



Supporting Infant and Early Childhood Mental Health in Occupational Therapy



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INTRODUCTION

Role of the Occupational Therapist in Care of Children 0-5 Years Old and their Families

Occupational therapy promotes function and engagement in everyday routines and daily life activities. Occupational therapists (OTs) working in early intervention partner with children, parents, and caregivers to facilitate the child's ability to engage in the occupations that enable the child to participate in everyday life. Occupations are the basic activities needed for mastery, competency, and identity.¹ The occupations of infants and toddlers center on playing, learning, and social interactions with family and caregivers.²

The period between birth to 3 is critical for facilitating the significant brain maturity and development progression that occurs during this period. Early intervention services can minimize developmental delay and enhance the capacity of parents to meet the needs of their infant or toddler. To promote a young child's optimal development and participation in daily living and family life, the daily parenting experience becomes a focus of therapy in early intervention.³

Early childhood influences lifelong mental health. As the child's brain continues to develop over the early years, environment and experience exert a powerful influence. During this sensitive period, the architecture of the brain is highly receptive to positive and negative experiences. The primary center and moderator of experiences in the child's life is the family. Secure attachments to caregivers based in responsive and sensitive caregiving during young childhood have long-lasting effects on the mental health of a child. Caregivers struggling in a stressful environment or with mental health issues of their own may find it difficult to respond to their child with warmth and support. Typically young children reach out to caregivers by exhibiting behavioral cues such as babbling and facial expressions, and adults respond in kind. These fundamental "serve and return" interactions between parent and child lay the foundation for a secure attachment relationship and consistent progress toward appropriate developmental



outcomes. Lack of consistent responsiveness to these cues can affect the child's long-term mental health.⁴ One of the roles of an occupational therapist is to provide support to the family in the context of secure attachment relationships and responsive patterns of interaction.

Through experience, children learn early whether to trust that their need for safety, comfort, warmth, food, sleep, etc., will be consistently met. Parents who intervene to sooth the child's discomfort or stress set a pattern for future self-regulation and organization. Basic caregiving activities provide the opportunity for quality interactions; for example, play during bathing, reading to prepare for sleep, or playing peek-a-boo while changing. However, unpredictable, poor-quality or insensitive routine-based care activities risk future problems with effective cycles of sleep, waking, and feeding. These problems create a cycle that compounds itself. A child who is difficult to soothe and has unpredictable routines disrupts family routines and relationships. Tired and stressed parents find it difficult to be consistently nurturing and responsive.

Occupational therapists help children and families to be successful in everyday routines, such as feeding or sleeping, play time, and positive family social interactions. The OT has expertise in the modification and adaptation of typical activities and environments; advanced training in development in childhood; and an awareness of how atypical development can adversely affect the child's play, learning, and occupational performance. These skills can contribute to the promotion of the child's optimal growth and development and build the family's ability to care and address their child's needs. Occupational therapy has an emphasis on family-centered care; the promotion of play and functional performance; and occupational, social, and behavioral interactions.^{5,6} OTs are well-trained to provide work on interprofessional teams to implement interventions to increase the child's participation in their family and their community.⁷

Best Practices in Early Intervention and Family-Centered Care

Occupational therapists provide services to infants and toddlers in their homes, child care or preschool, and community clinical settings. Though some services are provided in private, out-patient pediatric clinics, programs such as Early Start or Head Start focused in early intervention services and provided through the Individuals with Disability Act (IDEA)⁸ support the mission of

family-centered care of children. These programs provide services for both children with diagnosed disabilities and children at risk for disability because of the impact of neglect, abuse, poverty, or parental mental health issues on their development.

Research has revealed that early intervention services can be preventative and overall produce more favorable long-term outcomes than later intervention for children with behavioral issues resulting from stressful events during the first five years of a child's life.⁹ Child-centered issues and needs are not the primary focus of early intervention; enhancing the parent's competence in meeting the child's needs is. Family-centered and relationship-focused early intervention promotes the family's capacity to care and support the development of the child. It is important to recognize that both the family and the child are recipients of OT services in early intervention.

Practice guidelines in early intervention published by the American Occupational Therapy Association are based on systematic reviews of occupational therapy intervention practices with young children. These reviews synthesize the discipline's literature addressing social and emotional development,¹⁰ feeding difficulties,¹¹ motor performance,¹² and cognitive development.¹³ Interventions that promote parent-child relationships, services provided in the child's natural environment, and the use of play-based and behavioral approaches all had positive effects.

