Uniting Infant Mental Health and the Pyramid Model

Connecting Principles and Practices to Improve Outcomes

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by

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Dr. Costa is a licensed developmental psychologist, a professor in Family Science and Human Development at Montclair State University (NJ), and an associate faculty in the Infant and Early Childhood Development Ph.D. program at Fielding Graduate University. He holds a Ph.D. in Developmental Psychology from Temple University, a faculty certificate in the Brazelton Touchpoints model, and a Clinical Mentor Endorsement in Infant Mental Health, and he is a Training Leader in DIRFloortime. Dr. Costa founded the Center for Autism and Early Childhood Mental Health at Montclair State University and the YCS Institute for Infant and Preschool Mental Health in New Jersey. He is an expert faculty in the DC:0–5 Classification System and was among the first 16 professionals issued the DIR Certificate by Drs. Stanley Greenspan and Serena Wieder. Dr. Costa was a gubernatorial appointment to the New Jersey Council for Young Children and was the first Principal Investigator of the New Jersey Autism Center of Excellence (ACE) Coordinating Center (2012–2018). He is past president of the New Jersey Association for Infant Mental Health and the International Council on Development and Learning (ICDL). He has conducted presentations and trainings throughout the United States and in 12 countries, and he is the recipient of many awards, including the 2021 recipient of the Weatherston Leadership in Infant Mental Health Award, from the Alliance for the Advancement of Infant Mental Health. Dr. Costa is the author of articles and book chapters on autism, infant mental health, and professional formation.

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Dr. Horen is a clinical psychologist who has focused on early childhood mental health for the last 20 years. He is Director of the Infant and Early Childhood Development and Early Relational Health Division for the Georgetown University Center for Child and Human Development. Dr. Horen has worked closely with all 50 states and with numerous tribes, territories, and communities in supporting their development of systems of care for young children and their families. He is Co-director of the Head Start National Center on Health, Behavioral Health and Safety; Director of the Center of Excellence for Infant and Early Childhood Mental Health Consultation, the Infant Early Childhood Mental Health TA Center; Co-director of the National Training and Technical Assistance Center for Children's Mental Health; and Georgetown lead for the MIECHV TA Center, the HRSA Evidence to Impact Center, and the Early Childhood Comprehensive Systems TA Center. In that capacity, Dr. Horen has delivered hundreds of trainings across the country and has co-led development of nationally recognized materials. He leads Georgetown's Early Childhood Mental Health Certificate programs and has helped to develop innumerable materials related to infant and early childhood mental health consultation, including books, training guides, evaluation guides, and monographs. He leads international work in the Middle East and Latin America aimed at enhancing early childhood systems of care. In addition, Dr. Horen's primary interest is in early childhood mental health, and he has lectured extensively on infant and early childhood mental health, challenging behaviors in young children, and social skills development, as well as the impact of trauma on child development.

Robert M. Corso, Ph.D., Executive Director, Pyramid Model Consortium

Dr. Corso is the executive director of the Pyramid Model Consortium. Previously, he served as the project coordinator of the Center on the Social and Emotional Foundations for Early Learning (CSEFEL). In addition, he was on the leadership team for the National Center on Quality Teaching and Learning (NCQTL) and served as the principal investigator for the Head Start Disability Services Quality Improvement Center (DSQIC) in Region V. Dr. Corso's interests include the evaluation of professional development projects for programs serving young children and their families. He has conducted many large-scale evaluations of programs serving children and families over the last decade and developed

outcomes frameworks for measuring the impact of in-service training for a nationwide training program's efforts aimed at improving the capacity of Early Head Start, Migrant and Seasonal Head Start, and child care to enhance their services to young children and their families. In addition, Dr. Corso served as an administrator for both Head Start and child care programs. He has co-authored several works about professional development and the delivery of culturally and linguistically responsive early childhood education.

Introduction

The following statement was jointly written by the past and current leaders who represent the two organizations (Pyramid Model Consortium and the Alliance for the Advancement of Infant Mental Health) that serve as the foundation for the two perspectives.

I. THE IMPORTANCE OF APPLYING TWO PERSPECTIVES

There is broad and growing agreement that the social, emotional, and relational needs of infants and young children are undeniably linked to healthy development and well-being. Of equal importance, it is widely accepted that parents and caregivers are deserving of support that 1) promotes positive, responsive interactions; 2) is trauma-informed; and 3) is delivered with humility and cultural sensitivity. These principles are central to professionals supporting both the Pyramid Model and infant and early childhood mental health (IECMH). A unified voice is critical in order to bring attention to these essential concepts. *Organizations, programs, and professionals who work with or on behalf of infants, young children, parents, and caregivers need to find a common language when communicating with policy makers, funders, the infant/young child and family workforce, and families.* The intent of this book is to highlight principles and practices shared by the Pyramid Model, the IECMH community, and their complementary approaches. By leveraging the strengths of both frameworks, we can better ensure that babies, caregivers, and families receive services that best meet their needs and that advocate effectively for them.

The Pyramid Model Perspective

The Pyramid Model was initially developed in 2001 with the Center on the Social and Emotional Foundations for Early Learning (CSEFEL) funded by the U.S. Department of Health and Human Services, Administration for Children and Families from 2001 to 2011 and continued through an explicit collaboration with the Center for Evidence-Based Practice: Young Children with Challenging Behavior funded by the Office of Special Education Programs (OSEP) in 2002 and then later with the Technical Assistance Center on Social Emotional Intervention for Young Children (TACSEI) in 2008. Through the assistance from these federal funds, the work focused intentionally on developing a model that states could implement on a large scale. Through the CSEFEL and TACSEI funds, work was launched initially in 15 states. As of the writing of this book, the Pyramid Model has been expanded to include statewide efforts in 39 states and territories. In addition, Pyramid work has been tracked in more than 50 countries around the world.

