and program artifacts, as well as interview transcripts. Examples of the initial descriptive codes included words and phrases such as "hands-on", "further training", "tools and tips", and "learning things".

Structural coding was also employed in an effort to organize connect units of data to the subject matter under investigation as it relates to posed research questions. This method of coding has been noted as particularly useful for various types of qualitative studies, including those with multiple participants (Saldana, 2013). Structural coding allows researchers to index relevant data within a larger data set. Using this technique, researchers are able to quickly access and locate similarities or differences within the data. Program and job acquisition, participation goals, participant activities and contributions are a sampling of the codes that emerged.

Codes were analyzed using the computer assisted qualitative data analysis software program, known as NVivo. This computer program enabled me to analyze, organize and categorize subsections of the data that were found to have meaning and

presented relevance to the research questions posed. Given the large amount of interviews and focus groups that were conducted during this case study, NVivo proved to be a valuable tool in the coding analysis of the transcripts.

Multiple cycles of coding helped further manage, filter and reduce prominent features of data for the development of categories and themes. Codes were developed as a method to compute or derive meaning from participants' responses and categories were developed to impute, or ascribe meaning for understanding. Categories included items such as professional development, collaboration, and contributions. Codes were then analyzed for similarities and differences between and among them and collapsed as themes began to emerge.

All statements were coded, including interview questions and other unrelated statements. When I asked a question or provided clarification when asked, those statements were coded as interviewer talk. Unrelated comments, stories about unrelated activities or utterances made by participants were labeled filler talk and not coded.

A member of the research team collapsed the coding categories into themes across a subset of the transcripts to establish reliability. This research team member was a recent graduate in the Early Childhood Education doctoral program and during the time of her participation, served as a director to a child care center. This research team member coded a variety of transcripts in order to achieve 25% of the data collected. Discussions were conducted following the inter-coder analysis until inter-coder reliability reached 100%.

Quantitative Data Sources

Formal observations were conducted as part of the consultation program. The infant and toddler consultant was responsible for administering the initial ITERS-R observation and a hired consultant provided the post observation rating. A paired t-test was run using the pre and post ITERS-R scores to determine the significance of the consultation services. Comparisons are also drawn at the individual infant and toddler classroom level from the seven subscales of the ITERS-R.

Methodological Limitations

When studying social constructs within a natural setting, methodological limitations among the research study are inevitable. Those contextual elements and measures taken to minimize their impact on the results of this study are described below.

The self-report nature of the surveys, interviews and focus groups is one limitation of this qualitative multiple case study. Participants may seek social desirability and answer questions in ways they believe to be correct or desired even if it does not accurately reflect their own opinions. As the aim of the study is to explore the consultation experience of the participants, it is critical to utilize primary sources for gathering data. Multiple data sources were used eliminate the possibility of socially desirable responses during the interview process.

Researchers conducting observations as a data collection technique must prepare for the Hawthorne Effect. When participants take part in research studies, there is the possibility they will modify or even improve their behavior due to the presence of outsiders. Through the use of multiple data sources including interviews and multiple observations, over time the participants are likely to act natural within their environment

and forget they are part of a study.

The sampling strategy utilized also serves a methodological limitation to this study. Consultants have volunteered to participate and are responsible for recruiting the child care center. It is possible that the consultant may have chosen to encourage “strong organizations” to become center participants. The center director is recruited by the consultant and the caregivers are usually told they will participate in infant and toddler consultation. Though research shows that volunteer participation is an important element in ongoing, on-site PD (Helterbren & Fennimore, 2004; Wagner & French, 2010) this case study explored a consultation setting in its most natural form.

Trustworthiness

Several strategies were employed to establish credibility and trustworthiness within this qualitative case study. Trustworthiness has been well established and maximized in order to construct a sound, scientific study through the use of member checking, reflexive journaling, prolonged engagement, persistent observation and the triangulation of collected data sources (Yin, 2014). Thick descriptions provide a vivid account of the experiences of the center staff and the consultant.

Credibility was established through consultation of outside, unbiased sources. Professional development experts, infant and toddler child care staff, and families of infants and toddlers not currently participating in this study serve as content experts for instrument development. Because I also serve as an infant and toddler consultant, I sought the advice from those who are currently or previously participated in consultation services regarding instrument development.

Researchers must establish transferability through thick descriptions and details to allow individuals to apply findings within their own setting. Through multiple interviews, observations and conversations throughout this case study, information was shared by participants and included in this report to provide background and situational details. Observations were conducted over the period of no less than five months to establish dependability. Each participating case experienced multiple visits and individuals clearly exhibited a level of comfort that allowed for a true representation of their experience. Prolonged engagement and observations provided me with an extended amount of time to gain the trust of the participants.

Member checking has been utilized to ensure confirmability amongst the participants. Upon each site visit, participants were given an opportunity to elaborate or modify a previously answered question, or address an event that occurred during an observation. Specific examples derived from observations were generated to ensure clarity of the responses provided during the interview protocol. Member checking helped maintain an accurate interpretation of the voices of the participants.

In addition to the primary researcher, a research team of several PhD graduates in early childhood functioned as a group to maintain accuracy and stay true to the original goals and content of the proposed study. The research team met monthly or as needed to ensure agreement amongst the research findings and bracket my assumptions. Peer debriefing was also used to strengthen the credibility of the qualitative study.

Qualitative studies need to be conducted with a sense of flexibility and creativity based on the needs of the research topic. Flexibility requires an open mind and I revisited the data as often as needed with breaks in between in order to review it with a fresh

analytical perspective. Participant feedback was the driving force of the research design and data analysis. Authenticity was be maintained through a reflexive process (Hays & Singh, 2012). Opinions and biases about the subject have been identified and labeled prior to the exploration and bracketed with the help of the research team. The research team was instrumental in maintaining creativity throughout this project. As the primary researcher who most identifies with the consultant participant, the research team not only helped identify the possibility of assumptions, but brought a creative outside perspective to the process of consultation as a PD strategy to enhance child care for infants and toddlers.

Researcher bias is a threat to internal validity. Peer debriefing, regular research team meetings, and results from pilot study data minimized my biases and assumptions (Merriam, 1988). Piloting the interview questions helped ensure that the language used was compatible and understood by the participants. The questions were adapted based on feedback from pilot participants to make certain they were clear and answered in ways that contributed to the data in order to answer the research questions. The pilot process also provided the practice needed to conduct the study interviews with clarity and confidence.

External Validity

This study examined four cases and explored cross case patterns, as well as, provide comparisons within cases. Conducting this study in four infant and toddler consultation settings strengthens the results of the data and its analytical generalizations regarding PD according to key stakeholders in the field of infant and toddler child care (Yin, 1994; 2009). This study provided a thick-rich description of the consultation

experiences of an average child care center serving infants, toddlers and their families.

Content Validity

Content experts aided in the development of the instruments used for this study to help me formatively evaluate the current design, develop appropriate questions, and clarify elements of the research design (Yin, 1994). Early childhood doctoral candidates and recent recipients of doctoral status were critical members of the research team. In this capacity, they reviewed the methods planned for this study and provided assistance and feedback on the interview questions. The research team member who served to represent parents also participated in a pilot interview to ensure clarity and understanding of the information being sought. When it was deemed a question wasn't clear or elicited irrelevant answers, she contributed to rewriting the question.

Construct Validity

Yin (1994) recommends that researchers collect data from multiple sources and this study proposes to utilize several strategies to construct a convergence of evidence. Yin (2009) and Merriam (1988) recommend collecting and analyzing data simultaneously to strengthen the results. Doing so permits the researcher to guide the data collection phase more effectively, and reducing the data more efficiently (Merriam, 1988). Analyzing data as it is collected for a qualitative study is advantageous for the researcher (Merriam, 1988) and providing a thick description strengthens the results of this qualitative multiple case study and provides the context for which this case study took place (Geertz, 1973).

Reliability

To establish reliability, a case study protocol was developed to ensure complete, accurate and consistent data collection and documentation throughout the life of the study (Yin, 1994). The case study protocol describes the details of the implementation giving researchers the ability to conduct this same study in another setting (Yin, 2009). All data collected has been dated and encoded with a proper label identifying to which case it belongs. Digital and paper copies of all documents have been filed and stored for easy retrieval.

Chapter Summary

Consultants and center staff provided their expectations and goals for participation in the consultation program. This information has been triangulated with specific quantitative results, as well as program artifacts of each participating classroom. This chapter provided an overview of the research design, sample, and population of this qualitative study. The role of the researcher was described to provide openness and address biases. Data collection procedures and analysis were explained. Study limitations were elucidated and addressed. The following chapters will outline the results illustrated through the data collected and provide a discussion for implications and areas for future research.

CHAPTER IV

RESULTS

This study examined the perspectives of consultation professional development program participation by stakeholders. The stakeholders are comprised of the infant and toddler caregiving staff, director, family members and the consultant providing training and technical assistance. The purpose of the study was to understand the consultation process and how those activities matched the expectations of the participants. An additional purpose was to examine the impact program participation had on the quality of the participating child care center following consultation.

The first chapter served as an introduction to this study, described the research problem and supplied the purpose of the study. The second chapter provided a review of the literature supporting the need to provide meaningful, effective PD for infant and toddler caregivers in order to enhance the quality of that care. In chapter three, I reported the sampling strategies and provided rich descriptions of the participants and the case to which they belong. The qualitative methods used for data collection as well as the analysis procedures utilized to gather data to examine stakeholder perspectives of consultation participation were also described. The current chapter provides results that were derived from data analysis of the interview transcripts, observations, and supporting program artifacts from which several themes emerged. The final chapter will present implications of the current study and ideas for future research.

This chapter is organized by themes that were uncovered through triangulation of the various data collection strategies that were employed during this study. Evidence was provided through direct quotes, field notes from observations made by the researcher, and

documentation collected from program participation. Research questions explored within this study included:

1. To what extent are site stakeholders' (center director, infant and toddler caregivers) expectations of infant and toddler consultation participation similar to infant and toddler consultants' expectations of program participation?
2. In what ways are site stakeholders' expectations of infant and toddler consultation being fulfilled during the course of participation?
3. To what extent do family expectations of infant and toddler care reflect the services provided through infant and toddler consultation?
4. In what ways is participating classrooms' quality of care affected by infant and toddler consultation?

During data analysis, across cases and stakeholders, three key themes emerged as important for study participants. Those themes included relationship building, professional growth, and environmental enhancements. Relationship building refers to the opportunities that the participants had to establish a relationship with the other participants as well as the children in care. Professional growth was cited as an important factor of the infant and toddler consultation program by its participants and the families receiving child care services. Gaining new knowledge, understanding of infant and toddler development can lead caregivers towards implementing newly developed skills that promote growth and development for young children. Enhancing the environment to include more elements of quality child care is part of the infant and toddler consultation mission. Study participants stated various elements of the environment were impacted by

program participation. I will present a detailed discussion of each of the three key themes below.

Opportunities for Relationship Building

“We’re building the foundation for a relationship here with one another and I’m hoping that type of relationship will continue and continue with the children that they serve and hopefully those children will have positive relationships down the road” (Darlene, interview, December 16, 2014).

While the experiences of the participants varied, the development of relationships was a prevalent theme throughout this study. Through observations, documents, and interviews, it was evident that interactions between and among consultants, caregivers, directors, children and their family members had various opportunities to use their relationship to enhance the child care environment. The support and challenges experienced by study participants are included within the overall theme of building relationships among the participants.

Opportunities for relationship building is defined as activities conducted that promoted a positive relationship between program participants. This theme was derived from categories such as collaboration, guidance and support. Statements made by participants included the importance of “establishing a really good relationship,” “working together,” and having “everybody involved.” For example, Krystal described her experience with her consultant as, “pretty good. She was very easy to talk to, someone that had a lot of knowledge in things you really needed to learn. She’s just a great person to work with.” (interview, July 22, 2015). This illustrates the ease at which

Krystal found it to work with an infant and toddler consultant allowing her to fully utilize the services offered.

Support was a theme that emerged as part of the relationship developed between the consultant and center staff. It is defined as assistance provided to ensure the successful implementation of best practices. Statements derived from this theme include “success is the support of the director,” “provide support to caregivers,” and “be a support to the director.” One Comments such as, “She was very understanding of the things I needed. She was very knowledgeable about the things I needed. The support was good.” (Krystal, interview, July 22, 2015).

Responsive care was also identified by study participants as an important aspect of infant and toddler child care. It is defined as a consistent caregiver providing a safe classroom with developmentally appropriately materials to explore, accompanied by sensitive, caring and dependable interactions with adult caregivers. In the context of this study, the relationship with a consultant that includes mutual respect and collaboration can contribute to the caregivers’ ability to extend respect and be responsive to the infants and toddlers they care for.

Challenges were also presented by study participants regarding program implementation and the development of relationships with the participants of the consultant program. Factors that impede the consultation and relationship building process are identified as challenges. Examples of challenges provided through participant interviews included turnover, lack of engagement from participants and not enough time for adequate relationship building and the implementation of newly acquired child care practices. Participants used the word challenge to describe barriers, such as, “I

think a challenge was that once the children were settled down for nap, then that's when the teachers started their break" (Georgia, interview, May 13, 2015). Others shared changes they would like to see made to the consultation implementation, including, Selina's description of what would have made the program better, "Obviously, it would have been better if I didn't have to have an interim person. There was a big chunk of time where we didn't have a visit whereas before that it was a consistent every month or every month and a half she was here" (interview, July 23, 2015).

These categories have been grouped together and collapsed within the overall theme of opportunities for building relationships. Each category lends credence to the activities and strategies that supported or undermined participants' abilities to establish a positive relationship with one another.

Relationships between Center Staff and Consultants

Caregivers and directors reported working together and collaborating was instrumental in their success of enhancing the quality of care provided to infants and toddlers. This section includes information supporting the characteristics of study participants that nurtured their relationship and enhanced their time together. The director of Many Hearts concluded her consultant was, "Not just I'm here to teach you something, now you do it. I think a relationship was built with the staff as well" (interview, July 23, 2015).

Krystal appreciated opportunities to work with her consultant. "We worked side by side and that's something I really liked to do because I need something hands (on) and that was something that spoke to me" (Interview, July 22, 2015). Marty, the caregiver from The Play Yard, also found her collaborative experience to be a positive one.

I believe we all worked together. Kayla would give us ideas, staff would see them through. We were both going back to the director and how we thought it would work or tips for better ways that it would work for our program...It took everybody working together to make sure we're following (best practice) but doing to in a way that works for us (Interview, May 13, 2015).

This statement signifies that Marty valued the opportunities provided to her by her consultant. Through her comment, it was clear that her consultant respected the individual needs of the caregivers by allowing them to determine the best way to implement caregiving strategies based on best practice.

When asked about highlights of program participation, the director from Many Hearts recounted,

It was not just the resources; it was the relationship was established. They wouldn't hesitate to contact her if they needed to. Not just providing in-house things, knowing we have her there and she's got our back on a long term basis. Not just I'm here to teach you something, now you do it. I think a relationship was built with the staff as well (Selina, Interview, July 22, 2015).

Selina acknowledged that while there were other contributing factors to successful participation, she also recognized that the development of a relationship with the consultant would provide additional help for her staff even after their participation ends.

The director of The Play Yard also found, "They (staff) trust her (consultant), they trust her knowledge which I think plays a big part of whether or not they're going to do the things she recommends" (Shameka, Interview, May 20, 2015). Shameka recognized the importance of this element in the relationship between her staff and her

infant and toddler consultant. She indicated that her caregivers trusted the knowledge of their consultant and were willing to learn and follow through with her recommendations based on that trust.

