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The Action is in the Interaction: Clinical Practice Guidelines for Work with Parents of Children with Developmental Disorders[i, ii]

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What is good for parents is good for their children. What is good for their children is good for parents. Aiming for both stimulates good outcomes. The invisible but powerful thread is relationship.

PARENTS AS "CENTRAL ORGANIZERS" FOR THEIR CHILD

All children need parents to keep them safe, to notice and respond to their needs and achievements and—gradually and over time—to bring them into the human community through interactive relationships, which include love, shared attention, evolving communication, and the burgeoning of symbols, of narrative, and of values. Indeed, the primary social institution responsible for children is their family, with their parents in the lead and at the heart. Families render humans human. Recent research and clinical experience demonstrate that such primary reciprocal attachments support, mediate, modify, and organize a child's genetic, central nervous system endowment to a far more significant degree than previously understood in areas as fundamental to later adaptation and achievement as cognitive and emotional intelligence, language, personality, and relational style (cf. Ainsworth et al., 1978; Greenspan, 1997; Schore, 1994; Siegel, 1999; Sroufe, 1983). It is, therefore, in society's best interests that parents function optimally—or at least satisfactorily—during their children's developing years.

Children spend many, many hours in the context of their family life. Those with relational and communicative challenges have a harder time than typically developing youngsters in engaging others constructively, even within their own families. Their parents also are often at a loss in knowing how to constructively fill their children's time and get them through simple daily requirements. Parents may resort to television and videotapes to help their children get through the day, rationalizing that they are at least learning something when memorizing bits of scripts or songs. Parents may give up when their children engage in perseverative or self-stimulating behavior.

As Stanley Greenspan (this volume) has noted, most parents are happier, more productive, less stressed, and more apt to view

themselves as competent, resourceful parents, able to meet their child's needs when they can involve their child—by themselves and/or through others—in a rich, interactive, home-based program. "In fact, these interactions at home can become the most important factor in (children's) growth" (Greenspan & Wieder, Chapter 12, this volume). This same observation holds true for parents! To become—and feel like—a capable parent, an individual finally *needs* to interact productively with her child.

And just as parents of typically developing children are their first and most profoundly effective teachers, parents of children with developmental, communicative, and relational disorders are as well. As pediatrician and psychoanalyst D.W. Winnicott quipped decades ago, "There's no such a thing as a baby," by which he meant that it is nonsense to consider the development of a young child outside the context of the adults who surround him night and day. A parent (or two) is, quite literally, the center of the child's emotional, social, and learning world. This happens spontaneously during everyday playtimes, feedings, bathtimes, and bedtimes (Shahmoon-Shanok, 1997b). Although the needs of these children may be masked by their avoidance of human contact, young children with serious relational and communicative challenges urgently require meaningful interactions with their parents. Paradoxically, their challenges prevent them from making their needs—and how to respond to those needs—known to parents.

When a child has severe difficulties relating and communicating, these obstacles affect not only the child's development. They also bear upon the parent's sense of self *and* the *relationship* between the child and his parents. Children with developmental disorders are compromised not only because of *constitutional* challenges but also because of *relational* challenges (which usually stem from constitutional challenges and ensuing mismatches). Clinical or educational practice that addresses only the child's symptoms and behavior, rather than the underlying processes, must be revised to address the *context;* that is, mutual regulatory processes with intimate caregivers. Every element in a system reverberates—or not—with the others; when one element is stuck, it constrains the others (Sameroff & Friese, 1990; Shanok, 1981, 1987, 1990). As evidence mounts that children with difficult temperaments are more vulnerable to and modifiable by parental influences (Thompson, 1999), it becomes more evidently critical that the field of early intervention integrate a range of services to help parents cultivate growth-promoting relationships between themselves and their children. Therefore, working with the individual needs of parents is crucial to treating their children.

Special Challenges for Parents of Children with Special Needs

Children with special profiles have a profound, ongoing reliance on their parents as primary loved ones, as intermediaries, and as advocates. Yet, to be able to meet the particular needs of a child with a developmental disorder, parents must meet the following six profound challenges, which go well beyond the usual, already heavy demands of parenting young children.

1. *Parents must come to recognize the precipitous risks of their child's disability*, even as they cope with deep feelings of disbelief, loss, grief, confusion, isolation, helplessness, fear for the future, and "why me" anger.
2. *Parents must overcome the sense of mystification, distance, and rejection* inherent in their child's idiosyncratic,

perseverative, and impoverished range of behaviors and interactions.

3. Instead, *parents must learn to notice, observe, and read their child's odd and frustrating behaviors as individual differences*—meaningful signals explained by specific sensory processing and perceptual-motor capacities and challenges—in order to cross the bridge their child cannot yet cross, to meet and draw the child over and into interactive relationships.
4. *Parents need to recognize themselves as the central, organizing, and contingent force on behalf of their child*, even within the professional context of various assessments and interventions.
5. *Parents must recognize, welcome, and respond contingently to their child's increasingly complex functional communicative, cognitive, and emotional levels* (Greenspan & Wieder, 1998)—a complex challenge with children who tend to pull for sameness. For parents, this means recognizing that just when they become accustomed to dealing with one level, they must shift to another to keep up with and/or to stimulate their child's incipient growth.
6. *Parents must become knowledgeable, effective, and engaged advocates for their child* within a complex and grossly uneven maze of assessments and services.

In order to overcome these challenges, virtually all parents of children with a developmental disorder need facilitating partnerships with the professionals who serve their children. They may be so uncertain that they can generatively parent this child that they may need help to discern that their child favors them above others and that *they* have the central role to play in his improvement. Given facilitative partnership, some—perhaps even many—parents are able to meet at least the majority of these challenges.

However, the range of individual differences is as great among parents as among their children. With personally tailored supports, many more parents could become the significant resource that their children need them to be. When it is noted that, on the one hand, early parenthood is itself a time of enormous vulnerability, transition, and potential growth, and, on the other hand, that no professional, no matter how deeply committed or involved, can substitute for the profound impact parents have on their child, the magnitude of significance—and of potential—to parental inclusion may be grasped.

With the 1996 passage by the United States Congress of the Individual with Disabilities Education Act (IDEA), the field of treatment for children with disabilities took a significant step in the direction of parents by mandating the Individualized Family Service Plan (IFSP). However, the field has not yet focused on how to engage and respond to the enormous range of parents, nor has it attended to the differentiated, comprehensive spectrum of services and education needed to support not only parents but the staff who potentially could work with them.

Consequently, some professionals who work with challenging young children still conceive of *themselves* as the central rehabilitative agent for the child, even though it is *parents* who are their children's first, most significant, and life-long teachers. The contribution of parents is underscored by a quantitative analysis of early intervention programs serving disabled children and their families that found that "programs that ... targeted their efforts on *parents and children together* appeared to be the most effective" (Shonkoff and Hauser-Dram, 1987, p. 650, italics added). When the early intervention field recognizes that, for children with difficulties in relating and communicating, it is not only the child who needs assistance but, by definition,

also the relationship between parents and child that must be supported, the focus of treatment becomes liberated. Clinicians may then see that the needs of parents and children are felicitously intermeshed in that parents need—and children need their parents—to reclaim their role as fundamental teachers. The less experienced or mature the parents and the younger or more challenged the child, the more attention this area will require. But all parents benefit from a developmentally sensitive alliance for how to "read" their child so that their child may become engaged with them.

Just as the recognition of each child's unique needs is placed in a developmental-relational understanding of typical childhood, so, too, must the understanding of each parent's needs be placed within an understanding of adulthood. The next section, "Parenthood and Parenting as a Marker of Adult Development," briefly describes the nature of adulthood and the developmental-relational facets of parenthood within that context. The chapter then goes on to address the following major topics:

- Parents and professionals as complementary, reciprocal, yet asymmetrical partners.
- Evaluating and working with a child conveys meaning to parents.
- Establishing and maintaining relationships with a range of parents.
- Developmentally appropriate practices and interactions: Using the concepts of relationship, individual differences, and development to understand parents, organize information, and intervene generatively.

PARENTHOOD AND PARENTING AS A MARKER OF ADULT DEVELOPMENT

Although development continues to occur in the adult years, it is different from development occurring in childhood. In contrast to the burgeoning maturational forces of childhood and adolescence and to the decline of late life, adulthood is freer of an age-related timetable. Parenthood may begin anywhere within a period of 35 or more years for women and an even longer span for men. Rather than the sequential emphasis that typifies the unfolding earlier life stages, adulthood is instead characterized by increased layering and complexity among aspects of the self and between the self and the social world (Seligman & Shanok, 1996, 1995a, 1995b; Shanok, 1981, 1987, 1990, 1993). Context is a critical thread in this rich fabric. Picture, for instance, parenting a baby dearly desired following several miscarriages in contrast with parenting a baby conceived in error.

Yet, whereas parenthood is intrinsic to a mother's development as a woman and a father's as a man, it is only one among several other marker processes, all of which affect the capacities for identity and intimacy in that person. Nonetheless, parenthood does *mark* adult development. But, although it is interconnected in a cogwheeled manner to the child's development, parenthood is not *itself* a developmental stage for the adult (cf. Benedek, 1959; Galinsky, 1981). Imagine, for example, how different an experience it is to become a parent at age 15 compared with becoming one at 45.

Visualize the daily care a small child requires: Parent*hood* is a role, a career, a defining activity. Parent*ing* is an intimate, evolving, and demanding relationship of enduring impact. Parent*hood* profoundly affects the experience of, and structures for, identity. Parent*ing* influences the capacities for and evolution of intimacy processes (Shanok, 1987, 1990, 1993). People become parents through experience, by "doing and being" (Musik, 1993).

It is in the nature of parenthood that, especially when a child is young, the parent's

sense of well-being is inextricably tied not only to how she judges her child to be faring (cf. Galinsky, 1981; Shanok, 1987, 1990, 1993; Stern, 1995) but also to how she judges herself to be doing as that particular child's parent. Parents *need* to feel that they are ample resources for understanding and caring for their young child. Indeed, there is likely no greater wound to a parent's fledgling sense of competence as a parent, and of relatedness as *this* child's parent, than to see and feel the child losing developmental ground and turning away from their relationship, all the while not knowing how to help him.

As a marker process, becoming a parent is, by definition, a long transitional period of great openness and, thus, of both potential and vulnerability. What new mother doesn't recall being deeply upset, angry, or both by an ill-chosen remark from a stranger about her child? When that new mother *knows* there is something wrong with her child, and the stranger is a professional whom she believes understands far more about such topics than she does, the power to support or to undermine confidence and functioning is greatly intensified.

Thus, it is with abiding awareness of the power to potentiate or disequilibriate that any professional who evaluates or intervenes with a child must work. Indeed, it is not sufficient to evaluate and/or to treat a *child*. Concurrently, care and attention to the emotional state and attitudes, the resources, and the dilemmas of the adults responsible for that child are also required. When parents are able to function resourcefully and effectively with and on behalf of their child with special needs, that caring, careful professional attention can remain informal and in the background, at least until the first components of the child's program—which should always include parents as much as is feasible—are underway.

Still, professionals need to bear in mind that the fact of having a young child with special needs forces parents to cede some of their rightful centrality to virtual strangers. Parents become caught in a paradox: Their autonomy and authority is eroded while their child's particular challenges heighten and lengthen his dependency upon them. Supporting a dawning sense of satisfying centrality within parents is a critical, if often poorly understood, piece of the clinician's role *on behalf of the children*, parents, and families they serve. Bearing in mind that the parents' sense of self and capacities for relationship are being *marked* by the overall experience of parenting this child, and that these, in turn, profoundly affect the moment-to-moment availability of parents to the child, the professional must respect the parents' central roles and help them build on the child's strengths.

To illustrate how a child with developmental challenges may affect not only a parent's identity as a parent but also that person's very capacity *to* parent that child, consider the following case vignette. It has been selected to highlight the importance of working *within* the relational interface between parent and child—for the sake of the parent and on behalf of the child.

"Working with Ezekiel's family was difficult both because this child was hard to understand and because his parents (Phil and Roz), and especially the father, found it very hard to accept how reactive Ezekiel was to a range of stimuli. Early in my work with the family, the father, an outwardly jolly and confident fellow, began to relax enough to find words to reveal that he felt rejected by Ezekiel every day. I asked Phil to describe the scenes in detail, as though they were a movie which I could not see. What would happen routinely, I gathered, was that Ezekiel and his mother would usually be together in his room

at the time that Phil, a big bear of a guy, would arrive home from work. Eager to see his family, he would burst in with 'Hullo's' and 'How are ya's?' He would frequently bring a big gift in a (noisy) bag. Ezekiel would resolutely avoid looking in his father's direction. Phil believed that Zeke was not ready to give up cozy time with Roz, and that, in fact, he *preferred* mom. This hurt Phil, who tended to give up trying to make contact with his son for the rest of the evening. 'I'm not important to Zeke,' he would surmise. 'Roz can do it better. I'll (*turn off the pain by*) watch(*ing*) TV.'

