A. Pastorova, V.Ryskina "Early intervention strategy in working with families (A case study.)" , Congress of Educational Therapy, Lillihamer, Norway, 2002

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Early intervention strategy in working with families (A case study.)

The paper deals with the role and the place occupied by the work with parents in choosing and implementing a strategy of early intervention. It is well known that the parents' role in the early intervention programs is equally easily underestimated or overestimated. The paper contains the ideas of a multidisciplinary team of the Institute of Early Intervention, St.Petersburg, Russia, on formulating a strategy while working with a child at different stages of the relationship with the family, and an analysis of the outcomes of a particular strategy chosen.

From the very first early intervention programs practiced in the world and in the Russia, special attention was paid to the environment in which the child is growing up. Today no further evidence is needed for the fact that social environment plays a significant role in the child's development. It influences the developmental process no less, and at times more, than biological factors. This concerns both the normally developing children and those with developmental problems.[1] Numerous research projects also show that the effects of working with a young child's environment are much higher than when working with just the child, not considering the social context[2] (Guralnik, M. 96, MacDonald, Blott, Gordon, Miller & Sloane, A.Kaiser, 97).

When speaking of babies and young children, the most significant factors of the child's environment are his parents or the family members who bring him up and provide care. The influence they exert upon a child and the child's developmental process is in many aspects determined by their own views and attitudes towards the needs of the child and the ways and means of bringing up children. [3] (Clark, Brazelton, Fraiberg, Muhamedrahimov)

The issue of parental role in early intervention is very relevant. It has been long discussed in literature. There are indications that the parental

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[1] This is why the existing early intervention programs are based on family-centered intervention, making use of various guide-books for parents (Carolina Curriculum, Portage Program, etc.) (Kozhevnikova, Chistovich, 1996).

[2] It has for instance been demonstrated that using the Parent-Implemented Language Intervention when working with children whose language development is delayed is highly effective, with results often more stable, than when none but trained specialists have been working with the child.

[3] The parents' subjective interpretation of their relations with their child have been called "imaginary interactions". They are considered to be derivatives of fantasies of self and close relatives, of ideals and fears taking source in their own childhood. The infant, when born, reawakens some of these fantasies and is thus at birth included in the imaginary scenarios brought in by the parents. The mother's contribution to these imaginay interactions is in general identifiable by what she says of the baby, of herself as mother, and of their emotional life in general.

attitudes and beliefs are in the last extent determining the outcome of the intervention. The study by Cathryn and Booth (1976) has shown how the parents' explanation of what is the reason of the child's disturbance may change overtime. Initially the parents explain the difficulties in the child's development or behavior either as a temporary lapse or as influence of the environment. But if, in spite of all the parents' effort, the child does not achieve the expected progress, parents tend to move on to other explanations – the child's innate biological traits. According to Cathryn and Booth, this process defends both the image that parents hold of themselves and their representation of their child, since it rids them of perceiving themselves as unsuccessful and of the shame for the child. Cathryn and Booth also suggest that when parents are explaining their child's behavior by factors beyond their control, it may influence their idea of how active or passive they should be in attempting to effect a change in their child and promote his development. Where parents are convinced that the reasons of their child's behavior are innate or biological, parents may to a lesser extent participate in the intervention process.

The research of the past decades has also revealed how far the individual traits of the child itself ("difficult" temperament, developmental delay, etc.) may modify the habitual behavior of the mother, thus exacerbating the problem. Barnard and Kelly (1990) have found evidence that the less frequent and weaker vocalizations in babies with developmental delay may cause the mother to behave erratically and be less oriented towards the signals of the baby. On the other hand, the mother having an image of her baby as weak and retarded leads to hyper protection and controlling parental behavior. Interaction in such a dyad become disturbed, and provoke numerous difficulties in the child's development, including the behavioral and emotional ones. (Muhamedrahimov, 1999).

The complex and multifaceted influence that parents and child exert upon each other causes us to try and retry to understand: what should be the role of parents in our work with children?

Thinking of the parental role in therapy, we ask ourselves the following questions:

- What part of the parental behavior helps, and what on the contrary hinders the development of the child?
- Are the parental ideas about the child and the child's problems an important factor dictating the choice of style and strategy of early intervention or merely a context, the framework for the early intervention?
- What is the extent of influence upon the early intervention program of the family culture context (social position, adherence to national traditions, level of education, etc.) ?