The Infant and Early Childhood Mental Health Perspective

The history of IECMH is documented in Chapter 2 of this book. There, you can read about the evolution in research and service delivery over the last several decades. What is important to note is that it is a relatively young field with a set of principles and practices that guide culturally sensitive, relationship-based work done with or on behalf of infants, young children, caregivers, and families.

These principles and practices are applied to all sectors and multiple disciplines. More widespread adoption of an IECMH approach has been fueled by *advocacy* at local, state, and federal levels; the rise of *professional membership organizations* known as Associations for Infant Mental Health (AIMHs); *scholarship* (including a peer-reviewed journal); and a *globally recognized credential.* These structures bring credibility to the field and enable collaboration to strengthen IECMH best practices and evolve them to be more equitable and inclusive.

The Crosswalk

As noted in the Letter to the Reader, a collaboration between the Pyramid Model Consortium and the Alliance for the Advancement of Infant Mental Health (Alliance) was formed to address the need for clearer communication about the synergy of the two perspectives. In 2020, the group partnered to develop a co-branded crosswalk across the Pyramid Model training modules and the Alliance's Competency Guidelines.[1] The co-development of the "Crosswalk Between Pyramid Model Training Modules and Competency Guidelines for Culturally Sensitive, Relationship-Focused Practice Promoting Infant & Early Childhood Mental Health" offers an officially sanctioned guidance document for the field. Importantly, this crosswalk highlights both commonalities and differences to illuminate the ways these two systems complement one another. A link to this crosswalk is provided in this book's Online Resources. (See the About the Download page for information about accessing the Brookes Download Hub.) The crosswalk provides an important and tangible resource and supports the development of holistic statewide systems that could benefit from both perspectives. However, there was also a sense that much more needed to be shared, addressed, and developed.

II. WHY THIS BOOK IS NEEDED

Leaders from those states using both the Pyramid Model and IECMH Competency Guidelines and Endorsement credential (via the Alliance) noted that inaccurate or incomplete understandings of the two approaches were limiting their growth and application. We summarize some of those misconceptions below and hope the book provides more in-depth clarity.

Addressing the Misconceptions About the Term *Infant and Early Childhood Mental Health*

IECMH as a term has been misunderstood both inside and outside the infant and early childhood–serving sectors. For some, there was a worry that attention to an infant's mental health meant "labeling" babies with diagnoses of mental illness along with a worry that such a diagnosis might follow them throughout childhood, attaching stigma to the child. In fact, the most widely accepted definition of IECMH comes from ZERO TO THREE and states that "Infant and early childhood mental health is the developing capacity of the child from birth to five years old to form close and secure adult and peer relationships; experience, manage, and express a full range of emotions; and explore the environment and learn—all in the context of family, community, and culture. Nurturing, protective, stable, and consistent relationships are essential to young children's mental health" (2001). Essentially, IECMH emphasizes that the relationships that babies form with their families and caregivers have the power to strengthen or hinder their social and emotional development. It is about how an individual's mental health is present from the very beginning and that strong relationships can protect it.

This understanding drives IECMH-informed practices that are used by professionals in behavioral health, sometimes to diagnose disorders of infancy and early childhood. However, IECMH principles and practices are also applied by those in child welfare, early childhood education, early intervention, health, home visiting, IECMH consultation, and beyond. IECMH-informed concepts and practices strengthen the practitioner's support of the infant/young child's

[1]The Competency Guidelines for the Endorsement for Culturally Sensitive, Relationship-Focused Work Promoting Infant and Early Childhood Mental Health are copyrighted by the Michigan Association for Infant Mental Health. The Alliance for the Advancement of Infant Mental Health is responsible for licensing, technical assistance, and quality assurance of these standards in other states and countries.

early relational health by attending to and supporting the relationships that impact them, often by providing therapeutic support but not necessarily "therapy."

Addressing the Misconception That Infant and Early Childhood Mental Health Is Not an Evidence-Based Approach

Another misconception related to IECMH is that it is not an evidence-based approach. Even though IECMH is a relatively new field (as compared to psychology or education, for example), the research about the effectiveness of IECMH-informed approaches has grown rapidly over the past decade. Evidence-based models[2] such as Attachment and Biobehavioral Catch-Up (ABC), Child First Child-Parent Psychotherapy, Healthy Families, Infant Mental Health Home Visiting, Minding the Baby, and Nurse-Family Partnership are examples of those that demonstrate an impact on the quality of caregivers' responses to their infants, improvements in the infant/young child's communication and social/emotional development, caregivers' capacity to be reflective, reducing child abuse risk, and other child wellness aspects. Each of these models is grounded in building supportive relationships with the parents/caregivers in order to strengthen their capacities to support their babies.

Addressing the Misconception That the Pyramid Model Is "Too Behavioral" or Based on a Special Education Approach

As the Pyramid Model for Promoting the Social Emotional Competence of Infants and Young Children was being developed, there was a great deal of concern coming from the field that the practices and framework would not be developmentally appropriate for use with all children across a variety of settings. Although the framework was intended to be conceptually holistic to Schoolwide Positive Behavioral Interventions and Supports (SW-PBIS) and other multi-tiered systems of support (MTSS), the practices being supported by the Pyramid Model come directly from the research inclusive of regular early childhood education, early intervention/early childhood special education, and IECMH. In spite of the origins, several misconceptions existed for years after the development of the model that it did not reflect best practices in the field at large.