Because the early intervention program Ezekiel had been attending had not offered Phil and Roz details about their son's processing and sensory system in ways they could comprehend and identify with, Phil found it difficult to believe that Zeke's behavior could represent his effort to cope with too much stimulation coming at him at once. It was also quite painful to Phil to imagine that Ezekiel had unique sensitivities. Insulting as it was to believe that Zeke preferred his mother, given his own demanding father, that was easier for Phil to bear than to recognize the vulnerability of his boy.

I proposed to Phil and Roz that Phil try this approach for a week: He would bring nothing into the room when he arrived home and, in fact, he would himself linger very quietly in the doorway. Only once Ezekiel appeared to register his father's presence, could Poppa gently smile and wave—no big, fast movements, no sounds. 'Let the first move for further contact come from Zeke,' I suggested, to give Phil a visible benchmark before taking another action.

Although he was doubtful, Phil agreed to try this approach. Even I was surprised at how well and how quickly the strategy worked. On the first evening, Phil silently leaned in the doorway for about one full minute, he told me later. Ezekiel looked up, looked away momentarily, looked up again, looked away, a hint of a smile beginning to tug at one corner of his lips. With his head still averted, he murmured in a low voice, 'Pop,' and smiled slightly. Utilizing enormous restraint, Phil remained where he was, quietly beginning to beam. His wish then came true: Ezekiel gazed at him, looked away, got up, sidled haltingly over to Phil and, at last, hugged his legs. This experience with his child contributed to a turning point in Phil's relationship with Zeke, in my relationship and work with Phil, and in Roz's sense that she could count on her husband as a father. Phil was so happy to garner his son's attention, he became better able to consider and be sympathetic to Zeke's sensory profile (Shahmoon-Shanok, 1997b)."

Relationships hold the potential to help people grow and change. By reinterpreting the reasons for Zeke's behavior and suggesting an alternative approach to try, the therapist enabled Phil and Zeke to have an interaction far more satisfying for both of them. Such experiences add up over time to mark each individual involved.

A central tenet of this chapter is that all children, and especially those with severe difficulties in relating and communicating, actually become differentiated socially, emotionally, and cognitively in everyday, ongoing, nuanced interaction with their parent(s). Another central point is that, with their children's special needs as profound inspiration, parents' relationships with professionals can similarly have a deep effect on their own growth as parents, as adults, as a couple, and on their abilities to affect and help their children. As parents begin to believe that they can relate to their child and help him unfold, wholesome developmental forces are unlocked, liberated to energize all that comes next. People find out who they are in their

every day, every hour experiences with each other. When Phil found that Zeke would welcome him if only his son was not overwhelmed, Phil was learning that he could provide what was needed, and that he was ample as a father. He could then bounce back to be with his highly sensitive son and Roz could feel partnered. Just as children come to know who they are by their hour-by-hour experience with others so, too, do their parents. As has been said, the action is in the interaction.

PARENTS AND PROFESSIONALS AS PARTNERS

In designating the IFSP as a requirement, Congress pushed the field of early intervention into taking a significant step forward by recognizing parents as significant partners. What the legislation did not do, however, was to address the *nature* of this "partnership." In fact, parents and professionals each bring something quite different to the association. Although parents and professionals are complementary and reciprocal partners, they are not identical helpmates. The next three sub-sections explore the complexity of this relationship.

An Asymmetrical Balance

It is probably not surprising that so much anxiety often surrounds individualized family service planning. Embedded in the requirement for IFSPs lurks a set of unacknowledged and somewhat unrealistic factors confounding parents and professionals at this point in time. These factors are interrelated. The first is that parents and professionals are equal—they are not. The "we-are-equal" stance ignores the tensions built into any relationship between people whose perspectives, roles, and power differ greatly, even when they are working toward a common goal. The second confounding factor is that the professionals in this field come from many different professional traditions and orientations, with differing views and levels of preparation for work with parents. The third confounder flows from the silent expectation that all parent/professional partnerships should be identical; that is, professionals should work with all parents in similar ways.

These factors ignore the fact that the range of parents who have a child with regulatory, communication, and/or relationship challenges is as diverse as any "group" could be. Actually, they are not a group at all, but rather individuals or couples with greatly varying circumstances, capacities, and even children. Yet many disciplines have little or no training that focuses on work with parents in general, let alone on recognizing their differences and individualizing the work. Other disciplines emphasize some aspects of parent work (such as psychotherapy) at the expense of others (such as home-based intervention or learning how to play resourcefully with their challenging child). Many programs offer little or no in-service training to support their staff in this critical area. It is not surprising, then, that many professionals report "flying by the seat of their pants" and feeling deeply awkward about the manifest expectation for "partnership" dictated by IFSPs. In this, they sense at the outset that it is not possible to partner everyone the same way, and that it is overly simplistic to "partner" people who may also see themselves as stakeholders, consumers, advocates, or clients.

Mental health professionals may know more than others about how to navigate through the levels and complexities of "many hat" work with adults. Yet individual parents and family advocates are sometimes wary of this group of professionals. They are concerned that these practitioners are likely to treat parents of children with challenges as though the *parents* have an emotional or mental disorder. They maintain, quite rightly, that

having a child with a disability does not imply that the parents, or the family, is compromised.

Still, it is clear that any family whose child has severe difficulties in relating and communicating is living with significant stressors, perhaps particularly when they are in the process of discovery and decision making. Beyond that, there are many circumstances in family life, such as the birth of a baby, a move from one home to another, or parental unemployment, that must be considered and thoughtfully factored into the ways of working with that family. Marital strains are common in families with young children and are more likely when a child has unusual difficulties. Enduring factors, such as parents' personalities and their relationships with their families of origin, also need to be considered in order for intervention to be appropriately subtle, rich, and responsive (see Box 1, shown later in this chapter). Just as recognizing individual differences among children improves intervention, appreciating the individual differences among parents also immeasurably enriches clinical work. IFSPs should be just that: Individualized—and responsive to the *parents'* needs, strengths, challenges, *and* preferences, not just to their child's.

Shifting Leadership

Parents sometimes feel that professionals hold all the power while, paradoxically, professionals often feel the converse. In our society, ultimate responsibility for child-rearing decisions rests with parents.

Still, parents of children with challenges often rely on professionals when making nitty-gritty decisions and in developing day-to-day care. When trust develops, power is shared—a relief to both sides. It is useful to recognize the shifting nature of leadership in robust, trusting parent-professional partnerships. Sometimes parents are in the lead, as when they decide to select a program, take their child out of a treatment program for a vacation, or hire an auxiliary practitioner. Sometimes, the professional is (temporarily) in the lead, as when she coaches parents in play skills, helps them set limits with their child, assists with a referral to a new therapist or program, or uses her general knowledge of development as a framework for helping the parents know what is realistic to expect from any young child. For example, first-time parents whose child has severe difficulties in relating and communicating may be relieved to learn that some of their child's challenging behavior is "normal." The professional might offer guidance in setting limits when a toddler is tired, saying, "No child Benny's age could be expected to stop by himself. All young children need help pulling away from activities, especially when they are wound up. One boy I know simmers down when you pick him up decisively but soothingly. How about trying that with Ben when he gets overtired?" Professionals (and parents) can learn to lead and follow, follow and lead.

Most professionals regard the care of a child as a precious trust. They base their recommendations on deep emotional concern for the child's wellbeing as well as on observations and overall experience. They may become especially aware of their feelings when they find themselves in disagreement with parents about the care of the child.

Embracing the perspective of each parent while also recognizing her own, the reflective practitioner can usually facilitate the making of rich, nuanced decisions by consensus. In the case of a hyperactive, driven boy, for instance, suppose that one parent wants to try dietary alterations, the other thinks applied behavioral analysis (ABA) would be best, while the therapist, based on her experiences with other, similar children, is convinced that the child would improve with medication.

Thoughtful discussions with each participant respecting the other's perspective, could yield a prioritized plan, one that would systematically and quickly get further information about each option while also beginning a trial of the safest, least invasive alternative first, all with the goal of identifying the best fit for the particular child at this time.

The professional's role as a partner with parents is best attained by:

- *Realizing that it is the professional who sets the tone for collaboration*, especially at the beginning.
- *Meeting parents with respect.*
- *Welcoming parents into the program* and encouraging them to participate in decisions about their children's care (Bredekamp and Copple, 1997).
- *Establishing frequent, open, yet tactful and supportive, two-way communication with parents.*
- *Studying and understanding the parent's own personality, historical and current context and developmental factors* (discussed later in this chapter).
- *Offering an individualized program to parents*, based on their particular needs.
- *Seeing the parent-child and parent-therapist relationship as units of observation, assessment, and intervention.*
- *Becoming self-aware by recognizing and taking responsibility for their own emotions and predilections.*
- *Discovering flexibility and responsivity in the relationships with parents and child* at both staff and programmatic levels.
- *Holding mixed identifications or "co-identifications"* with *both* child and parent(s).
- *Recognizing the power of parallel process* (that is, for example, realizing that to join parents and support *their* intent almost always strengthens the parents' ability to do the same for their child).
- *Noticing implicit parental concerns and clarifying the scope and agenda of the work together so that it may shift and deepen over time.*
- *Openly negotiating differences of opinion,* using clear guidelines to agree about setting priorities, and making decisions about what to try first, next, and so forth.

When professionals can meet these challenges, they will very rarely, if ever, feel thwarted by parents. Parental "resistance" is bypassed when therapists stay with, and build shared attention around, the parents' intent. The result builds an alliance through which an open, collaborative learning process moves the parent, the practitioner, and the team forward.

Teamwork

Teamwork is a critical, if grossly underestimated, element of service from the point of view of the child's integration. Some programs function as though a team is automatically a team because it is made up of people who are assigned to the same case. Parents, however, may find themselves caught between appointments and competing priorities, often carrying the burden of ferrying messages back and forth between practitioners. In some home-based programs, practitioners have never even met each other. Growth-promoting team development does not just happen—it requires attention and cultivation. Before several practitioners, each of whom comes from another professional tradition, join cooperatively together as a *team* with deeply understood, shared goals for particular children and families, they must:

- Have regularly occurring times to talk.
- Describe, view videotapes or watch each other's practice, then think and talk together some more.

- Become dedicated to cross-fertilization and collaborative learning, building insight and generic knowledge from each discipline's perspective.
- Become ready to utilize observation and knowledge coming from another perspective within their *own* work with child and family.

Other purposes of team meetings include:

- Supporting parents as they plan, distinguish between, select, and advocate for various approaches and programs.
- Individualizing work with parents and getting clear on roles vis-a-vis parents.
- Promoting integration of parent and child work.
- Collaborating on timing: The team should help to answer "When do you do what, and how do you decide?"
- Quickly studying what is occurring and intervening deliberately when a child plateaus or begins to lose ground.
- To share what does and does not work with the child and family in an effort to speed the child's learning curve and foster progress.
- Shifting practice as the child improves, amplifying alternative approaches, or finishing up one approach/modality or another and moving on.

Center-based programs lend themselves most easily to collaboration because everyone working with a child and family is in one place and knows each other. But whether the treatment is center-based, home-based, practitioner's office-based, or some mixture of these elements, frequent 1- to 2-hour meeting times are key to practitioners becoming a team. Furthermore, only a rich, multifaceted approach based on birth-to-three developmental knowledge and staffing patterns will serve the variety and complexity of families and children who seek early intervention services for young and older children with special needs. An interdisciplinary group of birth-to-three leaders working closely together over time to identify best practices across disciplines identified four requisites to acceptable practice: (1) a framework of concepts common to all disciplines, (2) ongoing observation, (3) reflective supervision, and (4) collegiality (Fenichel & Eggbeer, 1990). These considerations, carried through with respect, allow difficult concerns to emerge and receive the best of shared thinking.

Teams and Parents

Teams should include parents if they want to be involved. However, parents are not simply another discipline on a team, similar to an occupational therapist or a social worker. They were neither trained for their job nor did they ask for this type of assignment. Yet parents, by definition, have the most at stake. For them, this is a lifetime commitment, a life-long endeavor grounded in their love for their child and their dreams for their family. Furthermore, because what happens to their child in his relationship with them and in their home are, in critical ways, the most significant elements of any treatment approach, shared consideration of their participation in the team's work must be active and ongoing. It may shift, ebb, and flow depending on circumstances, their propensities and personalities, and team needs. The critical element is that their participation is discussed periodically in an atmosphere of open communication.

This can get sticky for practitioners when they need to work through disagreements with each other or when they feel the need to discuss the parents themselves and their own reactions to them. Practitioners realize that parents may be partners, but they are not

exactly colleagues. In fact, parents are *both* partners and, to varying degrees, clients, at least in the sense that what they had been doing for their particular child was not all that he needed. Sometimes, other jointly identified purposes may emerge for which the parent wants or needs assistance. But whatever the needs and strengths of parents, they are the experts on the history, minutiae, and emotional flavor that make up their child's day-to-day life. Their critical role and knowledge of their child cannot be overexaggerated; they are the experts in areas at least as salient as any that the professionals represent. When treated with abiding respect and empathy, most parents accept—even welcome—that the team will sometimes meet without them present, particularly when they feel secure that private aspects of their own lives and histories will not be shared and that they will hear the highlights of the team's deliberations and have ample opportunities to integrate their views.