Several directors viewed their role as a mediator and nurturer of the relationship between the caregivers and the consultant. Selina explained, “I’m like a mediator between the two of them to make sure they are both understanding each other, what the needs are and make sure it’s happening in the classroom” (interview, January 22, 2015). She understood the importance of the team actively listening to one another and understanding the process in order to ensure effective implementation. Donna commented that it was her role to

make sure that what consultant is working on is implemented after she leaves because I’ve seen staff who take trainings or go through trainings and it doesn’t affect what they do in the classroom. I think my role is to come down and make sure I know what the consultant shared and make sure it’s being implemented in the classroom. To communicate with consultant about that process so that we can continue to work together (interview, January 22, 2015).

This statement illustrates the support that Donna believes her staff need from her in order to utilize consultation services effectively. Ronnica viewed her role as a facilitator and enforcer, “I guess to make sure that the shared ideas continue to follow through even though she’s not here. That the staff are able to contribute to her ideas to make it of their own but still staying within company policy of course” (interview, January 30, 2015). This statement demonstrates her intention to support the work of the program while respecting the need for staff to have an active role in the relationship and in the efforts

put forth toward higher quality care. These statements illustrate the contribution the directors planned or actually implemented during the consultation phase. They understood their role as vital to the sustainability of the new knowledge and skills that caregivers may have acquired through program participation by encouraging positive relationships between the caregiver and the consultant.

All four consultants were observed or reported utilizing strategies to develop a relationship with center staff. The various strategies included providing warm greetings upon arrival, inquiring about the caregivers as individuals, answering questions and helping in the classroom. Kayla expressed the importance of taking the time to get to know individuals before assuming you know information you think you know. She offered what she calls “grace” until she could get background information about a person or particular situation in order to understand and get to know who or what you are working with. Georgia also said she begins the consultation relationship by observing and getting to know the caregivers as individuals.

The participating consultants collaboratively shared their own personal stories with caregivers. They valued part of the consultation program as a time for getting to “know who they are as a person and slowly letting them know who I am” (Georgia, Interview, January 12, 2015). It is clear through this statement that building a relationship is a process that occurs over time. Kayla noted that by taking the time to develop a relationship with caregivers, she was able to get

to that comfort level where we can have honest conversations. And you know once I’ve been able to assure them that I am here for them, it tends to open the doors and we can have some honest conversations that I don’t know would

necessarily occur with a director because I don't pose a threat to them (Interview, December 23, 2015).

Even after a relationship between consultant and caregiver was established, the relationship building strategies continued throughout the consultation program as evidenced by Georgia's comment,

Then when I can and when it's appropriate to bring up some personal questions about their families or that type of thing. It's nice on reoccurring visits, 'Oh by the way, how's your mom doing?' Or, 'How's your children doing?' To have that connection besides just talking about our work (Interview, January 12, 2015).

Consultants shared that they understood the significance of the relationship with staff and adjusted their activities based on that development. In an effort to provide effective services while maintaining a positive rapport with staff, Eliza commented that she would "File away any concerns or things that I'll process once we've established a little more relationship for the day. As the relationship evolves, over time I become more suggestive and at times more directive" (Interview, December 23, 2014).

Georgia believed that involvement of all stakeholders was an important aspect of program participation. "Everybody that's involved, everybody has to feel that we are all working towards the same goal, they're not my goals, it's the center's goals and I'm just there to help them achieve that (Interview, January 12, 2015). She emphasized that in her role, she wanted to ensure that child care administrators understood the importance of communicating with the staff about the goals that have been developed. She contended that she is not working "in isolation on (her) own agenda," but "working towards a goal that is going to benefit the classroom, the center as a whole."

Support

I view my job is to ideally provide information and provide support to caregivers so that they feel more comfortable and confident providing care and support and learning to the young children - Eliza

Caregivers shared they were looking for new strategies to handle and address classroom challenges through program participation. A variety of approaches were utilized that included observation, modeling and training as noted during participants' interviews and observations as techniques that provided them with support and guidance. A caregiver from Jumping Jacks stated, "As it's been explained to me, she is here to observe our room and see what could be done to either make things flow smoother or suggestions that we can be given to help us" (Katherine, Interview, January 12, 2015). Krystal, the infant teacher from Many Hearts, explained the positive support she received from her director. "She would talk with Darlene and whatever we needed, she would make sure we had whatever we needed as far as the classroom supplies. We needed milestones, she would make sure and try to get the resources. Just like she brought in Darlene for us, she was supportive of a lot of things" (Interview, July 22, 2015). Lauren, the infant caregiver of My Child Care, spoke favorably of the support received from her director. She shared that, "she lets us know when the consultant is coming. She reiterates and enforces everything that has been taught" (interview, May 13, 2015).

It is evident the infant caregiver from the The Play Yard was interested in guidance because she is working with inexperienced staff and claimed,

It's very hard for me to give people the right training tools they need because it's something I've done my whole adult life. So it's very hard for me to train them

and be understanding that they don't just know this isn't second nature to them like it is for me. I'm hoping that she has more of a, or better way to give them tools and tips on ways to deal with the infants (Marty, Interview, May 13, 2015).

From program participation, Marty hoped to be able to receive and also give better support to her staff as evidenced by her statement. It indicates her desire to benefit from the strategies employed by her consultant to share and extend this experience to her co-workers. Krystal also indicated an appreciation for the support provided by her consultant through the following statement. "She's been real supportive, giving us a lot of training, make sure things we needed especially supplies, and make sure the kids are good." (interview, July 22, 2015).

Directors expected the consultant to be part of the support system that stabilizes infant and toddler caregiver capacity to provide quality care. During her initial interview, Selina identified consultant support she expected to receive as a result of program participation as talking with caregivers about what's happening in the room, answering questions regarding child care concerns and collaborating on the overall goals. She also looked forward to support for herself as this is her first infant and toddler experience and "it helps the staff have someone besides me to run their problems through" (Interview, January 22, 2015).

The director of Jumping Jacks, Donna, recognized the importance of a stable support system, especially for her teaching staff. She stated that her role is to provide that support and sometimes it is helpful to provide it through the work of others. Donna believed that having Georgia as a consultant supported the quality improvement efforts of the staff in several ways. She recognized that staff may perform a certain way because

the director is present. Donna appreciated having an additional person to support the staff provided an alternate voice of reason toward quality and best practice in early childhood education.

A way to support their willingness to do that because I think you get some information across to people who aren't willing to hear it. But if you've got a director that's backing it up, if you've got the goals out in the open, I think it's a little bit easier to do. I mean and to me it's a way for the teachers to take ownership of their own professional development and their own professional growth (Donna, Interview, May 20, 2015).

Selina also added that it was her responsibility to provide support to the staff when her consultant was gone. She would remind staff of the goals and emphasized her implementation expectations of the new strategies discussed during the consultation visit. She also indicated that she provided materials for the classroom and planning time for the caregivers to create meaningful experiences for the children. To directors entering the infant and toddler consultation program, she offered this advice, "Be prepared to put your own time and give them resources they need. It can't just be the consultant working with your staff. You need to be actively engaged in the process, too" (interview, July 22, 2015). This statement exemplifies the supportive role that directors can take for successful implementation of newly acquired skills and strategies.

Another director acknowledged that the consultant provided support not only for teachers and staff, but for the children as well. Ronnica noted that her consultant, Eliza, is "here to support us, the teachers, me and she's here to support the children. She's even helped during the class, at lunch. She helped the staff in a positive way to keep the

children calm; giving them other ways to have them wait for lunch” (Interview, June 2, 2015).

During the initial and final interviews with consultants, they shared their views and experience with various supports to the center staff. Georgia claimed that director support was a vital part of the consultation process. “I would say the biggest factor in terms of my success is the support of the director” (interview, January 12, 2015). She understands that while she can provide experiences, knowledge and PD through program implementation, follow through must be carried out by the director who actually supervises and enforces policies and procedures.

The consultant from The Play Yard expressed her plans to provide guidance to her center staff and director through training, mentoring, and modeling. Kayla, a consultant, acknowledged that support is also needed for the director.

Getting to the place to be a support to the director, a sounding board but also trying to bring the staff together to help. Not that I created, they created the vision, trying to help them come a long side them as they are on this journey. To try to help them (Interview, June 10, 2015).

Eliza shared the idea that support is one of her responsibilities as a consultant to infant and toddler caregivers as evidenced by her statement describing her role as one who provides “support to caregivers so that they feel more comfortable and confident providing care and support and learning to the young children” (Interview, December 23, 2014).

Georgia, also contended that her relationship with the director was, “very supportive in the sense that we were on the same page in terms of where we wanted to help support the staff” (Interview, June 9, 2015). She continued by stating that,

I’m fairly certain she shared that she would like to be there more in the classroom more often, which would have been helpful during my time there. It’s hard because the reason she wasn’t there, wasn’t because she didn’t care, there were other circumstances that kept her from being there often (interview, June 9, 2015).

Georgia understood that her director aspired to be more present than she was able but they were able to maintain a positive relationship where they were able to help one another. Eliza also recognized the importance of supervisor support for a staff member who appeared to be burnt out. She stated that the director would “check in with the teacher and encourage her. She just, because I only would come out twice a month, she was the one who sort of supported her and helped her and really did support her” (Interview, December 23, 2014). To harness future success, Eliza recommended that directors participating in the infant and toddler consultation program choose one simple weekly goal, provide reminders for the staff of those goals, and delegate the work as a way to provide support and ownership of the accomplishments of the center.

Responsive Care

Responsive care is defined as warm and friendly and promotes the development of security and trust not only for the child attending child care, but also for the parents who utilize these services. This theme was composed of coding categories such as qualifications as desired by families. Statements provided in participant transcripts

included, “passionate about children”, “nurturing them”, “caring people”, and “engaging children.”

Care that is provided to infants and toddler based on their expressed needs is responsive and provides them with the foundational base for the development of positive attachments with adults (de Schipper et al., 2008; Drake et al., 2007). Study parents believed that meeting the needs individual of children was considered an important aspect of infant and toddler child care which aligns with research (Carlson & Stenmalm-Sjoblom, 1989). One parent noted that her child’s caregivers,

were real nice, greet me in the morning. They always go further, not just in school, they make sure I’m doing okay at home (Lanisha, Interview, April 13, 2015).

This statement illustrates the level of engagement the parent felt with the caregivers. Lanisha’s perception and comfort level with the staff was positive and she believed the caregivers are going beyond their classroom responsibilities by reaching out to parents even when she is at home.

Finding someone trustworthy was stated by several participants when sharing what they look for in a caregiver for their young child. As noted by, Patricia, the mother of a ten month old, “You look for someone you can trust because that’s my child. You want someone to have that same, they are going to (provide care) just like it was their child (Interview, July 24, 2015). Getting to know the caregivers can help parents develop trust and increase their comfort level that their child will be cared for. Determining whom to trust with your child may take time. Lanisha, from Jumping Jacks, cautions that parents should take their time to find the appropriate caregiver for their child. Her first

child care experience was chosen because the caregiver was a known person to the family and child. She trusted the caregiver because she was already familiar with the children and family. Lanisha stated that,

You might need child care soon or you know you need to hurry but you shouldn't want to rush. Take your time to look. You might find affordable and want to jump on it, or it might be convenient and you want to jump on it. But you really need to take your time to find good child care. They are the ones who will be with your children the majority of the day (Interview, April 13, 2015).

Lanisha recognized that a hasty child care decision may not result in the child care experience expected. As a parent, she acknowledged the need to know the individual caring for her child.

Several parents chose their child care situation because of a family connection. In each of the three cases, the mother had a family member that either began caring for children in their home or purchased and operated a child care center. It was reported that one cousin, one aunt, and one mother were utilized in this capacity. Choosing this option for child care was based upon the existing relationship. The family was already familiar with and had an established relationship with the caregiver.

Marty, from The Play Yard, recommended that parents looking for quality child care for their infant or toddler, they should, "judge a book by its cover." Similarly, the mother from Many Hearts suggested parents, "go with your instinct and how you feel." She was looking for a caregiver who can be attentive, consistent and fair. Another parent described quality as, "friendly and clean, organized and inviting. You can walk in to some centers and no one speaks or anything like that" (Kelly, focus group, May 13,

2015). These qualities as expressed by families utilizing child care services indicate the value of developing a relationship that evokes positive feelings. The terms friendly, inviting, instincts signify that quality should not always be measured by a checklist.

The mothers who participated in the focus group and interviews wanted their child's caregiver to be a passionate about children. They should also be a caring, nurturing individual, treats the children with respect, tends to their physical and mental needs, be attentive, fair, and consistent. Lanisha shared a little about how she feels about having her son cared for in the child care environment.

People are like, he's been changed and fed, but he can't express himself yet even though he's two, he does a lot of crying. I look for people who are understanding about that. Not just, I don't understand why he's just crying, I did everything for him. He's real nurturing, he likes to be held, so I'm looking for them to make sure he's taken care of (Interview, April 13, 2015).

She believed should be happy in the presence of their caregiver and not left in isolation. Lanisha desired for her child to have adult-child interactions that were positive and respectful with an understanding of the child's individual temperament type. Other parents resonated with Lanisha's views.

I expect the highest expectations for the caregiver. As far as they would treat my child like they would treat theirs, with respect, with care, that they tend to the needs of my child when it comes to taking care of her physically and mentally. They would be just as attentive to my child, be fair and consistent. That's what I expect. Just in care and that, quality care (Patricia, Interview, July 24, 2015).

Based on observation, consultants spent a considerable amount of time interacting with children. Dinnebiel and colleagues also noted this phenomenon in their study of itinerant consultants working in classrooms where a child received therapeutic services. While the consultant was tasked to work with the adults, they spent the majority of their time with the children. They were observed helping children, engaging them in play activities and books, and responding to conflicts among children.

On the other hand, less time was spent collaborating with adults during observations. Nelson et al (2011) and Morrow (2003) recognize collaboration as a predictor of caregiver implementation and motivation for new practices. Many of the study participants indicated that they needed more time with their consultant even though all centers received more than the five month minimum and three of the four centers received at least 15 extra hours of on-site consultation services.

Challenges to Relationship Building

Caregivers and consultants alike identified barriers to the successful development a mutual partnership. Turnover, low participant engagement and lack of time were cited as challenges to effective consultation experiences. Unfortunately changes in child care staff are common within the field of early childhood and this study was not immune to this phenomenon. Due to availability issues, illness or lack of motivation, interactions between some of the participants were limited resulting in low participant engagement. Many of the study participants maintained that there was not enough time to work towards and achieve desired goals.

Turnover. Turnover is defined as the rate at which child caregivers leave the early childhood education field. Participants noted that there were several instances of

changes in staff and that negatively impacted services rendered. Responses such as, “when I came back, she was gone,” “the teacher abruptly left,” “I’ve been spending less time on-site....because of the turnover,” and “there hasn’t been continuity” were provided by the consultants.

When centers have high turnover, infants and toddlers have to familiarize and learn to trust new caregivers on a regular basis. Parents expressed this as a concern for their young children. “My child can’t get used to the daycare worker because we have somebody new” (Patricia, Interview, July 24, 2015). Parents have already reported how important it is for them to trust their child’s caregiver and how they value the relationship they share. It is a concern for parents if their child’s caregiver changes because that becomes a new individual they and their child must get to know and trust.

