Therapists’ Perceptions About Making a Difference in Parent–Child Relationships in Early Intervention Occupational Therapy Services

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OBJECTIVE. The purpose of this study was to better understand occupational therapists’ experiences of making a difference in parent–child relationships.

METHOD. In this qualitative, instrumental case study, occupational therapists working in early intervention were asked to reflect on and describe occasions in which they believed that they made a real difference in parent–child relationships. The primary investigator interviewed nine experienced pediatric occupational therapists.

RESULTS. All nine therapists highly valued the parent–child relationship and focused on these relationships in therapy. Eight themes emerged that described the therapists’ practice insights and methods by which the therapists facilitated the parent–child relationship.

CONCLUSION. The occupational therapists in this study reflected insights that resonate with the literature regarding the role of the parent–child relationship in the development of children. The authors raise the question about the adequacy of instruction at the pre-service level that prepares therapists to both assess and facilitate the parent–child relationship in early intervention.


Occupational therapists working in early intervention are well aware of the role of the parent–child relationship in influencing developmental competence (Kelley & Barnard, 1999; Letourneau, 1997). Several studies support the essential role of parent involvement in early intervention (Beckwith, Cohen, Kopp, Parmalee, & Marcy, 1976; Beckwith, Rodning, & Cohen, 1992; Bee et al., 1982; Coates & Lewis, 1984; Guralnick, 1989) and have precipitated changes in service delivery policies over the past 10 to 15 years. These changes include an emphasis on family involvement in early intervention programs. Currently, most early intervention programs within the United States provide family-centered services (Bromwich, 1997; Kelley & Barnard, 1999; Schultz-Krohn, 1997) that encourage parental involvement in intervention activities as well as parent contributions to therapeutic focus and goal setting. An additional component of family-centered services focuses on the relationships between parents and their children. Substantial evidence exists in the literature that supports links between optimal developmental outcomes and quality relationships with parents, making this component of intervention one of critical importance (Bromwich, 1997; Kelley & Barnard, 1999).

Although occupational therapists in early intervention generally accept relationship-focused intervention as salient to effecting developmental change in children with disabilities or at risk of developing them, promoting positive relationships between children and their parents in occupational therapy intervention may
be difficult (Guralnick, 1989; Mahoney & Bella, 1998; Mahoney, Spiker, & Boyce, 1996). In fact, service providers may not be prepared well enough at the training level to intervene in the relationship dynamic between children and caregivers (Mahoney & Bella, 1998).

The multiple positive effects of the parent–child relationship on the developmental outcome of the child have been documented in the literature (Ainsworth & Bell, 1970; Beckwith & Cohen, 1987; Beckwith et al., 1976; Beckwith et al., 1992; Coates & Lewis, 1984; Cohen & Beckwith, 1979; Finkelstein & Ramey, 1977; Letourneau, 1997). High-quality parent–child interactions have been linked to child resiliency, or the ability to adapt successfully to difficulties (Letourneau, 1997); high IQ scores and accelerated language development (Beckwith et al., 1992; Bee et al., 1982; Cohen & Beckwith, 1979); increased exploratory behavior (Ainsworth & Bell, 1970); and high-level sensorimotor development (Beckwith et al., 1976).

Relationships defined by secure attachment quality provide the context for proficiency in social and cognitive skills development (Coates & Lewis, 1984; Provence, 1990). Greenspan and Greenspan (1989) termed this relationship the “essential partnership” (p. 5) to emphasize the vital importance of the interactions for both the parent and the child. The ability of a parent and child to create this essential partnership influences early learning (Modi, 1999). Moreover, recognition of how this partnership influences development has implications for early intervention services.

The development of the parent–child relationship is affected by various factors, including, but not limited to, parental or child health, parental educational background, family income level, parental work status, and work environments (Bailey, McWilliams, & Winton, 1992). In addition to these factors, families of children with disabilities experience specific life challenges, such as frequent or lengthy hospitalizations of the child and in-home medical treatments or procedures that may place their family relationship more at risk. The extraordinary effort and stress that challenges most families with children with disabilities may adversely affect relationships among all family members (Bailey et al., 1992). Early interventionists working in programs in which parents have had active roles have observed better quality parent–child interactions and more reported satisfaction from parents than programs where interventionists worked with children or parents in isolation (Beckwith et al., 1976; Bee et al., 1982; Guralnick, 1989; Kelley & Barnard, 1999). Parental involvement in early intervention programs thus is recognized as an essential component (Hanft, 1988; McCollum & Yates, 1994).