In any case, parents should have regular and frequent access to all the interventionists who work with their child. But they also need an integrative, overarching person for themselves, someone with whom to build a more intimate relationship over time, for the purposes of working with and through their emotions about the specific interactive capacities needed to best reach their child. They need this

- for their child,
- for their own identity development as parents, and
- for the *relationship* with their child and with other key people in their lives, relationships that may be buffeted by the stresses and demands of the child and his special needs.

Often, this special professional for parents becomes the team leader, the convener, and the central organizer of all the people who work with the child, the person who helps everyone concentrate on the particular profile of the child in the context of his parents' developmental and relational capacities. Since home activity and relationship-building is a critical, though sometimes neglected, aspect of the child's treatment, this person is the one who helps the parents and the professional team organize and carry through a rich, home-based program no matter what center-based services he receives, no matter the age of the child.

The following example demonstrates what can begin to happen in terms of team development when practitioners working with the same child begin to meet together, facilitated by a leader who tries to think across disciplines.

Dale Shipley (age 4) was just turning 21 months old when his parents sought a Developmental, Individual Difference, Relationship-based (DIR) mental health consultation.[iv] He was a sweet, low-tone child, who was just beginning to walk and say single words. Born 7 weeks premature and at a low birth weight, Dale was identified for early intervention during follow-up when he was 7 months old because he was not progessing adequately. He had been receiving an intensive, mostly home-based program since then. Greg and Gail, his parents, are serious-minded, devoted parents who have focused their efforts on constructing a full program for him. They struggled with feelings of depression and guilt.

Gail and Greg were particularly concerned about Dale's apparent lack of curiosity; he did not investigate by taking things out of drawers or closet floors, for example. They also questioned about how to set limits, because Dale sometimes hit them when they restricted him or, more often, just limply acquiesced. A question emerged following the DIR therapist's observational home visit

about moving Dale out of W-sitting, as the parents had been instructed to do by his occupational and physical therapists (OT and PT), without discussion of alternatives. However, as soon as Dale legs were moved, his play was disrupted because poor pelvic control compromised the use of his upper body.

The Shipley's also felt unsure about how to play with him, were upset at being asked to leave his intervention sessions more often than before, and raised questions about one physical therapist, who insisted that Dale be held in place as she worked on his lower trunk and legs. Indeed, the parents had argued painfully with each other over this latter practice. They had taken him to a physical therapy session together, and the therapist asked that they hold Dale in place while she worked on his legs. Dale objected, but the father held fast despite his crying. The mother, who had endured many medical procedures herself as a child, felt frantic watching this and finally demanded that they stop, which they did. She was furious with her husband for having gone along with the therapist. In retrospect, he also felt badly about the incident and had questions about the therapist's approach.

Although some of the professionals had been working with Dale for just over a year, no meeting between them had yet been held. The first team meeting—organized by Gail and held at the DIR psychotherapist's suggestion—began with each practitioner describing what he or she was doing with Dale. Many questions coming from a general developmental, relational perspective were raised by the DIR therapist about what was being said. As the meeting progressed, discussion became increasingly animated and elaborated. This was a good sign, the first step toward building a team.

One topic of concern to all was Dale's attention span. His attention to one activity usually lasted for only 1 or 2 minutes, and his play often consisted of taking out each item in a box, holding it up for the adult to label, and then with an "aw-ga" ("all gone"), putting everything back in the box, shutting it, and putting it away. Given the fact that Dale tended to be distractible, several of the therapists mentioned that they were asking him to put each thing away before going on to the next activity. What had not been thought about prior to the meeting was the fact that Dale was not going far enough with the playthings that he did use. Although putting toys away before going on to the next thing might reduce his distractibility, there might be other approaches that could accomplish the same objective, such as having a more affectively lively interchange about whatever he played with or did. Furthermore, putting one thing away before taking out another would seem to constrict Dale's chances to discover that islands of interest could be linked one to another. For example, if the people figures were put away before the blocks were taken out, then the idea that he could use people figures *with* blocks by, for example, using a block as a bed, would be less likely to occur to him later down the developmental line.

The goal of this first meeting was to facilitate a good discussion, such as that just described. Talk that gets questions of concern onto the table and engages everyone reflectively begins to build knowledge about each other's thinking and, eventually, trust. There was so much to talk about that everyone agreed to meet again in 3 weeks, although some team members had been reluctant to put aside the time to meet the first time. The newly forming team also thought it was important to raise the possibility with Greg and Gail of meeting occasionally without them so that the practitioners could openly discuss their views about parental presence in Dale's sessions. They agreed that the notes taken by the DIR therapist on questions

raised (Figure 1) would be distributed at the next meeting for further discussion, and additional questions could be integrated later on as well. The ability to accept and tolerate a certain tension inherent in different viewpoints emerging is key to teambuilding.

A constituency in the field of disabilities believes that professional *training* should be available to parents. Having parents as active participants in their child's treatment is, in fact, an apprenticeship of sorts. Some parents find their calling in the process and may flourish as advocates, support group leaders or, if they already work in an allied field such as speech/language, pediatrics or psychology, may turn their practice toward early intervention work. For them, their passionate, new sub-specialty becomes a gift of enhanced meaning and commitment given to them by their child. Parents should certainly be invited and encouraged to read widely, to attend conferences, courses, and even training programs, if they wish. Yet care needs to be taken not to press parents to do things that demoralize them or are simply too much. The most essential element of staff training is case discussion. Similarly, regular and frequent discussion of their child, their interactions with him, and their sense of their own participation is the crucial element of work with parents, always in the context of their own capacities, inclinations, and needs.

CHILD ASSESSMENT AND INTERVENTION CONVEYS MEANING TO PARENTS

Parents bring their child to a professional for expert advice. The professional's demeanor, words, and emphasis have a huge impact on how they feel and what they will do with and for their child. *The assessment of a child is always an intervention for his parents.* How parents come to define what is hindering the appropriate unfolding of their child's development has great impact upon how they handle him and how they feel when they interact with him. In turn, these qualitative differences in parents' behavior and emotions influence how their child responds. This is true even for children who are very difficult to engage. Therefore, *how parents understand their child's problem is crucial* to the eventual outcome. Once parents understand their child's particular profile and absorb more about how to reach him, they can once again regain their rightful and powerful position as the central organizing agents on his behalf. Reaching this goal is so critical that it is essential to recognize their own and their child's strengths, even while acknowledging the work that lies ahead for everyone.

However, the initial contacts that most parents have with early intervention personnel are centered on an evaluation of the *child*. Often, in the process, parents (and child) encounter several specialists who offer little feedback, instead of seeing one thoughtful professional who establishes a relationship with them, who guides them through a process that concentrates on expeditiously bringing assistance to their child, and who reaches out to *them* with interest, increasing specificity, clarity, and support.

Establishing Eligibility Within a Mandated Time Period vs. an Integrated Evaluation

Professionals need to bear in mind that establishing eligibility for early intervention services is not the same thing as conducting a complete, integrated evaluation. In many jurisdictions, a child's development must be shown to be below certain norms before the child can qualify for services. As a result, securing the services that a child needs may involve emphasizing his deficiencies. It is crucial to help parents understand this so that the assessment

Figure 1. Notes of Questions Raised at an Actual Team Meeting about a Child with a Mild Regulatory Disorder, Low Tone, and Delayed Motor and Language Development

Team Meeting #1: Dale Shipley **Date:**
Age: 23 months

Present: Greg and Gail Shipley (parents); Jill Roth (PT); Melanie Allen (OT); Michelle Carr (OT); Jill Toniada (speech); Barbara Andrus (speech); Rebecca Shahmoon-Shanok (DIR psychotherapist for parents and child)

Absent: Tina Henderson (PT)

The following major questions were raised during the course of each practitioner's description of her work with Dale:

1. How do each of us learn to integrate aspects of what the others are doing in our own work with Dale such that the demand for integration doesn't fall to him and, secondarily, to his parents?
2. How can we really share what we're doing with him, beyond the general/specific descriptions that each practitioner offers (e.g., observation of each other's work or videotapes)?
3. How can we come to recognize Dale's usual day-to-day capacities, as well as the fleetingly glimpsed next level capacities across developmental lines, so that we can set up his human and physical environment in such a way that he can more readily practice those dawning capacities and come to know himself as that capable person?
4. How can we assist Gail and Greg to really know and practice the approaches and capacities that each therapist offers Dale so that Dale will have as full a home program as possible with the people who are closest to him?
5. How can we work with him best, maximizing his intent (and supporting appropriate social-emotional development), when we recognize that his intent may include, for example, seeking his mother (who is asked to leave) during a particular session?
6. How can we help Dale go deeper and elaborate his play sequences to promote richer and more nuanced discovery, and, gradually, representational play?
7. How can we help Dale attend for longer periods and link islands of interest, one to another?
8. A question was briefly raised about how Dale can support himself to do an activity when he is taken out of or is requested to move from W-sitting. (When requested, Dale usually does straighten out his legs.) Reference was made to his doing activities while kneeling, standing, or sitting on a small chair at table position. There was also an allusion to some sort of back or prop to help position him when he's sitting on the floor, but we didn't get to a clear recommendation yet.

The decision was made to meet again in 3 weeks and that, in the meantime, each of us will try to videotape parts of sessions in order to facilitate our cross-sharing.

Reflections: Questions and thoughts and plans that came to me after the meeting to be discussed with the team:

1. Does Dale cross midline and what can we do to help him develop and hone those capacities?
2. Following Gail's description of Dale watching/studying children going down the slide in the park and his

Continued

Figure 1. *Continued*

ability to then copy them and go down the slide, like them, on his stomach and feet first, the question occurs: "What sensorimotor acts does Dale need to *see* in order to maximize his capacities?" (i.e., it seems like his motor planning is a strength). Bearing in mind that we want to develop *his* intent in this area, not his opposition, how can we take advantage of this developmental capacity?

3. As I contemplated the discussions of the meeting, it dawned on me that, while the OT's and PT's were focused on motor function, perhaps one of the reasons that Dale does not go further with various toys is avoiding or not aware of their sensory properties. He is not exploring: for example, banging them, mouthing them, smelling them, or touching them with various parts of his body. This suggests that he would be assisted by an expansion of *sensory based* play invitations. As has been said, learning is much more than labels, colors, numbers, and days of the week. I think that we should try to develop a very, very rich home-based sensory world for Dale and will explore this with Gail and Greg, as well as with the newly forming team next time.
4. It is important for me to explore with Gail and Greg how they would feel about a meeting of the team without them present.

process does not devastate their capacity to believe in a future for their child.

Professionals must reframe what they have been trained to think of as levels of deficit and instead concentrate on the fleetingly glimpsed, higher developmental levels that the child evidences. It is these fledgling promises that require nourishment. They are what challenged children need their parents to observe and aim for in order to motivate the children into developmentally in-tune interaction, one tiny step at a time.

Thus, the child's behavior and interactions with his most trusted caregiver(s) should form the cornerstone of assessment. Extending the developmental model described in *New Visions for the Developmental Assessment of Infants and Young Children* (Greenspan, Meisels et al., 1996), a growth-promoting assessment of a child will be guided by the following interrelated sequence:

1. *Establish an alliance with parents*, listening to their views of their child's strengths and challenges and discussing the issues to be explored in the assessment.
2. *Within this dawning alliance, obtain a developmental history of the child and a preliminary picture of the family's experience.* The alliance comes first; the details are secondary. Some details may only emerge over time (see Box 1 in a later section in this chapter), as part of an ongoing relationship and working alliance. The key is to be responsive to the needs of the parents' explicit and implicit concerns.
3. *Observe the child in the context of unstructured play with parent(s)* or other familiar caregivers, preferably in a setting familiar to them. Observation of the child with his family can readily be done in conjunction with step 2 above. Most parents are relieved if, after seeing their child, the therapist maintains a positive, strength-based stance within the context of the dawning alliance.
4. *Remember that the parent-child, parent-parent, and parent-therapist relationships are essential units of observation, not just the child.*
5. *If needed, gently coach parents in interactions with the child to help them elicit the child's highest developmental levels.* Once the child has become accustomed to the therapist's presence, the therapist may also try to help the child interact and/or play directly with him. The idea is to glimpse

higher-order, incipient capacities in the child and help parents see how they can mobilize them. This is an intervention-centered assessment (Thomas, Benham, & Guskin, 2000; Shahmoon-Shanok, 2000) that can immediately initiate a significant component of the intervention program.

6. *Call for specific assessments of individual functions in the child only as needed,* within the context of a rationale specific to the particular child and the therapist's relationship with the parents. Similarly, target any medical tests to respond to particular questions.
7. *Be mindful of both explicit and implicit parental needs, concerns, strengths, and challenges,* tactfully articulating and elevating them for shared consideration and treatment planning.
8. Using a developmental model as a framework for integrating the data obtained from parents' reports, direct observation, and any other sources, *discuss findings with parents in the context of the alliance,* with the potential for beginning (or continuing) an intervention program, if needed.