The effectiveness of PD activities can also suffer at the hands of high turnover. The consultant, Eliza, worked with a number of caregivers from My Child during her 11 months on-site. During her initial interview, she stated that she had already encountered turnover twice within the first six months. For each of the three planned observation for the duration of study participation, there was a new caregiver. Even as the hours came to an end, the final infant caregiver shared news that she would be leaving the center sometime in the coming months.

When consultants experience caregiver turnover, maintaining previous goals and effective strategies to accomplish can be difficult to manage. Eliza described this difficulty from her first experience with turnover at My Child Care.

It was exciting to see when I shared transition songs with her how she took hold of those and got more wind in her sails. She had the smile back in her face and the

laughing with the kids and having fun. The defeat was the next visit, I learned she quit abruptly and was no longer there (Interview, June 2, 2015).

The progress that was made during the time spent with this caregiver was gone and Eliza had to start new with the next hired staff member. She also shared that lack of caregiver consistency makes goal achievement “tricky” and that objective “has been put on pause.” Darlene also asserted that with all the staff changes she experienced, she feels as though progress was stop and go.

Changes in caregivers also impacted directors. Eliza described shifting her primary role of consultant to provide support for the director. She described it as, “emotional triage for the director to encourage her to you know because she is devastated that she lost this expert staff person and she’s grieving that” (Interview, December 2015). The amount of turnover was a salient theme throughout Eliza’s participation with My Child Care. She felt the staff couldn’t put much effort towards quality improvement due to the high prevalence of turnover for the duration of the program.

Parents were also concerned about the consistency of the caregiving staff. When looking for child care, questions asked by one parent included, “Is there a high turnover rate for the facility? Do we have new people coming in and out? (Patricia, Interview, July 24, 2015). The parent from Jumping Jacks with two children under three recognized the need for caregivers to understand how to work with young children because “working with the age group can be difficult” (Interview, April 13, 2015). In centers with high turnover, getting to know and understand the individual needs of children can be challenging and have a negative impact on the children.

Turnover is prevalent within the field of early childhood and recognized by parents and professionals alike (Whitebook & Sakai, 2003). Patricia, the mother of an infant attending Many Hearts acknowledged this challenge in her interview. Establishing a relationship with new staff can be difficult for consultants as expressed by Eliza in the previous paragraph. When interviewed about the services provided to her center, the newly appointed infant teacher of My Child Care stated, “I just know what I’ve been told, that she is a consultant, part of a program that we’re with. I don’t know specifically what she does” (Lauren, Interview, March 23, 2015).

Low Engagement. Low engagement refers to the concept that there was limited active participation by participants. This theme was derived from statements and field notes taken during interviews and observations. Caregivers described their engagement with their consultant as “at the beginning there was some confusion,” “I had no idea what I needed from (her),” Consultants and directors noticed the caregivers were “a little slow” and “a little hesitant” to engage with the consultants. During the interview process, my field notes indicated that one participant was withdrawn and provided simple, sometimes one word responses. This participant was unable to recall the name of her consultant and could not provide a description of her contributions made during the consultation process. During her site visit, she was observed providing care for the children and appeared withdrawn when the consultant attempted to interact directly with her.

Kayla described one of the younger caregivers at The Play Yard as “somewhat engaged.” While she inquired about resources for program improvement, she did not further engage with Kayla regarding those resources. Kayla gave her the *All About*

ITERS-R book because the caregiver “really wanted to read it.” However, on two of the three observations I experienced with Kayla at The Play Yard, she asked if the caregiver had questions about the book, she always answered in the negative. The caregiver followed up by saying she wished she had the book at the center. Kayla also reported that she never got her book back and the caregiver never asked any further questions.

Darlene shared an experience of low engagement and attributes it to a language barrier. One of the teachers has English as a second language.

When I would ask or recommend things for her to do, she would smile and nod her head like she understood but it wasn’t actually happening. I kept trying to think or say to myself, I don’t think she understood what I said even though she said she did. Because it wasn’t getting done or it was done in a different way (Interview, July 3, 2015).

This statement demonstrates the lack of progress one caregiver contributed. Darlene’s comment indicates that while the caregiver responded positively to her recommendations, she was unable to follow through.

During her post interview, Katherine shared several challenges to active collaboration. There was no point in time for the duration of the infant and toddler consultation program that the director, caregiver, and consultant shared time together in or outside the classroom.

it would be good to have the director, the assistant director, and all teachers and consultant get (together) at least a couple times. Even if it’s just 10 or 15 minutes where we all get to be in the same room so that whatever is said can be heard by everyone all at once (Interview, May 18, 2015).

Katherine was assigned to receive infant and toddler consultation services, and expressed that, “It would have been good to know in advance... That way everyone can be on the same page” (Interview, May 18, 2015). She does concede that once everyone got on the same page, the consultation process was “a lot smoother.” Upon the termination of services, Katherine felt the changes brought upon by consultation participation would have been smoother if there was an opportunity for her, along with all partners in administration, and the consultant to meet together to work towards the goals.

Lauren from my child care lacked active engagement. She described her role in the consultation relationship as “to be an infant teacher, honestly I don’t even think about (her) being here. I just go on about my day”. She also had no memorable moments to share about participation and was unable to elaborate on her contribution to the quality of the center outside of caring for the children. When asked about her specific contributions, she responded, “I don’t know, I just have my ways of inputting stuff and it usually works out pretty well” (interview, May 13, 2015). In fact, upon the mention of her consultant’s name during the final interview, Lauren was unable to recognize Eliza by name and needed me to clarify who she was.

Georgia also experienced a similar lack of collaboration due to inconsistent contact with the director for uncontrollable reasons. Directors were not the only participants she was challenged to collaborate with.

It was kind of difficult to come together to do that reflective piece. I certainly had opportunities to do it with them (caregivers) individually at different times. But when you’re talking about a classroom functioning as a unit or a team and you don’t have both people there talking about what works and what doesn’t work,

why they chose to do things the way they're doing it. It makes it difficult (Georgia, Interview, June 9, 2015).

Lack of Time. Defined as having minimal opportunities to spend building relationships between participants and collaborating together to achieve center goals, time was cited by nearly every site stakeholder as a challenge. Consultants felt that “we didn’t have enough time,” while caregivers wished they were able to “carve out time for me, my assistant teacher, both directors (to be) all in the room at the same time” and one director stated there was a gap in consultant visits that lasted for a “two month time period.”

When asked what she would change about the infant and toddler consultation program, Katherine, of Jumping Jacks, stated that it would be to have time specifically planned for collaboration. Lack of time is defined as minimal opportunities to spend time building relationships between participants and collaborating together to achieve center goals. When the director was present on-site, Katherine was responsible for a classroom of toddlers and there was no time available for the consultant and center staff to meet together as evidenced by the next statement.

It would be great if we were able to carve out time for me, the assistant teacher, consultant and both directors all in the room at the same time so that some of the changes that we ended up doing could have probably been done smoother (interview, May 13, 2015).

This statement illustrates Katherine’s need to feel included in the relationship established between the consultant and the center. Instead, she felt as though there were two

exclusive relationships; one between the consultant and director and another between the consultant and the caregivers.

Marty shared that the time for her consultant's visits were poorly scheduled. Many of the visits were scheduled during the winter months and had to be canceled due to inclement weather. She also reported that the consultant often arrived after Marty's shift ended or was soon ending or when Marty was taking her break. She wished she could have spent more time with her. Marty also expressed her wish to have more time with her outside the classroom with no responsibilities caring for children. Finally, Marty explained that when Kayla's required hours were coming to an end, she was unaware the program was not longer. Similarly, when asked how she would change the consultant program if she could, Shameka replied that she would make the program last longer. She felt that she needed more time with her consultant because she had more to learn. Due to the amount of turnover early in program participation, Eliza determined that she would need to extend her time with the staff of My Child Care in order to "get everyone the knowledge and practice with skills to achieve the director's (and teacher's) desired goals" (interview, December 23, 2014).

The director of Many Hearts experienced a gap of time, approximately two months with no consultation services provided due to unforeseeable circumstances. Darlene stated there wasn't enough time within her role in the program to provide the staff of Many Hearts. She believed that the relationship building process is so important and recognized that it can take time to develop. "By the time we begin to understand what our role is, and what they can learn and what is available to them, our time is finished" (interview, July 3, 2015). Georgia experienced a similar gap in time with one of

her Jumping Jacks caregivers due to the birth of her baby. Once she returned to work, Georgia reported a positive change in the teacher as she had become more open to the information being offered.

Kayla recommended that future directors allow more time for the consultant to spend with the caregivers. She wished she had more time to spend working on interactions between the caregiver and child. She acknowledged they spent most of their consultation time enhancing the environment but without addressing the interaction aspect of child care she felt that the child's benefits aren't as great. She valued the nurturing of caregiver-child relationships. On the other hand, she also stated that she may have spent too much time working with The Play Yard. She stated that perhaps if she shortened her time she could have had more intense visits. She also recognized that if the time were shorter, there were other quality elements that may have gone unaddressed.

Opportunities for Professional Growth

“Having Darlene here has helped (caregivers) to know more about what they’re doing. I don’t think there was a lot of training occurring before that. They were just kind of thrown in the deep end.” – Selina, Many Hearts Director

Increasing ones skills often requires an increase in knowledge and education. Professional development is one approach to achieve that outcome and is defined as strategies that contributed to increased knowledge and skills of center participants. This theme emerged from categories such as knowledge, training, and PD. The participants in this infant and toddler consultation case study recognized that enhancing their knowledge base is one efficient strategy that can lead to higher quality child care practices. Members of the center staff stated they wanted “further training” and “a better

understanding of an infant and toddler (childcare) program.” Understanding basic infant and toddler development can serve as the foundation to providing the type of individualized care they need.

The participants in this study have acknowledged their need for increased PD opportunities to enhance their professional growth. The director of Many Hearts recognized the consultation program as one that can provide PD for staff. The consultant of The Play Yard wanted to instill in her center staff that despite opposing social views they have in important job. The director and infant caregiver of The Play Yard also valued the training opportunities provided by the consultation program.

Many Hearts’ infant caregiver, Krystal, valued an increase in her knowledge of infant and toddler child care and development. When asked about her expectations of her participation, she responded with, “we’ll gain some knowledge so that it (infant and toddler development) becomes more of my specialty” (Interview, January 22, 2015). In her first interview, Lauren of My Child Care, also hoped to gain knowledge from her consultation experience and learn better ways to handle situations that occur while caring for infants. She found that the discussions she had with her consultant were helpful.

Marty, the infant caregiver at The Play Yard, found it was helpful to not only take the new information shared by her consultant and apply it, but she also did her own research to support the decisions that were made for the classroom as well as increase her own personal knowledge base on child care and development. Krystal also believed her role was to learn and receive training to understand her own needs better. “Absorbing more knowledge and understanding what I have to do as far as being an infant teacher” (interview, January 22, 2015). She felt like her consultant was someone with knowledge

who was there to answer questions about her role as a caregiver and then implement those skills in the classroom to ensure the infants are “reaching their milestones and learning as much as they can” (interview, July 22, 2015). Katherine endorsed those sentiments as she believed it was her role to accept suggestions and try to implement them. She stated that sometimes the suggestions worked, other times, they didn’t but most importantly “you learn as you go” (interview, May 13, 2015).

Krystal characterized the director’s role as “making sure that the staff is fully educated on what is needed as far as being a teacher. Just making sure that we have a clear understanding of what we need to do with providing care for the education” (Interview, July 22, 2015). When staff believe they are doing just fine without extra assistance or knowledge, it can be a struggle to present new information. This is evident in the comment from Katherine at Jumping Jacks,

at the beginning there was some confusion because when she came she wanted to know what I needed from her and my thing was is, things are going okay so you tell me what you need me to do, but I have no idea what I need from you (interview January 12, 2015).

She later divulged that she looked forward to her consultant’s visit. Her consultant was able to, “give some of her knowledge (on) how to make things easier” (Interview, January 12, 2015).

The Play Yard director and caregiver each also expressed the expectation that the staff would receive training opportunities as a result of their participation in this program. By the same token, Selina also wished for the consultant to “work with (staff) on professional development” (Interview, January 22, 2015). It was the hope of the director

that caregivers receiving infant and toddler consultation would understand how important they are and “to be prepared to try new things and learn new things” (Selina, interview, July 23, 2015). Jumping Jacks director, Donna, also endorsed this program as one that is a “really good opportunity for professional development and growth” (interview, May 15, 2015).

On-site technical assistance allows the content that is shared to be individualized within the context of the setting. Selina shared this experience,

The consultant would come in and talk with me a little, review our previous visit or emails. Then we would talk about the goals for the current visit. Then she would spend the rest of the time in the classroom. We have a couple classrooms that served infant and toddler kids. She would spend time in those classrooms working with those teachers on the goals we talked about and if I had certain concerns that I felt needed to be worked on in the classroom she would address those (interview, July 23, 2015).

Darlene was able to utilize time with the director and the center staff and address specific concerns or provide pertinent professional development and knowledge based on the individual needs of the present staff.

Almost every participant suggested that having an open mind to learning new things was essential to program success and effectiveness in achieving higher quality child care. Ronnica acknowledged that the consultant contributed to making the infant and toddler classrooms better by providing different ways to meet their needs and that of their family.

Knowledge and experience were notable qualifications also desired by parents. Having at least a bachelor's degree is valued by one parent. Working with young children requires a working knowledge base of child development and operating a child care requires business knowledge. Patricia declared that, "it's good if they have education or a degree, at least a bachelor's degree in child development" (Interview, July 24, 2015). This statement shows Patricia's appreciation for utilizing formal education as path to increase one's knowledge.

Parents also understood that some child care providers have not achieved degree-level status of education. There are additional paths for child caregivers to increase their knowledge about young children. When searching through the child care database online, one parent learned about the certifications that teachers can earn in the field of early childhood education. Because the staff was enrolled in the Child Development Associate's (CDA) program, Lanisha knew they were seeking further education. Marty, the mother of a two year old, noted that the absence of certain certifications would deter her from enrolling her child in a center. "The main one to me that would turn me away from a child care setting is if they weren't First Aid/CPR certified. I feel that the other ones are important but that's the (main) one" (Marty, Interview, May 13, 2015).

Knowledge can also be increased through the attendance of workshops. Parents reported that going to workshops can help keep caregivers up to date on regulations and general information. Marty felt that caregivers should be "properly trained" and "up to date on their trainings" (Interview, May 13, 2015). Temperament is a topic that Lanisha believed caregivers should be knowledgeable about. Additional topics mentioned included child development and milestones, and how to teach children.

Through interviews, the consultant from My Child Care shared the technical assistance she provided. “Well, with the director we talked about outdoor learning, nature learning, because that’s another thing she’s done is improve the outdoor which used to have plastic playground equipment (Interview, December 23, 2014). Additional topics included sensory processing, child development, communicating with families. Eliza shared that she also, “helped one child connect with early intervention. I helped one family and I also did triage on several children with certain behavioral concerns” (PC December 23, 2014).

Eliza also mirrored the sentiments of many of the study participants. She believed that recipients of infant and toddler consultation should “be willing to accept we are all learning...taking constructive criticism and learning from it” (June 2, 2015). Darlene shared an experience she had during one of her visits that resulted in an unplanned training for the Krystal, the caregiver.

She started asking me questions about ‘What centers should I have in my space?’