Addressing the Misconception That Infant and Early Childhood Mental Health and Pyramid Model Frameworks Are Not Synergistic

A hallmark of IECMH is that it is a transdisciplinary, cross-sector approach. IECMH relies on science from child development, education, medicine, nursing, psychology, psychiatry, social work, and more. The competency standards that define best practice in IECMH require a balance of knowledge and skills from across these disciplines. Each family benefits from a unique blend of therapeutic and educational approaches depending on their unique circumstances. For example, the IECMH strategy of *developmental guidance* requires an understanding of typical and atypical child development to inform parents/caregivers about what to expect and how to manage behaviors that may seem like developmental setbacks. This strategy is most effective in the context of a therapeutic, relationship-centered approach, one that respectfully honors the families' strengths and promotes the parents'/caregivers' capacity for insight about their child.

The Pyramid Model offers a specific method for weaving knowledge about infant/young child development and behavior into support for parents/caregivers. Individuals who have been trained in the Pyramid Model can become thought partners with parents/caregivers, working together to understand why an infant/young child might be behaving in a particular way. Little ones have not yet fully developed the capacity to communicate verbally; they use behavior as their primary form of communication. It can be frustrating to try to "translate" the behavior. Professionals trained in the Pyramid Model approach can serve as translators, working with the parent/caregiver to make sense of the puzzling behavior and consider how best to address it. This kind of partnership can reduce frustration experienced by both the adults and the infant/young child. And it can reduce the sense of isolation parents/caregivers might feel when trying to figure it out on their own. Best of all,

[2]California Evidence-Based Clearinghouse for Child Welfare: https://www.cebc4cw.org/search/

it can lead to the infant/young child feeling seen, heard, and understood—all of which strengthens the early relational health of the child.

III. HOW PYRAMID MODEL AND INFANT AND EARLY CHILDHOOD MENTAL HEALTH FRAMEWORKS SUPPORT EACH OTHER

Competencies

In the crosswalk that was collaboratively developed, the Infant/Toddler, Preschool, Parents Interacting With Infants (PIWI), Positive Solutions for Families, and Trauma-Informed Care modules from the Pyramid Model were carefully reviewed to determine which of the knowledge and skill areas overlap with the IECMH competencies. Notably, areas such as infant/young child development and behavior; family relationships and dynamics; attachment, separation, trauma, grief, and loss; observation and listening; developmental guidance; and relationship-focused therapeutic practice were often found as meeting the requirements for professionals seeking the Endorsement credential in the promotion and prevention categories.

Fostering Cultural Humility

The Pyramid Model and the IECMH Competency Guidelines frameworks share the foundational understanding that early experiences and relationships shape brain development—for better or worse. There is a transgenerational and toxic impact that racism and other systems of oppression have on pregnant people, infants, young children, caregivers, and families. In efforts to create paths for healing, both IECMH and Pyramid Model best practices emphasize understanding the impact of systems of oppression on infants/young children, families, caregivers, and members of the workforce—and the knowledge that stable and nurturing caregiving relationships are the antidote to toxic stress. Reflective supervision/consultation (RSC) is a required professional development activity for professionals seeking the IECMH credential in most categories. (See Section II for more about RSC's role in identifying and addressing the ways systems of oppression affect babies, families, and the workforce, including support for critical self-reflection and the identification of the professional's implicit bias.)

Cultural humility is central to any IECMH-informed approach. For practitioners, cultural humility means, "entering a relationship with another person with the intention of honoring their beliefs, customs, and values. It means acknowledging differences and accepting that person for who they are" (Wheeler, 2018, p. 7). It also means the avoidance of discrimination, exclusion, the imposition of one's own cultural values and beliefs, and a judgmental approach, among others (Foronda et al., 2015). Authentic curiosity is critical. How does this family's culture show up in the way they respond to their baby? What is it like to be a baby in this family? As the practitioner, are my own values, assumptions, and cultural experiences impacting how I understand this family and offer support?

Cultural humility in the Pyramid Model approach is reflected in the understanding that a child develops in the context of their culture and community. Addressing an infant or young child's behavior requires first considering the caregiving environment and the cultural expectations of the caregiver and/or family.

Infant and Early Childhood Mental Health Service Sectors Are Complemented by Pyramid Model Approaches

IECMH consultation is one sector of the infant and early childhood service delivery system. IECMH consultants have specialized knowledge in infant/early childhood development and attachment, the impact of trauma, and the impact of adult mental health on developing children. IECMH consultants use the "consultative stance" in their work to partner with and support adults who care for infants and young children. The consultative stance is defined as "a way of being and a way of guiding the collaborative work between consultant and consultee, embodies elements and practices that represent this relationship-based, capacity building approach" (Center of Excellence, n.d.).

The Pyramid Model framework and mental health consultation fit well together toward understanding and addressing the needs of the infant/young child. The Pyramid Model approach adds to relationship building by offering concrete tools that can be shared with the caregiver/family that give language to better understand the meaning of an infant's or young child's behavior.