Establishing Eligibility Within a Mandated Time Period vs. Prompt Intervention

In order to secure services for children in a reasonable amount of time, many jurisdictions limit the number of days the assessment phase can take, yet mandate that specific, specialty assessments all take place within the time limit. These simultaneous pressures often result in children and families being impersonally exposed to one assessor after another, each from a different discipline, within a short period of time, sometimes even on the same day. What is sacrificed by this approach is the opportunity to build an *integrated* picture of the *child within his relational context and at his best.* What is all too often simultaneously lost is the opportunity to begin building a generative relationship with his parents. This is unfortunate because such a beginning would likely yield more attuned interactions of parent with child which, in turn, might begin to exercise the child's fledgling relational capacities.

Instead, the assessment phase should be as brief as possible, which is to say that the earlier the treatment program can begin, the better. It is often not necessary to have each discipline's evaluation finished—or even begun—before a *provisional* diagnosis and one or two components of a treatment plan can begin. In fact, a provisional diagnosis for a child with developmental challenges is not difficult to make. It is often possible for an experienced practitioner to offer provisional impressions as well as generative guidance within an extended first or second contact. Thus, an intervention-centered assessment can begin assistance to child and parent almost immediately. The child's responses to the intervention and enhanced parental responsiveness inform next steps and help to clarify the diagnosis.

A word on diagnosis: Driven by considerations of public funding and insurance eligibility as the field is currently, reaching a diagnosis is sometimes reified as an end, as if the label itself would offer answers. In fact, diagnoses *are* critical in medical conditions in which discovering the correct pathological entity is requisite to finding the specific, appropriate treatment. Accurate diagnostic labels for agreed-upon entities are also necessary across cohorts for research to become meaningful. And whenever it is suspected that a child's developmental disorder is part of an active medical condition such as epilepsy, or a genetic abnormality with various risk factors such as tuberous sclerosis, the search for an accurate diagnosis is critical. Nevertheless,

even in such cases the intervention program for the developmental disorder must be specifically informed by abiding scrutiny of the child's developmental, relational, and individualized sensory, motor, and processing profile, and how these shift over time. Since it is those particulars that inform professionals and parents about how to reach and engage the child relationally, they are the key to bringing him into the interactive, communicative, and learning world.

For many young children with developmentally significant functional impairments, the "impairment, in itself, should serve as a criterion for initiating appropriate intervention" (Greenspan & Wieder, Chapter 12). Often, the most significant *initial* interventions will be supportive coaching with parent and child to get shared attention and gestural interaction within their relationship moving, as well as occupational therapy with a heavy, sensory-integration emphasis. The information yielded by those interventions provides a rich picture, which can then direct the selection of further specific assessments. Speech/language and educational approaches can often begin just a little later and be layered in responsively, based on what is being learned about the child, the parent(s), and their relationship.

It is very unfortunate that many jurisdictions currently confuse subspecialty assessments with evaluation per se. They require all such assessments to be completed before treatment can begin and they further insist that only individuals who will *not* be treating the child and the family can assess. This usually tips the process toward a direction in which several different practitioners automatically evaluate the child outside an integrated context of the individual-in-family profile and outside of a supportive relationship-building process with parents. Going straight to specific interventions without attending to the parent or the child-parent relationship either ignores or takes for granted necessary and critical fundamental levels of service. Yet for children with severe multisystem, autistic spectrum disorders, it is those basic levels that need strengthening first and foremost. Only upon a sturdy, substantial foundation can the upper levels be securely built.

Thus, continuity and relationship-building are requisite for thoughtful assessment to become effective intervention (and vice versa). The making of a diagnosis per se can—should—wait until effective intervention has begun to support the child, parents, and the relationship between them. Since labels tend to stick, a diagnostic determination should be made only in a favorable context, through which the child's better levels can be glimpsed. By then, the thoughtful practitioner will have helped parents begin to know their child's particular profile of strengths and challenges. In this context, parents are more likely to experience the diagnosis as a summarizing term rather than as a verdict. When funding considerations require a diagnostic label such as autism to secure services, professionals can acknowledge this with parents and then set out together to disprove it.

When work with a child and family *must* be limited to assessment, professionals should put forth every effort to make personal and meaningful their introduction to the family of the intervention program or practitioner. This step, so hard to achieve in these times of overlarge caseloads, involves both assessors and intervenors. Recognizing how difficult a transition from one to the other may be for parents may inspire professionals to sustain their efforts to achieve such connections.

Setting the Tone of Partnership

Whether work with the child and family continues from the assessment phase through intervention or not, it is critical to bear in

mind that from the very first contact, each professional's observations, ways of listening, ways of coaching, and ways of explaining the child's difficulty make a difference for families who are likely to be groping for some sense of an unfolding future for their child. Given parental anxiety during initial contacts, it is the professionals who set the tone for how they will work together. By acknowledging relative strengths, by discerning points of contact with their child (fragile as those may be), and by concentrating on next developmental steps, a growth-promoting partnership, and intervention plans, a practitioner—in any discipline—can offer some promise of a working future to parents and, through them, to their child.

Also during the initial phases of contact, the relationship potential between the professional and the parents on behalf of the child mandates consideration. Too frequently, this is given only passing attention in either the assessment or intervention phases of work with a family. Sometimes it is not even formally noted or discussed unless or until it becomes problematic. But, especially for children who struggle with developmental challenges, how the adults involved feel and think about each other is of significance to both the treatment process and the outcome. Not only should this potential be carefully considered but the *development of mutual respect and trust between parents and practitioner needs to be placed as a highest priority, equal in stature, even during the assessment phase, to assessment and diagnosis.* With most parents, the practitioner can openly discuss the potential for a relationship between them as a way of understanding more about parental expectations, preferences, and needs and also as concrete evidence that the practitioner and parents are forming a partnership and open exchange on behalf of the child.

For the mother or father of a child with special needs to function competently on behalf of their child, each parent must become open to utilizing professional resources for their child, for her- or himself, and sometimes for the family, while simultaneously experiencing the centrality of her or his position for the child. When professionals recognize this dual challenge, it becomes obvious that they have a fundamental responsibility to support these capacities over time. In order to fulfill this responsibility, reflective professionals will want to understand each *particular* parent within his or her unique developmental-relational-communal context.

A generative question that practitioners can ask themselves is, "How is this set of experiences *marking* this mother, this father, this family?" Having a child with special needs is a process that marks parents either for better or worse in terms of their sense of themselves and their capacities to be resourceful and relationally aware. When this question is pursued openly and empathetically, the vast majority of parents are responsive to—and deeply appreciative of—the care being offered. Parents want—even need—to be heard, understood, and treated with respect: They need their professional partner to recognize what the challenge of this child is like for them in the context of their life at this point in time.

When professionals manifest this basic investment while they help parents to see what *they*, as parents, can do for and with their child, when they are able to support parents' search for ways to meet and become resourceful in dealing with their challenging child, then they support parents in their search for their better selves in the face of enormous challenge. In this way, parents feel partnered and can work with the professionals to build and pursue the next therapeutic steps for their child. Furthermore, when professionals find this individualized

footing, they find it easier to frame recommendations in the specialized, responsive ways that particular parents can understand and appreciate. Finally, when professionals reach out with the empathic interest described, they become able to discover which of the many parents are able to function optimally on behalf of their children with ongoing professional collaboration, and which parents may need additional, specialized interventions themselves.

In order to accomplish this kind of meaningful, individual- and couple-specific partnership, one professional should become the overall, responsive, resource-coordinator-integrator for parents and child. That key practitioner should work closely with parents to help them prioritize and build the intervention program their child needs as well as the supports they need to function optimally. Naturally, needs change over time, and as the key practitioner works closely with the parents, he learns how to respond resourcefully to shifts in their and/or their child's organization. The section that follows addresses some of the generic *content* knowledge necessary for any practitioner working with parents of young children with special needs. In order to learn how to work in these enhanced ways, *process* knowledge needs to be cultivated by practitioners through on-the-job reflective practice (cf. Fenichel & Eggbeer, 1990; Gilkerson et al., 1995; Gilkerson & Shahmoon-Shanok, 2000; Shanok; 1992, Shanok & Gilkerson et al., 1995).

ESTABLISHING AND MAINTAINING RELATIONSHIPS WITH DIVERSE PARENTS

As a rainbow of researchers, theoreticians, and poets have observed, "The child resides within the (hu)man." Thus, what has been learned about children's development and about how to build relationships with them can also be applied to work with adults (cf. Greenspan, 1997b; Greenspan & Wieder, 1987). Understanding and using developmental perspectives with parents enriches the practitioner's potential with them.

In work with all parents and children, there are many intertwining and parallel relational factors. Prominent among them are:

- The development of the person/parent within his or her relationship with the child
- The emergence of recollections, attitudes, and patterns, conscious and unconscious, from the parent's own early experience (Benedek, 1959; 1995b; Seligman & Shanok, 1995a; 1996; Shanok, 1987; 1993), sometimes called "internal representations," or "transference," or "internal working model" when these emerge in a current relationship
- The development of the person/parent within his or her evolving relationship with the professional.

Furthermore, there are stages to the development of any relationship (cf. Greenspan & Wieder, 1984), and developmental levels predominating within any individual. Each relationship can, itself, become a unit of observation, care, and growth. Indeed, relational forces are all in dynamic, cogwheeling relationship with one another; any influence on one constituent force affects the others. Looked at in this way, the idea that a parent's relationship with the professional can have significant influence on the parent and on the unfolding parent/child relationship may be glimpsed. Parents need *individualized* consideration and planning, simply because each one has a different history and set of perceptions, as well as widely varying abilities, sensitivities, and transferences to both child and professional.

Thus, not only do parents vary, but their children are also very different from each other,

even if their "diagnosis" is the same. Furthermore, parental abilities to work with others in handling such an intimate responsibility vary widely. Just as "child-centered" intervention is now recognized as insufficient, so, too, "family-centered" intervention that only provides support, information, and guidance about their child's developmental needs is not enough. Even a two-or-three-size-fits-all programmatic approach cannot make the most of relational opportunities. Rather, responsive work, which begins and continues where *both* the parents *and* the child "are," is far more likely to support and mobilize the range of different parents on behalf of, and at least equally important, *with* their child.

Reaching the "Hard-to-Reach"

Parents of children with developmental disorders are as widely diverse a lot as the general population. They meet us with varying degrees of relational and communicative capacities themselves and with very different internal and contextual resources. It stands to reason that a segment of them would be hard to reach for a vast array of reasons. The idea of "holding so that others can hold" or "nurturing the nurturer" is considered fundamental to all work with parents of very young children (cf. Bronfenbrenner, 1979). It is perhaps even more critical in work with any parents whose child has severe difficulties in relating and communicating and who, for whatever reasons, are having difficulties engaging either with their child or with the team. This is especially true early on in intervention, before their child begins to consistently give back reassuring, interrelated feedback.

Depending on their capacities and preferences, avoidant parents should be offered regular contacts in their home, office, coffee shop, or on the phone—anything that works for them. They require time they can count on with an empathetic, deeply interested, optimistic and (occasionally, when crucially important) authoritative professional, time in which the entire focus can be on them and their child. Strength-centeredness and acceptance of such parents are key.

The knowledge and practice base emerging from community-based outreach work must be integrated into early intervention. Practitioners need to support one another when they find themselves feeling that they are selling something that the parents do not know they need, let alone want. Responsive creativity also can make the margin of difference in reaching a parent or not. In one project with very poor teenage moms and their challenging children, the "way in" to reluctant parenthood was through a support group that got off the ground with a focus on hair styling. As the young women fixed each other's hair, conversation drifted (and was *then* facilitated by the professional) to their children.

This parallels what children with difficulties in relating and communicating need from their parents. And again, it mirrors what some parents need from their program or practitioner. Consider another example: The director of an early intervention program serving young foster care children and their families brought the following topic for discussion to a professional seminar on leadership. Her agency a school-based program for young children with developmental challenges, invited biological parents to observe and participate in their children's classrooms on a daily basis. But, because the teenage mothers were very disruptive—talking among themselves, chewing gum loudly, moving around the room but not paying attention to the children, and going in and out of the room "just to have a cigarette"—she and her staff felt that they had to set strict limits on the times during which the young mothers could visit their children's classrooms. Using the leadership seminar discussion as a way to step back and reflect, the director was quickly

able to see that, while she and her staff had wanted to be inviting and helpful to the biological parents by setting an open-door policy, they had been so focused on services *to the children* that they had ignored the needs of the biological parents who, by definition, are parents with challenges. The parent's negative expectations of relationships, based in all likelihood on powerful past experiences, made them skittish and, paradoxically, invited rejection, the opposite of what they needed. The program would have to find a way to build trust, to violate these young parents negative, anxiety-ridden expectations to succeed in constructive outreach.