- How far is it necessary or possible to affect the parental representations, when working in early intervention programs with a family having a child with developmental problems?

Specialists need answers to those questions in every specific case in order to chose the optimal strategy of help and to carry it out effectively.

The way a working strategy is chosen, carried out and modified upon what we learn about the family, may be followed using a clinical case.

The story of Mitya T.[4]

The family of Mitya T., aged 2 years 10 months, referred to the Early Intervention Institute in October 1998. According to the parents, the boy was seriously delayed in speech development and was aggressive. In the first interview it was found out at once that Mitya was not using the potty yet, at times got so excited that he was difficult to calm (the parents often resorting to the belt on such occasions), would rock obsessively for long periods of time (similar behavior had been observed since the age of seven months). The receiving specialists noted that Mitya is very agile, often falls down, steps on toys, is overexcited, the eye to eye contact was glancing (when anybody looked in his eyes longer the child would scream and thrash about with his head). During the interview he was for some time moving a car monotonously before his eyes, very close. (It was the specialists' impression that Mitya showed some autistic traits in his behavior). Mitya would at times articulate separate sounds, some of them at the parents' request. He would follow the parents'simple instructions – jump, say "cat". It also evolved that the family had two years before moved to St.Petersburg from the Far East. The father being in the Army, the family had moved extensively in Mitya's first year. Mitya's mother is a housewife. At the time of referral the family was living in a communal flat (rooms with several families sharing a communal kitchen and sanitary facilities) with Mitya's maternal grandmother.

<u>The stage of choosing a strategy</u>

The early intervention system is based on two main principles: a family-centered approach and multidisciplinary teamwork. The ***family-centered*** *approach makes it possible to take into consideration not only the specifics of the child's problem, but of the family as well, that is, to work with a parent-child system, and to actively involve the parents in the intervention process. While the* ***multidisciplinary*** *principle permits considering the parent-child system not merely from the perspective of one particular problem and through the eyes of one professional coming from a medical, educational or psychological paradigm, but also as a living, multifaceted, integrated, constantly changing system. The analysis and discussion of the developments by various specialists is necessary*

[4] The name has been changed.

in order to choose the optimal strategy and to change it timely to suit the changing circumstances. This is also called ***dynamic (non-discrete) assessment***[5] *(E.Kozhevnikova, 1999).*

In accordance with the structure of the early intervention service of the Institute the pediatrician and psychologists conducting the initial interview with Mitya have on the grounds of the primary interview of the parents and the assessment of the child's development according to the CDI scale, suggested checking out Mitya's hearing with an audiologist, as well as have him see a neurologist and a speech therapist, and to have an eye specialist assess his eyesight.

By the time Mitya had been through the neurologist and the speech therapist the following data was already collected by the specialists:

- The CDI assessment[6] At the passport age of 2years 10 months Mitya's development in various aspects was as follows:

Socially	1 year 9 months	(36% delay)
Self-service	2 years	(28% delay)
Large-scale movement	2 years 9 months	
Fine movement	2 years 3 months	
Speech development	1 year 6 months	(47% delay)
Speech understanding	2 years	(29% delay)

- Audiologist

  While with the audiologist, Mitya covered himself with his arms, avoided contact, screamed. The audiologist has, like the other specialists, noted some autistic traits in the behavior of the child.

According two the data of two assessment sessions, Mitya's hearing is normal.

- Eye specialist

  Mitya's basic visual functions and acuteness of sight were measured and also found to be within the norm.

While interviewed by a *neurologist* and a *speech therapist*, Mitya showed much better contact than in the previous sessions. He preferred playing with the male neurologist, his parents remarking that this was typical of him.

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[5] The question of the essence of **assessment and diagnosis** in the early intervention is not a simple one. Assessment of a child's development is made on a scale evaluating (once every three months) the development of motility, speech and socialization (cognitive development is mostly assessed on the basis of the child understanding speech directed at him|her). Development in the various areas is assessed by a specializing expert. The need for a **diagnosis** is dictated by the desire to describe, assess and define the child's condition as best one can in order to provide the most adequate help.

[6] Child Development Inventory, Harold R.Ierton, 1994, transl. "Early Intervention Institute" – a scale of child's development from 1.5 to 3 years.

