Supporting Infant and Early Childhood Mental Health in Speech Therapy

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INTRODUCTION

Role of the Speech-Language Pathologist (SLP) in Care of Children 0-5 Years Old and their Families

A speech-language pathologist (SLP) who specializes in the birth-5 population (Early Intervention) can expect to work with children with a wide variety of feeding/swallowing, language, and articulation disorders resulting from a vast array of etiologies. The SLP will identify these children, provide screenings and evaluation/assessments, determine eligibility for speech-language pathology services, determine goals (with the input from the family), and provide possible referrals. At times, when delays are anticipated, because perhaps the child was born with a more common diagnosis, the SLP may use preventative measures to stimulate speech and language and alleviate or lessen problems. At other times, speech delays may be due to environmental issues such as exposure to trauma.

The scope of practice for the SLP working with Early Intervention (EI) includes feeding and swallowing, oral motor system development, communication, language, social/emotional caregiver-child interaction, and the utilization of assistive technology. The SLP must be able to form trusting relationships with the families he/she works with, provide counseling and information to the caregivers of these children, and collaborate with other members of the EI team. There will also be many transitions that the child may have to go through—for example, the transfer from the hospital to home, home to a daycare or other center-type environment, home to pre-school, and finally the transition to kindergarten. The SLP will be a part of this transition planning.[1]

Best Practices in Early Intervention and Family-Centered Care

Feeding and swallowing take precedence as far as life-sustaining importance with services provided by the SLP, but these skills also lay the foundation for all other early developing communication abilities such as receptive and expressive language and articulation. Eventually, these early skills will culminate to provide the child with the ability to become a functional

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communicator. The SLP is the professional responsible for habilitating these developmental skills in skilled therapy sessions, but the SLP must also work closely with the child's family and train the caregivers of these children with the imperative task of stimulating these skills in the child's everyday environment. Because EI relies so heavily on all members of the team, the SLP will collaborate with other professionals to help them facilitate the child's functional communication in their sessions.

Four core principles that reflect the current consensus on best practices have been identified by the American Speech-Language-Hearing Association in its 2008 *Roles and Responsibilities of Speech-Language Pathologists in Early Intervention: Guidelines*.[2]

1. EI services must always include the family unit while being culturally competent and catering to the family's specific value system.

2. Including the family in the EI population is imperative. The child will spend the greatest amount of time with her family regardless of how many therapy sessions she has per week. The family is her main unit of socialization and is the ultimate expert on the child. Not only should the family be included when the intervention goals are created, but they should have the ability to choose goals that they value as important for their child's speech and language development. The family's participation in choosing activities of high interest to the child will increase the likelihood that the child will respond in a positive manner. The family will be more apt to follow through with the goals outside of therapy if the goals are meaningful to them.

   It is also important to be mindful of the family's culture when choosing goals. By doing so, you also make the possibility of following through more realistic for the family, as they are more likely to work on activities with the child that are aligned with their beliefs. Since early communication is primarily used for social interactions, the optimal environment for services to be provided is the natural or home environment.

   When providing therapy for the child, the home environment is always the best choice. It is most realistic for the family if their home and the child's personal items are used. The family will be able to imitate the activities more easily if the equipment used is readily available and familiar to them. The child will likely generalize skills outside of therapy if the location of therapy is consistent and familiar to them.[3]

3. For the child to receive the highest quality of intervention, the services should utilize a comprehensive, organized, and team-based approach.

   Many experts coming together can combine their skill sets to determine the best possible treatment for the child. While they do not have specific goals outside of their scope of practice, they will be able to keep in mind the whole child and the child's overall development and its relation to early communication skills.[4] The SLP and other professionals, while reinforcing skills outside of their specific goals, can serve as a model to the child's family, showing them how to stimulate the child's overall development. Adding specialists with a background in infant mental health to the team can provide additional support to the child and family when social, emotional, or behavioral issues are present.