After much shared discussion with her staff, they decided to offer a support group to the parents, complete with food and beverages, every day just prior to their entry into the children's classrooms. They reasoned that, if they attended to the parents, then perhaps the parents could better pay attention to their children, and indeed, the support group did the trick: It transformed these needy parents' behaviors such that many were able to participate and observe more appropriately in the classroom. In addition, within 2 or 3 months of support group attendance, several parents became more involved and asked for individual appointments "for themselves."

Just as adults naturally modify their approach to fit particular children, professionals must become thoughtful about how to approach parents, always aware that, inadvertently, they may put parents off. A good rule of thumb is that when parents do not show up or if they "behave badly," it is time to step back and reflect upon practice with resourceful colleagues. Parents' "lack of interest" or problematic attitude almost always conveys something about how the program is not yet connecting with them. Growth-promoting work with parents flows from *their* needs and concerns, from where *their* initiative is activated. Shared observations and then shared views develop over time. Working toward an alliance that has pleasurable components and can survive negative feelings is critical to long-term partnerships.

Co-identifications, Time, and Reflection

More than other types of psychotherapy or even child guidance work, this work is, in fact, child-centered. This point may seem to contradict the call for sensitive, relationally alive work with parents fueled by recognition of their many individual differences. There is a tension between children's and parents' needs, to be sure. But a young child's threatened development is in no small measure experienced as a threat to the parent's own sense of self; it provides a major impetus for parents to place the child's needs above their own, as if the child's needs *were* their own. "Best practice" requires that professionals not only evade the "contradiction" but also recognize and even embrace the tension inherent in identifying with each family member and in building family-specific relationships. What is good for children is good for their parents. What is good for parents is good for their children. Aiming for both stimulates good outcomes. The invisible but powerful thread is relationship.

All small children are a far more constant responsibility than could be imagined before they arrive, and children with special needs require far, far more than their typically developing peers. The level of demand on parents can be excruciating. Professionals need to be mindful of how overwhelming the task demands can be for parents with children with severe difficulties in relating and communicating.

Becoming fully engaged with a family requires time—time for the professional to become saturated with observations, details,

and nuances about the child *and his relational context*. Especially in the first several stages of assessment and intervention, parents and children with severe difficulties relating and communicating should be seen *together*. This enables the professional to focus on the current strengths of the parent-child relationship, on how to help their relationship and communication become more lively and resourceful, and on how to enable the parents' own interactions with their child to support and extend whatever treatment is recommended.

It is also essential to see parents without their child regularly, predictably, and often enough to exchange information and develop shared perceptions, to reflect, to take stock, and to plan. Just as with children, parents need a supportive context. Not infrequently, the support that anxious or depleted parents experience in their own sessions liberates them to return to their child refueled. Sometimes, the sessions may involve talking about mutual frustrations with uneven or inadequate service systems. At other times, a parent may need to sort out memories and child-directed impulses based on the past. Or, parents may need to sort out subjective feelings of discouragement in the light of more encouraging objective reality. That is, sometimes parents may feel that they are not accomplishing enough and worry about the future. If the professional recognizes that they are, in fact, doing a great deal and that the child's developmental trajectory has already "taken off," then she can offer much-needed reassurance.

Guidance and coaching must be based on specific observations and interactions between parent and child, that the parent and the professional have witnessed together. Most parents and key caregivers are highly motivated: With sensitive, developmentally geared assistance, they can learn to observe, read, and respond to their child contingently, drawing their child into the relational, learning world.

Working with parents and children together and then reflecting with parents regularly without the child present allows the professional and parents to build a durable, insightful, resourceful relationship. Allowing time for sharing and thinking together makes for a partnership that can withstand differences and navigate through uncharted waters.

TOWARDS DEVELOPMENTALLY APPROPRIATE PRACTICE: APPLYING THE CONCEPTS OF RELATIONSHIP, INDIVIDUAL DIFFERENCE, AND DEVELOPMENT TO *PARENTS*

At the beginning of the 1900s, theorists such as Sigmund Freud, George Herbert Mead, and Harry Stack Sullivan began to recognize that personality—enduring ways of behaving, perceiving, and thinking about oneself and others—arises through early social interactions, beginning with the first relationships in earliest childhood. The patterns of those mutually regulated (or disregulated) early encounters (cf. Schore, 1994; Tronick, 1998) become the largely subconscious template through which current attitudes, interactions, behaviors, and expectations are governed. Over time, practitioners can recognize a parent's particular patterns and often find ways of acknowledging them. These patterns become the basis upon which the practitioner and parent come to set, and shift, their agenda or contract with each other. It is helpful to become aware of each parent's:

- Strengths and risk factors.
- Developmental levels and internal representations.

- Social capacities, especially vis-à-vis the child; that is, the effect of this child on the parent now and the effect of each treatment resource for the child on the parent.

Knowledge and familiarity build a shared and sympathetic perspective between practitioner and parent, and boosts the likelihood that a practitioner will understand a parent's predilections and hesitations. Yet, whereas many parents readily respond with openness and trust, others take time to build the trust that comes before openness. Pulling together impressions of a parent's individual style, her developmental and relational level and capacities offers the reward of increasingly targeted practice. All practicioners serving a child should have general familiarity with these parental factors, while one person will hold major responsibility for seeing them regularly, and understanding and connecting with them.

Most parents will readily reveal personal details when they feel the interest of the professional and trust her intent. For *each* parent, information learned can be aggregated and organized, as shown in Box 1. This box includes important areas to notice and what to inquire of parents. This information usually becomes available in the course of meaningful discussions with parents over time. With this rich and nuanced picture in hand, developmentally appropriate interventions for parents can be planned. To accomplish this, programs and professionals must move toward providing interventions for *parents* based on their individual capacities and styles.

Unfortunately, in many programs, no one professional is designated to be "the parent person" for a particular family. All too often, even when there is such a designee, resources and knowledge to support more individualized work with parents are slim. Critical needs of both child and parent tend to be ignored.

Figure 2 compares intervention pyramids for both children with special needs and their parents. Although parents are requisite at every level of the Intervention Pyramid for Children, current evaluation and service programs nevertheless tend to cluster their offerings exclusively around specific interventions for the child; that is, they congregate at the uppermost section even of the child pyramid. By definition, the child's foundational levels remain weak and uneven while the engagement and intimacy the child desperately needs from the parents to build mutual regulation and repair (Tronick, 1986) are neglected.

As can be seen in the Intervention Pyramid for Parents, there are similar developmental and relational considerations for adults; in fact, they have striking parallels. Yet, most often, oferrings for parents in early intervention programs are add-ons, not the developmentally based, comprehensive, integrated layers required. When working appropriately, each of the four levels of interventive support within each pyramid would be seamlessly interwoven, with the basic levels providing the ongoing foundation for the others. Just as children need additional supports at the basic levels, so do many parents, given their levels of stress and/or their own pre-existing vulnerabilities.

When individual guidance or group support sessions are offered to parents in most early intervention programs, they are offered as program components rather than as an individualized, responsive, and tailor-made plan. How can these programs provide something meaningful enough—verbally and generally—about interactions that are preverbal, gestural, and specific? What is needed for contact to be effective is knowledge of each parent's individual functional developmental capacities, including their educational, social, economic, and cultural resources (as shown in Figure 2) as well as the specific, developmentally and relationally targeted needs of their

Box 1. Organization of Family Information[1]

- **History**
  - Where, when, and with whom did the parent grow up
  - Cultural beliefs, customs, aspirations, and support systems
  - Educational level and experience of self at school
  - Socioeconomic factors
  - How do they characterize their key relationships and memories of
    - Parents • Grandparents • Siblings
    - Is there a psychiatric history/oddness on either side of the family?
  - Work history
  - Impressions of *how* each parent tells life story (e.g., continuities, coherence, gaps, confusions, affect)
  - Circumstances of conception, pregancy, and birth
  - For whom was the designated child named? Does child remind the parent of anyone?

- **Current situation**
  - Housing
    - With whom they live
  - Current work situation
  - Financial resources, challenges, and attitudes
  - Familial/marital strengths and stressors
  - Descriptions and ages of other children
  - Next of kin and extended family—strengths and stressors
  - Social network-friendship base
  - Spiritual beliefs and practices
  - Attitudes toward and subjective experience of each key person in their lives, especially the designated child
  - Where is this parent in the emotional and adaptive process of encountering the child's significant challenges?
  - How does each parent respond to/feel about various symptoms and strengths of the child?
  - Cogwheeling between developmental needs of various family members
  - Does this parent (or other of their family of origin members) report over- or under- responsivity to stimuli? That is, what is this parent's sensory profile?

- **Impressions**
  - Where is this parent developmentally?
  - What distinguishes this parent from others? What are his/her strengths, vulnerabilities, particularities and life view?
  - Where is this parent relationally
    - In general? • With child? • With spouse? • With key practitioner?
    - What do we know about this parents internal representations and inner life?
  - Coherence, confusion, and gaps in this parent's narrative (cf. Main, 1993; Main & Goldwyn, 1984)
  - Summarize your impressions of the child as a marker experience for this parent in the context of other resources and stresses in his/her life

[1]**This outline is not meant to be a semistructured interview**. Instead, it is a series of sections with which to sort, aggregate, and organize information gathered over time about *each* parent. (Other sections may be added to the outline for additional information about particular parents and their families.)

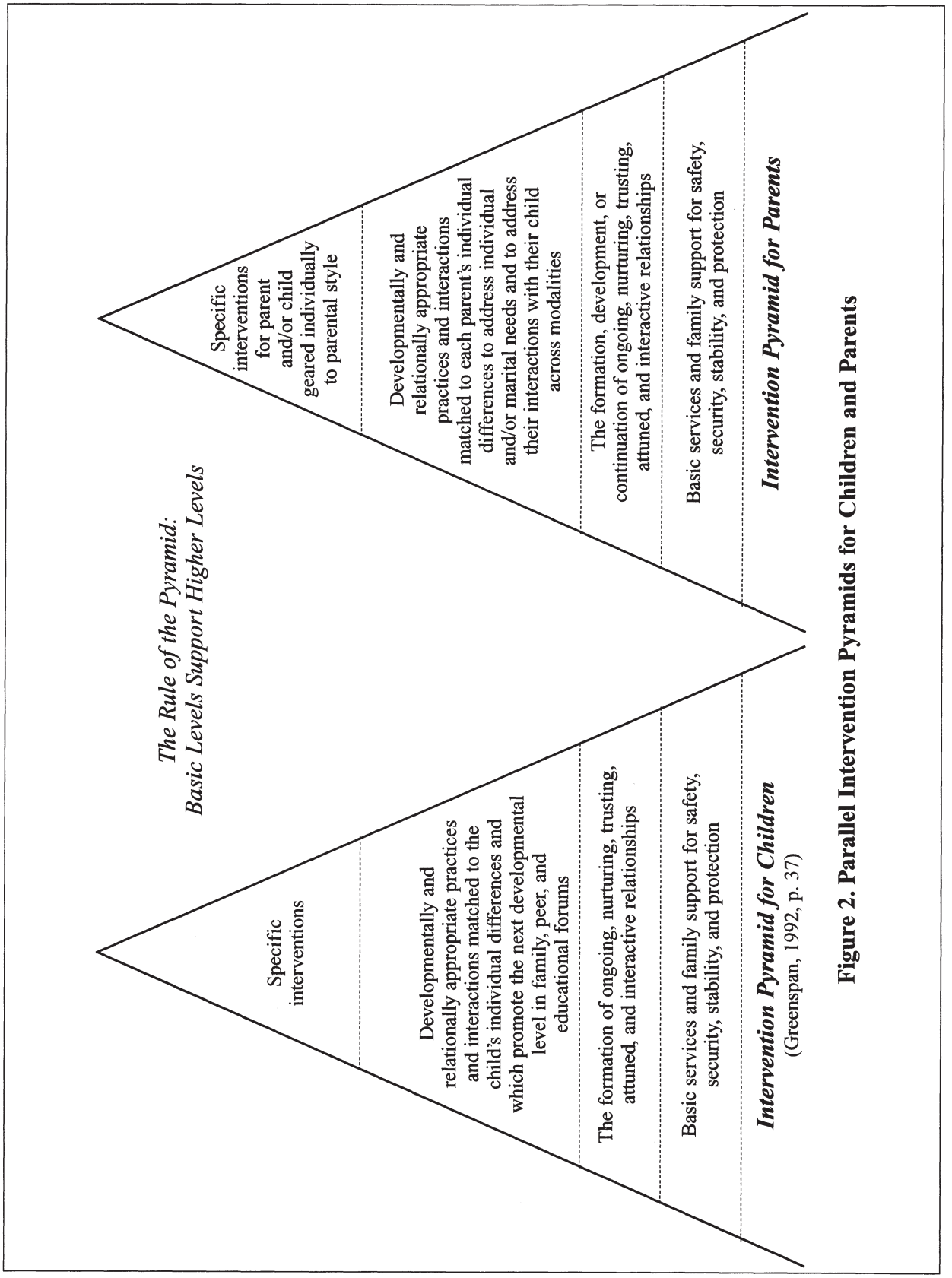


Figure 2. Parallel Intervention Pyramids for Children and Parents

child. It is these factors that should drive the *plan* (i.e., the type and frequency of interventions) for each parent and for parent(s) and child together.