Occupational therapy practice in early intervention focuses on the occupational behaviors of the child embedded within a family system. These occupational behaviors include movement, play, self-help skills, and social skills that promote interactions with others. Some early interventionists may address the occupational behaviors of parents as well, including interaction and caregiving activities (Moroni & Hickman, 1989). In fact, helping parents to develop a repertoire of skills to enhance their interactions with their child at times may be a primary goal of occupational therapy in early intervention, particularly when working with children with limited social interaction skills (Washington & Schwartz, 1996). As part of an early intervention team, best-practice guidelines in occupational therapy suggest that therapists should be providing services that promote both the infant’s and the parent’s occupational behaviors to facilitate the development of the parent–child relationship (Calhoun, Rose, Hanft, & Sturkey, 1991; Hanft & Humphry, 1989; Humphry, 1989).

Although there has been much discussion about early intervention practices among the professions involved in early intervention service delivery, including occupational therapy, most of the early intervention literature focuses on what should be done (Bromwich, 1997; Kelley & Barnard, 1999; Humphry, 1989). Little research is available within the occupational therapy literature about how occupational therapists are actually providing these services. The purpose of this qualitative study was to gain understanding of therapists’ experiences of making what they perceived as real differences in the parent–child relationship in children and families with whom they worked. Participants were asked to describe ways in which they facilitated the parent–child relationship.

Method
This qualitative study explored how early intervention occupational therapists influence the parent–child relationships of families in practice. Therapists were asked through interview to reflect on their practices and to give story examples. The study is presented as a collective (more than one participant), instrumental case study. An “instrumental” case study examines a particular area of interest and describes, in detail, the everyday activities involved in that phenomenon (Stake, 1994). In this study, the area of interest was occupational therapists’ focus on parent–child relationships when delivering early intervention services. Phenomenological aspects were present in the way in which the interviews were conducted and in the way the study is reported, as participants were asked to describe and reflect on the lived experience of their work. “The point of phenomenological research is to borrow other people’s experi-
ences and their reflections on their experiences in order to better be able to come to an understanding of the deeper meaning or significance of the whole human experience” (Van Manen, 1990, p. 62). Van Manen (1990) suggested that a method for getting at the lived experience of a phenomenon involves describing a particular example of the experience. An Institutional Review Board, Human Subjects Committee, reviewed and approved the study proposal for human participation, including the informed consent forms and procedures.

Participants

Written invitations to participate in the study were sent to all 64 members of a state occupational therapy organization who listed early intervention as their area of specialty. Five additional occupational therapists who were not members in the state organization also were given letters. Twenty-one therapists returned a form indicating interest, and the first 10 who met all the criteria for participation were selected. These criteria were that each participant (a) was currently serving children from birth to 3 years of age, (b) had at least 5 years experience working with this age group, (c) had completed at least one class about pediatric issues in the past year, (d) worked with children and their families in a home setting, and (e) had an occasion in which they believed that their intervention as an occupational therapist made a real difference in the parent–child relationship of a family. Nine participants completed the study. One participant did not complete the study because of a schedule conflict. A small number of participants were used because case studies are not necessarily created to generalize information or theory to a larger population but are “the intrinsic study of a valued particular” (Stake, 1994, p. 238). The participants’ perceptions of their effects on the parent–child relationship were the particular focus of the study. See Table 1 for participant characteristics.