4. The treatment provided must be evidence-based and best practices must be used.

   The highest quality of therapy will be based on recent and well-founded research. When creating a treatment plan for the child, peer-reviewed research is the gold standard, but best practices that utilize clinical expertise, professional judgment, and the ideals and preferences of the family will also be used.

HOW THE SLP DISCIPLINE SUPPORTS INFANT MENTAL HEALTH CONCEPTS

Serve and Return

The young developing brain is very plastic, and the ability to learn through experience at this age is astounding. This experience comes from the caregiver responding to the child and helping to mold the child's unintentional communication into a functional and intentional communication system. This interaction is referred to as "serve and return." The terminology nicely describes what happens between children and their caregivers. The infant "serves" through crying, vocal play, gesturing, and body language; the adult "returns" by responding to and interpreting those unintentional bids of communication

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with intentional responsiveness and appropriate language. These "serve and return" interactions begin at birth and continue throughout the child's development.

The field of infant mental health (IMH) is concerned with children from the prenatal period through age 5.[5] The foundation on which the IMH field places its focus is the necessary "safe relationship" that occurs between the caregiver and the child and will serve as the underpinning for the child's future ability to form strong interpersonal relationships. The attachment formed between the child and caregiver is rewarding for both the child and the parent. It allows the child to have the confidence to move outside of the parent-child dyad and explore her environment while having the security of knowing she can return to the caregiver when she needs encouragement or reinforcement. Children essentially learn what they are living; if the parent responds appropriately and in a loving way, the child knows that she is loved and in return learns to respond lovingly. In this process, she is unknowingly learning about the reciprocal nature of relationships.[6] Along with early learning regarding relationships, the child learns the reciprocity of communication, which also requires "serve and return" in order to be successful.

In addition to the important aspect of bonding and attachment for the overall development of the child, the field of infant mental health is also associated with EI services and specialized treatment for the child when her environment is less than optimal and she has not received the necessary care to form attachments to her caregivers, which are needed for ideal development. Sometimes EI is needed even though a child is born into the best circumstances, but is born with a biological condition or birth defect that creates a hardship in early infancy, such as difficulty with feeding or breathing, which can make forming attachments difficult. The level of support that the child and family need and will receive is an individual determination based upon their distinctive situations.

Multidisciplinary Nature of IMH

Infant mental health is a broad field that is not only concerned with the development of the child, but the overall well-being of the child, the caregivers, the immediate environment of the family, and the interpersonal relationship between the child and the caregivers.

The three main areas of focus that the field of infant mental health are focused on are: 1) promotion and prevention; 2) early intervention; and 3) discipline-appropriate treatment. Since interruptions and difficulty with early relationships between the child and the caregiver can cause a disturbance of normal development, other licensed professionals who work in the different areas of child development are often involved. This multidisciplinary nature of infant mental health and other professionals is imperative as the child-caregiver relationship is at the root of all developmental skills. Many times, potential stress may cause an interruption in cognitive development and the first professional to see the child may be the SLP. This is a common referral because the first noticeable problem may be that the child is delayed in using her first words. Language and communication are dependent upon both a communication partner and a reason to communicate. The first and foremost communication partner for the child is the caregiver as the caregiver's responsiveness lays the foundation for intentional symbolic communication.

All professionals who work with children in this age range should be well-versed in the field of infant mental health and the red flags that indicate the child is exposed to potential stress and may need additional services and referrals. Additionally, they should have knowledge of adverse childhood experiences (ACEs), toxic stress, and complex trauma. There are 10 categories of ACEs: physical abuse, emotional abuse, sexual abuse, emotional neglect, physical neglect, domestic violence, mental illness or mental health disorder, parental separation or divorce, substance use disorder, and incarceration of a family member. The more ACEs a child is exposed to, the greater the likelihood of a developmental delay resulting in the child requiring special education services in school. More information may be found in the Florida State University Center for Prevention and Early Intervention Policy's (CPEIP) Early Childhood Health Optimization Module at www.cpeip.fsu.edu/mma.