In situations when either the parent her- or himself has challenges, intervening developmentally with a parent can make a margin of difference for parent and child. As was said at a recent conference, "Where the patient (in this case, parent) is evidencing significant deficit in any of the developmental levels, we must engage and challenge the (parent) at the earliest level of deficit and make that level the primary focus of treatment until that level is mastered. Then the next level is addressed and so on. Obviously, addressing one level does not mean that other higher levels of development are not engaged at the same time—it is a matter of emphasis. In other words, successful (developmental) psychotherapy addresses and remediates developmental deficits in a systematic and progressive manner" (Mann, November 1999).

Figure 3 illustrates developmental levels in the therapeutic process with parents. A relationally oriented mental health professional may be critical in moving parents up the developmental ladder.

Resources That Should be Available to Parents/Caregivers

Parents are society's agents for the care and raising of its young. Yet parents are a widely differing bunch, with diverse histories, profiles, resources, and needs. As they care for their children, parents must have choices in order to discover what will work for their child and their family. Parents of children with special needs also require choices. In fact, with greater demands placed upon them compared with those on parents of typically developing children, they need more choices, as well as a more responsive communal infrastructure surrounding them than do others. And, for those who arrive at the therapist's door not fully knowing what could be helpful to them, parents also benefit from personally tailored supports and information so that they may become active participants in what they receive. Along complementary lines, professionals require an array of selections with which to constructively buoy the parents with whom they work. The interventions offered must be based on individual differences in the parents' surrounding ecological matrix and on their functional-developmental-relational capacities.

Integral to the intervention pyramid for parents is the recognition that *basic levels support next higher levels, and that each family must be fully considered level by level in order to help them help their children.* This requires that the field of early intervention move toward a state-of-the-art interweaving of supportive and, sometimes, insight-oriented psychotherapy, as well as experientially based adult education. Bearing in mind the developmental level and ecological context of each parent, programs and practitioners must consider each level on the comprehensive continuum of services (see the right side of Figure 4) necessary to reach parents and determine at what level to focus the interventions. The continuum begins with the most disadvantaged, wary, or preoccupied parents.

"Difficult" Parent or Child-Centered Program?

The reasons for which parents come to be considered difficult or disinterested by practitioners fall into three major categories: their own histories-profiles, an inadequate or otherwise mismatched response to parental needs by practitioners-program, or some mix of the two. Some parents, for reasons stemming from their own histories and/or reactivi-

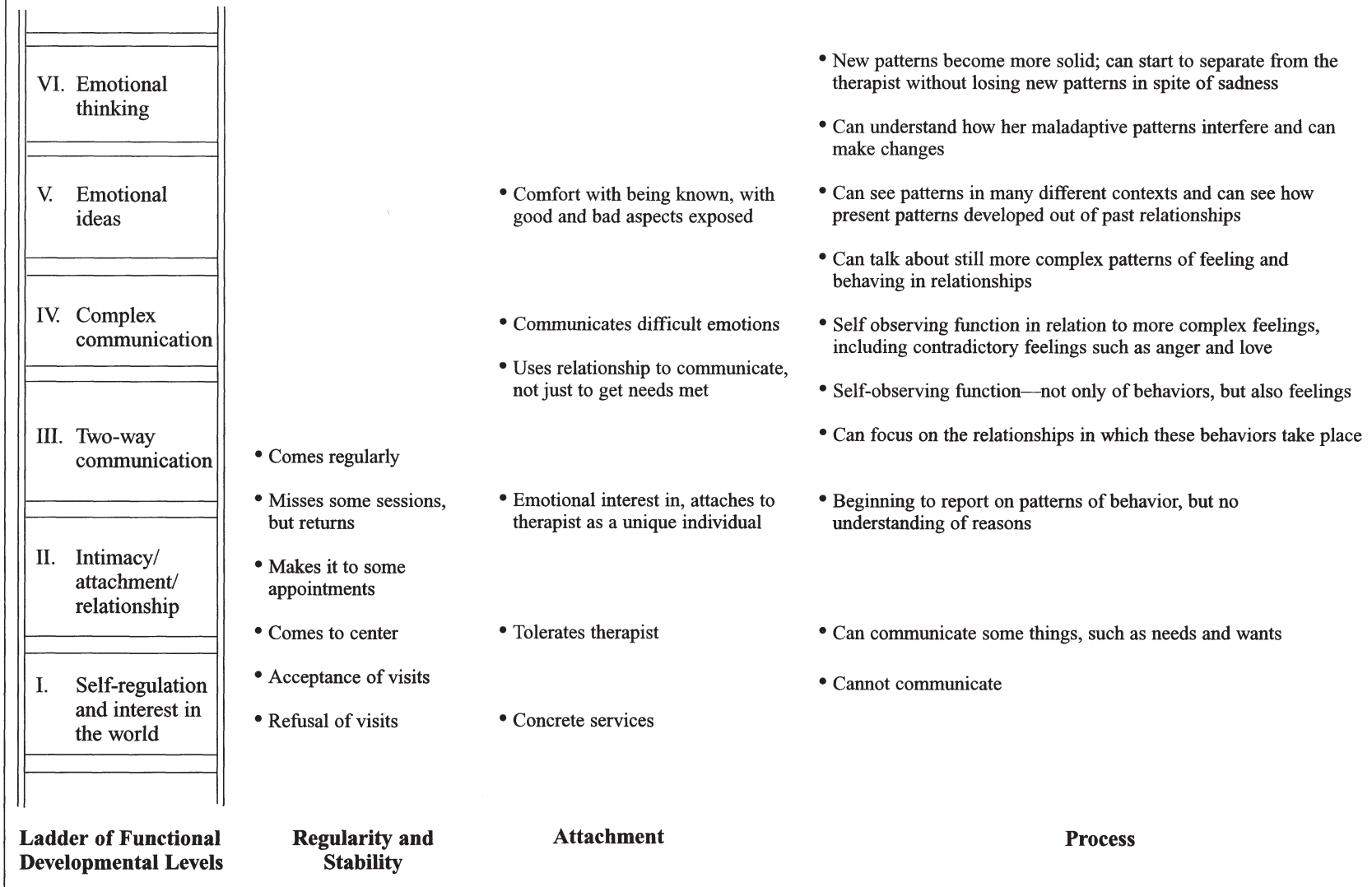


Figure 3. The Developmental Ladder and Levels of the Therapeutic Process with Children and Adults
(Greenspan, 1992)

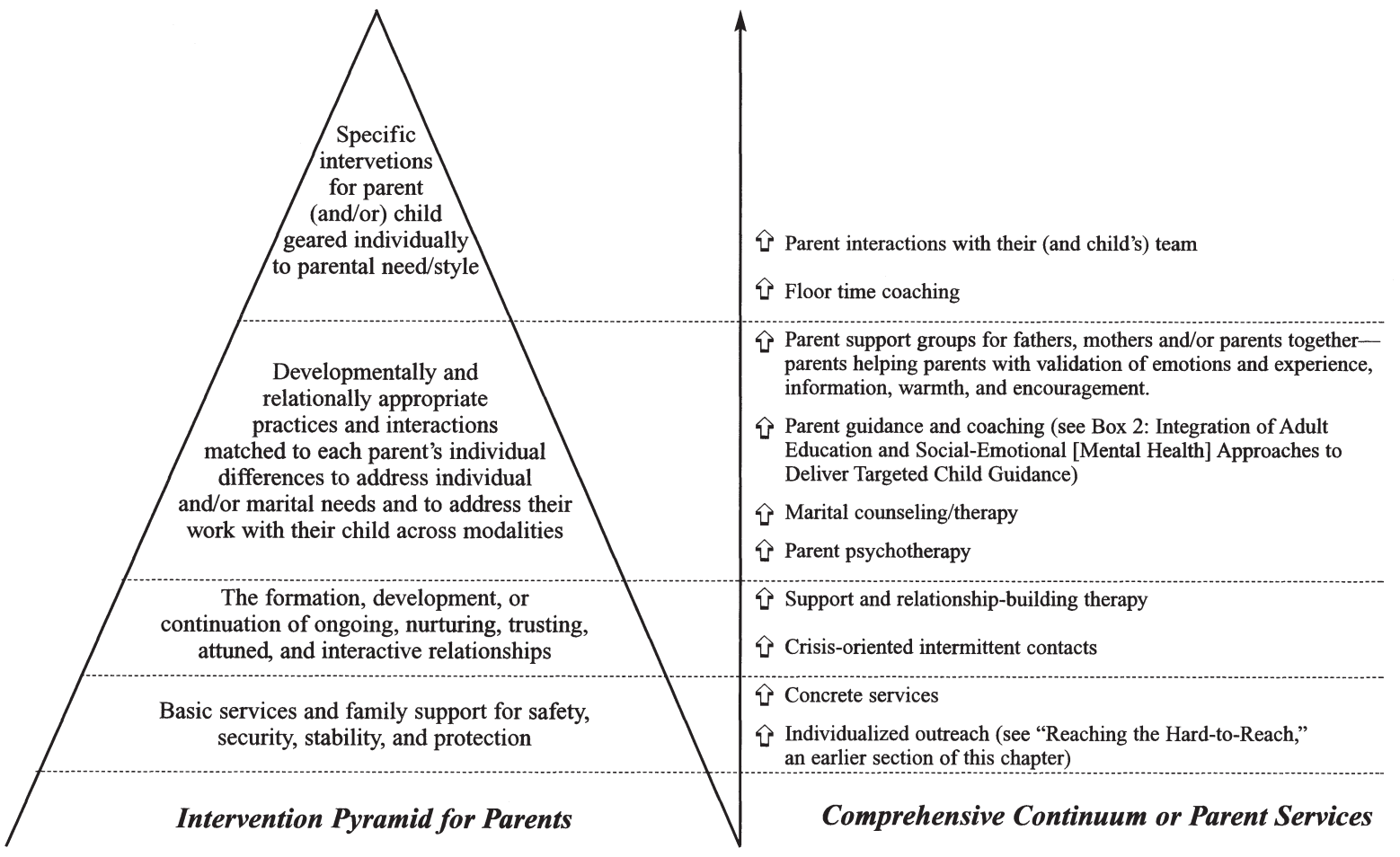


Figure 4. Intervention Pyramid for Parents and the Continuum of Services Necessary to Reach all Parents

ties, may find it difficult to engage in regular collaboration. A parent may be "stuck," but with sensitive outreach, the marker process of having a needy child could become a motivation for new growth. These are parents whose own life experiences have left them mistrustful, resistant, disorganized, or overwhelmed, as briefly discussed earlier in the section called "Reaching the Hard-to-Reach." It is essential for the practitioners involved to talk with each other, sympathetically considering different approaches to outreach depending on what the *reasons* for a parent's avoidance may be. Just as children need their parents to woo them up the developmental ladder so, too, do some parents need professionals to do the same with them.

All too often, a program gives up on a parent who "never comes to meetings, let alone to appointments." Practitioners end up believing that parents may not care enough about their child or that they haven't accepted the child's disorder when, in fact, the reasons for noncompliance are likely to be far more complex. Outreach is an exercise in caring and extending developmentally based invitations over time—sometimes over a long time. If there is no one on the team who has experience with resourceful outreach, this is an area where generative consultation and staff training are indicated. What the parents need is sensitive, individualized outreach, with careful attention given to the levels of the developing therapeutic relationship (Greenspan, 1997) and an understanding of the parents' own perspective. Developmentally appropriate practices and interactions are based upon a recognition of individual differences and an increasing awareness of the state, mood, and intention of the parent on the part of the professional.

It is always crucial to stay connected with what parents are looking for and how parents view the professional's role, as well as the trajectory of events and interactions that led up to the present one. When the parents of a severely delayed toddler reached the third intake social worker who asked them how they *felt*, the mother blurted out, "I *feel* like hitting you in the head! What I *want* are services for my child, not a discussion of how I *feel*. What I feel is that he needs services—NOW!" Although there is increasing recognition that parents' emotions are important, practitioners do not always know how to gain access to them. In-service training can target this area. Becoming aware of both manifest and latent elements boosts a practitioner's ability to meet parents "where they are." As it happened, the particular mother in this example is an exceptionally competent, warm, and related person and a very strong advocate for her child. She was not avoiding her feelings. She was simply fed up and needed the social workers to join her in addressing "first things first." Her emotional connection with her son had to be addressed first by providing services to him, which would make room for deepening the work with her a little later.

What might have appeared to be a difficult mom was, in fact, a frustrated mother-lioness, roaring to protect her young. She had already accepted her child's challenges and the fact that she had to work with others to help him. She was past ready to move ahead. A responsive social worker could use this mother's outburst to shift gears, welcoming it as a terrific opportunity to empathize with her frustration and to move the acquisition of child services along.

Mismatches are more likely between parents and practitioners of different cultures, ethnicities, and classes. Talking openly with parents about their views, reflecting with staff members, and consultation may all help minimize misattributions.