The family is the child's main social unit and parents are the experts on their child. Parents should be included in the evaluation and intervention process, specifically in determining the priority goals for their child's development. A 2013 review of studies of early intervention service delivery models for occupational therapy revealed that interventions that provided for family participation and family training resulted in positive outcomes.¹⁴ Parents' perception of family-centered practices and routine-based interventions were positive. Routines are sequenced tasks and activities that provide a natural structure and are essential to social and emotional development. Routines for meals, bedtime, getting ready to leave the house, etc., that are embedded in family life, and have been found to lead to enhanced performance.¹⁵ When these routines are not in place, the home may feel chaotic and may not be conducive to meeting the child's needs. OTs can help families establish predictable routines as part of their intervention.



Family and relationship-based services that emphasize parent-child interactions can enhance their communication skills, their child's play, and behavioral outcomes.¹⁶ Families tend to learn strategies best through explicit learning. Parents value active modeling by the OT because of the opportunity to practice new approaches in

the presence of a therapist.¹⁷ Ensuring that the modeling includes showing families the essentials for interacting with their young child helps support the child's early mental health development. Modeling makes families more likely to follow through with goals and strategies that are meaningful to them and to their child.

HOW THE OCCUPATIONAL THERAPY DISCIPLINE SUPPORTS INFANT MENTAL HEALTH CONCEPTS

The field of infant mental health (IMH) is concerned with children from the prenatal period through age five.¹⁸ The foundation on which the IMH field places its focus is the necessary "safe relationship" that occurs between the caregiver and the child and serves as the underpinning for the child's future ability to form strong interpersonal relationships. The attachment that is 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.¹⁹

Research strongly suggests that the experiences of the first five years of life have profound effects on later development.²⁰ As critical brain functions and structures are formed at this time, children experiencing harmful

levels of stress that are unmitigated by parents and caregivers can find future adaptive learning and self-regulation behaviors difficult.²¹

While empathetic, sensitive, and responsive caregiving promotes positive developmental and behavioral outcomes, parents unable or unwilling to provide such support can seriously compromise developmental outcomes. In addition, harmful events such as abuse or neglect can disrupt the child-parent relationship, affecting attachment and fostering lifelong emotional and physical difficulties.²²

Many of the children with whom OTs work have disabilities that result in behaviors that can be difficult to interpret. Under the best of circumstances, parents and caregivers can find their challenging behaviors annoying and confusing, but under stressful circumstances child abuse or neglect can result. To promote a young child's optimal development and participation in daily living and family life, the parenting experience becomes a primary focus of therapy. The occupational therapist is concerned with how the parent is interpreting the child's cues and how they are responding to the child's needs. Occupational therapists can intentionally address the parent-child interaction and help the parent to be more responsive to the child.

Signs that the child and caregivers are struggling may be apparent—for example, difficulties with the child's daily routines and delays in acquisition of developmental milestones. Family routines must adapt to the daily caregiving needs of the child. Timely and sensitive caregiving routines provide the support a child needs to function confidently and the structure that enables the child to fully participate as a family member. Delays in acquiring associated developmental skills can be reflective of disruptions in these routines. Feeding or sleeping problems and difficulty getting into a routine schedule are examples of common parental concerns and priorities.





HOW STRESS MIGHT AFFECT PARENT-CHILD INTERACTIONS

Because parental responsiveness is paramount in fostering the early developmental skills of the child, the effects of potential stress can be detrimental to the development of the parent-caregiver and child relationship. Substance abuse, mental illness, and/or preoccupation with other issues can cause problems with many aspects of the caregiver relationship. The caregiver and child will not likely develop a bond and mutual love for each other. This can have a domino effect on the

relationship; when the child experiences developmental delays, the self-esteem of the caregiver may suffer and the cycle of a lack of interaction will continue.²³ See Center for Prevention and Early Intervention Policy's [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.

HOW STRESS MIGHT POTENTIALLY AFFECT DEVELOPMENT

For an infant or young child, one of the most important aspects of development is the quality of interactions with caregivers and the responsiveness of the caregiver. Positive early experiences increase the capacity of the brain for cognitive, language and social emotional development. These domains of development support later learning potential. Caregiver interactions with the child take place through routine based care (feeding, bathing, diapering, etc.) and play.

A child is completely dependent on caregivers for all needs, both physical and emotional. When the caregiver is experiencing stressful situations in their own life due to mental illness, separation or divorce, substance use, or other issue, he or she may not be emotionally available to relate to the child and the emotional and/or physical needs of the child will not be met. The brain development that is the foundation for later developmental outcomes can be forever altered. In early intervention, OTs can coach caregivers to interact effectively with their infant during daily routines. Parents can begin enjoy the interactions they have with the child during these responsibilities and gain confidence in their abilities.