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IMPACT OF STRESS

How Stress Might Affect Development

Potential stress can manifest itself by causing an interruption in the development of feeding/swallowing, language/communication, and speech skill acquisition. For an infant, a paramount aspect of development is the interaction and the trust and love the child has with her caregiver and the responsiveness of the caregiver to the child. A child is completely dependent on her caregiver for all of her needs, both physical and emotional. When the caregiver is unavailable due to mental illness, separation or divorce, substance use, or any other extremely stressful situation in her life, she may not be attending to the child in an appropriate way, and the emotional and/or physical needs of the child will not be met.

In infancy, it is important for the child and caregiver to form a mutual, loving bond, which often happens through reciprocal interactions, or "serve and return" interactions. Including the entire family is necessary in an EI environment as the health and well-being of the caregiver directly impact the health, development, and well-being of the child. When caregivers are not sensitive to the needs of the child, cognitive and linguistic skills may suffer.[7] These reciprocal interactions occur with eye contact, reciprocal vocal play, and appropriate attending to the child when the child needs caregiving.

Early behaviors that the child exhibits are vegetative in nature, but the response of the caregiver to the child's needs leads the child to develop the appropriate neural connections to eventually become an intentional communicator. This will lay the foundation for the child using joint attention which will eventually lead to the child becoming a symbolic communicator (verbal/gestural/pictorial). Joint attention is the ability of a child to share in an exchange with a communication partner and communicate without words. A key component of joint attention occurs when the child draws in the caregiver to share in some aspect of the environment, such as an object or activity.

The child's caregiver serves as a communication partner, and if the caregiver is attentive and interested in what the child is trying to "share," the child will likely be more interested in keeping the communication exchange going. The child essentially communicates with her eyes and later, before the first word develops, a gesture such as pointing will often be used. Lack of caregiver responsiveness can have a domino effect because when these behaviors are absent and the caregiver is less attentive and interactive, the child will be less likely to engage in triadic communication exchanges.[8] This may cause the child to miss the cause-and-effect nature of communication and to not experience the pleasure of social communication; their vegetative or pre-intentional communication may be delayed in becoming intentional in an appropriate developmental time frame. When caregivers are less interactive and attached, the language growth of the child may be impaired. Parental responsiveness is key to the cognitive, attachment, language, and academic achievement of the child.

How Stress Might Affect Parent-Child Interactions

Because parental responsiveness is paramount to acquisition of the early developmental skills of the child, the effects of potential stress can be detrimental to the development of the parent/caregiver-child relationship. As discussed earlier, substance abuse, mental illness, and/or preoccupation with other issues can cause problems with many aspects of the caregiver relationship. The caregiver and child likely will not develop a bond and a mutual love for each other. This also can have a domino effect on the relationship; when the child is having developmental delays, the self-esteem of the caregiver may be reduced and the cycle of a lack of interaction will continue.[9]

Speech and language therapists treat a large number of children who have been the victim of abuse and/or neglect, as children who have been abused are more likely to have developmental disabilities. Conversely, when children are born prematurely, have chronic illness, or delays in their development, it is more likely that they suffer abuse or neglect. The abuse or neglect of a child can be detrimental to cognitive and linguistic development and may cause disabilities in both of these areas.[10]

Children are also at risk for abuse when adults expect more from them than is developmentally appropriate. Adults are particularly likely to expect more from children with nonvisible disabilities (such as language-learning disabilities) than from children with visible or more obvious

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disabilities. A national survey revealed that many adults have misinformation about typical child development, and as a result have unreasonable expectations for children's developmental milestones and overall behavior. For example, 51 percent of parents expected a 15-month-old to be able to share her toys and 26 percent of all adults expected a 3-year-old to be able to sit quietly for one hour at a time. Both are unrealistic expectations and not likely to occur. The survey also showed that 26 percent of adults believed that a child as young as 6 months will not suffer any long-term effects from witnessing physical violence.[11] Yet research in childhood development demonstrates that witnessing acts of violence in infancy can have long-lasting and damaging effects on children's social and emotional development and on their evolving brains.[12] See Center for Prevention and Early Intervention Policy's *Home Visitor Brief #1: What the Home Visitor Can Look for in the Parent-Child Relationship* for indicators of possible stress and trauma.