So that was like a hands-on kind of training. (She was) really excited and the kids were too. It was interesting because the kids starting playing differently in that space. So It was an opportunity to do a training right there and as we went along I just kept adding more information. Because we were actually doing it, I think it was more beneficial for her than me just doing training for her (Interview, January 22, 2015).

The consultant for The Play Yard described a similar experience. In her post interview, Kayla stated, “There were times that I actually did trainings on the floor in between

different things, tasks going on. I would just sit on the floor” (Kayla, Interview, June 10, 2015).

Darlene shared that the staff “wanted to do a good job.” She went on to say that the staff would report trying to implement her recommendations and would ask for additional suggestions when those attempts were unsuccessful. “They seemed to be open to that. Like I said, when the director changed, they became very open toward wanting to learn and wanting to improve what they were doing which made a big difference” (Darlene, interview, December 16, 2014). These are prime illustrations of the utilization of both training and on-site experiences for the benefit of the caregiver and the children alike.

Modeling with feedback is one strategy utilized by consultants. Darlene noted that she would “do some of the modeling. I would have them do some things for me to see. Particularly, if we talked about something we discussed last week” (Interview, July 3, 2015). Another example of Darlene modeling with feedback is described by her,

I got down on the floor with the babies and while they were on the floor, some of them were on the floor, which is good. I just talked about this is a wonderful opportunity for you to have a conversation with the babies and the babies to have a conversation with one another. I would specifically show them, make sure you are on the child’s eye level, talk to them. Even if the child makes a sound, copy the sound and wait for the child to respond - to have the back and forth exchanges (Interview, July 3, 2015).

Feedback is provided to directors and caregivers on a variety of program and non-program related topics. Examples of feedback observed included goal oriented changes,

classroom supplies, quality child care and resources, child, caregiver, and consultant behavior, and child development. Upon arrival, consultants were observed discussing changes and concerns with the director. Darlene approached the director of Many Hearts to discuss the changes that have been made to the infant caregiving environment. She also offered to talk with the director about providing better supplies for the caregivers. I observed Darlene asking a caregiver, “How do those gloves work for you? I’ll talk to Selina about other gloves” (Darlene, Interview, January 30, 2015).

Consultants also sought feedback and information from the caregiving staff. Kayla, the consultant serving The Play Yard, engaged the assistant teacher of the infant classroom, with the question “Have you looked through the *All About ITERS* book I gave you? Do you have any questions?” (Kayla, Interview, May 9, 2015). During the various opportunities I spent in the classroom observing the teacher and consultant working together, I witnessed teachers sharing successes and information regarding child concerns.

Caregivers and consultants shared conversations about the consultant’s role, child development, and consultation strategies utilized to enhance the infant and toddler child care services. During my first observation, Georgia asked her caregivers, “Did you complete the self-assessment?” It was shared that the self-assessment would be used to help the staff recognize their strengths and areas for improvement which would guide them in the creation of the Quality Improvement Plan. The consultant often responded with questions seeking clarity or additional information regarding the situation.

When Kayla struck up a conversation with the caregiver during my first observation, the caregiver showed her the new pictures she put on display. Follow up

probes like, “Have you taken the children outside?” resulted in Kayla remarking that she will provide training on the importance of nature and science for infants and toddlers when the answer was provided in the negative.

I observed the provision of technical assistance as noted in my field notes. Examples of the various content areas covered such as nature and science, information on literacy, nutrition, a screen time, safe sleep, handwashing and caregiver scholarships were covered within the consultation period. Through the use of the Consultant Activities Summary Form, I deduced that during the consultation period, the primary topics reported by the consultants were group care, learning and development, QIP development and review, and health and safety. Together, the four consultants spent an average of ten visits dedicated to group care with learning and developing a close second with an average of nine visits. QIP development was the third time spender with eight visits focusing on creating, developing, and reviewing quality improvement strategies. Inclusion and literacy each had less than two visits in which the consultant reported those two as a visit topic.

Modeling engaging behavior and appropriate practices were observed in all four centers. Based on the field notes taken during the observation sessions, I noticed a variety of modeling sessions. Consultants modeled and encouraged language with children in each center. They also sat on the floor with the children, modeling floor play and interacting with children on their level. One consultant shared this about providing modeling with her infant and toddler caregivers, “Sometimes I’ll go in and do some modeling. I’ll sit down on the floor and see if they’re paying attention to what I’m doing” (Darlene, Interview, December 16, 2015). Eliza noted that part of her contribution

to enhancing the quality of care provided to infants and toddlers included modeling, “I modeled more effective and responsive behaviors” (Interview, June 2, 2015).

Through interviews and analysis of program artifacts, such as the Consultant Activity Summary, consultants provided technical assistance and trainings on a variety of topics. An average of seven training hours were provided across the four cases covering the content areas including group care, health and safety, social and emotional growth, learning and development, literacy, and characteristics of quality.

Opportunities for Environmental Enhancement: The Intersection of ITERS-R and Participant Interviews

In addition to opportunities for relationship building and professional growth, environmental enhancements were frequently reported within the data collected during this multiple case study. These opportunities are defined as factors that contribute to increased quality of infant and toddler child care. The infant and toddler consultation program under study is one that focused on improving the quality care infants and toddlers receive in child care settings. Because program participation is voluntary at the center level, it is logical that enhanced quality is one of the expressed expectations of the participating consultants, directors and caregivers. Two categories that preceded this final theme included ITERS based and quality child care. According to the participants, environmental enhancements can be achieved through “becoming better,” making changes, professional growth, successfully accomplishing goals, and continued progress.

Center quality is measured through the use of the child care environmental rating scale commonly known as the ITERS-R, or simply ITERS. Items such as space and furnishing, personal care routines, listening and talking, activities, interactions, program structure make up the tool. After the consultant completed the measurement observation,

a report was created that provides direct feedback about the quality of care observed on that day. When those results were shared, a quality improvement plan, or QIP, was developed that includes the ITERS items that the team has chosen to focus their quality enhancement consultation efforts. Study consultants indicated that growth and an increase in quality according to this tool were desired. All participants expressed an interest in advancing their quality in specific items denoted in the ITERS tool.

ITERS based expectations expressed that appeared frequently within the data included health and safety, and furniture for routine care and play and provision for relaxation and comfort. Furniture for play and provisions for comfort are items that can be categorized as part of the environment. Each of these items was mentioned by three participants during the interview period and was notated as a QIP goal of two centers, as well. Jumping Jacks study participants noted on their QIP that they wanted to, “improve our health and safety practices.” The QIP created by the director and consultant of My Child Care included furniture for routine care. Kayla expressed a deficit of soft spaces for infants and with the director of The Play Yard, indicated it would be their goal to create one.

Health and Safety

Within the ITERS-R observation tool, health and safety is comprised of practices that promote the well-being of infants and toddlers in child care. The participating parents recognized health as an important aspect of the child care environment as well. At least one parent shared that she visited the state website that lists regulations and compliance of child care centers to view health and safety information. She stated, “I understand there will be a compliance issues sometimes with the facility but it depends on how

severe or exactly what I'm looking at. (I would be concerned with) issues with neglect or any major issues that would put a child in harm's way" (Patricia, Interview, July 24, 2015).

The safety of the children is also of utmost importance. Infants and toddlers are not aware of environmental risks and they depend on their caregivers to provide a safe environment for their natural inclination to explore their world. One parent from The Play Yard Focus Group noted that when looking for child care, "First, I look for safety, to make sure my child is safe. And the people caring for them are safe" (Interview, May 13, 2015).

Two study participants shared goals regarding health and safety. One had not been obtained yet but still working on them as denoted by this director's comment, "They were still working through basic procedural stuff was done like diaper changing and handwashing. We were still making sure those were being done properly; and by each teacher that came in the room" (Interview, Selina, July 23, 2015). Jumping Jacks also noted that they added "a stool to the sink so they (children) could wash hands more independently" (Georgia, June, 9, 2015).

Space and Furnishings

Space and Furnishings was identified by participants through interviews, observation and program artifacts and defined as environmental factors that contribute to high quality child care. The physical space where children spend their day was mostly noted within the interviews conducted with site stakeholders and noted on all four Quality Improvement Plans as areas needing to be enhanced. The physical arrangement

of the environment was most widely noted with six participants sharing their expectation of program participation to result in this area enhanced.

When asked to describe what she knew about the infant and toddler consultation program, Many Hearts Director, Selina, responded, “the consultant comes in and she talks and works with teachers about what’s happening the room, answers questions they have about how to set up environment” (Interview, January 22, 2015). Darlene, the corresponding consultant, shared the importance of the children’s physical classroom space. “You got carpeting here, some books, something for them to play with is fine, but they don’t think about how the environment can really influence a lot of other areas in your classroom” (Interview, July 3, 2015). This goal was also notated on the QIP created by the consultant and director. It was also feature in the QIP belonging to My Child Care and The Play Yard as well.

Each study participant from The Play Yard referred to their expectations of enhanced room set up during the interview process. Kayla shared that the staff had only begun providing child care services to infants and had not had any prior experience. She said, “it was not quite conducive to infants at all. A lot of what we did was going through the environment, of what that environment should look like for infants” (Interview, June 10, 2015).

Some center staff expressed that softness should be added and others needed to include smaller, child-sized furniture. During program participation, My Child Care was able to

eliminate a group feeding table and replace it with high chairs. They looked at materials to make sure the infant area and toddler area had recommended ITERS

materials. They added more softness, they didn't add a chair to the infant area, but they added a yoga ball (Eliza, Interview, June 2, 2015).

Jumping Jacks' experience was similar to that of My Child Care. They also added softness to the room and got rid of the larger table in lieu of getting a smaller, toddler-friendly one. Katherine shared that the children love the table because it was lower for them. She credited that with the help of her consultant, a positive change was made. "That was a good change but not something I would have figured out on my own (Interview, May 18, 2015).

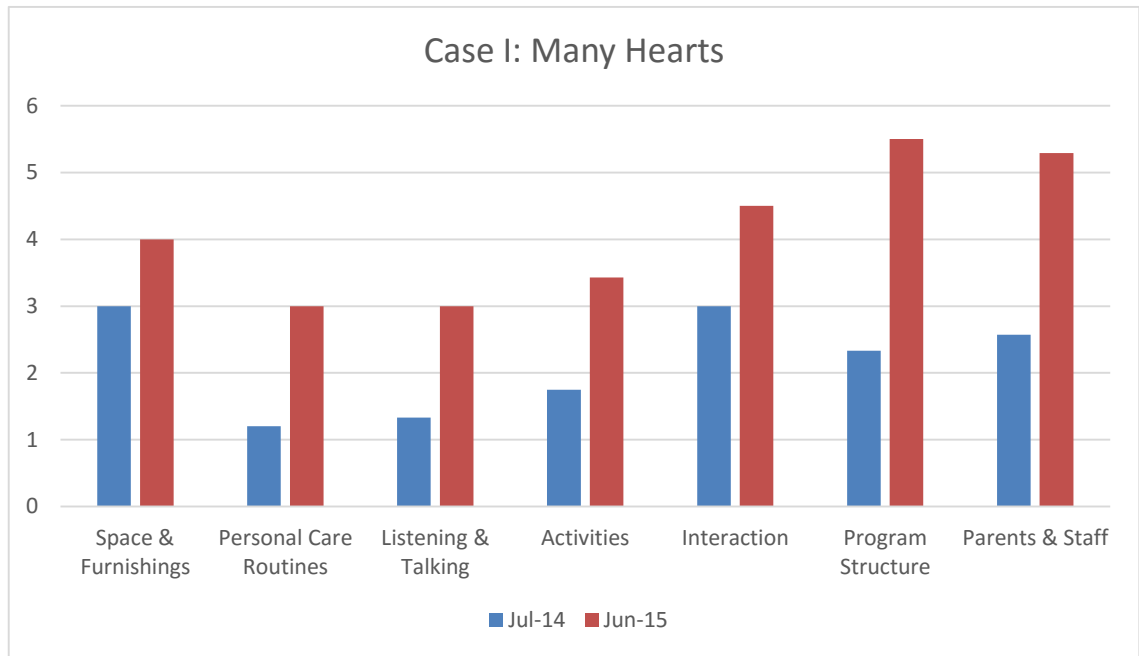
Directors and consultants shared additions in the area of display for young children. Eliza remarked, "They also added display, pictures of realistic images whereas before they had cartoonish and not any display" (Interview, June 2, 2015). Not all goals that were created materialized as evidenced by the next comment. "Pictures on the wall, that's what we're still working on, getting the wall covered. That was one of the things that was big we needed to work on as well" (Shameka, Interview, May 18, 2015).

Infant and Toddler Environment Rating Scale – Revised

An independent consultant was hired to conduct a post-consultation ITERS-R for each of the participating centers as a condition of the consultation program. A paired t-test was conducted to compare the quality of child care before and after infant and toddler consultation program implementation. There was no significant difference between the pre-assessment ($M = 3.105$, $SD = 0.836$) and post-assessment ($M = 4.01$, $SD = 1.315$) conditions; $t(-1.25) = 3$, $p = 0.296$. These results suggest that the consultation experience alone did not impact the quality of care received by infants and toddlers in child care settings.

The tables below present pre and post ITERS-R data to illustrate the difference in quality before and after consultation services were provided. The infant and toddler consultant was tasked with determining the pre consultation ITERS-R scores. An outside consultant not affiliated with the center was employed to conduct the post ITERS-R score.

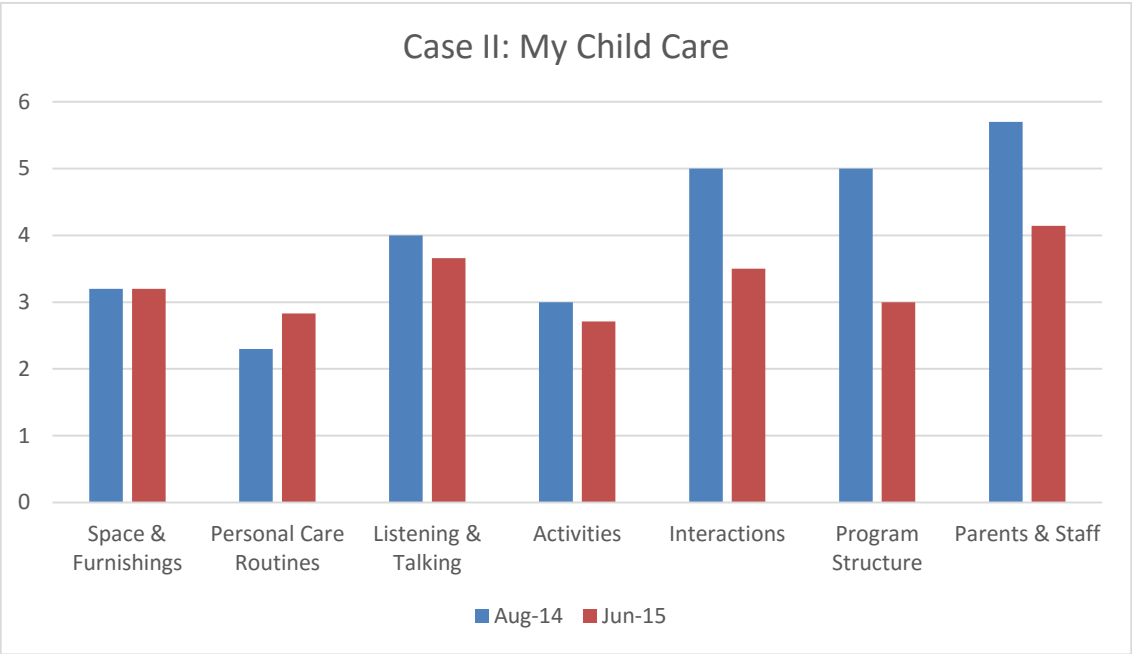
Table 8

Case I: Pre/post ITERS-R

Many Hearts has shown an increase of least one in each of the seven areas since they began work with their infant and toddler consultant. The largest gains were identified within program structure and parents and staff and the smallest gain occurred in space and furnishings. When Many Hearts entered the consultation program, the quality of their infant room was rated “inadequate” according to the ITERS-R tool and increased that quality to “minimal” by program’s end.

