



# EIT Newsletter

Early Intervention Training Institute  
Rose F. Kennedy Center ■ University Affiliated Program

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## **BABY TEAM: MAKING FAMILY CENTERED EARLY INTERVENTION A REALITY**

Family centered early intervention for young children with developmental disabilities is not only considered best practice, but is now mandated by law. Family systems theory tells us that anything which affects one member of a family unit necessarily affects the other members of the unit. Family centered intervention can bring about change in the identified child and the family unit as a whole.

A child's disability can affect the family in profound ways. Parents grieve and experience a wide range of emotions when they learn initially that their child has a developmental disability. The pain is re-experienced as the child passes through the various developmental changes of childhood. The parent may continually mourn for the "perfect" unborn child who never arrived. As a result, the disability may take precedence over the child and may inhibit the natural attachment process.

Attachment is defined as an enduring emotional tie between a primary caregiver and an infant or child. It refers to a special first relationship that develops out of mutual responsiveness: mother responds to baby's signals of distress, baby responds to mother's nurturing, reliability, and a quality of warmth and affection that is communicated across both members of the dyad. Out of the bonds of healthy attachment develops the basic trust that underlies all future relationships. When attachments are insecure, disordered relationship styles may develop.

The foundation of mutual responsiveness can be found in the early give and take of touching, holding, feeding and loving. How does a mother cuddle a baby with abnormal muscle tone who stiffens or arches her back in response to loving touch? How does a social smile develop when the baby is unable to tolerate visual stimulation? How does reciprocal cooing emerge when a baby is unable to listen and look at the same time? How does a mother feel competent when the baby does not respond as expected? These kinds of questions are

addressed in our early intervention program.

Baby Team is a family centered intervention program offered during or at the completion of a multidisciplinary evaluation at the Rose F. Kennedy Children's Evaluation and Rehabilitation Center. The program serves children, from one month to over one year of age, with diagnosed or suspected developmental delays, and their families. These families represent the community at large, ethnically, racially and socio-economically. The primary goal of the program is to support and nurture a "comfortable fit" between parent and child, in other words, to enhance the attachment process and help parent and child "fall in love."

Team members include a special educator, speech-language pathologist, psychologist, and physical therapist. One of these staff members serves as the primary therapist for a parent-child dyad and as consultant to other families as well as to team members in the group. Assignments for primary therapist are made in consultation with all staff, based on previous assessments of the child's and/or family's needs. Although the team members meet children and families together in a large playroom space, often dyads or small dyadic groups are treated in other rooms due to the specific needs of the child/dyad. Groups are formed based on a variety of factors. At times groups have been divided so as to address the unique requirements of either biological or foster families.

As the team members move toward a transdisciplinary treatment model, professional roles often change. All of the staff will handle, position, feed and play with children, enlisting the professional with the most expertise for guidance. The psychologist and special educator will provide information to families and staff on developmental progression, children's learning styles, coping with regulatory and behavioral distress and other issues which impact on development. The speech-language pathologist will educate families and staff members in typical language development, language facilitation, play, feeding and the emergence of oral-motor skills. Finally, the physical therapist

will demonstrate positioning and handling techniques to encourage and normalize movement patterns.

Families gather when they arrive in the waiting area and are initially greeted by staff members. Over time, this has become an essential component of the program as the parents are given an opportunity to share their morning's experiences with each other, and to discuss events which have occurred over the past week. Parents and children are then invited into the large treatment room where mats have been placed on the floor and appropriate toys have been set out. Parents and siblings will sit with the therapist and baby, playing, feeding, moving and interacting around developmentally appropriate activities. Parents are encouraged to participate in routine activities and to try new toys, games, techniques and ways of interacting with the guidance of their primary therapist.

After the dyadic sessions, the parents join the clinicians in a conference room for coffee and conversation while the children are cared for by paraprofessionals and graduate students. This time is used to problem-solve, to provide guidance about activities of daily life and to support parents through the diagnostic process. Common topics include sleep difficulties, feeding issues, discipline, sibling rivalry, tantrums and managing day-to-day existence with a child who has a developmental disability.

Over time, parents begin to notice and comment on the progress of each child within the group. Information is shared by each dyad with the group about what transpired during the morning session. A perspective is gained by each participant about the unique qualities of their own experience as well as the commonalties which exist. Through weeks of sharing, parents learn to accommodate the stresses and strains of day-to-day living, and to share their joys and pain with other members

of the group. A network is formed among the members which the participants may call upon for emotional support, emergency child care, and information regarding community resources.

Individual cases are discussed during weekly staff meetings and preparation of quarterly reviews. The team shares information about the children and families in order to determine the best way to meet their individual needs. These weekly discussions allow the primary therapists to avail themselves of the expertise of other professionals in problem-solving the needs particular to each dyad. At times outside case management agencies have been contacted in order to provide greater resources to a family. The team interfaces with child protective services, the housing authority, foster care agencies, other service providers and the clinic at large.

The current program model has evolved through research, experimentation, discussions, and relationship building among the professional staff. Each team member brings particular professional expertise to the work, as well as personal and professional bias. It has been important to schedule time for in-service training and planning meetings in order to keep communication lines open. Ongoing discussion of short-term and long-range goals, revision of program planning, and reshaping of the team philosophy have been integral to the personal and professional growth of each clinician.

Through redefining goals in order to broaden the scope and thrust of the program, we have achieved one of our most essential aims: the ability to function as a cohesive unit while providing a secure base of support as a parent begins the process of loving and caring for a child with a disability.

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