ASSESSMENT/EVALUATION

How Typical Screening and Assessment Tools Might Identify Children At Risk for Toxic Stress

During an initial evaluation, the intake questionnaire form, parental interview, observation of the parent and child, and actual assessment tools help to identify children who are at risk for toxic stress. A good intake questionnaire is important for an initial evaluation because it will keep the parental interview focused and help serve as a guide for the clinician to make sure that the important topics are covered. A good intake questionnaire is designed to ask the right questions, such as pregnancy history, birth history, medical problems, illnesses or surgeries after birth, living arrangements, people who live in the home and their relation to the child, educational levels of the parents, employment (or lack of), parental/family medical/developmental history, feeding history, how the child spends her days, daycare if any, and other services that the child is receiving at the time.

These types of questions are likely to reveal any ACEs and will aid in any diagnoses for a speech and language disorder as well as provide a springboard for referrals to other professionals. In addition to going through the questions on the intake questionnaire, many clinicians will ask the caregiver in the interview what their main concerns are for their child and what they hope to gain from the services provided by the SLP. Sometimes the caregiver will not have any concerns but was referred by another professional. A lack of concern or animosity and blame directed toward the child can be a red flag that there are problems with the child-caregiver bond. When families are going through potential stress in their lives, developmental problems with the child are not in the forefront of their lives and may not be a main priority.

Along with the intake questionnaire and the interview, a formal (most often standardized) assessment is performed to determine the developmental level of the child. Some common evaluation tools used in the field of speech-language pathology for the birth to 5 population (when dealing with overall communication, receptive and expressive language) are Preschool Language Scales, Fifth Edition (PLS™-5); Receptive-Expressive Emergent Language Test, Third Edition (REEL-3); BTAIS-2: Birth to Three Assessment and Intervention System, Second Edition; and New Reynell Developmental Language Scales. Often more comprehensive tests, such as the Battelle Developmental Inventory™ Second Edition (BDI-2™), are used when a multidisciplinary evaluation is conducted.

All of these tests have one common factor; they utilize parental reporting to gather information about the child's performance when the skills cannot be demonstrated during the evaluation. The questions asked of parents during these assessments often lead to a dialogue between the caregiver and the clinician. In addition to supporting a diagnosis of a language delay, the caregiver's responses may also reveal ACEs and other risk factors that indicate a child is exposed to potential stress in her environment.

Parent-Child Observations that Might Indicate Parent-Child Relationship Issues

A clinician can learn much about the parent-child relationship by observing the interactions between the pair during the evaluation. Sometimes a parent will not be forthcoming with problems occurring in the home or family as they may not feel comfortable with the clinician

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and may not have established trust with her. Obvious signs that the child is living in a potentially stressful environment can be easily observed: yelling at the child; hitting the child (or one of the parent's other children who may be present during the evaluation); the child looking dirty; the child wearing ill-fitting clothes or shoes or clothes and shoes not appropriate for the weather (which may also be a sign of sensory integration issues); and/or the child having age-inappropriate food or drinks, such as an infant drinking soda out of a bottle.

The parent's behavior may also provide subtle clues. Directive language toward the child (e.g., the parent always ordering the child to do something) during the evaluation is a good indication that this is the type of language used in the home. Directive language is not interactive and is not a good model for reciprocity needed in communication. An obvious lack of interest on the part of the parent often can be observed; sometimes he/she may not have any concerns and express that he/she is there because the child's doctor wanted the parent to come. Another red flag is the parent complaining about the child and the child's behaviors. Finally, the parent may also appear unclean, act socially inappropriate with the clinician, or may be under the influence. See Center for Prevention and Early Intervention Policy's *Home Visitor Brief #1: What the Home Visitor Can Look for in the Parent-Child Relationship* for other clues of an impaired parent-child relationship.