Similarly, IECMH-informed professionals offer guidance to parents and caregivers about the development and behavior of their infant or young child within the context of their helping relationship. In behavioral health, early intervention, home visiting, and other service delivery systems, an IECMH-informed practitioner is trained to see the family as the "expert" on their infant or very young child's needs. When with an infant/young child and their parent/caregiver, the practitioner observes, encourages, and partners with the parent/caregiver to think together about what the infant/young child's behavior might be communicating, the meaning of the behavior to the parent/caregiver, and the impact of that behavior on their developing relationship. In addition to building collaborative relationships with families/caregivers, the Pyramid Model framework offers specific strategies, based on a strong understanding of infant/young child development. The unique contribution of IECMH is that of a therapeutic approach intended to support both parent or caregiver and child. IECMH professionals listen for and respond to what a parent or caregiver observes and shares about the infant/young child's development and behavior within the context of their caregiving relationship. Even though "therapy" is typically only delivered in the behavioral health sector, all IECMH professionals understand the impact of unresolved grief and loss or previous troubled relationships. They are attuned to how those "ghosts" may show up in the way they interact with and care for the infant/young child. They use the relationship they have developed with the parent/caregiver to provide a therapeutic experience that they hope will shift the interactions and improve the relational satisfaction for both the adult and the infant/young child. They are often less inclined to share strategies, instead leaning into the maxim "How you are is as important as what you do" (Pawl & St. John, 1998).

IV. CONCLUSION

The IECMH and Pyramid Model perspectives are complementary. It is imperative that we highlight the interdependent and overlapping nature of the work we do. They provide different frameworks to achieve the same outcomes. The authors collaboratively created this book to demonstrate that we are all working toward the same goal: optimal caregiving for all infants and young children at the most critical point in their development through supportive interactions and relationships with their caregiving families. Through years of collaboration and the creation of this book, we have strengthened our professional relationships with each other to demonstrate our commonalities and shared commitment. This is also what babies, children, families, and caregivers deserve: an array of supportive approaches and services that meet their unique needs.

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I

Setting the Stage

1 Then and Now

The History and Theoretical Framework of the Pyramid Model

Julia Sayles, Kelli McDermott, and Neal M. Horen

KEY TERMS

Behavior incident report (BIR) is a form used by educators to record serious behavior incidents and gather critical information on specific factors including the following: type of problem behavior, activity when behavior occurred, others involved, possible motivation, response, administrative follow-up, child's race and gender, individualized education program status, and if the child is a dual-language learner.

Intensive individualized intervention refers to a process developed by a team of adults (to include educator and family) based on observation and interview data that set clear ways of supporting the needs of a child.

Office of Special Education Programs (OSEP) is a unit within the U.S. Department of Education focused on services for infants, children, and youth with disabilities ages birth–21 years by providing leadership and financial support to assist states and local districts.

Persistent challenging behavior is defined as any repeated pattern of behavior, or perception of behavior, that interferes with or is at risk of interfering with optimal learning or engagement in pro-social interactions with peers and adults. Persistent challenging behavior is thus defined based on its effects.

Positive behavior support (PBS) offers a holistic approach that considers all factors that have an impact on a child and the child's behavior.

Pyramid Model is a tiered framework for supporting social competence and emotional regulation, and for preventing challenging behavior for infants and young children.

Teaching Pyramid Infant-Toddler Observation Scale (TPITOS™; Bigelow et al., 2019) is an assessment instrument designed to measure the fidelity of implementation of practices associated with the Pyramid Model within infant and toddler care and educational settings.

Teaching Pyramid Observation Tool (TPOT™; Hemmeter et al., 2014) is an assessment instrument designed to measure the fidelity of implementation of practices associated with the Pyramid Model within preschool educational settings.

PYRAMID MODEL: GUIDING PRINCIPLES

The Pyramid Model is a framework of evidence-based practices for promoting social and emotional competence in infants and young children. This equity-focused, multi-tiered system of supports can be used across a variety of settings that serve children from birth to age 5 years. The Pyramid Model fosters growth and capacity building in adults to support social and emotional development through nurturing and responsive relationships, creating high-quality supportive environments, offering developmentally appropriate social and emotional teaching strategies, and creating individualized interventions for children if and when they are needed. This chapter provides a brief history of how the Pyramid Model came to be, as well as an overview of its tiers and practices (Hemmeter et al., 2014) (Figure 1.1).

Figure 1.1. The Pyramid Model. (Reprinted from Hemmeter, M. L., Ostrosky, M. M., & Fox, L. [2021]. *Unpacking the Pyramid Model: A practical guide for preschool teachers.* Paul H. Brookes Publishing Co.)

The Pyramid Model has a rich, evolving history that has been and continues to be informed by numerous research scholars across multiple institutions, research grants, and scholarly work funded at the federal, state, and local levels (National Center for Pyramid Model Innovations [NCPMI]; https://challengingbehavior.org). In 2001, the Center on the Social and Emotional Foundations for Early Learning (CSEFEL) was funded by the U.S. Department of Health and Human Services (DHHS) and Administration for Children and Families (ACF). Additional funding from the Center for Evidence Based-Practice: Young Children With Challenging Behavior and the Office of Special Education Programs (OSEP) supported the creation of The Teaching Pyramid, a model for supporting social competence and preventing challenging behavior for young children.

The Teaching Pyramid was an early iteration of the Pyramid Model, and it aimed to fill the need many early childhood educators voiced regarding wanting more strategies to meet the needs of children with challenging behaviors. Early childhood teachers reported spending much of their time trying to address the behaviors of a few children, leaving little time to support the development and learning of other children (Fox et al., 2003). Evidence showed an effective solution to this problem was the use of a model that focused on promotion of social-emotional development and supporting developmentally appropriate behavior, and the prevention of challenging behavior (Fox et al., 2003). The first Pyramid Model framework included four levels of practice with the goal of recognizing the needs of all children, including those with persistent challenging behavior (Figure 1.2).