In infancy, it is important for the child and caregiver to form a mutual attachment through reciprocal interactions, or "serve and return" interactions. Including the entire family in early intervention is important to the health and the well-being of the caregivers as it directly impacts the health, development, and well-being of the child. Interactions with caregivers are the first steps toward social and exploratory play behaviors. Children learn and develop through playful interactions with the environment and the people in it.

Early behaviors that the child exhibits are often more passive in nature, but the response of the caregiver to the child leads the child to develop strong neural connections to self-regulate behaviors, form appropriate social emotional relationships, and develop cognitive and communication skills. Parental responsiveness forms the foundation for cognition and language, and attachment and learning. Supporting the family reduces caregiver stress and increases the family's capacity to care for the child and meet the child's developmental needs.

ASSESSMENT/EVALUATION

During an OT evaluation, the therapist studies the interaction of the child with expected tasks, activities, or occupations. Viewing the child's performance within the environment or context reveals the supports or barriers to the child's development. OT focuses on those aspects of the child's performance that enhance or inhibit the child's participation in their natural environment or daily routines. The OT also works with the family to gain an understanding

of their concerns and priorities and the impact of the child's performance on family home life. In early intervention the family is a key partner in the evaluation process, helping to identify the child's strengths and weaknesses and the context of the child's natural environments and routines.²⁴ In a family-centered approach the goal of the evaluation team is to complete an evaluative process that determines the desired priorities and outcomes for intervention



based on the family's and child's priorities. By adding the relationship-based focus, the therapist also evaluates how the child-parent interactions are contributing to the child's sense of safety, trust, and security which are fundamental to developmental progress.

Evaluations funded by programs such as IDEA, Part C (§ 635)7, are required at minimum to be comprehensive and multidisciplinary. Typically an evaluation of an infant or toddler contains quantitative and qualitative assessments and takes into consideration data from the evaluations of other disciplines or services (e.g., social services). In an ideal transdisciplinary setting, a comprehensive developmental assessment tool that addresses communication, motor skills, social and emotional health, cognitive abilities, and learning would yield data relevant to all disciplines and lessen the need for multiple evaluation appointments.

The Occupational Therapy Practice Framework describes evaluation best practices as having two parts: 1) an occupational profile; and 2) an evaluation of occupational performance. The occupational profile gathers qualitative information about the child's strengths and needs and the family's current concerns. It summarizes the child's and family's routines or patterns of daily living and addresses any past or current experiences that assist in understanding the child's issues or problems. For infants and toddlers, family members or caregivers are the primary source of data. The profile is often compiled during a formal interview and is supplemented through casual conversation or observation while the parent and OT are otherwise engaged with the child. Therefore, the profile can become a working document as intervention progresses. Play is often an occasion for observation. How the child interacts with parents, the therapist, and play objects can provide valuable information. Additional profile information can be gathered through more direct observation. If the parent reports that one of the primary concerns is how inefficiently the child is feeding, the OT would observe the parent feeding the child under natural circumstances, gathering data about feeding techniques and child-parent interactions. Informal observations of child-parent interactions should also answer the following:

- How does the parent physically interact with the child? Does the parent appear comfortable holding and feeding the child?

- What is the quality of parent-child interactions? Do they appear interested in each other; sharing smiles, vocalizations, etc.?
- Does the parent express positive feelings about the child and about being a parent?²⁵

The second part of the evaluation process identifies specific strengths and needs and supports or barriers to the child's occupational performance. Through the use of valid and reliable assessment tools, data are gathered about learned, goal-directed, and developmentally appropriate performance skills. Infant and toddler performance development includes: sensorimotor, cognitive-perceptual, communication, social emotional regulation, and adaptive skills.²⁶ The performance of these skills occurs within social and environmental contexts. Information concerning how these contexts support or inhibit the child's developmental performance must also be considered.