When several parents in a program do not participate or when practitioners experience the "we"/"they" phenomena—as in, *we* hold events/make appointments, *they* don't show up—professionals should see this as an unequivocal announcement that there is a problem with the program. Discussing how to revise the program with a resourceful, trusted professional or a parent experienced with a range of parents can be a breath of fresh air for parents and professionals alike. Often, parent-facilitated support groups provide a lively, deep-feeling forum within which many ideas for improved parent-professional relations emerge. But flexible, responsive, self-aware, and thoughtful practitioners are needed for wholesome changes in programs to evolve.

The early intervention program for young children in foster care described earlier in this chapter illustrates how even situations that look nearly hopeless can be turned around. Well-intended personnel were about to abandon open visits in the classroom by disruptive and demanding birth parents. When helped to think about these parents as people having their own significant needs, the staff decided not to rescind the open visits but, instead, to hold a support group prior to the classroom visits, with refreshments provided. Before long, the program personnel not only found the birth parents more responsive, and even helpful, in the children's classes, but several parents used the support group as a stepping stone to individual, psychotherapeutically oriented intervention and/or skills training, such as, for example, studying for their high school equivalency exam.

In a privately run suburban speech/language and occupational therapy program, staff complained that they never glimpsed parents because their children arrived for sessions with nannies and au pairs. At a single meeting with an experienced consultant, open discussion revealed that the intake practices of these professionals—which left parents sitting in the waiting area—sent a clear message to parents that this place delivered services for *children*, not for *them*. Recognizing this, the staff could have accepted the status quo. Fortunately, they had become increasingly aware of the relational basis for wholesome growth in young children and realized that they wanted the presence of parents. Over time, the director and her key supervisors pursued training and further consultation, which yielded revised, relationally sensitive practices from a family's first visit onward.

Each of these vignettes, one from the south Bronx and the other from a wealthy Connecticut suburb, exemplifies the principle that early intervention program staff will work successfully with parents to the degree that they become aware of parental needs and concerns, on the one hand, and of their own latent messages, on the other.

Mission Integration: Charting New Directions

State-of-the-art practice with parents of children who have special needs requires a generic base of knowledge coming from across, and integrating, several fields. It is time that practitioners, programs, policymakers, and managed-care companies recognize that this knowledge base is growing rapidly and requires life-long learning and growth. This implies that while a good professional education and internship are necessary, they are not sufficient.

The single word "integration" refers to several challenges faced by parents and their children and the professionals dedicated to helping them. The first challenge is to note and integrate with the strengths that a parent brings. Some strengths are obvious from the outset; some emerge over time. Some are

known to the parent, but only become manifest to the practitioner able to draw a parent out. Still others are discovered by the parent in the process of trying to meaningfully parent a special needs/hard-to-read-and-reach child. Practitioners able to follow both manifest and latent emotional content are able to play midwife to these parental discoveries, to cultivate them in their inception, by seeing and meeting them contingently.

To meet their children where they are, virtually all parents need to learn a great deal about topics ranging from typical unfolding development to:

- the complex meanings and layers of sensory processing,
- their own child's profile,
- ways of encouraging and limiting the child effectively, to
- service delivery options.

Thus, a second integrative challenge is that of education—how to offer parents the knowledge they need, when they need it, and in a form which they can use. *Targeted child guidance* can be very helpful for many parents who cope fairly well (see Box 2). They feel and function better as they become more effective on behalf of their child. Some of the knowledge coming from coached dyadic sessions is content knowledge, but much of it is process—doing and being—knowledge. In order for both kinds of knowledge to be synthesized and, thus, made usable, they need to be tailored to the particular parent, the particular child, and their particular relationship—what comes alive and grows, or does not, between them. Because several early intervention professions, such as education, speech, and occupational and physical therapy, do not prepare their practitioners to work with parents, mental health workers are often best able to do that tailoring. They are only effective, however, if they integrate a strength-centered perspective and learn a great deal from their body-based colleagues about individual differences in development.

The work is far more *in vivo* than the laid back, patient-does-most-of-the-talking-in-office type of work for which most mental health professionals were prepared. The process is less about interpretation or resistance, although experience with those domains of practice can provide productive guidance. It is more like life-space (Redl, 1966), community-based work (Shahmoon-Shanok, 2000), or kitchen-table psychotherapy (Fraiberg, Adelson, & Shapiro, 1975) in that it is not all talk and may, in fact, occur on-the-spot or in places of the parents' choosing. A lot of this work is preverbal, gestural, behavioral, interactive, and play-based, tailored to draw the person into relationship and communication.

Together, early intervention professionals must develop a generic foundation of developmental and relational knowledge that can be geared to the individual parent and child. The material necessary for professionals to serve parents and their children adequately is both *content knowledge* (for example, the material contained in this chapter) and *process knowledge* (the "being and doing"—interactional, what-we-do-spontaneously-when-we're-with-someone knowledge that is absorbed in a reflectively supervised apprenticeship). There is no better forum for learning than ongoing, long-term, specific-child-and-family oriented in-service training with trustworthy teachers over time. The kind of training, in which strengths are cherished and vulnerabilities are partnered (Shanok, 1992, p. 40), enhances awareness and self-awareness so that practitioners are enabled to use their own professional knowledge base with increasing sensitivity and connection to the feelings and relational capacities of parents (and children).

Box 2. Integration of Adult Education and Social-Emotional Approaches to Deliver *Targeted* Child Guidance[1]

I. Ask each parent what they enjoy with their child and (help parents) build variations and continuities from there. Help them by meeting them where they are and noticing what *they* bring to their child. To find meaning, satisfaction and hope within the demands and resources of the child and the program, they must feel engaged and effective.

II. Observe each parent with their child over time.

III. Woo parents and other key figures (grandparents, babysitters, siblings, inclusion aides) *for* the child by helping them to:
- Imagine the particulars of their child's sensory processing and arousal profile.
- Understand how this profile affects the in-flow and output of signals to and from him.
- Appreciate the fundamental role of (their) relationship in his learning.

IV. Coach parents and others in developmentally appropriate floor time play using knowledge coming from all team members.

V. See children *with* their parents and other key figures to support their abilities to woo their child into communicative relationship and play by:
- Observing.
- Recognizing and understanding their child's evolving developmental and relational profile.
- Reading and responding to his weak signals.
- Meeting their child at his developmental level and building from *his* intentionality, the affective key to learning.
- Drawing their child into an interactional, joyful relationship.
- Building the child's capacities for floor time circles of communication by strategically following and building from the child's intent and pleasure, using high affect and/or a sense of playfulness, as the child can tolerate.

VI. Recognize with parents both the content *and* process elements of developing knowledge.

VII. Notice with parents what bubbles up for them in their recollections and associations.

[1]Targeted child guidance means guidance *tailored* to the particular parent, the particular child, and their particular relationship.

Another point about integration is that, since individuation grows out of attachment and not out of separation, children with challenges need to have essentially achieved the first four steps on the Developmental Ladder (see Figure 3) before it makes sense to work toward greater individuation (cf. Ainsworth, 1978; Sroufe, 1993). Hence, parents should be included in child sessions unless there is an important reason not to; for example, if they are disruptive or self-absorbed during periods when they are overwhelmed. When the child has already achieved a good deal and is finally ready to move towards greater individuation, then separations in digestible doses can become part of the work. But even when the child is developmentally ready to move towards greater autonomy, attention needs to be given to a particular parent's own styles of, and desires for, connecting and disengaging. Professionals are there to assist the dyad, not to dare, provoke, or pressure either child or parent to hurry separation along. Nuanced awareness of cultural differences is particularly significant here.

In many jurisdictions, there is an arbitrary shift from one set of providers to another when a child reaches age 3. This shift seriously undermines parents who need people who know their children intimately and over time, people who share the history of this crisis, this marker process, in their lives. The age cut-off also undermines the professionals who work with children and families, forcing their practice into a revolving door operation, their emotions and dedication blunted with each arbitrary turn. And, for children whose main challenges include relationship, interaction, communication, and integration, this abrupt age-based dislocation can only be termed ridiculous.

Parent involvement is necessary for a developmentally appropriate family-based program for every child. This includes in home floor time play— how to make the most of playing together developmentally—as well as a sensory integration motor program. It also includes the routines, expectations, and limits—depending on the age and capacity of the child and on the style of the parents—of interactions that occur at bathtime, bedtime, and mealtime. It is important that professionals learn to work with parents to develop shared attention over day-to-day details, mutually enlarging the picture of the child, each from their own perspectives.

Each of the professionals involved with a child can come closer to responding to the parents' needs. For example, parents are often desperate to have two-way interaction and, later, a conversation with their child. Professionals can join their intent. Occupational therapists, for instance, can teach parents about constitutional, maturational variations in terms of their child's particular strengths and challenges and about how to provide a sensory diet that helps a child down-regulate for hyperarousal or up-regulate for hypoarousal. Indeed, while parents or caregivers are providing children with appropriate sensory exercise, reciprocity of affect and increasingly long chains of interaction become possible. This helps children connect their heightened intent with motor planning and sequencing so that they enjoy a behavioral outcome that matches their intent. There is no greater reward than that for the child and, when parents have a hand in facilitating it, for parents.

In addition, occupational therapists have a vital role in helping parents understand how they can provide for their children's basic needs by supporting their in-flow and out-flow filtering capacities. Occupational therapists also have a critical role on the team, helping all the adults understand the particular child's sensory, processing, and motor-planning profile, as well as his challenges, in practical ways so that he can be helped to

function at his highest levels more consistently across all his therapies.

Speech/language practitioners also can build upon the parents' growing desire to have reciprocal exchanges with their children by helping parents:

- Observe and notice their child's intent
- Slow down
- Use simple words or phrases
- Stay contingent to the child's interests
- Offer support
- Build joint attention
- Slow down some more
- Offer lots of clear cues
- Stay on the (child's) topic (S. Gerber, July 1999)

The dyadic, floor time, communication- and strength-savvy psychotherapist can help parents recognize even weak signals emerging from their child. One severely compromised, low-tone, bland, and pale-faced 2½-year-old boy, for example, manifested precious few shifts in facial expression in the course of a 90-minute dyadic assessment session. He did, however, evidence mild distress upon falling, and fleeting anxiety crossed his face as he stumbled against and made eye-to-eye contact with the seated therapist. The father seemed to see both encounters, yet ignored each one. The therapist quietly inquired, "Did you see that?" He responded, "My father would walk away when I hurt myself." Brief discussion and an on-the-spot acceptance of his own childhood feelings were followed by a few sentences about the need—especially the need of hypo-registering, weak signal senders—that signals be validated.

This brief interchange helped this father offer gentle, complementary affects. Thus, the next time his son registered an aversive reaction, the father quietly mirrored, gestured and said, "Ooh ... I see that banging your finger hurt ... ooh-ooh ... that's my boy ... okay now" in time and pace with the child. The therapist helped the father see that his son's response—leaning into the father's lap and appearing *more* hurt for a long moment—as dawning progress. The child was distinguishing his sensation within the relational field: Sensation was becoming emotion, and emotion was becoming signal. And signals are, of course, communication. A hint of the mutual regulation familiar in typical early development (Tronick, 1986) can also be glimpsed in this example.

The issue addressed in the foregoing example—that practitioners and parents often ignore manifestations of a child's sensations, emotions, and intentionality that the child experiences—is a critical challenge for the field. The disorders professionals are trying to correct have to do with *relating* and *communicating*. In typical development, babies and young toddlers experience sensations—say, stomach distress—which are "read" by the caregiver familiar with his eat-sleep-poop schedule and his repertoire of sounds and behaviors. When projected into a caring relational field, the sensations are, in effect, *elevated* to the status of signal by the signal reader. It is not a mirroring of the child, exactly. Rather, initial, two-way communication begins as mirroring-empathizing, as if to say, "Ooh-ooh, looks like that hurt" (or "was it fun?") and becomes, "I'll join with you on this so that you come to know what you feel. Only then will we move on." It is an amplification of the child's signals by contingent attunement. These interactions, repeated hundreds of times a day over many days, become the very basis for communication and relationship. Children with challenges need even more, not less, practice than their typically developing counterparts, especially with their closest caregivers. Therapists can and must help parents move their responses into slower motion: as in "Oh, you got hurt.

I see that this happened, that it registered on you. I emphathize and can stick with you while it is processed further. Only *then*, when it is processed further, will I help you move on." The response should not be "Let us cheerfully move on right away!" because the child is having trouble proessing the experience appropriately in the first place and conveying something about it in the second (cf. Fonagy & Target, 1998).

All practitioners would do well to note that people learn most effectively and thoroughly not by hearing or even by watching, but by doing, then reflecting on what they did, and then doing again. Facts, descriptive material, and theory boost and organize learning, but nothing can substitute for *experiential* knowledge. This is the idea behind supervised internships and field placements. Why should parental learning be any different? Thus, it is not sufficient to discuss general approaches with parents, nor is it enough to have them sitting to one side observing. Rather, parents have to be active in the child's therapies for them to really develop their potential for their child.