The Teaching Pyramid identified positive relationships with children, families, and colleagues as the foundation of an effective early childhood program. Having positive, supportive relationships between teachers and children, teachers and families, and teachers with each other and other professionals was the cornerstone of effective teaching and guidance when it came to social, emotional, and behavioral development (Fox et al., 2003). The premise was that young children will not

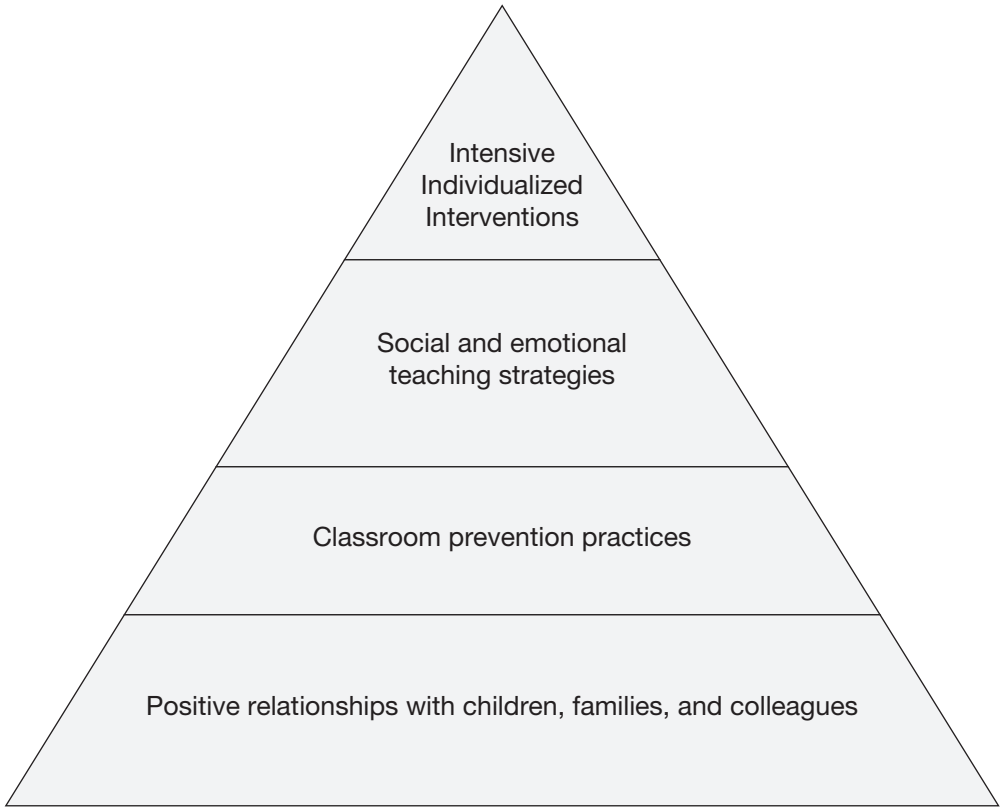

Figure 1.2. The Teaching Pyramid—an early iteration of the Pyramid Model.

effectively learn from people with whom they do not have a positive relationship. The importance of positive relationships was followed by classroom preventive practices. This level of The Teaching Pyramid focused on the classroom environment. This included the importance of child–adult interactions and classroom design as preventive practices for challenging behaviors, while simultaneously promoting child development and appropriate behavior. Reflecting on the environment and making simple changes to daily routines, schedules, or activities had a big preventive impact. The next level of The Teaching Pyramid was social and emotional teaching strategies. This recognized that many children benefit from explicit instruction to develop social-emotional skills (e.g., impulse control, managing big feelings like anger, problem solving, friendship skills) and emotional literacy skills (e.g., identifying feelings in self and others and recognizing and labeling a wide range of feelings) (Fox et al., 2003). Best practices for teaching social and emotional skills became hallmarks of this model. Planning, individualization, diversification, and providing multiple opportunities to practice and learn social skills through positive interactions while giving specific positive feedback were emphasized.

Planning intensive individualized interventions was the final level of the original Pyramid Model. Positive behavioral support (PBS) was introduced as an evidence-based approach to address persistent challenging behaviors. PBS offered a method for identifying environmental events that may be occurring, circumstances, and interactions that could precede a challenging behavior, as well as the purpose or meaning of the challenging behavior. This data would guide the development of a plan outlining supportive strategies for preventing the behavior, as well as teaching new skills to replace it (Fox et al., 2003). The goal of PBS was to help a child develop new social and emotional skills and communication skills, and to grow relationships with peers and adults, resulting in an improved quality of life. Recommendations for individualized interventions using PBS included using a team approach to develop and implement the plan. A comprehensive team might be made up of classroom teachers and staff, family members, and other professionals who may be supporting the child, family, or teacher. Once established, the team would complete a functional

assessment—a process of observing the child in different environments and situations, reviewing a child's records, and collecting information from a child's family, caregivers, and any other professionals working with the child (e.g., mental health consultant, speech and language therapist, occupational therapist) and analyze the data collected to identify possible factors related to the child's challenging behavior and inform the creation of the support plan. The intensive individualized interventions were then implemented across a variety of settings including the child's home, school setting, and community (Fox et al., 2003).

An important factor of this earliest version of the Pyramid Model that holds true today is the hierarchal implementation of strategies, with one level building on the next. The effectiveness of the framework is supported through data indicating that when the three lower levels of the pyramid were in place, only about 4% of the children in the classroom or program would require more intensive supports (Sugai et al., 2000). The most impactful strategies for understanding and addressing challenging behaviors in young children were found when adult behavior and classroom practices were examined and changed, not by singling out individual children for intensive interventions (Fox et al., 2003).