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

The relationship between the infant and the parent is considered the foundation for all aspects of the child's later development. In family-centered and relationship-based approaches, barriers to and supports of the child's development performance, including these interactions, can be identified. If the parent is unable or unwilling to provide the positive experiences needed, optimal age-appropriate developmental performance can be affected. Many parent-child interactions during caregiving routines or play activities can be observed throughout the evaluation process. Typical problems expressed by parents often center on patterns of daily living skills such as sleeping or feeding or difficulties establishing a predictable schedule. Parent-child interactions during these routines can reveal negative or atypical relationships. Lack of positive interactions during caregiving can indicate deeper relationship issues. The following observations of parent-child interactions can indicate relationships that place the child at risk for mental health issues: lack of warmth and consistent comforting; negative or critical remarks about the child and about caregiving; harsh or rough handling or voice tone; and unrealistic expectation of the child's performance.²⁷

Typically 'serve and return' type behaviors occur naturally between parent and child. Based on behavioral cues from the child, the parent directs the appropriate



meaningful response. From observations of the parent, for example, if the child grimaces or fusses during a diaper change, typically the parent in return tries to distract the child with soothing vocalizations and entertaining facial expressions. Parent-child behaviors during play can be observed too. How the parent spontaneously initiates or adapts interactive play experiences with the child ('peek-a-boo', etc.) also provides data on patterns of social behaviors.

From the observations of the child during routine-based and play activities, reciprocal and approach responses can be noted. The child should respond to the parent's attempts at interaction with behaviors such as eye contact and/or brightening or relaxing in response to the parent's voice. Behaviors such as an inability to be soothed or distracted or appearing disinterested in the interaction might indicate stressful or negative caregiving experiences.

INTERVENTION STRATEGIES TO SUPPORT THE CHILD'S MENTAL HEALTH

OT services in early intervention are provided to enhance the family's ability to care for their child, support the child's development and, although not the primary purpose of the service, can enhance the child's mental health. Though child-centered difficulties or disabilities may lead to a referral for OT evaluation and intervention, ultimately engaging the parent as the primary caregiver in the child's life becomes the focus of therapeutic intervention. Part C of IDEA-7 mandates that services to infants and toddlers and their families "enhance the capacity of families to meet the special needs of their infants and toddlers with disabilities" (20 U.S.C. §1431(a)(4)). The purpose of family-centered care is the achievement of family outcomes as well as child outcomes. Adding a relationship-based focus helps the therapist to address the child-parent interactions as part of the provision of OT services.

Through the intervention process, the OT works collaboratively with the family and other team members. Utilizing consultation, collaboration, and team work, the OT provides services that enable the child's participation in age-appropriate occupations and activities. The

following are key principles that provide the foundation for family-centered early intervention practice:²⁸

1. Children learn and develop best through everyday experiences within their natural environmental context and with familiar people (parents, family, and caregivers).
2. The purpose of family-centered care is to enhance the family's capacity to meet their child's needs, benefiting the long-term developmental outcomes of the child.
3. All families, with appropriate support and resources, can enhance their child's growth and development.
4. The primary role of the clinician is to build the capacity of the child's family. Families are active participants in all aspects of the early intervention service. In addition to performing the duties that support the child's occupational goals, the clinician supports the child's social-emotional well-being within the context of his/her primary relationships.
5. Families are not heterogeneous. Working with families involves identifying their priorities, concerns and needs, and their unique strengths, contexts, and supports.

INTERVENTION STRATEGIES FOR FAMILY-CENTERED PRACTICE

Family-centered approaches in early intervention include modeling and coaching. These approaches provide support to families through training within the child's natural contexts. The clinician can facilitate a dynamic conversation with the parent that results in implementation of strategic behaviors. Through coaching and modeling, the OT can support the family by increasing their competence in supporting the development of their child.^{29,30} This modeling and coaching should also address the relationship between the parent and child. The occupational therapist should be alert for signs

that the parent is struggling with interactions and be supportive of the parent as they learn to respond to the needs of their child.

During intervention with the child, the OT may model strategies or behaviors that can be copied by the parents. By observing the success of the strategies used, the parent can add them to their own repertoire of actions. Colyvas et al found that parents appear to learn these strategies best when they are explicitly modeled. Parents report that they value the opportunity to learn and then practice approaches in the presence of the OT.³¹ As part



of the modeling, the OT should show the parent how to respond to the child's accomplishments in a way that is supportive to the child and encourages the development of their attachment.

Working side-by-side with the parent, the OT may work through issues with the parent directly. Through coaching the parent as the adult learner, the child directly benefits from the new strategies and skills that the parent learns to implement. As a team, the OT and the parent can adapt routines and environments to enhance the child's experiences and facilitate the competency of the family. In some circumstances, that OT may notice some serious issues with the child's environment that might indicate that the child is struggling with excessive stress or trauma. Some of the signs that might be evident include:

- Flat affect, no range of emotions, withdrawn, unsmiling or no shared smile response
- Rejects/avoids being touched, held, or cuddled
- Difficult to soothe or console or unable to comfort or calm self
- Extremely fearful or on-guard

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. This lack of early interaction may have had an impact on the family's early bonding and attachment with the infant.