Jointly watched videotapes of child and parent or child and therapist, discussed together, can also become an asset in what should become a mutual learning and growing process. Practitioners may sometimes be surprised at how much there is to take in from observing a child with a parent. Certain approaches, such as comforting the child, may be adopted, adapted, or built upon.

SUMMARY

This chapter has briefly described the potential inherent in moving the state of the field toward the state of the art by meeting the needs of parents so that *they* can meet the needs of *their* children. Policymakers must move to fund varied options for parents as well as reflexive supervision and other forms of care-based training for staff. Still, there are many actions that programs and practitioners can take to push forward in these directions. With concentrated work and concerted attention, programs and professionals can:

- *Remember that intervention begins at the first moment of contact and assessment never ends until the case is closed.*
- *Learn how to conduct outreach effectively* by making their approaches more individualized.
- *Designate one key person from the staff to serve the particular family.*
- *Engage in in-service meetings* that emphasizes social-emotional, developmental, and transactional themes as well as cross-disciplinary fertilization, case-by-case.
- *Help parents become active partners* in therapeutic sessions for children rather than being passive viewers or being excluded altogether.
- *Work with parents with regularity* and address their developmental level and both latent and manifest themes.

All the professions can also help parents recognize that baby steps do build incrementally over time. While it is sometimes difficult to believe that tiny baby steps can get anywhere, in most cases they do, so that children with significant challenges often become related and capable of sharing pleasure and fun. As one deeply dedicated mother of a child with special needs noted, "We measure miles in millimeters."

Developmental disorders are not only constitutional challenges residing in the child; they become *relationship* disorders. Because all children depend on their primary relationships for cognitive, social, emotional and identity development, practitioners must attend as much to the

child's relationship with parent(s) as to the child. By placing the child's deep needs for the parents' love—and by placing the parents' deep needs for the child's love—both on center stage, therapists can nudge the spotlight away from symptoms and deficits and place it where it belongs: On the circular, back-and-forth transactions which, over time, become relationship and communication and which, simultaneously, nurture the developing emotional and cognitive intelligence of the child.

Virtually all parents of children with special needs require support, partnership, and substantial new skills and knowledge learned in the context of their particular child. Most parents also need assistance with difficult feelings. And some parents have a range of other needs, from concrete services, to crisis intervention, marital counseling, and psychotherapy, all of which need to be closely linked to the work with the child. Attuned, individually geared work with parents is likely to bolster their growing abilities to be attuned, engaged, and individualized with their children. Even as the child is being helped to function better during therapies, the parent is being assisted to more closely respond to the child's shifting states and capacities. Some interventions noted in this chapter respond primarily to the child's needs, whereas others respond to the parents' needs. A family is a dynamic system—what benefits one transactionally supports the other. Indeed, the action *is* in the interaction. ■

Notes

[i]Parts of this chapter were previously published in Shanok, R. (1997a). Giving back future's promise: Working resourcefully with parents of children with severe disorders of relating and communicating. *Zero to Three, 17*(5), 37-48. The author acknowledges ZERO TO THREE, the National Center for Infants, Toddlers, and Families (formerly the National Center for Clinical Infant Programs) with profound appreciation. With the inspiration and leadership provided by its first president, Stanley Greenspan, M.D., ZERO TO THREE became the pioneering national forum for transdisciplinary exchange and network-building on the issues addressed in this chapter.

[ii]Throughout this chapter, for simplicity, all children are referred to as "he," and all therapists as "she."

[iii]As a set of guidelines, this chapter represents what *should* be in place for parents within every program that serves children who have developmental challenges. As such, it is a call to policymakers to provide the necessary funding, not only for the services themselves, but also for in-service training to support staffs as they move in these directions. At the same time, shifts can be initiated to improve interventions with parents through democratic program leadership with an engaged, mission-expanding staff. While discussion of program-based shifts per se lie beyond the scope of this chapter, some guidance about how to move toward the relationship-based, reflective practice that supports fine parent work may be gleaned from Gilkerson and Shahmoon-Shanok (2000) and from Shanok and Gilkerson et al. (1995).

[iv]All names and identifying details of children, families, and practitioners in these and other examples have been concealed, except for those of the author.

REFERENCES

Ainsworth, M. D. S., Blehar, M. D., Waters, S., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation.* Hillsdale, NJ: Erlbaum.

Benedek, T. (1959). Parenthood as a developmental phase: Contribution to libido theory. *Journal of the American Psychoanalytic Association,* 7, 389-417.

Bredekamp, S. & Copple, C. (Eds.) (1997). *Developmentally appropriate practice in early childhood programs.* (Rev. ed.) Washington, D.C.: National Association for the Education of Young Children.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Cambridge, MA: Harvard University Press.

Fenichel, E. S. & Eggbeer, L. with the TASK Advisory Board (1990). *Preparing practitioners to work with infants, toddlers and their families.* Washington, D.C.: National Center for Clinical Infant Programs (now ZERO TO THREE: National Center for Infants, Toddlers and Families).

Fonagy, P. & Target, M. (1998). Mentalization and the changing aims of child psychoanalysis. *Psychoanalytic Dialogues, 8*(1), 87-115.

Fraiberg, S. H., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytic approach to the problem of impaired infant-mother relationships. *Journal of the American Academy of Child Psychiatry, 14,* 387-422.

Galinsky, E. (1981). *Between generations: The six stages of parenthood.* New York: Quadrangle/New York Times Book Co.

Gerber, S. (July, 1999). Comments made at a meeting of the Training and Certification Workgroup, Interdisciplinary Council of Developmental and Learning Disorders, Annapolis, MD.

Gilkerson, L., & Shahmoon-Shanok, R. (2000). Relationships for growth: Cultivating reflective practice in infant, toddler and preschool programs. In J. Osofsky and H. Fitzgerald (Eds.), *WAIMH Handbook of Infant Mental Health, Vol. II: Early intervention, evaluation and assessment.* New York: Wiley and Sons.

Greenspan, S. I. (1992). *Infancy and early childhood: The practice of clinical assessment and intervention with emotional and developmental challenges.* Madison, CT: International Universities Press.

Greenspan, S. I. (1997a). *The growth of the mind and the endangered origins of intelligence.* Reading, MA: Addison Wesley Longman

Greenspan, S. I. (1997b): *Developmentally based psychotherapy.* Madison, CT: International Universities Press.

Greenspan, S. I. & Meisels, S. J., with the ZERO TO THREE Work Group on Developmental Assessment (1996). Toward a new vision for the developmental assessment of infants and young children. In S. J. Meisels & E. Fenichel (Eds.), *New visions for the developmental assessment of infants and young children.* (Chap.1). Washington, D.C.: ZERO TO THREE: National Center for Infants, Toddlers and Families.

Greenspan, S. I., & Wieder, S. (1984). Dimensions and levels of the therapeutic process. *Psychology, 21*(1), 5-23. Reprinted (1987) in S. I. Greenspan, S. Wieder, R. Lieberman, R. Nover, R. Lourie, & M. Robinson (Eds.), I*nfants in multirisk families: Case studies in preventive intervention* (Clinical Infant Report No. 3). New York: International Universities Press.

Greenspan, S. I., & Wieder, S. (1998). *The child with special needs.* Reading, MA: Addison Wesley Longman.

Main, M. (1993). Discoveries, prediction, and recent studies in attachment: Implications for psychoanalysis. In T. Shapiro & R. N. Emde (Eds.), *Research in psychoanalysis: Process, development, outcome* (pp. 209-244). Madison, CT: International Universities Press.

Main, M., & Goldwyn, R. (1984). Predicting rejection of their infant from mother's representation of her own experience; Implications for the abused and abusing intergenerational cycle. *Child Abuse and Neglect, 8,* 203-217.

Mann, H. (1999). Developmental therapy and mirroring. Presentation at Invited Session, Interdisciplinary Council of Developmental and Learning Disorders, McLean, VA, November 11, 1999.

Musick, J. (1993). *Young, poor and pregnant: The psychology of teenage motherhood.* New Haven: Yale University Press.

Redl, F. (1966). *When we deal with children.* New York: Free Press.

Sameroff, A. J., & Fiese, B. H. (1990). Transactional regulation and early intervention. In S. J. Meisels & J. P. Shonkoff (Eds.), *Handbook of early childhood intervention.* New York: Cambridge University Press.

Schore, A. N. (1994). *Affect regulation and the origin of the self: The neurobiology of emotional development.* Hillsdale, NJ: Erlbaum.

Seligman, S., & Shanok, R. S. (1996). Erikson, our contemporary: His anticipation of an intersubjective perspective. *Psychoanalysis and Contemporary Thought, 19*(2). Reprinted in R. S. Wallerstein & L. Goldberger (Eds.) (1998). *Ideas and identities: The life and work of Erik Erikson.* Madison, CT: International Universities Press.

Seligman, S., & Shanok, R. S. (1995a). Subjectivity, complexity and the social world: Erikson's identity concept and contemporary relational theories. *Psychoanalytic Dialogues 5*(4), 537-565.

Seligman, S., & Shanok, R. S. (1995b). Psychoanalytic theories, subjective experience, and clinical perspectives: Reply to Wallerstein, Sander & Altman. *Psychoanalytic Dialogues 5*(4), 605-613.

Shahmoon-Shanok, R. (1997a). Multisystem developmental disorder (MSDD), pattern B. *DC: Zero to Three casebook,* 335-358. Washington, D.C., ZERO TO THREE: National Center for Infants, Toddlers and Families.

Shahmoon-Shanok, R. (1997b). Giving back future's promise: Working resourcefully with parents of children who have severe disorders of relating and communicating. *Zero to Three, 17*(5), 37-48.

Shahmoon-Shanok, R. (2000). Infant mental health perspectives on peer play psychotherapy for symptomatic, at-risk and disordered young children. In J. Osofsky & H. Fitzgerald (Eds.), *The WAIMH Handbook of infant mental health, Vol. IV: Infant mental health in groups at high risk.* New York: Wiley and Sons.

Shanok, R. S. (1981). *Motherhood, womanhood and the life cycle.* Unpublished Master's Thesis, Clinical Psychology Program, Teachers College, Columbia University.

Shanok, R. S. (1987). *Identity and intimacy issues in middle class married women during the marker processes of pregnancy, adoption and Ph.D. work.* Unpublished Doctoral Dissertation, Clinical Psychology Program, Teachers College, Columbia University.

Shanok, R. S. (1990). Parenthood: A process marking identity and intimacy capacities. *Zero to Three, XI*(2), 1-9 & 11-12.

Shanok, R. S. (1992). The supervisory relationship: Integrator, resource and guide. In E. Fenichel (Ed.), *Learning through supervision and mentorship to support the development*

of infants, toddlers and their families: A source book (pp. 37-41). Washington, D.C.: ZERO TO THREE: National Center for Clinical Infant Programs (now ZERO TO THREE: National Center for Infants, Toddlers and Families). (pp. 37-41).

Shanok, R. S. (1993). Towards an inclusive adult developmental theory: Epigenesis reconsidered. In G. Pollock & S. Greenspan (Eds.) *The course of life, Vol 5: Adulthood* (pp. 243-259). Madison, CT: International Universities Press.

Shanok, R. S., & Gilkerson, L., with Eggbeer, L., & Fenichel, E. (1995). *Reflective supervision: A relationship for learning.* (Discussion guide and videotape). Washington, D.C.: ZERO TO THREE: National Center for Infants, Toddlers and Families.

Shonkoff, J. P. & Hauser-Cram, P. (1987). Early intervention for disabled infants and their families: A quantitative analysis. *Pediatrics, 80*(5), 650-658.

Siegel, D. J. (1999). *The developing mind.* New York: Guilford Press.

Sroufe, C. A. (1983). Infant-caregiver attachment and patterns of adaptation in preschool: The roots of maladaption and competence. In M. Perlmulter (Ed.), *The Minnesota symposia on child psychology* (Vol. 16) (pp. 41-84). Hillsdale, NJ: Erlbaum.

Stern, D. (1995). *The motherhood constellation.* New York: Basic Books.

Thomas, J., Benham, A., & Guskin, K. A. (2000). Intervention-centered assessment: Opportunity for early and preventive intervention. In J. Osofsky & H. Fitzgerald (Eds.), *WAIMH Handbook of infant mental health, Vol. II, Early intervention, evaluation and assessment.* New York: Wiley and Sons.

Thompson, R. (1999). Plenary address for a session entitled *Temperament: Who has it and why should we care?* Delivered at the ZERO TO THREE National Training Institute, Anaheim, CA, December 1999.

Tronick, E. Z. (1986). Interactive mismatch and repair: Challenges to the coping infant. *Zero to Three,* Vol. VI(3), 1-6. Washington, D.C.: National Center for Clinical Infant Programs (now ZERO TO THREE: National Center for Infants, Toddlers and Families).

Tronick, E. Z. (1998). Dyadically expanded states of consciousness and the process of therapeutic change. *Infant Mental Health Journal, 19*(3), 290-299.