Several times, however, he threw himself on the floor screaming, apparently, as a way of demanding a toy. In a number of instances it was difficult to understand his wish, and he made no attempt to express it by any other means. It was obvious he was attentively watching what the reaction to his tantrum was. Several times he would raise his arm strike at the father. From time to time he would ask for pity, demonstrating pseudo-hurts or scratches. The parents looked helpless, making almost no attempt to regulate Mitya's behavior. The nother gave the impression of emotional coldness and indifference towards mitya, and spoke much about how difficult it was for her to manage him. The father, on the contrary, was very sensitive and responsive, but also managed the child's behavior (or rather, regulated it) with difficulty.

The speech therapist's assessment revealed that the boy's active vocabulary consisted of 17 words: mostly names of persons and imitation of various noises, and 3 words to denote actions. There were no characterizing words whatsoever. These data were acquired from the parent questionnaire for assessing active speech, no objective data being forthcoming at the time. For this reason the speech therapist hesitated to give the final assessment of Mitya's speech development as delayed, further observation being clearly in order.

The neurologist found indirect signs of residual organic damage to the CNS (MBD): asymmetrical face, irregular scull outline, awkward movements, veins clearly visible, inability to control emotion, primitive ways of contacting, mechanistic actions[7]

The decision was made to offer no medication.

From a more detailed history, medical and psychological (from 'the parents' spoken report and the medical records):

Mother: The boy was born of the third pregnancy, preceded by two medical abortions – the last one three years previously. During pregnancy had toxicosis in the first half of the term, temperatures up to 31.5. Blood pressure 140. Received dibasol, calcium, vitamins, and infusotherapy. The parents wanted to have a girl, Kate, at 4 months of pregnancy were told it was to be a boy. Named for the paternal grandfather. Parturition on schedule, 40th week,

[7] Though Mitya had a medical (neurological) diagnosis (in Russia it is a neurologist who diagnoses and treats a condition like that), it is obvious that when dealing with social and emotional problems the assessment of a neurologist and the CDI are insufficient. Mitya's condition could be defined as delayed psycho-speech and psycho-motility development, neuropathology with autistic manifestations, and hyperactivity. According to other classifications Mitya's behavior and condition could be characterized as emotional disturbance, pervasive developmental disturbance (DSM-IV, IDH-10), disturbed or regulation, troubled sleep, impulsive behavior (0-3 Diagnostic Classification). There could also be a disturbed relationship, but the situation demanded a deeper and more detailed study

It should be noted that we saw such a diagnostic assessment, thinking over of Mitya's problem, as necessary for elaborating and systematizing our hypotheses in order to form a dynamic diagnosis and to help us choose, and at need to modify, our strategy.

Apgar –8\9, weight 3200, height 52 cm. The head would not pass through, needed anesthesia. The boy cried at once, was put to the breast at once, sucked badly – kept falling asleep. The mother would leave him on the bed and roam the hospital. The boy would sleep for 10 hours. Would not take a pacifier, took to it at 2 months, then would turn away and cry. Breast-fed in arms until 3 months. When the baby was 3 months old, the mother returned to work, the baby was given the bottle. The boy accepted the bottle when the hole was made larger. He was fed in a pram, not taken up in arms as the parents feared that would be pampering. At 4.5 months would no longer fall asleep in arms in the airplane, being used to the crib. Until 1 year was calm. The development in the first year proceeded normally. Virtually no illness. Started rocking at 7 months. From 1 months to 2 years often woke up at night. Was fed on demand (day or night, every 2-3 hours) to stop him crying. At 2 years they started taking him off the bottle at night. For a week Mitya cried a lot in nighttime. The mother kept saying she will not give him the bottle.

At present, he dislikes dressing, sometimes asks for the potty, but more often shows wet pants. Lived almost all the time with the maternal grandmother (except for periods from 4 m to 7 m and from 8m to 1 year 6 months).

At 2 years 1 month referred to the policlinic neurologist with the rocking. Took the prescribed sedative, but it did not help.