Table 1. Characteristics of Participating Therapists

<table>
<thead>
<tr>
<th>Participant</th>
<th>Degree</th>
<th>Experience (Years)</th>
<th>Caseload (M)</th>
<th>Work Status</th>
<th>Ages Served</th>
<th>Area Served</th>
<th>Work Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>BS</td>
<td>19</td>
<td>15</td>
<td>PT</td>
<td>18 mo–18 yr</td>
<td>Urban</td>
<td>Hospital-based home care</td>
</tr>
<tr>
<td>2</td>
<td>BS</td>
<td>6</td>
<td>6</td>
<td>FT</td>
<td>Birth–22 yr</td>
<td>Rural</td>
<td>Public school</td>
</tr>
<tr>
<td>3</td>
<td>BS</td>
<td>30</td>
<td>20</td>
<td>PT</td>
<td>Birth–22 yr</td>
<td>Rural</td>
<td>Public school</td>
</tr>
<tr>
<td>4</td>
<td>MS</td>
<td>23</td>
<td>23</td>
<td>PT</td>
<td>4 mo–9 yr</td>
<td>Suburban</td>
<td>Public school</td>
</tr>
<tr>
<td>5</td>
<td>BS</td>
<td>18</td>
<td>18</td>
<td>FT</td>
<td>Birth–42 mo</td>
<td>Urban</td>
<td>NICU and public school</td>
</tr>
<tr>
<td>6</td>
<td>MS</td>
<td>17</td>
<td>17</td>
<td>PT</td>
<td>Birth–3 yr</td>
<td>Urban</td>
<td>Public school</td>
</tr>
<tr>
<td>7</td>
<td>MS</td>
<td>28</td>
<td>21</td>
<td>PT</td>
<td>Birth–5 yr</td>
<td>Urban</td>
<td>Public school</td>
</tr>
<tr>
<td>8</td>
<td>BS</td>
<td>6</td>
<td>6</td>
<td>FT</td>
<td>Birth–6 yr</td>
<td>Rural</td>
<td>Public school</td>
</tr>
<tr>
<td>9</td>
<td>BS</td>
<td>9</td>
<td>7</td>
<td>FT</td>
<td>Birth–18 mo</td>
<td>Rural</td>
<td>Public school</td>
</tr>
</tbody>
</table>

Note. BS = bachelor of science degree, FT = full time, MS = master of science degree, NICU = neonatal intensive care unit, OT = occupational therapist, PT = part time.

Data Collection

Interviews were scheduled by phone and conducted at locations of each participant’s choosing. Five interviews were conducted at work sites, three in participants’ homes, and one in a public library. Two audiotaped interviews with each study participant were conducted. The first interviews were face-to-face and ranged in length from 27 min to 60 min. All second interviews were conducted by telephone and ranged in length from 10 min to 20 min.

In a letter before the interviews and then again at the face-to-face interviews, the participants were given the following instructions: “I would like you to think of an occasion in which you believe that your intervention as an occupational therapist made a real difference in the parent–child relationship of a family with whom you were working. I would like you to tell me the detailed story and any reflections about this occasion. In your story, please include information about
• how you realized that you needed to assist with the parent–child relationship;
• what you did to facilitate the development of this relationship;
• any barriers or constraints you perceived to the development of this relationship; and
• your thoughts and feelings about this experience—why you believe this was successful, what you learned from this experience, why this occasion stood out in your memory.”

These guidelines were adapted from Niehues, Bundy, Mattingly, and Lawlor (1991) and are based on Atkinson’s (1998) premise that “direct and simple questions that are designed to get at the person’s own deep experience will bring forth the richest stories” (p. 31). The participants were asked to tell stories; however, most chose to reflect on their thoughts about the therapy experience without constructing stories per se. This process of reflection is well suited to the purpose of the study, which was to understand the ther-
apists’ thoughts about their experiences. Phenomenological inquiry seeks to describe the world as it is known through consciousness (Bentz & Shapiro, 1998). Bentz and Shapiro (1998) called this kind of study “mindful inquiry” in which “the inquirer makes space and time for the reflection” (p. 43). The structure of the study gave the participants a time and space for thinking and describing. The primary investigator engaged in reflection during the interviews and worked with the interview material. This process continued as themes emerged, and the researchers synthesized the interpretations and themes with the related literature.

The initial face-to-face interviews were open-ended, and the participants were allowed to talk without interruption (Atkinson, 1998). The topic of the interviews was described in the informed consent form. In addition, the primary investigator was prepared to stimulate conversation with an example of her experiences in fostering parent–child relations. All first interviews were audiotaped and transcribed, and the text was analyzed and coded into emerging themes. A few participants provided both stories and explicit statements about how and why they valued the parent–child relationship as well as how they believed they intervened effectively to facilitate quality relationships between parents and their child. However, the majority of the data consisted of reflections about the participants’ work, expressed in explicit statements or examples. The primary investigator primarily used the explicit statements and some stories in the data analysis.