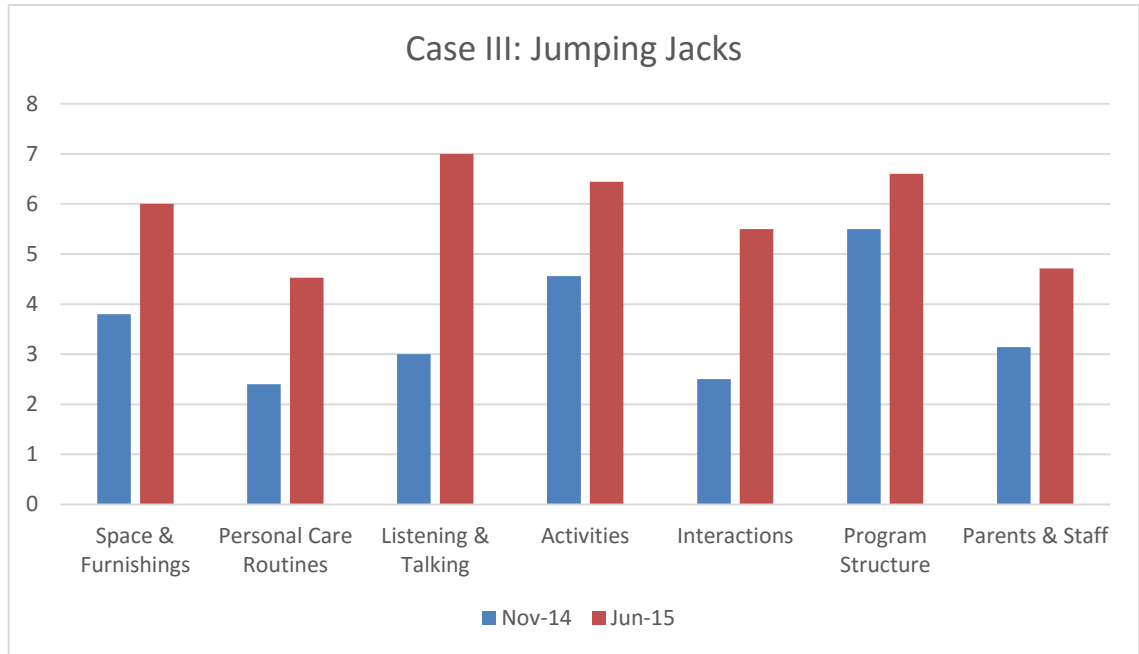
Table 9

Case II: Pre/post *ITERS-R*



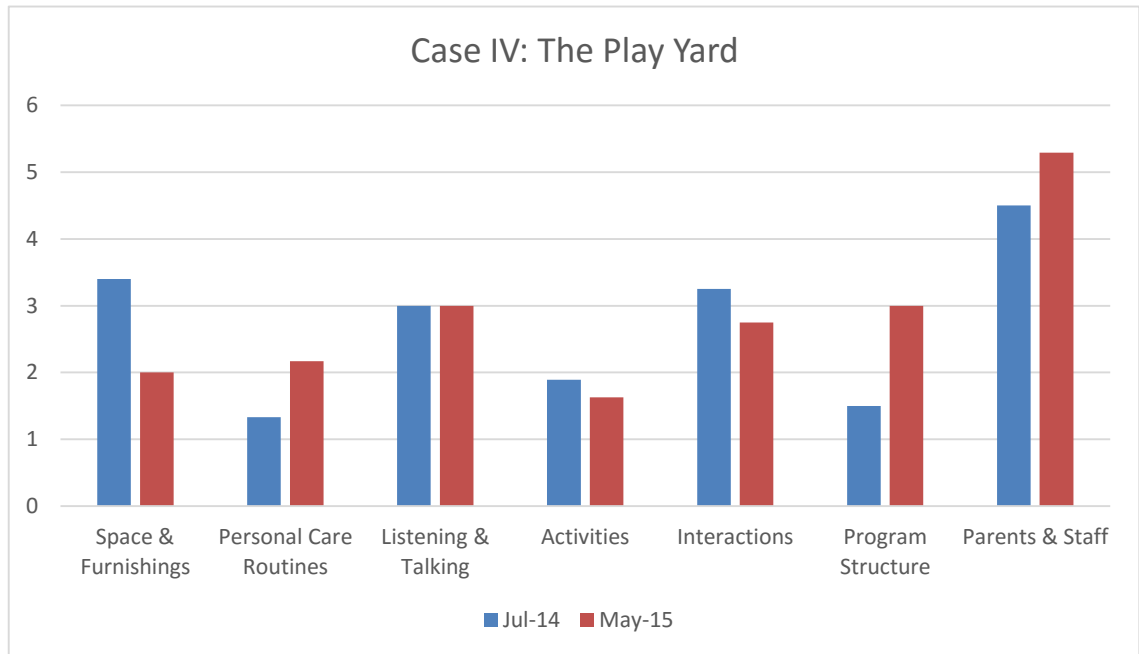
In the case of My Child Care, the only gains noted by this graph occurred in personal care routines. Space and furnishing saw neither a gain nor loss; however, each of the five remaining areas show a decrease from the pre *ITERS-R* observation to the post. They originally scored as providing minimal quality and even though their score decreased they remain in the minimal quality range.

Table 10

Case III: Pre/post ITERS-R

Similar to Many Hearts, Jumping Jacks also experienced an increase in their ITERS-R scores since the onset of infant and toddler consultation services. The smallest gain was shown in the areas of parents and staff, activities, and personal care routines. The largest increase was noted in the area of listening and talking. A full four point difference occurred between November 2014 and June 2015. At the end of consultation services, Jumping Jacks was rated as providing “good” quality as compared to prior to services when they were rated as providing “minimal” care.

Table 11

Case IV: Pre/post ITERS-R

This center received gains in three areas and losses in three areas. They received the same score from pre to post observation on the seventh area, listening and talking. Increases were shown in personal care routines, program structure, and parents and staff. Lower scores were indicated for space and furnishings, activities, and interactions.

Resources

Study participants reported that resources were an influential component of the infant and toddler consultation program. Through direct observation and interviews, the use of many resources was recorded. Resources are defined as assets provided through program participation that contributed to increased knowledge, skills, and quality of the child care environment. Center staff, consultants and families each shared their

experience with various resources as part of program participation. Resources were provided to the staff, families in the form of physical materials or through access to an individual with the ability to provide assistance.

Several participants noted that they planned to use their infant and toddler consultant as a resource. At least one director, one consultant, and one caregiver reported during the interview process that the consultant was a resource. Katherine commented that, “I know that she’s there as a tool for me to use and I just need to use it” (Interview, January 12, 2015). During her initial interview, Many Hearts director, Selina, described her consultant as someone she can contact when questions arise. She later followed up with the notion that her consultant is

a resource and a good person to go to when I had questions...A continued resource I can call on when I need information on positive discipline with infants – can you give me some resources? I know she has those and can give them if I need them (Interview, July 23, 2015).

Kayla confessed that she “felt like a resource. Because I had been a director and this director had lots of questions about being a director. I felt like I was a resource that she could utilize” (Interview, Kayla, December 23, 2015). In support of caregivers’ mission to achieve certain goals, consultants provided materials and resources to enhance the quality of care they provide.

During the observations, Darlene brought board books, fleece socks, offered a laminator and grocery bags for diapers. They also discussed useful resources and Darlene asked if there were additional resources available on-site for teacher use. Eliza was observed offering a feeling and emotion chart to the caregivers of My Child Care.

Georgia was observed giving Jumping Jacks staff a classroom quality self-assessment and Kayla shared infant toys as well as the *All About ITERS-R* book with staff.

Additional resources were reported by study participants during initial and post interviews. A catalog supporting room arrangement and environment improvement was shared with the staff from Many Hearts. Another catalog supporting outdoor environments was shared with the director of My Child Care. Each participating child care center reported receiving supportive resources. Some items were purchased, such as classroom materials (infant books) while others were created (laminated pictures for display).

Lanisha described the resources her center provides for the children and their families. They supplied resources necessary to care for infants. For example, diapers and wipes were provided for the children in attendance. “It was a big help to me that I don’t have to lug and have all that stuff with me everyday” (Interview, April 13, 2015).

They also have a staff person who makes home visits. The benefits of these visits include “they try to make sure not only in the school aspect and your personal aspect, what can help with any situation at home. They do a lot of one on one when they come to your home. Someone tries to help you find resources that help you and your family” (Lanisha, Interview, April 13, 2015)

The curriculum, or activities experienced by the children during the day were valued by parents as well. Parents wanted activities to prepare them for school, be hands-on and engaging. Learning how to count and recognize the alphabet, how to get along with other children, manners, how to use the toilet, and reaching those milestones as they

should were valued benefits from child care attendance by the parents participating in this study.

Kids can get early benefits before school and be able to learn how to get along with different people. It makes it easier to transition to real school. They're not just at a day care center getting watched, they are actually learning. They are still in an environment like home but structured like school. Getting them prepared to be able to cope with being in a bigger school, some of the things you're going to be doing. Be able to interact with different kids (Lanisha, Interview, April 13, 2015).

Placing the care of your child with virtual strangers describes what parents are asked to do when they are members of the work force with no familial child care options available to them. As our interview was coming to a close, Patricia, parent of Many Hearts, explained that "When you have your first child, you're scared! You don't know where to go" (Interview, July 24, 2015). She also shared as a parent one can only hope that the experience described by the child care facility matches the reality of the child care day.

For many parents choosing a child care center is no easy task. Determining where and who should provide care for their young child while they are at work can be difficult. The location of the center was mentioned by at least two of the participants though they had opposing views. One parent selected her daughter's center because it was near their house as that was her first criteria. Another parent noted,

looking for somewhere convenient, not far out..... I need somewhere close by that is convenient that is not going to make me late for work. I can get them there

and get (to work) on time. I looked and looked but didn't care for the one (near my work). They had a couple things I was concerned about (Lanisha, Interview, April 13, 2015).

She continued to say that the center near her work was not only convenient but affordable as well but did not have the quality she believed her son needed. The center she ultimately chose was, however, slightly convenient because she already had one son in attendance.

Chapter Summary

The current qualitative, multiple case study was conducted to learn about the experiences and expectations of infant and toddler child care stakeholders engaged in an infant and toddler consultation program. Consultants, directors, caregivers and family members of infants and toddlers attending child care at participating centers were invited to share their experiences as they participated in an infant and toddler child care quality enhancement PD program. Using multiple data sources, I conducted a qualitative analysis which yielded three primary themes: opportunities for relationship building, professional growth and environmental enhancement. Caregivers, directors, and consultants reported that during the consultation period, they received training and assistance, opportunities for collaboration, and classroom resources. Parents provided their expectations from infant and toddler child care as specific caregiver characteristics, environments that promote growth and development, and resources that support the whole family. As a result of participation, site stakeholders reported they felt supported by their director and consultant. The engagement levels of participants varied and they shared challenges to implementing quality practices. The quality improvements that occurred in the months of

on-site consultation were reported as enhanced health and safety practices, increased display for infants and toddlers, and child friendly space and furnishings.

Chapter V

Discussion

They (Caregivers) already have a general idea of where the director would like to go in terms of improvement and in a general sense where I think probably we need to go. But we need to match that up with where they would like to focus. – Georgia, interview, February 4, 2015

Introduction

Over 12 million infants and toddlers spend time receiving care outside the home in a child care setting and many of those child care classrooms offer low quality care (Laughlin, 2013; Helburn, 1995). Professional development of the caregivers is one strategy utilized to enhance the quality of care received by infants and toddlers. Because the professional development activities are primarily planned and implemented by the providers of PD, it is vital that caregivers contribute input regarding the type and level of PD they receive. The purpose of this study was to explore the consultation experience from the perspective of its stakeholders and the families with infants and/or toddlers. The following research questions were posed to gather the stakeholder's point of view.

1. To what extent are site stakeholders' (center director, infant and toddler caregivers) expectations of infant and toddler consultation participation similar to infant and toddler consultants' expectations of program participation?
2. In what ways are site stakeholders' expectations of infant and toddler consultation being fulfilled during the course of participation?
3. To what extent do family expectations of infant and toddler care reflect the services provided through infant and toddler consultation?

4. In what ways is participating classrooms' quality of care affected by infant and toddler consultation?

Interviews and observations were the primary data collection methods used to execute this qualitative multiple case study involving four child care centers with a total of 16 participants. Program documents, such as the Consultant Activities Summary Form, the Quality Improvement Plan and the ITERS-R were also part of data collection. The course of data collection was approximately five to seven months depending on the case. Data retrieved through transcripts, observations and program artifacts were analyzed using descriptive and structural coding techniques. Key themes that emerged included opportunities for relationship building, professional growth, and environmental enhancements.

Major Findings

The conceptual framework for this study was grounded in the notion that the development of positive relationships between an infant and toddler consultant and an infant/toddler caregiver would contribute to an effective PD experience. Buysse and Wesley (2004) outline three components essential to the consultation process including the following: identify challenges and problem-solve them together, support for caregivers as they learn and practice new skills, and the presentation of new knowledge through on-site training.

In the paragraphs below, I will provide a discussion of the consultation experiences as it was shared with me through the process of data collection. I will offer possible explanations and connections to the literature will be made to illustrate the results through the eyes of the participants. Following the discussion, I will present

limitations to the current study, implications for practice and recommendations for future research.

Opportunities for Relationship Building

Buyse and Wesley (2004) and Howes and Tsao (2012) promote the concept that establishing a relationship built upon trust and respect can positively impact PD activities and experiences. Study participants revealed there is not an easy, nor linear path to cultivating a positive relationship between consultant and center staff. In fact, several components of that relationship building process were noted as critical towards effective consultation. Mitigating factors that can influence relationship establishment include: the initiation of the relationship, continued support and opportunities for collaboration.

Buyse and Wesley (2004) stress the importance of establishing a relationship between consultant and caregivers early in the consultation process. In the current study only one case was able to illustrate this element of consultation. The staff at The Play Yard met their consultant prior to the onset of services allowing them the opportunity to begin building their relationship and gaining familiarity with one another. Other cases were not afforded this advantage. In some cases, staff were hired after the onset of those services. Regardless of the initiation of the consultation, all participants regarded their relationship with their consultant as a positive one.

The consultant met the staff of The Play Yard during a practice ITERS-R session and found them to be highly motivated to make positive changes within the center. In contrast, it was evident from the caregiver that they were not able to continually nurture the relationship throughout program duration. Marty reported that she missed many of the consultation visits and while Kayla found the director to be very engaged, she viewed

Marty as preoccupied. She noticed that their schedules were often conflicting as she would often arrive at the end of Marty's shift. Gable and Haliburton (2003) found that inconvenient scheduling was a challenge cited by caregivers regarding training opportunities. As relationship building is known to be a central component to effective consultation programming. Providers of PD need to allocate the time and resources to building relationships with staff in order to effectively facilitate change in caregiver behavior and child care quality.