INTERVENTION STRATEGIES TO SUPPORT THE CHILD'S MENTAL HEALTH

Intervention Goals to Promote Optimal Development

Intervention support is the key to promoting the optimal development in children. Although it is positive if a clinician can get a child to perform some developmental task during therapy, it is more important for the parent to have confidence that he or she can stimulate a child's language and overall development. The EI model recognizes the importance of involving the family in goal-setting as well as in actual therapy. A parent carrying out activities to stimulate the child's development is optimal; the child will essentially receive more therapy. It can also increase a parent's self-esteem to be an integral member of their child's treatment team. If an infant mental health therapist is not on the team, a referral should be made so that the therapist can complete a full assessment and make appropriate treatment recommendations.

Hanen's "It Takes Two to Talk" program (ITTT) places its entire premise on the caregiver-child interaction and strategies to promote this interaction are taught throughout the program—hence the title "It Takes Two to Talk."[13] Hanen's strategies provide parents with many opportunities to stimulate the child's language throughout the day in routine situations. To fully benefit from this program, the caregivers must have reflective functioning capacities.

A key strategy taught in the program is to get "face-to-face" with the child, and to Observe, Wait, and Listen (OWL). This is a strategy that teaches parents to identify the "serve" nature of their child's communication and to understand how their child may be communicating to them, along with teaching them the importance of getting on the child's level. Another important strategy taught in this program is to "follow your child's lead" and "imitate, interpret, and comment." This helps parents to understand how to "return" their child's communication bid.

By following the child's lead, the parent is being responsive to the child and reinforcing the reciprocity of communication and relationships. Imitation is important not only to establish and reinforce the initial back-and-forth nature of communication, but it is theorized that imitation may stimulate the child's mirror neurons, thought to be key in imitative skills. In turn, this increases the likelihood of the child imitating the parent, an important skill when learning how to talk or gain any developmental skill.[14]

The ITTT program teaches parents many strategies that can be used throughout their daily routines—no time needs to be set aside for parents to use them. This is optimal for families with limited resources available and which may be experiencing stress. The ITTT helps parents make sense of childhood-friendly activities such as "people games," music, toys, and books—all of which are an important part of interacting with children. While some clinicians may not be specifically trained in ITTT, the ideology behind the program provides excellent evidence-based activities to teach families.

> "The EI model recognizes the importance of involving the family in goal-setting as well as in actual therapy."

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How to Incorporate Parental Priorities

When providing treatment for a child with developmental delays who lives in a potentially stressful environment, setting parental priorities is of great concern. Often the parent has many other things going on in his/her life and needs a lot of coaching to help provide the responsiveness that the child needs to appropriately develop language.

An important component of accomplishing this is "buy in" by the parent of the necessity of the treatment. If the clinician can help the parent see the value in the treatment, the parent will be more likely to carry out the necessary home program. It may require the clinician to educate the parents and meet them on their level. This will likely take place during the time that goals are established with the parent and family. This step is important and should be given great care; the future of the treatment program depends on the change in behavior of the parent, which will take learning on the part of the parent.[15]

After getting the parent's attention, fostering the relationship with the parent will continue to be vital. Introducing therapy into the life of a family may be daunting to the family, and if given too many things to do every day, the parents may shut down. One strategy or goal at a time can be introduced to the family and when it becomes an easy part of the routine, another can be introduced.

Intervention Strategies to Strengthen the Parent-Child Relationship

Many times, when a mother is discouraged by her child's lack of development, her self-esteem suffers greatly. The clinician can help by praising the mother during therapy when she does something well and continuing to offer her verbal praise when warranted. The mother's confidence will also continue to improve as the child's skills improve.

After the mother is taught the importance of responsiveness to help increase joint attention and intentional communication, the child in turn will become more responsive to the mother which may boost her confidence. Her role may also become clearer in the development of her child. What she is learning in treatment may generalize to her interactions with her other children and increase responsiveness across the board in their family. As the child receiving therapy begins to make improvements, the mother's stress may decrease.