In the follow-up telephone interview, the primary investigator asked participants to clarify statements from the initial interview, reviewed emergent themes with supporting phrases from all participants to date, and requested feedback on these themes to explicate meaning and to identify different ways the phenomenon could be viewed through multiple viewpoints (Stake, 1994).

Data Analysis

Data analysis was an ongoing process, beginning with the primary investigator’s transcription of the interviews. The transcription process provided the opportunity to experience the interview at a deeper level. Emerging themes were identified and coded for each interview, beginning with the first two. Further coding was done after four additional interviews and finally after all interviews were completed. A code–recode strategy was used (Lincoln & Guba, 1985). All interviews, transcriptions, and coding were completed by the first author.

Initial coded interviews were set aside while more interviews were conducted, transcribed, and coded. The process was iterative because as additional themes emerged, previous material was revisited and codes were revised. Coding was checked after six interviews with the second author and with one other faculty member with expertise in qualitative methods. The process included reading samples of interview text and summarizing the essence of the passages. These summaries aligned with the identified emergent themes without any discrepancies. In the follow-up interviews, member checking was used as the themes were presented to the participants. Participants were given the opportunity to clarify or make changes as they deemed appropriate. According to Atkinson (1998), “The storyteller should be considered both the expert and the authority on his or her own life” (p. 59). This triangulation process of using multiple checks of data was used to ensure credibility (Creswell, 1998). In the final analysis, a theme had to appear in at least two participants’ reflections and stories to be included.

Results

Each participant recounted experiences and reflections about at least one child from her practice. From the recorded stories and reflections, eight themes emerged in the analysis. In a sense, the child who was discussed became a metaphor for the participant’s own practice and intervention philosophy. Many participants also included reflections and stories about other children they served to help illustrate a point.

Valuing Relationships and Connections

All of the participants expressed beliefs that the parent–child relationship was of utmost importance in the child’s life and that it had a critical effect on the child’s development. They spoke of the value they placed on this relationship and why they believed it was essential for the child’s development. Some, however, initially had a difficult time describing why they valued this relationship. As one participant stated, “That seems so basic.” Asking the participants to put their feelings and beliefs into words seemed to help them to better articulate what supported their valuing of the parent–child relationship. They believed that the parent–child relationship interdepended with the child’s development and maturation and that both the parent–child relationship and the child’s developmental progress could be used to facilitate each other. Indeed, several participants spoke about how they used the parent–child relationship to facilitate the child’s development.

I suspect that I don’t intend to facilitate the relationship so much as use the relationship as a strength for facilitating development in the child. And the two start to work interactively. As you facilitate development, you also impact the relationship, and in teaching how to help development, you can’t really separate the two out so much. Primary is
the developmental process, but my primary tool is the relationship between the parent and the child and the family system. (Participant 4)

These participants believed the parent–child relationship to be the foundation of later relationships in the child's life. Using the relationship as a "tool" to facilitate growth in the child's development was viewed as the basis for more successful interventions. An example given was how one child more readily demonstrated certain skills and was more persistent in working on reach and grasp activities when playing with the mother rather than with the therapist. The parent–child relationship became a resource on which the participant could draw to facilitate the child's growth and development. In this situation, the participant also noted that the interactions increased between the mother and child, with both laughing, smiling, and maintaining eye contact for longer periods as they continued in this activity. The participant later built on this skill in other games. Thus, the relationship was a tool to help the child grow, and the child's growth, in turn, provided more opportunities for interactions to strengthen the parent–child relationship.

Valuing the Parent's Perspective

All of the participants believed that the parents should act as guides during the intervention. They believed that the parents knew their child best and knew what would best meet the family's needs. Ensuring that parents know that they are in control of their child's services was viewed as being integral to successful intervention. Respecting the family's values, actively soliciting parental input for intervention needs, and always providing the parent with the opportunity to disagree with certain interventions or techniques were mentioned as being essential to early intervention.