Support and Collaboration

Perceived support is an essential element towards successful PD implementation (Buysse & Welsey, 2003; Domitrovich et al., 2009). Wagner and French (2010) found that support was a need indicated by recipients of PD. Fontaine (2006) reported that staff will perceive PD as effective and positive when they feel they are supported. Participants in this study acknowledged the value of providing support when implementing new practices that contribute to higher quality child care.

Determining the level of support that is needed proved to be a challenge for some participants. Katherine described her experience as confusing and it appeared her expectations were at odds with that of the consultant. The caregiver expected her consultant to tell her what her needs were and the consultant felt it was her role to support her by asking the caregiver to share her specific needs. Ackerman (2008) found that administrative support can impact the likeliness of caregivers adopting new practices. When directors were perceived by caregivers to be active participants in the PD activities, they were better able to provide support to their caregivers. A link between training and program implementation was also reported with increased engagement from a director

(Douglass & Klerman, 2012; Knapp-Philo, 2004). Despite the lack of perceived administrative support, Jumping Jacks accomplished set goals and increased the quality of care according to the ITERS-R tool.

Wagner and French (2010) found that when caregivers were not provided with a choice to participate in training, they were found to be resentful and reported that the experience had no impact on caregiver behavior. In contrast, the director and caregiver of Many Hearts were not members of the staff requesting consultation services and they openly accepted the program when it was explained they were to participate. The director shared her inexperience working with infants and toddlers and found the program to be supportive in her role. However, consistent with the literature Katherine, of Jumping Jacks, stated that her consultant was “here to help us but we don’t have specific goals.” It is important to note that the caregiver was not involved in the creation of the QIP. In fact, only the director and consultant were listed as creators.

Caregivers who were required to participate in consultation activities were described as unmotivated and found the experience to be a waste of time (Wagner & French, 2010). They also reported that the PD activities had no influence on caregiver behavior. Morrow (2003) reported that collaborative efforts can impact change in behavior by sharing common goals and strategies. In the case of My Child Care, the caregiver was unable to identify established goals and saw the consultant as one who was going to remedy the child care quality. The lack of collaboration with this caregiver could possibly have lead to the decrease in quality care observed at My Child Care. A consultation study featuring consultation conducted by Early Childhood Special Educators found that caregivers reported collaboration as a missing component from their

experience (Nelson, et al., 2011). Gaining support and collaboration with staff is central to caregiver participation. Planning and building consultant supports around this goal would help caregivers and consultants accomplish a sense of community towards program goal achievement and increased quality in infant and toddler child care.

Challenges

Several challenges to effective consultation were revealed by participants through the consultation program duration and are grounded in research. Turnover and low engagement were prevalent themes that impacted the consultation program.

Child care turnover rates have been recorded between 30% and 40% (Manlove, 1993; Whitebook, Howes, & Phillips, 1990). My Child Care experienced several instances of turnover and it was noted that the relationship building process started over on several occasions for the consultant and new caregivers. The consultant reported two changes in staff members before study participation began and it occurred two more times during the study. Reasons for the changes in staff were not explained, but Whitebook and Sakai (2003) describe three types of turnover: caregivers move on to another center, take a new position within the center, or leave the field of child care entirely. Regardless of the reason for the changes, it is clear that turnover can have a negative impact on the quality of child care provided. The consultant reported that the director felt let down by the staff member who moved on and had to work through that to hire a new caregiver. When sharing center goals, Eliza did not mention that retaining staff was a priority for consultation as designated by the director. Forming a secure attachment with a new caregiver is a risk for children as they have to learn to trust and build a relationship with a new caregiver (Hale-Jinks, Knopf & Kemple, 2012). Helburn

(1995) found that centers with higher quality care experienced lower rates of turnover. Consistent staffing can contribute to the quality of the child care and consultants can provide resources and support to their participating center on this issue if the center has deemed this a need. None of the cases under study requested assistance or guidance on the issue of turnover in the child care field. According to the ITERS-R, a decrease in quality care resulted in each of the seven subscales with the exception of personal care routines which was not a stated goal and space and furnishings netted neither a gain nor loss.

The engagement level of participants was also varied and presented challenges during the consultation program. Georgia and Donna both found their caregiver to be resistant to consultation services while the caregiver, Katherine, stated that there were too many directions provided by too many people, perhaps contributing to the perception that she was reluctant. Georgia recognized Katherine's struggle with instructions received from the various sources. The aforementioned struggles can be connected to additional concerns expressed by all three participants. Donna and Georgia cited more time to work together was one thing they would change about the program. Katherine concurred with that opinion as perhaps it would have provided additional opportunities for the trio to collaborate and clarify any misunderstandings early on in the consultation process. She also explained that she was unaware of her participation in this program until the arrival of the consultant. The director and consultant both communicated the need to ensure clarity among caregivers regarding program purpose and expectations before or at the onset of services. As such, the present study supports and extends assertions by Hill

(2007) that consultation that incorporate collaboration as a strategy to improve practices were found to be effective.

Opportunities for Professional Growth

Though workshop style trainings are the most widely used method for professional growth and development (Bruder, 2009), on-site training, such as consultation, was found to be the most effective by caregivers. Ackerman (2008) reported that caregivers may not believe isolated trainings can provide individualization of PD activities. Dunst and Raab (2010) reported that the majority of the 255 participants in their study rated on-site training as the most useful method to professional growth.

On-site consultation allows for the individualization of targeted content based on the specific learning needs of the center staff (Powell & Diamond, 2013). In an effort to determine caregiver needs, one consultant reported that she gave her caregiver a self-assessment in order to promote self-awareness of classroom needs. However, the caregiver relied solely on the consultant to tell her what information was needed. Other participants were able to take advantage of their consultant and experienced trainings as requested, and at times immediately. In the presence of their consultant, they were able to express a challenge or concern and at least three cases it was reported that impromptu trainings occurred based on caregiver need. Thus, the present study findings underscore the need for consultants to be receptive to caregivers' expressed and unexpressed needs. Flexibility emerged as a key characteristic of the consultants participating in the current study.

Dunst and Raab (2010) indicated that adult learning is most effective when there are opportunities for the sharing of goals. Two caregivers were unaware that goals were

set through program participation. Because Helterbren and Fennimore (2004) suggest that adult learners should be self-directed, caregivers should be invited to play a more active role in their professional development experience.

One center created so many goals it seemed overwhelming and the participants were unable to recall all of them. While training was requested and expected, the caregiver and director were unable to recall specific topics or recite information shared during the training experiences. The fact that they couldn't recall goals and the number of goals may have negatively impacted their ability to adequately focus on specific strategies needed to change caregiver behavior in order to affect practice. Campbell and Milbourne (2003) stated that training should have targeted and specific goals. As such, the present study findings point to the need for limiting the goals which would have allowed them to hone in on specific caregiver skills and knowledge needed to increase quality care.

Opportunities for Environmental Enhancement

According to Garland and Rasmussen (2010) quality child care environments are defined as promoting proper health and safety practices, employing knowledgeable and responsive caregivers, and offering stimulating activities. Previous studies found that parents call for that quality in child care that includes elements such as a welcoming environment, developmentally appropriate learning activities, health and safety procedures, and educationally qualified staff with a continuity of caregivers over time Ceglowski and Davis (2004). Study parents resonated with that research stating they wanted their child's needs to be met in a safe and healthy environment with consistent, qualified caregivers. With the exception of health and safety, it is interesting to note that

the Quality Improvement Plans, or goals created by study centers did not include the elements stated by parents.

As documented by their QIP, parents and staff, health and safety, interactions and space and furnishings were goals set during program implementation. Program participation may have had a positive impact on the quality of care infants and toddlers receive at Many Hearts. According to the ITERS-R, all seven areas saw a gain in quality in each of the subscales. Largest gains were noted within program structure, which was not a stated goal. Despite feeling more time was needed to provide training on parents and staff, this particular subscale followed closely behind program structure. While they were rated as providing “inadequate” care at the onset of consultation services, by program’s end, it was rated as “good.” Additional areas set as goals also saw marginal gains. Health and safety practices were “inadequate” when they began in August and by May they were upgraded to “minimal.” Within the space and furnishings subscale, gains were made but not enough to pull them up and out of the original “minimal” rating they received before services were provided. Even though My Child Care study participants had not been the individuals to register for consultation services, they entered the experience with open minds and were able to cultivate and nurture a positive relationship with their consultant for the duration of the program.

Upon the completion of 55 hours of consultation services and My Child Care, minimal gains in quality were made according to the ITERS-R. The personal care routines subscale was the only item experiencing an increase in quality by a little more than half a point. They were rated as providing inadequate personal care routines at the onset of services and that rating remained throughout program completion. Space and

furnishings maintained its minimal rating, reporting neither gain nor loss. The five remaining subscales decreased in quality by at least .34 in listening and talking and as much as 1.56 in parents and staff. Decreases in quality could be attributed to several factors such as the lack of collaboration between participants, turnover, or low engagement with center staff.

ITERS-R results for Jumping Jacks indicated that the subscale listening and talking, a goal expressed by participants and documented on the QIP, increase the most gain in quality score. In November 2014, Jumping Jacks were rated in the “minimal” range of listening and talking and achieved a perfect score, a rating of “excellent.” The next biggest increase in quality occurred in interactions which was identified as a goal by Georgia and Donna, but not documented on the QIP. Initially, interactions received a score of “inadequate” care and by program end, increased their rating to “good.” Personal care routines and activities were also originally noted as “minimal” and Jumping Jacks nearly achieved “excellent” for both. The caregiver at Jumping Jacks felt more support and collaboration was needed and notification and clarification was also missing from their consultation experience. Nonetheless, the quality of care provided by the caregivers increased. This could be attributed to the intrinsic motivation possessed by the staff to increase quality care for infants and toddlers.

According to the ITERS-R tool, gains and losses were reported in the quality score for The Play Yard. Increased quality occurred in the area of personal care routine which included five of their documented goals. Gains were also observed in program structure and parents, not noted as program goals. Within the area of listening and talking, featuring two program goals, neither a gain nor loss was recorded. Quality care

ratings decreased in space and furnishings, interactions, and activities. Three stated goals were nested within those areas of decreased quality. The relationship building process between the consultant and center staff was initiated before services began but they found it difficult to maintain due to conflicting schedules. This suggests that consultants and caregivers need to communicate on several levels in order to plan the consultation experience together. The importance of collaboration is illustrated here as such, conversations or meetings to discuss the best days and times for the consultant to visit the program could have been determined with input from all site stakeholders.

Implications for Practice

All participants expressed satisfaction from participating in infant and toddler consultation services. Many also revealed challenges or barriers to effective services. The following paragraphs will illustrate considerations for future participating programs and infant and toddler consultants for more effective implementation that leads to higher quality child care for infants and toddlers.

While participation in infant and toddler consultation services was voluntary for the directors of each of the centers, the caregivers were not given a choice in regards to working with a consultant. In one case, the caregivers were unaware of the consultant's purpose until services had begun. Voluntary participation can provide an opportunity for the caregivers to gain clarity and understand the expectations of the professional development experience. Time should be dedicated prior to the beginning of services to explain the program and the role staff are expected to play. When all staff understand expectations of program participation, they may be more likely to actively participate and contribute to its success. Caregivers should have adequate time to ask questions about

the process and to begin the development of a relationship with the consultant. The relationship building phase takes time and providing that before services begin could create an environment that allows all participants to share their expectations and develop common goals and outcomes.

Consultation services should include ample opportunities to build and nurture the relationship between and among program participants and families. Almost all of the study participants voiced the desire to spend more time implementing the program even though they received more than 15 hours over the required minimum. If caregivers and consultants had more opportunities to work together without the presence of children and were able to spend more time providing meaningful feedback and reflecting on practices, perhaps they would as though their needs were being met. Planning together with caregivers can create feelings of unity and community. Nelson et al. (2011) found that the collaboration component of PD is often overlooked during the implementation process. Involving all participants in each aspect of the planning process, including goal writing, not only keeps each participant informed, but provides an opportunity for them to share their perspective of the problem and offer solutions.

Seeking to understand the desires of families of infants and toddlers could enhance the PD activities. Currently, the infant and toddler consultation program procures services to center staff. Inviting family members, even if just a few, would ensure that center goals and PD services rendered align with the needs of enrolled families. Taking it one step further, based on responses from various study participants, creating a quality improvement team that includes parents could be advantageous. The team would need at least one representative from the infant and toddler caregivers, center

administration, the consultant and two or three family members. Each member of the team would serve on a voluntary basis and would contribute opinions, expectations and suggested strategies based on their representative role.

Recommendations for Future Research

As this study explored a small number of cases operating out of a singular consultation program, there remains recommendations for future research within the field of infant and toddler PD literature. In an effort to understand PD experiences of infant and toddler caregivers, the following would be useful to explore: affects of professional development on infant and toddler development, target specific caregiver behavior during consultation, and investigate how caregiver and child temperament affect classroom quality.

The current study interviewed the infant and toddler consultant, center director and lead infant or toddler caregiver receiving PD services. Helterbren and Fennimore (2004) found that caregivers reported a change in the behavior of children as a motivator to accepting new classroom practices. In future research projects, it would be interesting to identify the impact that the quality of child care has on infant and toddler behavior and development. Research that focuses on benefits of high quality care for preschoolers abounds in the literature and more is needed to highlight the unique needs of infants, toddlers, and their caregiver (Ochshorn, 2011; Thomason & LaParo, 2009).

Enhancing the quality of infant and toddler child care is a primary goal of infant and toddler consultation by increasing the knowledge and skills of the caregivers. This study revealed that parents want infant and toddler caregivers who understand child development, implements appropriate curriculum activities and can provide care that is

responsive to the individual needs of the children. Future studies could explore the specific behaviors of caregivers to determine their level of responsiveness using an assessment such as The CLASS Tool for Infants and Toddlers created by TeachStone. These tools focus on responsiveness of caregivers and how they promote secure attachment, language, independence, and behavior regulation for infants and toddlers.

Temperament is a topic worth exploring within the infant and toddler community as well as in PD. One parent suggested that caregivers should receive training in order to understand that infants and toddlers have a unique temperament. Knowing each child's temperament can help them provide the individualized care each child needs. Exploring the temperament types of the children and comparing them with that of the caregiver could illuminate which caregiver-child dyads constitute a match and which do not. Investigating the temperament variances among caregivers, children and consultants could reveal strategies utilized to meet the needs of infants, toddlers, their caregivers and consultants.

The conceptual frameworks upon which this study is based presents two themes. The conceptual framework of professional development posits the idea that PD should be implemented through a parallel process by which each experience of the participants is enhanced by the others. The consultant provides respectful, positive relationship conditions provided a model for the relationship that also enhances infant and toddler development when they share in a positive, respectful relationship with their caregiver. The conceptual framework of consultation posits that the consultation process occurs in stages beginning with the establishment of the relationship between the consultant and consultee to the final evaluation of services stage. While these two stages are formalities

consistent within the current study, the six stages that were presented in linear fashion were not carried out that way. For example, consultants noted the importance of re-establishing their relationship on each site visit instead of relying on the relationship that began on their first visit. While goals were an important part of the consultation process, participants noted that goals were secondary to the other priorities within the child care center and classroom. Challenges that were presented earlier in the chapter were often the cause of the non-linear implementation of the consultation program.