Intervention Strategies to Address the Additional Stress of Parenting a Child with a Disability

After obtaining the parent's attention and getting them involved with therapy, fostering the relationship with the parent will continue to be very important. Ideally, trust will have been built between the family and the clinicians. Throughout the child's treatment, the parents will need to be supported as goals change for the child and they work through the emotions.[16] Recommendations for support groups for the caregivers, playgroups for the children, and professional counseling referrals may be necessary.

REFERRALS

Indications for Referral

Referrals are necessary when there are red flags that the child is in a potential stress environment or is not achieving milestones outside of your scope of practice. Most obviously, referrals for developmental milestones will be made to the appropriate clinician who specializes in the area in which the child needs assistance. Sometimes, the parent alone can benefit from counseling. If deemed appropriate by the infant mental health therapist on the team, a referral to Parent-Child Interaction Therapy (PCIT) or another treatment modality such as Child-Parent Psychotherapy may be necessary. If you suspect the child is in danger, a referral to the Department of Children and Families is necessary.

Referral Strategies

A trusting relationship between you and the family is ideal as the more they trust you, the more they will trust your recommendations for further treatment. Talking to the family about the potential to help the child further in an area—in which you are not trained—is usually a good beginning. Ideally, the decision to refer will be easy when the clinician is working as part of a multidisciplinary team.

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CASE STUDY

Jane is a 15-month-old girl with reported language, motor, and social delays. She lives with her biological mother and father, and the only other family available is a maternal grandmother with multiple health problems.

Jane was born at 30 weeks gestation. At birth she was admitted to the NICU, weighing less than 1000 grams (2.2 pounds), and required intubation. During her stay in the NICU, she had difficulty with feeding and temperature regulation, was slow to gain weight, and had poor state regulation. The visits of Jane's mother and father to the hospital were limited to weekends when they were not working.

Jane was discharged at 4 months old or 6 weeks adjusted age. After discharge, Jane received limited services through Healthy Steps. Scheduled visits were often canceled by Jane's mother due to scheduling conflicts. The mother quit her job soon after Jane came home, raising some concerns about social isolation.

Currently, Jane eats cereal mixed with breast milk and has limited experience with solid foods. She fatigues easily and has difficulty sleeping through the night. Jane does not like to be bathed.

Jane is crawling and cruising short distances. Mother reported that she discourages cruising as Jane has gotten several bruises due to falls. Upper extremity flexion posturing with bilateral thumbs adducted into her palms and bilateral UE flexion was more noticeable in the left than right extremity.

Jane is making sounds but has no recognizable words. She has limited play skills, preferring to listen to music or the TV or observe her mother as she cooks and cleans.

Mom reported that she is exhausted from constant worry about Jane and her mother. The maternal grandmother does not drive and is dependent for all transportation. Mom said she is having difficulty keeping up with taking care of Jane, her mother, and the house and being attentive to her husband, who is doing all he can to support the family.

Dad is concerned about their reduced income. He sleeps during the day and reported that he does not have time to play with the baby or help out with caregiving responsibilities. Mom must keep the noise down during the day in the house to avoid waking him. Mom and dad have little time for each other.

The interdisciplinary team has recommended that Jane receive services from speech-language pathology, physical therapy, and occupational therapy. The team has identified the following intervention goals: to strengthen parent-child interactions; provide support to the parent and watch for possible depression or situational-related emotional issues with the mother; and address developmental delays in sleep and feeding patterns and in language, motor, and play skills. See Table 1 next page for goals and strategies.