The Teaching Pyramid laid the foundation for more research, practical application, learning, and evolution of the Pyramid Model. Funding of the initial CSEFEL lasted from 2001 to 2012. In 2008, the Technical Assistance Center on Social Emotional Intervention for Young Children (TACSEI) was funded by the U.S. Department of Education, OSEP. Through this continued support, The Teaching Pyramid expanded to become the Pyramid Model. The flat triangle grew into a pyramid with a few important additions, one being the "effective workforce" base of the pyramid. The effective workforce includes infant and early childhood professionals, early education staff, teachers, caregivers, and programs. The goal of this base is to ensure that the aforementioned participants are supported with opportunities for self-reflection and/or reflection in a group; openness to learning; and respecting diverse ideas, perspectives, and beliefs that may be different from their own; and that they have access to the supports needed to implement the Pyramid Model practices with fidelity (Hemmeter et al., 2021b). Effective workforce also considers the wellness (health and mental health) of adults caring for infants and young children, diversity, equity, and inclusion, especially as it relates to disproportionality of suspensions and expulsions for children with challenging behaviors, and trauma-informed care.

Another important shift came in the expanded practices for each tier of the Pyramid Model. The first tier, "universal practices," included two key sets of practices: nurturing and responsive relationships and high-quality supportive environments. The second tier, "targeted social emotional supports," expanded to focus on intentional quality teaching of social and emotional competencies. All practices were grounded in the questions of what to teach, when to teach, and how to teach. The final tier, "intensive intervention," continued to be responsive to the latest research and guidance for best practice while maintaining a team approach to understanding and addressing individual needs. The emphasis on family engagement also evolved through the early 2000s. Partnering with families is an essential element of each tier of the Pyramid Model and part of all key practices. Evidence shows that when Pyramid Model work is done in partnership with families, the outcomes for infants and children are more consistent and lasting (Hemmeter et al., 2021b).

During this time, the Pyramid Model content, resources, and materials expanded to include developmental considerations for children from birth to 3 years, recognizing that social and emotional development starts from birth. Early Pyramid Model infant and toddler content focused on the promotion of the developing brain, supporting regulation, understanding cues and different ways babies communicate, taking temperament into account, knowing social and emotional developmental milestones, and the relationship between social-emotional development and behavior. This was framed in the context of safe and secure early relationships, attachment, and cultural responsiveness. Emphasis was also placed on building relationships with families and supporting the parent–child relationship. The Pyramid Model recognized that from birth, infants and toddlers have the capacity to form relationships, express feelings and emotions, lay the foundation for self-regulation through early relationships with caregivers, explore their environments, and begin to develop emotional literacy through nurturing and responsive relationships and high-quality environments.

The Pyramid Model practices have always considered the diverse cultural and linguistic factors of infants, young children, and families and how this may impact behavior and social-emotional development. Practices support cultural awareness and responsiveness. This is an area that continues to grow and evolve with the ongoing development and dissemination of culturally responsive tools, materials, and actions to enhance the Pyramid Model. Alignment of trauma-informed care principles and the Pyramid Model can support the ability of professionals and early care and education programs to meet the needs of young children and families impacted by trauma. Crosswalks between infant and early childhood mental health and mental health consultation have highlighted the intersection and importance of social-emotional health and development with recognition that Pyramid practices support children in this domain. It is also of note that when the Pyramid Model practices were developed, they were designed in a way to promote and support the social-emotional competence of all children, including those with identified, or at risk for, developmental disabilities (Hemmeter et al., 2021b).

Let's take a closer look at the tiers of the Pyramid Model, highlighting the key practices for infants connected to each tier.

Tier 1: Universal Practices

The bottom of the pyramid represents universal practices that benefit the social and emotional development of all children: responsive and nurturing relationships and high-quality supportive environments. These practices help establish a strong foundation for emotional competencies needed to thrive in relationships in infancy and as a baby grows. The Pyramid Model framework showcases best practices for infant social and emotional development by emphasizing the intentionality needed from adults who care for them.

Social and emotional development begins at birth and develops through the context of relationships. Infants are wholly dependent on adult caregivers to meet all of their needs. Nurturing and responsive relationships are critical to a baby learning they are worthy of love and care and can trust adults to meet their needs. Although it might feel like this happens naturally in many infant–caregiver dyads, it is important to note that there are opportunities to build skills to deepen practices.

In a fast-paced society with many competing priorities, finding the time to slow down and be truly present with an infant can feel significantly out of the norm. How a child's brain functions is directly influenced by their early experiences. Daily caretaking routines such as holding, rocking, bathing, feeding, dressing, and talking to an infant all help create important connections in their brain. Carving out small moments to intentionally connect in ways that are comfortable for the duo (e.g., through eye contact, physical touch, soothing tone of voice, animated facial expressions) during daily routines helps babies organize themselves by regulating their emotional state. Repeating this regularly teaches a baby to expect this type of interaction and anticipate the soothing effect of the relationship; these patterns result in a baby internalizing how to coexist in nurturing relationships and to tap into said relationships when things feel difficult (which will happen over and over through their development).

A high-quality, supportive environment refers to both the physical space layout, cueing for children to know what to do, and how it feels to be in that space. Of course, we want to ensure that infants are able to explore freely and safely with age-appropriate materials, and there are many tools to use to evaluate whether a space checks those boxes. The Pyramid Model pushes a bit further and taps into the social and emotional climate, with an emphasis on individualized warmth, nurturance, and responsiveness that are derived from nurturing relationships. The way an infant feels in their environment cannot be separated from their relationships, as everything they do is with an adult partner (even if there is some distance between the two during exploration, etc.). Explicitly stated expectations, consistent schedules, and predictable routines all require an adult who is paying attention and intentionally making choices to help build skills in the infant. These environmental supports also contribute to the patterns that shape brain development and prepare infants to thrive in relationships with others.