While this study provided a lens into the consultation experiences of four child care center caregivers, their director, and consultant, there are additional considerations researchers may want to explore for further insight of the consultation process. After reflecting back on this case study, I recommend that researchers plan to extend the caregiver-consultant observations to include the entire visit from beginning to end. I observed for one hour of each of the three visits planned and while I gained information from those experiences, beginning the observation when the consultant arrived on site, and concluding when the consultant leaves can provide a deeper level of understanding the process first hand.

Conclusion

Research studies that target the infant and toddler caregiver community are limited within the literature (Thomason & LaParo, 2009). This study contributes to the literature highlighting the infant and toddler consultation experience as it occurred within the child care setting. Through observations, interviews, and program documents, it was determined that center staff, infant and toddler consultants and families utilizing child care services find knowledgeable and responsive caregivers, engaging environments, and

adequate health and safety practices to be key elements of high quality which mirrors the findings of Garland and Rasmussen (2010). These elements resonate with the various types of quality (structural, process, and global) cited in research (Hestenes et al., 2007).

Ackerman (2008) reported that PD is a commonly used strategy to increase quality. According to Hill (2007), PD is designed and executed by the provider. Caregivers participating in this study stated they preferred training that was hands-on and others expressed a desire to have an opportunity to be part of the collaboration team planning the professional development experiences. Caregiver participation can enhance the learning experience (Dunst & Raab, 2010; Landry et al., 2006). Shpancer (2008) suggests that PD should not only target child development, but must also consider caregiver perspective as well.

The infant and toddler consultation program provides training and technical assistance to caregivers desiring to enhance the quality of care provided in their child care center. Professional development is a natural and common strategy used by child care centers to increase that quality. It can also be one of the biggest predictors related to increased child care quality (Buysse et al., 2009). Training and on-site consultation are two forms of PD that research has shown can impact the quality of child care (Ackerman, 2008; Zaslow & Martinez-Beck, 2006).

Through training, on-site technical assistance, modeling, providing feedback, caregivers and consultants were able to fulfill stated goals on the center's quality improvement plan. Trainings can be valuable opportunities to positively impact the child care environment (Burchinal, 2002). Research has shown that caregivers using training as their only method for increasing quality will have slightly higher quality than their non-

attending counterpart (Raikes et al., 2005). Combining training with on-site technical assistance is more likely to produce an increase in process and global quality (Fiene, 2002; Ontai et al., 2002).

Allowing caregivers to voluntarily choose which PD activities to partake in can increase participation and engagement levels. Recognizing that relationships take time to develop and nurture, the effectiveness of the PD experience can greatly benefit from multiple opportunities to interact and work together with professional development providers for a period of time before and during the consultation process. Inviting additional members to join a quality improvement permits family members to voice their perspective and desires within the child caregiving setting and creates a community amongst all participants to contribute to one common cause: increased quality child care for infants and toddlers.

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Appendix A
IRB approval letter

Approved Application Number: 201501051

Date: October 17, 2014

Dr. Angela Eckhoff
Department of Teaching and Learning

Your Application for Exempt Research with Christine John entitled “An Exploration of Infant and Toddler Child Care Consultation: A Multiple Case Study” has been found to be EXEMPT under Category 6.1, 6.2, and 6.4 from IRB review by the Human Subjects Review Committee of the Darden College of Education.

The determination that this study is EXEMPT from IRB review is for an indefinite period of time provided no significant changes are made to your study. If any significant changes occur, notify me or the chair of this committee at that time and provide complete information regarding such changes. In the future, if this research project is funded externally, you must submit an application to the University IRB for approval to continue the study.

Edwin Gomez, Ph.D., CPRP
Chair, Human Subjects Review, DCOE
Associate Professor and Coordinator of PRTS Program
Human Movement Sciences Department
Darden College of Education
Old Dominion University egomez@odu.edu

Appendix B

Consultant Informed Consent Form

Dear Infant and Toddler Consultant,

I am a doctoral student at Old Dominion University (ODU) studying professional development activities for infant and toddler staff. I am conducting a study to explore the consultation services provided to infant and toddler center staff and its impact on the quality of care provided in infant and toddler child care classrooms and would be honored for you to participate.

The attached letter explains some of the detail but I want to give you an opportunity to understand what participation will mean for you. The only cost associated with your agreement to participate is some of your time. Your participation means that you will share your experiences through interviews and email at times and in locations that are most convenient to you. The interviews will be audio taped for later transcription. I will also spend some time in your classroom observing the consultation process to gain a better understanding of your experience. Pictures of your environment will also be documented, but no children or adults will be photographed. Everything you share will be kept confidential. Paperwork that identifies you by name will be kept in a locked storage unit for up to one year after the completion of the study. Only the researcher will have access to the key and storage unit.

You will receive compensation for your participation in the form of a gift card in the amount of \$25. There are no known risks to your participation and your name and identifying characteristics will remain confidential. There are no benefits but the results of this exploratory study may potentially benefit researchers and stakeholders of infant and toddler child care including child care centers, families with infants and toddlers, and those who provide professional development to the infant and toddler community.

You are free to withdraw from this research study or ask questions about the study at any time. By signing this letter of consent, you are stating that you have read and understand the information and research study, and agree to participate. For questions or concerns, please contact Christy John by calling (757) 650-7166 or by email john.christinem@gmail.com. You may also contact Ed Gomez, the current IRB chair at 757-683-4520 at Old Dominion University, or the Old Dominion University Office of Research at 757-683-3460 who will be glad to review the matter with you.

Thank you for your time. I look forward to working with you.

Sincerely,
Christy John, ODU doctoral student

Consultant Informed Consent Form
Old Dominion University
Norfolk, VA 23529

Title of Project: AN EXPLORATION OF INFANT AND TODDLER CHILD CARE
CONSULTATION: A MULTIPLE CASE STUDY

Principal Investigator: Angela Eckhoff, instructor from Old Dominion University (ODU)

Responsible Project Investigator: Christine John, doctoral student from ODU

Contact Information: cell: (757) 650-7166 email: cbrow003@odu.edu

You are invited to take part in a research study exploring the technical assistance and consultation services provided to infant and toddler caregivers (birth to three years) because you provide consultation services to caregivers of infant(s) and/or toddler(s) attending child care. The purpose of this research study is to explore the experiences of that participation.

Procedures and Duration of the Study

If you agree to participate in this research study, the following will occur:

1. You will be asked to fill out forms collecting demographic information. Understand that all information collected will be kept confidential. If you are uncomfortable with any of the questions, you may skip that question.
2. You will take part in two interviews at the beginning and end of services rendered to be conducted by the researcher at a time and place that is most convenient for you. The interview questions will be about how you experience infant and toddler consultation services. Each interview will be audio-taped for transcription and will last approximately 30 minutes.
3. The consultation process will be observed by the researcher on three occasions.
4. You will provide research data in the form of program documents to be collected by the researcher. Such documents include, but are not limited to: Program Profile, Results of the ITERS-R, Quality Improvement Plan, and the On-site Contact Form.

Voluntary Consent

Your participation and identifying characteristics will be kept confidential. Your signature below means that you have received this information, asked the questions you currently have about the research and those questions have been answered. You will receive a copy of the signed and dated form to keep for future reference. By signing this consent form, you also indicate that you are voluntarily choosing to take part in this research and may end participation at any time.

Signature of Participant

Date

Time

Printed Name

Your signature below means that you have explained the research to the participant/participant representative and have answered any questions he/she has about the research.

_____ Signature of the Researcher	_____ Date	_____ Time	_____ Printed Name
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Appendix C

Center Recruitment Letter

Dear Child Care Owner/Director,

Caring for our youngest members of society is a complex and hard job. Your participation with the consultation services of the Virginia Infant & Toddler Specialist Network and efforts to enhance the quality of care your center provides for infants and toddlers are commendable.

I am a doctoral student at Old Dominion University (ODU) studying professional development activities for infant and toddler staff. I am conducting a study to explore the consultation services provided to infant and toddler center staff and families. With permission, your Infant and Toddler Specialist will share your contact information listed below only so that I may contact you personally to explain the study further and answer additional questions or concerns you may have about your participation. You and your staff will be compensated for your time.

Your signature on this document does not mean that you will participate in the study. Once you have had a chance to hear a full description and an opportunity to ask questions, then you will be given a participation form indicating your desire if you choose to participate.

The Infant & Toddler Specialist Network was created for you by professionals and it is my aim to capture your experience and opinions about the consultation services you receive. You are our most important asset and your voice is valuable in the creation of professional development. The opportunity to speak with you further about this study would be greatly appreciated. Please contact me if you have questions or concerns before our initial meeting at (757) 650-7166 or john.christinem@gmail.com.
Sincerely,

Christy John

I give permission to share the above information with Christy John, ODU doctoral student, so that I may learn more about the study.

Printed Name & Position

Signature & Date

Appendix D

Center Staff Informed Letter of Consent

Dear Infant and/or Toddler Teacher,

You are invited to participate in a study regarding the support you receive to complete the work that you do each day taking care of infants and toddlers. I am conducting a study about professional development and would be honored for you to participate.

The attached letter explains some of the detail but I want to give you an opportunity to understand what participation will mean for you. The only cost associated with your agreement to participate is some of your time. Your participation means that you will share your experiences through interviews and email at times and in locations that are most convenient to you. The interviews will be audio taped for later transcription. I will also spend some time in your classroom observing the consultation process to gain a better understanding of your experience. Pictures of your environment will also be documented, but no children or adults will be photographed. Everything you share will be kept confidential. Paperwork that identifies you by name will be kept in a locked storage unit for up to one year after the completion of the study. Only the researcher will have access to the key and storage unit.

You will receive compensation for your participation in the form of materials for your infant and/or toddler classroom when all the requirements have been fulfilled. There are no known risks to your participation and your name and identifying characteristics will remain confidential. There are no benefits but the results of this exploratory study may potentially benefit researchers and stakeholders of infant and toddler child care including child care centers, families with infants and toddlers, and those who provide professional development to the infant and toddler community.

You are free to withdraw from this research study or ask questions about the study at any time. By signing this letter of consent, you are stating that you have read and understand the information and research study, and agree to participate. For questions or concerns, please contact Christy John by calling (757) 650-7166 or by email john.christinem@gmail.com. You may also contact Ed Gomez, the current IRB chair at 757-683-4520 at Old Dominion University, or the Old Dominion University Office of Research at 757-683-3460 who will be glad to review the matter with you.

Thank you for your time. I look forward to working with you.

Sincerely,
Christy John, ODU doctoral student

Center Staff Informed Consent Form
Old Dominion University
Norfolk, VA 23529

Title of Project: AN EXPLORATION OF INFANT AND TODDLER CHILD CARE CONSULTATION: A MULTIPLE CASE STUDY

Principal Investigator: Angela Eckhoff, instructor from Old Dominion University (ODU)

Responsible Project Investigator: Christine John, doctoral student from ODU

Contact Information: cell: (757) 650-7166 email: cbrow003@odu.edu

You are invited to take part in a research study exploring the technical assistance and consultation services provided to infant and toddler caregivers (birth to three years) because you care for infant(s) and/or toddler(s) attending child care. The purpose of this research study is to explore the experiences of stakeholder participation.

Procedures and Duration of the Study

If you agree to participate in this research study, the following will occur:

1. You will be asked to fill out forms collecting personal background information. Understand that all information collected will be kept confidential. If you are uncomfortable with any of the questions, you may skip that question.
2. You will take part in two interviews at the beginning and end of services rendered to be conducted by the researcher at a time and place that is most convenient for you. You will respond to one email questionnaire approximately two months after the initial interview. The interview questions will be about how you experience infant and toddler consultation services. Each interview will be audio-taped for transcription and will last approximately 30 minutes.
3. You will allow research data to be collected through observation by the researcher. The purpose of the observation will be to view the consultation process.
4. You will allow research data in the form of program documents to be shared with the researcher. Such documents include, but are not limited to: Program Profile, Results of the ITERS-R, Quality Improvement Plan, and the On-site Contact Form.

Voluntary Consent

Your participation and identifying characteristics will be kept confidential. Your signature below means that you have received this information, asked the questions you currently have about the research and those questions have been answered. You will receive a copy of the signed and dated form to keep for future reference. By signing this consent form, you also indicate that you are voluntarily choosing to take part in this research and may end participation at any time.

_____ Signature of Participant	_____ Date	_____ Time	_____ Printed Name
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Your signature below means that you have explained the research to the participant/participant representative and have answered any questions he/she has about the research.

_____	_____	_____	_____
Signature of the Researcher	Date	Time	Printed Name

Appendix E Family Interest Letter

You are invited to provide your unique perspective of infant and toddler child care in a group interview.

Your child's center is participating in a program that will enhance the wonderful care your child already receives. Please share your view and expectations of infant and toddler child care so that those who create such programs can be sure to provide training and education based on your expectations of that care.

The Focus Group will consist of a few family members discussing their expectations of infant and toddler child care. The discussion is expected to last less than one hour and will take place at your child's child care center on a date and time that is determined by the center. You will receive a children's book in appreciation of your participation.

When you complete this form, please return the bottom portion to the director. You will then be contacted by me to confirm your attendance and I will answer any additional questions you may have. If you have any questions regarding your participation, you may also contact me at (757) 650-7166 or john.christinem@gmail.com. Thank you for your time and consideration. I look forward to learning about your child care experience.

Cordially,

Christy John

Christy John

Name: _____ Phone: _____

Child's Name/Age _____ Email: _____

Appendix F
Focus Group Informed Consent Form
Old Dominion University
Norfolk, VA 23529

Title of Project: AN EXPLORATION OF INFANT AND TODDLER CHILD CARE
CONSULTATION: A MULTIPLE CASE STUDY

Principal Investigator: Angela Eckhoff, instructor from Old Dominion University

Responsible Project Investigator: Christine John, doctoral student from Old Dominion University

Contact Information: cell (757) 650-7166 email: cbrow003@odu.edu

You are invited to take part in a research study exploring the technical assistance and consultation services provided to infant and toddler caregivers (birth to three years) because you are the guardian of infant(s) and/or toddler(s) attending child care. The purpose of this research study is to explore the experiences of stakeholder participation.

Procedures and Duration of the Study

If you agree to participate in this research study, the following will occur:

1. You will be asked to fill out forms collecting personal background information. Understand that all information collected will be kept confidential. If you are uncomfortable with any of the questions, you may skip that question.
2. You will take part in one focus group conducted by the researcher that will be conveniently located in your child's center and will not last more than one hour. The focus group questions will be about how your family expects and experiences infant and toddler child care services and will be audio-taped for transcription.

Voluntary Consent

Your participation and identifying characteristics will be kept confidential. Your signature below means that you have received this information, asked the questions you currently have about the research and those questions have been answered. You will receive a copy of the signed and dated form to keep for future reference. By signing this consent form, you also indicate that you are voluntarily choosing to take part in this research and may end participation at any time.

_____ Signature of Participant	_____ Date	_____ Time	_____ Printed Name
-----------------------------------	---------------	---------------	-----------------------

Your signature below means that you have explained the research to the participant/participant representative and have answered any questions he/she has about the research.

_____ Signature of the Researcher	_____ Date	_____ Time	_____ Printed Name
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Appendix G
Demographic Survey

Please circle the item that best describes you in each of the categories below.