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Table 1

Description of child	Speech-Language Pathology Evaluation	Speech-Language Pathology Intervention
Jane is 15 mos. CA (12.5 adjusted age) referred due to possible developmental delay. Parent's primary concerns are Jane's play skills, sleep routines, and physical health.	Referred to OT, PT, and SLP for evaluation. Evaluated using BTAIS-2: Birth to Three Assessment and Intervention System, Second Edition.[17] Cultural and family expectations are explored around development and routines. Additional information gathered regarding cumulative risk factors and experiences associated with utero/ birth history, attachment disruptions, developmental trauma, multiple placement, and/or hyper/hypoarousal concerns known to affect development.	Early intervention services provided in the home weekly. Parent coaching and video modeling will be used to help Jane's primary caregiver (her mother) to facilitate and stimulate language in everyday interactions in the home.
Jane has limited experience with solid food; does not finger feed.	OT evaluation revealed Jane consumes ½ cup of rice cereal with breast milk 4 times a day and has not begun to finger feed. Oral sensory defensiveness may be contributing to the limited repertoire of sounds the child makes.	OT will work with mother to offer activities for oral play to encourage oral motor skills and getting the articulators moving. OT will address possible sensory issues.
Jane does not sleep through the night and wakes frequently. She fatigues easily.	OT home visit revealed Jane sleeps with her mother. Both average 6 hours of sleep a night. Gather more detailed information regarding sleeping and feeding patterns during a 24-hour period.	Incorporate language-enriching bedtime routines, such as shared reading and/ or story telling as well as quiet songs or music.
Jane has limited play skills. Prefers listening to music or the TV or watching her mother.	Jane did not initiate play. She appeared attracted to objects and activities with auditory and visual interest.	Using coaching and modeling, introduce play activities encouraging movement, language and cognitive skills (e.g., books, blocks, colors, and shapes). Model language with rich music incorporating motor movements (e.g., 'if you're happy and you know it'). Introduce media - interactive with characters that can be utilized during play activities.
Jane makes a limited number of sounds with no recognizable words. Does not use gestures (e.g., pointing).	During observation Jane's affect remained flat. She used limited sounds. Had limited responses to interactive play ('peek-a-boo'). Significant receptive and expressive language delay. Additional information to support interventions includes mother and child in typical play or social interaction to observe (e.g., use of eye contact, shared affect, shared attention, pacing of activities, use of touch, or turn-taking skills of the dyad).	Coach and model imitation of all sounds that the child makes (with the exception of crying/screaming). Also, assist parents to interpret the child's limited sounds as intentional communication while providing more functional verbal models. Parents can be encouraged to make up novel songs about her daily activities (e.g., a song about taking a bath set to the music of one of the child's favorite songs). If there are affective and relational concerns with the mother or with the dyad that are contributing to language delays or if depression is suspected, a referal for IMH support and treatment will be made.

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Table 1 *(Continued from previous page)*

Description of child	Speech-Language Pathology Evaluation	Speech-Language Pathology Intervention
Jane is crawling and cruising short distances.	PT reports gross motor skills are delayed. Visually does not cross midline and loses balance when reaching to the side. Does not pull to stand. Mother reports little opportunity for ambulation due to mother's anxiety about falling and environmental conditions. Explore mother's fear around falling and safety for her child, as well as environmental modifications that would allow mother to feel more comfortable with her daughter's exploration and movement.	PT will focus on movement activities to encourage mobility and visual skills. Introduce family to active gross motor movement games to music through engaging child in anticipatory sets to increase cognitive and linguistic skills.
Jane shows gross palmer grasp bilaterally.	Upper extremity asymmetry with increased flexion tone in left elbow and hand; limited left thumb flexion and abduction. Jane shows gross palmer grasp bilaterally with no left hand active release.	OT will assist mother to offer activities to increase fine-motor development.
Jane lives with mother and father; Jane's grandmother is dependent upon family for transportation. Father works nights.	Mother reports anxiety about balancing her responsibility for her mother and Jane, and potential marital strain due to financial and relationship issues.	Consult with case manager for elder care transportation and support. Consider a referal to an IMH therapist to further assist mother with her anxiety, relationship difficulties, family obligations, and financial burdens in order to be emotionally available for her daughter.

Expected Outcomes:

- Increased parental engagement in play activities with Jane.
- Observations of spontaneous mother-child serve and return interactions will increase.
- Mother makes an increased number of positive statements concerning parenting and Jane's strengths.
- Increased number of instances where Jane's parents imitate her vocalizations.
- Increased times the parent's interpret Jane's eye contact, body language, or vocalizations as meaningful communication.
- Team with IMH and community supports if involved with the family.
- Monitor mother's positive and negative attributions about the child and link to progress.

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