But I do try to really keep in mind the frame of reference of the parent....And so I try to always keep that in mind, even though what they're saying may not sound like it is the most important thing from my frame of reference. I think that's where we can often get into issues with parents and feeling like they're not good parents because it's hard to step into their frame of reference....So I try to keep, keep going back to the parent perspective. (Participant 6)

I pretty much base it on the individual styles of the family members and try and build it that way. And I ask them quite directly, you know, what kinds of things work for you? What kinds of things don't work for you? And as we go through things, I'll try something, and if it works for me, I'll say, "Is this something that would work for you, that you would be comfortable with?" And if they say no—and families are pretty honest when you're in there every week....I say, "It's not a big deal. We'll find a different way. One that works." (Participant 1)

These participants spoke of the parents' role in therapy and appeared to be actively working for collaboration with the parents rather than getting the parents to "buy into" certain activities or treatment goals, as mentioned by Lawlor and Mattingly (1998). An example given by one participant illustrates this distinction. The participant suggested strategies for increasing independence in dressing, believing this would be of benefit to both the child and the mother. She later learned, however, that the parents never used them. After some discussion, the parents stated that they were not concerned about their child's dressing skills but were concerned about getting the child to play with an older sibling. As a result, play became the focus of subsequent therapy sessions. This participant noted that she thought she had included the parents in the planning of the treatment goals but realized that she must have missed some things that they were communicating. She also stated that she should have rechecked the goals as she and the family became more accustomed to each other.

Working Through the Family Versus “Fixing” the Child

The participants perceived their roles with the child and family as being change agents for the parents so that the parents in turn could be change agents for their children. All spoke of how this view had changed from their earlier years of practice when their perspective was that the therapist had the main impact on the child's development and that the family's impact was secondary. All agreed that they themselves could not affect the child's development without the family being involved.

I think I see myself in working with families as a consultant to the family and a help with problem solving and showing them how to observe so that they are the ones that are saying what the kid is doing so that I'm not the primary. The family is the primary. I'm there as a consultant to help support, to get what they want to happen to happen. Which is different from the old role when I first came out of school and we were in there fixin' the kid and doin' the exercises and the activities and that kind of stuff. (Participant 4)

This theme occurred in all participants' statements and was valued as important to successful intervention. All agreed that this change in their approach—from being the "expert" to spending more time working with parents to better facilitate the child's development—occurred as they gained more experience. Several also believed that it was a change in philosophy of the programs in which they worked. All believed that it was more beneficial to the family. One participant spoke of how some parents seemed to “almost glow” when she would come for her weekly sessions, and they spoke of new skills that their children had accomplished during the past week. This was a change from
her early practice when she would be the one working with a child, not the parents. Although the parents were happy with their children’s accomplishments, she did not see the “glow” she saw now. Several participants mentioned how the parents were able to take some of the information the therapists provided about various strategies and apply them to their other children or to other situations. One participant mentioned that a parent told her that she had begun thinking of how things affected her other children’s sensory systems, not just the child in therapy, and began adjusting activities for each one.

Interpreting Information From a Different Perspective

All of the participants mentioned that at times they had to help families understand diagnoses and reports from various professionals. They believed that they provided a different perspective on the concerns that were stated by other professionals by always discussing how the concern related to functional activities. This belief echoed a finding by Niehues et al. (1991) in their study of school district occupational therapists. The therapists in the Niehues et al. study believed that by restating or reframing the concern, they helped parents to better understand their child, leading to improved communication in the parent–child relationship.

Definitely we view it differently, and we put it in a whole different framework.…We, we put it into a relationship. We relate the limitations we see to the function. And we do introduce a whole new concept of things because the physicians have said nothing like what we’ve said. You know, they—it’s like they’re looking at strictly the diagnosis and to help him get better. But they don’t relate to any of the details. So it is all new.…We do put it in a totally different light for them in terms of what they can expect.