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 concerns about potential social isolation.

Currently, Jane eats cereal mixed with breast milk and has limited experience with solid foods. She fatigues

- Does not turn to familiar adults for comfort or help
- Unprovoked aggression
- Does not interact appropriately with parent (e.g., hits, bites, kicks)
- Hypervigilant (e.g., stays near mother or caregiver)
- Hypersensitive to sounds, light, touch
- Hyperactive
- Trouble sleeping
- Lacks curiosity and does not explore
- Little or no eye contact
- Frequent and long-lasting fussiness or irritability
- Trouble with eating/feeding—too much or too little³²

The OT may be able to be helpful in some of the situations above and provide support to the parent to address some of the problems. However, in many cases, the family and child may require assistance outside of the scope of practice of the OT, making a referral to an infant mental health therapist necessary. In those cases, the OT and other team members should work with the IMH therapist as a member of the multidisciplinary team.

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. These factors should be watched closely to ensure that the mother is receiving as much support as possible and is not experiencing any situational-related emotional difficulties.



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 a speech-language pathologist,

physical therapist, and occupational therapist. 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 for goals and strategies.

Table 1

Description of child	Occupational Therapy Evaluation	Occupational Therapy 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. Infant and toddler milestones in motor, self-care, language, and play are delayed.	Early intervention services provided in the home weekly. Coaching model of service delivery will be employed to problem-solve strategies facilitating Jane's development and encouraging family-centered outcomes.
Jane has limited experience with solid food; does not finger feed.	Jane consumes ½ cup of rice cereal with breast milk 4 times a day and has not begun to finger feed.	Using coaching, OT and mother will offer activities for oral play to encourage oral motor skills. Problem-solving with Mother new solid foods; finger foods will be gradually introduced.
	Mother reports Jane does not like to be bathed or have lotions applied to her skin. Jane limits clothing options to a diaper and onesie; does not like pants or socks.	Using modeling approach, introduce the use of massage and firm-touch strategies before and during bath time.).
Jane does not sleep through the night and wakes frequently. She fatigues easily.	Home visit revealed Jane sleeps with her mother. Both average 6 hours of sleep a night.	Problem-solve with mother bedtime and sleep routines.
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. Home visit revealed unsafe conditions with limited toys or play objects.	Using coaching and modeling, introduce play activities encouraging movement, language and cognitive skills (e.g., books, blocks, colors, and shapes). Problem-solve with parents' routine play time with both mother and father, and safe play area.
Jane makes a limited number of sounds with no recognizable words. Does not use gestures (e.g., pointing).	SLP reports significant expressive and receptive language delays. During observation Jane's affect remained flat. She used limited sounds and had limited responses to interactive play (e.g. 'peek-a-boo').	Instruct, coach, and model for family how to incorporate language stimulation during play and routine care.
Jane makes a limited number of sounds with no recognizable words. Does not use gestures (e.g., pointing).	SLP reports significant expressive and receptive language delays. During observation Jane's affect remained flat. She used limited sounds and had limited responses to interactive play (e.g. 'peek-a-boo').	Using coaching and modeling strategies, incorporate language-stimulation activities through play and interaction during routine-based care.


Table 1 (Continued from previous page)

Description of child	Occupational Therapy Evaluation	Occupational Therapy Intervention
Jane is crawling and cruising short distances. Mother is concerned that Jane is not walking.	<p>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.</p> <p>Mother reports little opportunity for ambulation due to mother's anxiety about falling and environmental conditions.</p>	<p>PT will focus on movement activities to encourage mobility and visual skills.</p> <p>Capitalizing on interest in visual and auditory interests, introduce mother to movement to music using recoded media; assist mother to implement. Problem-solve play environment with mother; introduce active movement games to music to encourage gross development and mobility through play.</p>
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 showed gross palmer grasp bilaterally with no left hand active release.	Using coaching and modeling approaches, mother will offer activities to increase hand extension and thumb abduction (e.g., play dough, soft-textured toys).
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; find community play groups and reduced-cost environmental safety devices.

Expected Outcomes:

- Mother will have 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 balance of wake and sleep time for mother and Jane.
- Mother will offer to report on techniques and strategies that were successful for at least one goal and request additional techniques for another goal.
- Increased balance of wake and sleep time for mother and Jane.
- Mother will offer to report on techniques and strategies that were successful for at least one goal and request additional techniques for another goal.



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