Table 1.1 contains a sampling of Tier 1 Pyramid Model strategies that support social-emotional development in infants.

Table 1.1. Tier 1 Pyramid Model strategies

Strategy	Put it into practice
Provide a daily routine that supports an infant's needs for eating and sleeping.	Maintain flexibility by engaging in activities around eating times and sleep/wake windows.
Use routines as opportunities for emotional interaction and learning.	Use songs, words, facial expressions, and hand gestures to describe your actions.
Prioritize continuity of care when possible.	Keep infants matched with the same caregivers for as long as possible.
Develop strong relationships with families to remain culturally responsive.	Learn about caregiving practices at home and do your best to match that in your interactions with the child.

The following is a reflection shared by a classroom teacher who is employing these Tier 1 strategies within her regular interaction with children in her care. For more information on this, and to view the Infant-Toddler Caregiver Reflection Tool, visit the Brookes Download Hub (see this book's About the Download page for details).

Ms. Cathie is a very experienced Pyramid Model–trained infant teacher. She has consistently built loving relationships with babies, families, and staff in her classroom over the years. She regularly receives feedback like "It just feels so good to be in this space—all the babies are so content!" when talking with classroom visitors. Ms. Cathie prides herself on getting to know the individual babies in her care—their schedules and preferences, and how to help them explore safely.

Tier 2: Targeted Social-Emotional Supports

Well-established responsive relationships and high-quality supportive environments create the foundation for Tier 2 practices, where social and emotional skill development is targeted. Again, all children benefit from use of these strategies. A hallmark goal of Tier 2 is to support the emergence of emotional literacy—the ability to understand one's own emotional experience and that of others. This is critically important because emotional literacy lays the groundwork for developing relationships with peers, problem-solving, and managing big feelings as a baby grows into a toddler and beyond.

Early emotional literacy skills start with the patterning of responsive relationships and safe environments because these give permission for a baby to have and express their needs. Adults support early emotional literacy by responding to babies with empathy and language to describe their emotional experience (e.g., "You are so happy to see yourself in the mirror. You have such a big smile!"). In addition, building social play skills is also part of Tier 2 practices. As infants become aware of others at a very young age, intentionally promoting early positive peer interactions paves the way for social skill development through early childhood.

Table 1.2 contains a sampling of strategies to intentionally target emerging social and emotional skills.

The vignette that follows further details how Tier 2 strategies are employed to support an individual child within an infant and toddler care setting.

Maya is an 8-month-old and new in Ms. Cathie's classroom. She has been in two other programs in the last couple of months. Maya's mother describes her as a baby who "keeps to herself" and "doesn't make a fuss." Ms. Cathie spends the first few days trying to get to know Maya. She follows the eating schedule provided by her family and watches closely for sleepy cues to determine the best times for naps. During wake times, Ms. Cathie tries to engage Maya by holding her, making toys available, and using a soothing voice to talk through the routines of the day. She watches Maya's facial expressions and narrates what she notices ("It looks like you are curious about this book. Why don't you take a turn to read it with me?"). Ms. Cathie makes sure to carve out intentional one-to-one interaction time with Maya multiple times across each day.

Table 1.2. Tier 2 Pyramid Model strategies

Strategy	Put it into practice
Incorporate a wide range of emotions words to build vocabulary.	Use pictures and books to practice labeling emotions and the ways they can be expressed.
Leave room for infants to respond in conversation, even if they don't have expressive language skills yet.	Ask a question and pause to signal that you are listening for their input. Respond to any cues you notice (e.g., facial expressions, coos, babbling).
Prioritize cultural responsiveness.	Acknowledge that families are a baby's first teacher and guide how they begin to read others' responses to feelings. Maintain a stance of curiosity with families when discussing how emotions are expressed at home.
Scaffold positive peer interactions.	Establish play areas that can accommodate two or more babies for side-by-side play.

Tier 3: Intensive Interventions

The top of the pyramid focuses on individualized interventions for children who display behaviors that are impacting their learning and/or relationships with peers and/or adults. It is important to begin thinking about supporting children around these behaviors in infancy, with the hope to limit the distress or delays experienced through continued development. For example, a baby who cries for most of the day might receive less positive attention and physical closeness than a baby who is less fussy. On the other hand, a baby who is quiet and hard to engage might be left alone more frequently because caregivers don't feel connected to them. Either of these scenarios might delay social development (e.g., responsive smiling). The longer these behaviors continue (on the part of the baby and their caregivers), the more likely they are to become habitual and difficult to change. Catching these patterns early provides an opportunity to disrupt them and intentionally use strategies to promote connection.

All children move through phases of development that elicit behaviors that can be challenging for adults to manage. Some babies experience difficulties (e.g., medical diagnoses, caregiver disruptions, various stressors in their environment) that impact their behaviors. Often, these difficulties are not easily identifiable and require open communication with an infant's family. Family engagement is a crucial part of Tier 3 interventions because all strategies should align with a family's values and be consistent across care settings whenever possible. Using a multidisciplinary approach, a team is able to ensure the universal practices of the first two tiers are firmly in place. Specific, individualized strategies to strengthen an infant's relationships, emotional expression, exploration of their environment, and emerging play skills in response to noted barriers to any of these are Tier 3 practices (Table 1.3).