( Participant 2)

Some participants mentioned that they frequently were asked about medical reports, especially neurological reports. One stated that she often brought a medical dictionary along to look up terms as she and the family discussed the reports. These participants noted that they always tried to give examples of a specific functional skill that would relate to the statements in the medical report so that parents could better understand the context of their child’s disability. Most stated that they frequently provided families with information about the child’s sensory system and how this system affected the child’s behavior. One participant recounted an incident with a family during which she explained that some of the child’s behaviors possibly resulted from specific sensory issues the child experienced rather than from noncompliance as a report had stated. The parents later told her that they had been thinking of themselves as “bad parents” because the report implied that they had fostered their child’s noncompliance due to a lack of consistent discipline. The therapist’s information made it easier for the parents to understand why the child was responding the way he was, and they were able to make some positive changes based on strategies that met his specific sensory needs. The participant believed that this intervention had a particularly positive effect on the parent–child relationship in this family.

Interpret the Child to the Parents

Assisting parents to read the child’s cues was another effective strategy that the participants mentioned to help parents to respond more appropriately to their child. Frequently, the cues of the children with whom the participants worked were not as obvious or interpretable as the behavioral cues provided by children developing typically. By helping parents read their child’s cues, the therapists believed that the parents could become more responsive to their child and enhance their relationship while also facilitating development.

Part of it is during my visit, I don’t just structure the kid. I sit back and I interpret the kid to the parents. I say, “Okay, this is what’s happening, and this is what we want: to show [us that] he’s learned it. And so, if this is going on here, watch what he does over the week and see if he’s doing it.” And so, I teach them to interpret that. ( Participant 1)

Helping parents to learn to interpret behaviors as communication seemed to be a common occurrence among the participants. One participant recalled a situation in which a child was playing with a toy truck but then began to run around a room, tantrum, and hide under a table. The parent sent the child to time-out in his room. As the parent and therapist discussed the incident, the therapist expressed her opinion that the child seemed frustrated because the tantrumming started when a wheel on the truck had stopped turning. The mother said that she had not thought of it this way, and the family began working on strategies for the child to request help more appropriately. The parents later told the therapist that the child’s behavior had improved and mentioned specific instances of how they knew their child was frustrated. Several of the participants mentioned that they focused on helping families to read cues that indicate frustration or needing assistance as well as to read cues that indicate the child wanted an activity to continue. They pointed out to the parent what they saw as the child responded to certain situations or activities. This approach appeared to be especially common when the children experienced sensory or physical impairments that interfered with communication skills.
Parents Need To Be Told and Shown
Positive Things About Their Child

All of the participants agreed that providing parents with positive information about their child helped the parent–child relationship. They believed that this positive information provided the parents with different information than they might be hearing from other professionals who might emphasize delays and disabilities. They also believed that positive information gave the parents opportunities to realize that their child could do things and had positive qualities. Finally, the participants believed that they demonstrated to the parents that others could value and enjoy their child.

I was the only one that every time I saw her, told them something positive. “Oh, she’s doing so great. She held her head up much longer today.” Or, “You guys are doing such a good job. I can tell you’ve been working with her on whatever.” I try every time to say something…I just think parents need to hear realistic stuff, but you can’t negate all the good things. They need to be told good stuff every day. (Participant 5)

Lawlor and Mattingly (1998) stated that parents need to “know that practitioners value their child as a human being, enjoy being with their child and ‘engaged’ with their child” (p. 264). One participant stated that she might just hold the child while talking with the parents. She believed that holding the child allowed both the child and the family that she cared for and valued the child. This theme did not emerge in the participants’ initial comments; rather, the participants discussed this theme during the second interview in which they were asked to verify and validate their comments from the first interview. All of the participants discussed some aspect of imparting a sense of value and caring toward the child in the presence of the parents.

Watch the Interactions

The therapists spoke of particular behaviors that they looked for to help determine the quality of interaction between the parent and child. Interactions were regarded as key to the parent–child relationship, and spending the time to watch these interactions was an important use of time with the families. They described touching, eye contact, facial expressions, and body language as some ways of providing information about the quality of the relationships.