Gender: Male /Female **Age:** 18-35 36-55 56-64 65+

Race/Ethnicity	Household Composition	Highest Level of Education
<input type="radio"/> White <input type="radio"/> Hispanic or Latino <input type="radio"/> Black or African American <input type="radio"/> Native American or American Indian <input type="radio"/> Asian/Pacific Islander <input type="radio"/> Other	<input type="radio"/> Single, never married <input type="radio"/> Married <input type="radio"/> Widowed <input type="radio"/> Divorced <input type="radio"/> Separated	<input type="radio"/> High School Diploma <input type="radio"/> GED <input type="radio"/> Some College Credit <input type="radio"/> Certification (eg. CDA) <input type="radio"/> Associate's Degree <input type="radio"/> Bachelor's Degree <input type="radio"/> Master's Degree <input type="radio"/> Doctorate or beyond

Complete the following information to the best of your ability.

Years of ECE _____ Years at current center _____

Current position _____

Years in current position _____ Years with infants and toddlers _____

Employment Status: Full-time Part-time Other: _____

List any employment benefits (health, dental, life insurance, paid time off, etc.)

Appendix H

Consultant Interview Protocol – Consultation Period

I thank you for agreeing to participate in this important study about professional development for infant and toddler caregivers. I sincerely appreciate you taking the time to offer your perspective of child care for infants and toddlers. As a researcher, but more importantly, as someone who provides infant and toddler support to our community, I believe your voice needs to be represented which is why I invited you to participate in my study. My goal is for us to have an open discussion about your experience regarding consultation in infant and toddler child care. The information you provide will help me determine if and how professional development is or will meet not only the needs of caregivers and families, but your needs as well. This conversation will take approximately 30 minutes and will be kept confidential.

If you don't mind, this session will be audio-taped so that it can be transcribed at a later time. Your name will not be attached to any of your comments. The recordings will be destroyed upon completion of the research project. Is there a pseudonym you would like to me to identify you with?

- Have you completed the demographic survey? Thank you (if yes), Take your time (if no).
 - Do you have any questions about the study or your participation before we begin? If yes, I will answer them. If not, great, then let's get started.
1. How did you arrive at your current position working with infants and toddlers?
 2. What forms of infant and toddler professional development have you experienced? Topics?
 3. How would you describe your role as the consultant in this program?
 4. What are your expectations from center participation?
 5. How do you spend your time during a normal consultation visit?
 6. How comfortable is the consultation process for you?
 7. What new information have you presented to the center? How?
 8. How useful do you think the information and delivery method is?
 9. How do you plan to address and meet Center A's needs?
 10. Have I left anything out that you would like to share or that you think would be helpful for me to know? About consultation or professional development?

Consultant Interview Protocol – Post Consultation Period

I thank you for agreeing to participate in this important study about professional development for infant and toddler caregivers. I sincerely appreciate you taking the time to offer your perspective of child care for infants and toddlers. As a researcher, but more importantly, as someone who provides infant and toddler support to our community, I believe your voice needs to be represented which is why I invited you to participate in my study. My goal is for us to have an open discussion about your experience regarding consultation in infant and toddler child care. The information you provide will help me determine if and how professional development is or will meet not only the needs of caregivers and families, but your needs as well. This conversation will take approximately 30 minutes and will be kept confidential.

If you don't mind, this session will be audio-taped so that it can be transcribed at a later time. Your name will not be attached to any of your comments. The recordings will be destroyed upon completion of the research project. Remember your answers are kept confidential. The pseudonym you chose, _____, does that still work for you?

- Do you have any questions about the study or your participation before we begin? If yes, I will answer them. If not, great, then let's get started.
11. Which parts of the consultation process were useful or successful? What parts would you say were challenging?
 12. What were some highlights of center participation?
 13. How would you describe the level of caregiver/staff engagement?
 14. In what ways has this experience contributed to the quality of the center?
 15. Looking back at this particular center's experience, what advice would you give a new consultant?
 16. Have I left anything out that you would like to share about professional development or that you think would be helpful for me to know?

Appendix I

Center Staff Interview Protocol – Consultation Period

I thank you for agreeing to participate in this important study about professional development for infant and toddler caregivers. I sincerely appreciate you taking the time to offer your perspective of child care for infants and toddlers. As a researcher, but more importantly, as someone who provides infant and toddler support to our community, I believe your voice needs to be represented which is why I invited you to participate in my study. My goal is for us to have an open discussion about your experience regarding consultation in infant and toddler child care. The information you provide will help me determine if and how professional development is or will meet not only the needs of consultants and families, but your needs as well. This conversation will take approximately 30 minutes and will be kept confidential.

If you don't mind, this session will be audio-taped so that it can be transcribed at a later time. Your name will not be attached to any of your comments. The recordings will be destroyed upon completion of the research project. Is there a pseudonym you would like to me to identify you with?

- First, I'll have you complete this short demographic survey.....Thank you.
 - Do you have any questions about the study or your participation before we begin? If yes, I will answer them. If not, great, then let's get started.
1. How did you arrive at your current position working with infants and toddlers?
 2. What forms of infant and toddler professional development have you experienced?
 3. What training have you had in the past year? How would you describe those training experiences?
 4. What do you know about the consultation being offered to your center for infants and toddlers? What are your expectations from participation?
 5. How would you describe your role in the consultation process? The role of the consultant?
 6. What new information has your consultant presented to you?
 7. How does your consultant provide feedback on classroom practices?
 8. How would you describe the support in this consultation program?
 9. Have I left anything out that you would like to share about the consultation process or that you think would be helpful for me to know?

Center Staff Interview Protocol – Post Consultation Period

I thank you for agreeing to participate in this important study about professional development for infant and toddler caregivers. I sincerely appreciate you taking the time to offer your perspective of child care for infants and toddlers. As a researcher, but more importantly, as someone who provides infant and toddler support to our community, I believe your voice needs to be represented which is why I invited you to participate in my study. My goal is for us to have an open discussion about your experience regarding consultation in infant and toddler child care. The information you provide will help me determine if and how professional development is or will meet not only the needs of caregivers and families, but your needs as well. This conversation will take approximately 30 minutes and will be kept confidential.

If you don't mind, this session will be audio-taped so that it can be transcribed at a later time. Your name will not be attached to any of your comments. The recordings will be destroyed upon completion of the research project. The pseudonym you chose, _____, does it still work for you?

- Do you have any questions about the study or your participation before we begin?
If yes, I will answer them. If not, great, then let's get started.
10. What were some highlights of your participation in this consultation program?
 11. Which parts would you say were challenging, or not useful?
 12. How did the consultant help you learn new knowledge or skills?
 13. In what ways has this experience contributed to the quality of your center/classroom?
 14. What advice would you give an infant or toddler caregiver/director entering a consultation program?
 15. Have I left anything out that you would like to share about the consultation process or that you think would be helpful for me to know?

Appendix J

Family Focus Group Protocol

Welcome to this family focus group. My name is Christy John and I am student at Old Dominion University working towards a doctorate in Early Childhood Education. I also have two daughters, 9 and 10, who were once in child care and a very supportive husband.

Today, my research assistant is _____. She is also a doctoral student and will be helping me take notes, keep time and operate the recording device.

I thank you for agreeing to participate in this important study about professional development for infant and toddler caregivers. I sincerely appreciate you taking the time to offer your perspective of child care for infants and toddlers. As a researcher, but more importantly, as someone who provides infant and toddler support to our community, I believe your voice needs to be represented which is why I invited you to participate in my study. My goal is for us to have an open discussion about your expectations regarding infant and toddler child care. The information you provide will help me understand how professional development can meet the child care needs of infants and toddlers and their families. This discussion will be kept confidential and we will respect the honest opinions of the group.

This session will be audio-taped so that it can be transcribed later and the recordings will be destroyed at the completion of the research project. Your name will not be attached to any of your comments. This focus group will last approximately 30 minutes.

- Have you had a chance to complete the demographic survey? Thank you (if yes), Take your time (if no).
 - Do you have any questions about the study or your participation before we begin? Answer them (if yes), Okay, great, let's get started (if no).
1. Please introduce yourself and the age(s) of your child(ren).
 2. How would you describe the ideal out-of-home, non-parental child care situation?
 3. How did you come to choose your current child care situation?
 4. If you visited more than one place before choosing your current child care situation, what was that experience like?
 5. What do you know about the requirements VA has placed on infant and toddler child caregivers?
 6. What role do you believe child care plays in our society?

7. What expectations do you have of your child care center? Child's classroom?
Child's caregiver?
8. What advice would you give families as they search for infant and toddler child care?
9. Is there any additional information regarding your expectations of the quality of infant and toddler care in your community?

Appendix K

Consultant Visit Observation Form

Observer	Center	Date
Start/End time	Consultant	Caregiver
Classroom	Age Range of children	Class Activity

Consultation Stage

○ Gaining Entry	○ Building the Relationship	○ Gathering Info/Assessment	○ Setting Goals
○ Selecting Strategies	○ Implementing the Plan	○ Evaluating the Plan	○ Summary Conference

Observations of Consultant Behavior in Classroom Visits

Primary Interaction

[illegible]

Appendix L
Field Notes Form

Date:		
Location:		
Interviewer/Observer:		
Interview #	Observation #	Focus Group #
Details from the field		
Interviewer/Observer comments		
Reflective Summary		

Appendix M

Case Study Protocol

Center #/Name

Data Collected	Data Source	Projected Date	Actual Date
Initial Interview	Director		
Initial Interview	Caregiver		
Initial Interview	Consultant		
Initial Observation	Researcher		
Initial Photographs	Researcher		
Program Artifacts	Consultant		
ITERS-R Report	Consultant		
Initial Quality Improvement Plan	Consultant		
On-Site Reports	Consultant		
Second Observation	Researcher		
Focus Group	Researcher		
Final Interview	Director		
Final Interview	Caregiver		
Final Interview	Consultant		
Final Observation	Researcher		
Final Photographs	Researcher		
Program Artifacts	Consultant		
Final Quality Improvement Plan	Consultant		
On-Site Reports	Consultant		
ITERS-R Report	Consultant		

Appendix N
Final Codebook

Category	Description	Examples of Text
Opportunities for Relationship Building	Activities conducted by study participants that promoted a positive relationship between program participants	“And you know once I’ve been able to assure them that I am here for them, it tends to open the doors and we can have some honest conversations that I don’t know would necessarily occur with a director because I don’t pose a threat to them”
Center Staff and Consultants	Characteristics of study participants that nurtured their experience together	“Not just I’m here to teach you something, now you do it. I think a relationship was built with the staff as well”
Support	Assistance provided to ensure the successful implementation of best practices	“She’s been real supportive, giving us a lot of training, make sure things we needed especially supplies, and make sure the kids are good.”
Responsive Care	A consistent caregiver providing a safe classroom with developmentally appropriately materials to explore, accompanied by sensitive, caring and positive interactions with adult caregivers	“I expect the highest expectations for the caregiver. As far as they would treat my child like they would treat theirs, with respect, with care, that they tend to the needs of my child when it comes to taking care of her physically and mentally. They would be just as attentive to my child, be fair and consistent”
Challenges	Factors that impede the consultation and relationship building process	“I think a challenge was that once the children were settled down for nap, then that’s when the teachers started their break”
Challenges: Turnover	The rate at which child caregivers leave the early childhood education field	“It was exciting to see when I shared transition songs with her how she took hold of those and got more wind in her sails. She had the smile back in her face and the laughing with the kids and having fun. The defeat was the next visit, I learned she quit abruptly and was no longer there”
Challenges: Low Engagement	Limited active participation by	“When I would ask or

	participants	recommend things for her to do, she would smile and nod her head like she understood but it wasn't actually happening"
Challenges: Lack of Time	Minimal opportunities to spend time building and nurturing relationships between participants	"It would be great if we were able to carve out time for me, the assistant teacher, consultant and both directors all in the room at the same time so that some of the changes that we ended up doing could have probably been done smoother"
Opportunities for Professional Growth	Strategies that contributed to increased knowledge and skills of center participants	"we'll gain some knowledge so that it (infant and toddler development) becomes more of my specialty"
Opportunities to Enhance the Environment	Factors that contribute to increased quality of infant and toddler child care	"You got carpeting here, some books, something for them to play with is fine, but they don't think about how the environment can really influence a lot of other areas in your classroom"
Health and Safety	Practices that promote the well-being of infants and toddlers in child care	"improve our health and safety practices"
Space & Furnishings	Environmental factors that contribute to high quality child care	"the consultant comes in and she talks and works with teachers about what's happening the room, answers questions they have about how to set up environment"
Resources	Assets provided through program participation that contributed to increased knowledge, skills, and quality of the child care environment	"I felt like I was a resource that she could utilize"

CURRICULUM VITA

Christine M. John

John.ChristineM@gmail.com

Education

Ph.D. ECE, pending December 2015, Old Dominion University. Dissertation title: AN EXPLORATION OF INFANT AND TODDLER CHILD CARE CONSULTATION: A MULTIPLE CASE STUDY

M.S. Ed., May 2000, Old Dominion University

B.S., December 1998, Old Dominion University

Experience

Infant and Toddler Specialist, Virginia Infant & Toddler Specialist Network. Norge, VA. 2009 – Present.

Assistant Professor, Tidewater Community College. Virginia Beach, VA. 2010 – 2014. Courses taught include *Infant and Toddler Programming* (CHD 166), *Math, Science, and Social Studies* (CHD 145), *Advanced Observation and Participation in Early Childhood/Primary Settings*, (CHD 265), and *Seminar and Project* (CHD 298).

College Instructor, Old Dominion University. Norfolk, VA. 2000-2009.

Taught class of two year olds while supervising undergraduate and graduate practicum students. ESSE 679 AND ESSE 476

Certifications

Program for Infant & Toddler Care (PITC) Trainer

Infant CLASS

Toddler CLASS

ITERS-R

FCCERS-R

Ages & Stages Questionnaire (ASQ) Trainer and Coach

ASQ: SE (Social & Emotional) Trainer

Center for Social & Emotional Foundations for Early Learning (CSEFEL) Trainer and Coach

Special Quest Trainer

Positive Discipline Parent Educator

Professional Memberships

National Association for the Education of Young Children (NAEYC)
 Virginia Association for Early Childhood Education (VAECE)
 South Eastern Association for the Education of Young Children (SEAEYC) Board
 Early Childhood Personnel Center Virginia (ECPC) State Team
 Governor's child care group
 Tidewater Community College Advisory Council
 Children's Harbor Safe Harbor Committee
 Portsmouth READS
 Hampton Roads Parenting Education Network (HRPEN)

Presentations

Annual Spring presentations conducted at Celebrating Babies and Tots between May 2010 and March 2015. Topics include: Discovery of Play, Potatoes, Peas, and Carrots, Culture and Families, Temperament, Early Math for Infants and Toddlers, Giving Children Their Best Chance
 Creating Connections to Shining Stars
 Annual presentation of 123READ!
 Annual Spring presentations VAECE including working with children with disabilities
 Various presentations offered during the annual NAEYC including working with parents, Leading toddler toward toilet independence
 Annual Fall presentations conducted at SEAEYC. Topics include: Nature for infants, Early literacy for infants and toddlers, Early Math for infants and toddlers, Responsive Care, Understanding Temperament, Giving Children Their Best Chance
 Annual presentation provided during Old Dominion University's Early Childhood Symposium. Topics include The Virginia Infant & Toddler Specialist Network and Responsive Caregiving
 Virginia Early Head Start Association presentation
 NHSA presentation December 2011 Journey to the Land of Literacy
 VAFFCA
 PFCEAA

Volunteer Work

United Way Day of Caring
 FoodBank