Table 1.3. Tier 3 Pyramid Model strategies

Strategy	Put it into practice
Identify children who are not thriving in social and emotional development.	Regularly inventory relationships between infant and caregiver.
Notice babies who have fewer positive interactions with caregivers.	Make a hypothesis about why that might be. It is helpful to use a behavior inventory to support your hypothesis.
Promote culturally responsive strategies.	Include family members in your team and explicitly ask for their input. Choose strategies that can transfer across care settings to ensure continuity whenever possible.
Consider baby's temperament when establishing your intervention strategies.	Use strategies and means of comfort that are responsive to baby's preferences.

Again, we revisit Ms. Cathie's infant and toddler classroom that is supported by Tier 3 supports and strategies when indicated for this new child.

At the end of Maya's third week, Ms. Cathie does not feel like they are making much progress in their relationship. When she talks to Maya, she does not feel any reciprocity—it feels very one-sided. Maya doesn't smile often and doesn't make much eye contact. Ms. Cathie has observed that Maya can crawl, but she will remain seated instead of exploring the classroom when she is on the floor. She has also noticed that it is getting more difficult to continue carving out individualized time to connect with Maya because she's not getting much back from her. She decides it is time to pull in a team for support and to make a plan to help Maya settle into her classroom.

A multidisciplinary team meets to discuss Maya's transition into Ms. Cathie's classroom; the team is made up of Ms. Cathie, her supervisor, the Pyramid Model coach, and Maya's mother. When Ms. Cathie shares what she has observed in the classroom, Maya's mother nods and says this seems similar to how she has presented in other programs. She adds that this is not typical behavior for Maya at home—that she is quiet and reserved, but she coos and babbles and plays. She shares a worry that Maya really misses her because she is clingy after being away from her all day. After their conversation and comparing notes, it is realized that Maya loves to dance and her family has music playing in the background at home almost all the time. Ms. Cathie has never seen her dance! Maya's mother volunteers to share a playlist of songs Maya is familiar with to play in the classroom and shows Ms. Cathie how they dance together at home. Ms. Cathie leaves the meeting invigorated and with a plan to dance with Maya to her own music every day. She and Maya's mother will check in again next week.

Although this vignette showcases implementation of Pyramid Model practices in an infant classroom, the Model also supports teachers of toddlers, preschoolers, and early elementary school children with specialized, developmentally appropriate strategies. The Pyramid Model continues to innovate in the field, expanding offerings to include specific foci of equity and trauma-informed care. Pyramid Model practices can be found in many settings: center-based early education centers, family child care programs, early intervention services, and mental health agencies.

Implementation science has guided program wide adoption of the Pyramid Model across age groups and settings mentioned previously. Systemic implementation of the Pyramid Model has led to the development of additional professional development opportunities and resources including rolling out the Pyramid Model in varied settings, creating a leadership team to drive implementation, training practitioner and program coaches to support data-driven action plans and goals, trauma-informed care, and supporting inclusion. The Teaching Pyramid Observation Tool (TPOT), Teaching Pyramid Infant-Toddler Observation Scale (TPITOS), and behavior incident reports (BIRs) can be used to collect data that can inform decision making while holding the lens of sustainability. Implementation does not stop at the program level. Statewide implementation of the Pyramid Model is currently happening in 40 U.S. states and a handful of countries across the world. Chapter 3 digs deeper into state systems for implementation of blended frameworks.

RESEARCH STRENGTH OF THE PYRAMID MODEL FRAMEWORK

The Pyramid Model has a robust research foundation, detailing the effectiveness of the framework when implemented with fidelity. There have been two randomized control trials to date pulling data from Florida and Tennessee, first in 2016 and most recently in 2021. As stated on NCPMI's website, these studies reinforced the following about the Pyramid Model framework:

- Teachers in the experimental condition who received training and coaching demonstrated statistically significant differences in their implementation of Pyramid Model practices.
- Children enrolled in the experimental classrooms implementing the Pyramid Model demonstrated statistically significant differences in their social skills.

- Target children in the experimental classrooms had statistically significant reductions in problem behavior.
- Preschool children identified with problem behavior were rated by teachers as having greater improvement in their behavior in Pyramid Model classrooms than children in the control classrooms.
- Preschool children identified with problem behavior were rated by teachers in Pyramid Model classrooms as having greater improvement in their social skills than children in the control classrooms.
- Preschool children identified with problem behavior in Pyramid Model classrooms were observed to have greater growth in their positive social interactions than children in the control classrooms.
- All children in the Pyramid Model classrooms were rated by teachers as having greater growth in their social skills than children in the control classrooms.
- Teachers who received training and coaching in the Pyramid Model implemented the Pyramid Model practices and continued to use the practices a year after coaching ended.

CONCLUSION

As detailed throughout this chapter, both research and practice are clear that implementation of the Pyramid Model framework equips adults with the skills and strategies to build strong social skills and support development of emotional regulation in infants and young children in their care. This naturally leads to decreases in both the frequency and intensity of behaviors that adults find so challenging, which often lead to dire consequences when left unaddressed for our youngest children and their families. The gift of the Pyramid Model is to provide communities, programs, administrators, and educators with a framework to hold and organize practices to increase positive social and emotional experiences for children and adults. This framework is consistent with multiple trainings, curriculum, and intervention models within the early care and education field.

REFLECTION QUESTIONS

- As the Pyramid Model has evolved over the years, what shifts stand out the most?
- How could the Pyramid Model framework continue to evolve to meet the needs of the infant and early childhood field in the future?
- What Pyramid Model practices support the mental health of infants and toddlers?
- In what other environments could the Pyramid Model framework support infants, toddlers, and their families?
- What are some ways reflective practice for professionals working with infants and young children can be promoted across the day?

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