I think with regards to that, my intention was I really watch. I watch the interactions. I watch the kids. Are they looking to mom or dad? Are they connecting with mom and dad? How about mom and dad’s faces when their kids do something? Do they light up? Are they anxious to tell me this week, “We worked on this, and this is what we did.” Okay, what is it I need to work on next, or what’s gonna come next? Is there touching? Is there touching between the child and the parent? I think that’s kind of key…Is there that eye contact that I think happens to be crucial? I know they’re connecting then. I know they’re communicating. I probably do more the approach of, you know, “I…really see you two watching one another. I really see that you’re really communicating, you’re really connecting.” I had a mom just recently—the little guy was just 3 months old, and I said, “Do you realize just how much you’re communicating with your little guy?” And she was! And I said, “You guys are really connected.” And then I gave examples of what I was seeing. Interesting that then she came back to me and she said, “Oh, we really were communicating the other night. We were talking about that.” So on…consecutive visits, then, she was talking about that. She then picked up on it. (Participant 8)

The parents’ body language was the main focus of observation related to the parent–child interaction. One participant noted that a specific mother would generally leave the room while the therapist worked with the child. Another said that one mother was always present during visits but always off to the side or far enough away from the child to preclude interaction. In each case, the participants noted that they discussed any potential signs of detachment explicitly with the participant’s work or were the result of parents’ concerns regarding their child’s health status. The participants noted that once the parent had resolved some issues about the child’s health through their discussions, the parent became more interactive with the child during the sessions.

A Change in Focus Over Time and Having My Own Child

All of the participants noted a change in their intervention approaches from their initial years of practice. All believed that they started out in a directive role but became less directive as they gained more experience. Some believed this was because of a change in service philosophy, but most stated that their own views had changed based on their experiences, especially the impact on their practice of having their own child. This personal parenting experience emphasized the importance of the parent–child relationship in their own lives, and they then brought this perspective into their practices. The participants also believed that their own experiences with parenting made them more realistic in their expectations and perceptions of families. Finally, they expressed the importance of experience, stating, as a group, that they had not received information about the importance of the parent–child relationship in their educational degree programs.
But I found what made the biggest impact, what I used to say to parents, I no longer said once I had my own children. I found a lot of things really do come from experience...and I know it changed a lot of ways that I approached things and the way and expectations for the parents. Not that they became less, but that it became more realistic. ( Participant 9)

Each therapist's reflections included this theme. They believed that the way they interacted with families changed once they had children of their own. One participant stated that she did not believe therapists needed to have children to become aware of the parent–child relationship, but in her case, she believed that it expedited the process. Another noted that initially, she was “concentrating so hard on my therapy skills that I wasn’t as open to the interactions occurring between the parent and child” ( Participant 9).

Discussion and Implications for Occupational Therapy Practice

The themes of this study show a strong commitment by the occupational therapists who participated to relationship-focused early intervention services. The fact that the participants were committed to relationship-focused intervention is not surprising because participants were selected based on self-identified beliefs that they could describe an occasion when they made a difference in at least one parent–child relationship. Although some question may exist about whether early interventionists as a group are actually translating beliefs about relationship-focused intervention into practice (Mahoney et al., 1996), the occupational therapists in this study provided reflections about their commitment to providing relationship-based therapy, articulating the importance of family relationships as both goals for therapy and a means for enhancing developmental progress in the child. Some participants initially had a difficult time expressing themselves about certain concepts. One said that the value of relationships seems so basic that she hardly thought about discussing it. This is an example of the “taken for granted” aspects of expert practice considered by Fleming (1994) when discussing the tacit aspects of occupational practice.

All participants agreed that the parent–child relationship is critical to the child’s development. Without this relationship, they did not believe that the child’s development would proceed optimally. This perspective resonates with literature regarding the role of the parent–child relationship in optimizing developmental potentials in children who are typically developing (Barnard, Morisset, & Speiker, 1993; Greenspan & Greenspan, 1989; Guralnick, 1989; Kelley & Barnard, 1999; McCollum & Yates, 1994). The participants appreciated that children at risk or with a disability were particularly sensitive to mediating factors in developmental processes. This appreciation that a good-quality parent–child relationship was critical to achieving the children’s highest potential developmental levels is well supported in the early intervention literature (Greenspan & Greenspan, 1989; Guralnick, 1989; Kelley & Barnard, 1999; McCollum & Yates, 1994). Moreover, the participants understood that parents need to receive positive experiences in order to feel good about their relationship with their child as well as about themselves as parents. The participants acknowledged that the parent–child relationship could be enhanced through their efforts in intervention, specifically by helping parents become more skilled in reading their child’s cues and by enhancing their understanding of reasons for certain child behaviors (Humphry, 1989; Mahoney & Bella, 1998; McCollum & Yates, 1994).

Five participants discussed how their own experiences as therapists and as parents affected their views on the parent–child relationship. All noted that their skill sets had developed over time. The participants in this study were open to change and used their experiences, both personal and professional, to guide their intervention approaches. Bromwich (1997) discussed that this availability to changing one’s perspectives through experiential learning and following the lead of children and parents was vital when working with children and families.

Several participants believed that they became more aware of the parent–child relationship as intervention philosophy changed during their practice. Earlier intervention philosophy placed the therapist in the role of “expert” whereas current philosophy places the therapist in the role of “facilitator” (Bailey et al., 1992; Letourneau, 1997; Resnick, Armstrong, & Carter, 1988; Schaaf & Mulroney, 1989). The earlier intervention “expert” model may have been easier for the therapists to follow initially because it allowed the therapists to concentrate only on one aspect of therapy, developing the child’s skills. However, all participants noted that their practice focus shifted over time to become less directive toward what the child needed and more sensitive to facilitating interactions between the child and the parents. Other participants spoke of how they came to view parent–child relationships as important as their experience grew or as they began working in the child’s home instead of in an outpatient setting.

It appears that as their therapeutic skills developed, the participants became more relaxed and then able to observe and consider the interactions and the relationship between the parent and child. This experience-building in assessing and valuing parent–child relationships in early intervention
has been discussed by others and plays a significant role in successful intervention (Kelley & Barnard, 1999; Letourneau, 1997; Provence, 1990). Findings that suggest that this experience is essential to effective intervention is key when designing or modifying pre-service curricula. Students need sufficient opportunities to participate and observe children and parents together as well as need instruction in the evaluation and interpretation of their observations (Lawlor & Mattingly, 1998; Mahoney et al., 1996).

By following the lead of children and parents, the participants came to embrace a client-centered approach, even though they did not always articulate the term. At least one participant noted that she believed her intentions were client-centered, reflecting changing practice models; however, she realized that her interventions were not always addressing what the parents desired. Most of the participants stated that listening, watching interactions, and then adjusting their approach to better target the parents’ needs or desires improved their own relationships with the parents as well as improved parental follow-through of suggestions at home. The participants felt more satisfied with their interventions when they could observe parents enjoying their child’s accomplishments. Moreover, the participants noted that this change in focus enabled them to work more effectively toward the intervention goals. Invested participation of the parents is essential in early intervention (Barnard et al., 1993; Beckwith & Cohen, 1987; Bee et al., 1982; Guralnick, 1989). Effective changes as a result of occupational therapy intervention in other areas of practice are noted primarily when the strategies are salient to the client (Law, 1998). Moreover, according to the literature, effective changes in early intervention are most pronounced when the strategies used to facilitate the parent–child relationship. Further research may determine which strategies are used most often and which, if any, are more effective at various times throughout the intervention process or with different family concerns. Additionally, exploring whether different strategies were more effective during different phases of a family’s adjustment to their child’s disability could yield useful information.

**Directions for Future Research**

Findings from this study support therapists’ beliefs in the importance of the parent–child relationship in early intervention as well as their beliefs in the need to both facilitate the relationship and use it to enhance the child’s development. We obtained and analyzed information from therapists through both face-to-face and telephone interviews. Several participants mentioned that some of the information was difficult to express because it seemed almost “second nature” to them to do certain things. Future studies could provide a more in-depth picture of how therapists actually conceptualize and then implement strategies to facilitate the parent–child relationship, perhaps using direct observation of interventions and follow-up interviews (Fleming, 1994). Moreover, a study investigating a therapist’s clinical reasoning during an intervention session is aligned with current educational practices using process-oriented learning models to train new therapists (Kielhofner, 1992; Neistadt, 1996).

The participants in this study discussed various strategies used to facilitate the parent–child relationship. Further research may determine which strategies are used most often and which, if any, are more effective at various times throughout the intervention process or with different family concerns. Additionally, exploring whether different strategies were more effective during different phases of a family’s adjustment to their child’s disability could yield useful information.

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