Father: Describes the wife's condition during pregnancy as calm, the pregnancy was planned. Mitya was born in a town in the Primorsky region, where the father was serving. They moved many times. Mitya adjusted easily to the changes of schedule and the time difference – at 4 months there was a move from Primorsky area to Petersburg, then at 7 months from Petersburg to the Kaluga region. When he was being taken home from the maternity hospital, he did not cry or weep, was silent, hardly ever slept at night till the age of 1 year. They thought he was "deaf and dumb". Liked to be held. Could not have enough food, had to supplement with formula. Made first vocalizations at 5 months. Asked for the kefir bottle at night, after they weaned him off it, started waking up. Sometimes comes at night, asking to be taken to the parents' bed. At 1 year they started potty-training him – he got stubborn. The grandfather got him bathroom trained. Now uses the grownup toilet. Appetite has always been good. Now he often spoils it with nuts and juice the mother gives him. At 1year 2 months started eating at table, would not readily take to the spoon, like with the potty. Now, especially in company, eats all by himself. At home asks to be fed. Often mentions the paternal grandfather, but when he comes visiting, hides from him and screams. The grandmother he is living with is not mentioned so often.

Remembers Iana, aged 7 (a cousin on his father's side), but sometimes hurts her without meaning to. He tends to hit or push other children out of excess of tenderness.

The specialists could not arrive at any consensus over what it was that was causing Mitya's current condition. One obvious thing was that the parents had proved unable to set consistent limits for the boy, that there was no regimen in the family (that is, problems caused by inadequate parenting), the mother's emotional coldness (disturbed relationship/attachment), organic damage to the CNS. Yet how far each of those factors was contributing, and how would that affect the subsequent strategy of helping the child? It was decided to see the family two more times in order to observe Mitya's behavior, and to try various ways of establishing contact with him. The family was also referred for further tests, including brain ultrasonics. The results of that examination did not shed any light on the child's condition.

The usual screening procedure in early intervention has enabled us to determine that the child had no sensory disorders, and this made it possible for us to focus on finding the reason for his further disturbances.

Therefore our initial strategy was to seek additional information and meanwhile to arrange for individual sessions with a speech therapist (since what the parents considered as the main problem was the delay in speech development).

The stage of implementing the initial strategy

The family coming to the speech therapist[8] are often worried by one thing only – the child lacking active fluent speech. It bothers them that the child either does not speak at all or repeats an occasional word after a grownup. ***Lack of fluent speech*** *is often formost among the worries of the family even in the face of other problems. It is rather frequently the case that parents just do not see or hesitate to present other problems, like "missing" the fact that the child is not always good at understanding speech directed at him, does not make good contact, etc.*

In this case the teacher has to solve several problems.

- What lies under the present problems in communication – speech disturbances (fairly difficult to differentiate at an early age), delay in cognitive development, problematic social and emotional development, or something else?
- How far are the parents prepared to accept that the problem of speech development may not be the key one? How important is that for working with the child successfully?

[8] In early intervention the speech therapist is a teacher meeting with both the child and parents for the purposes of facilitating communication (in its both verbal and non-verbal aspects) and stimulating the children's communicative behevior. Further in this paper we shall refer to the speech therapist as teacher.

- Which way to work with the family best? What approach, what form to choose? More structured or less? Group or individual framework? Involving other team members or not? To draw the parents into the working process outright or to be gradual about it?

In thinking of the strategy proper for Mitya, the teacher would have to find some solution at least for all those questions.

In the first two sessions in a situation of free play we could watch Mitya's reaction to the parents joining his play, to new adults and new toys, how much active can the teacher get to establish a contact and speech communication. We watched Mitya react to touch, watched for how essential it is for him, and how much affect he displays in answer to the nature of the contact. It was important to see in which situations the stereotypical rocking we have described would start, and in what state Mitya is then.

One major problem at this stage is to assess how well the child is able to understand verbal communications directed at him, to see in which communicative situations he can and will answer, imitate, ask, comment, etc.

What procedures does an early intervention teacher have at his disposal?

The most structured procedure is an interventionist-directed approach. In this approach the specialist knows beforehand what he wants the child to learn, given the level of the child's development, repeatedly applies the same kind of stimulus, actively confirms the child's achievements, until the lesson is learnt firmly. Such an approach is based on direct teaching instructions, and is often successfully used with children in child institutions and groups.

Yet for Mitya this approach was obviously not feasible. The quality of contact and motivation to cooperate with an adult were too low, while his level of emotional responsiveness made it impossible to quickly activate the contact and then use the situation for teaching.

In the so called naturalistic procedures (milieu, responsive interaction, incidental teaching, etc.) (Cavallaro, Kaiser, Warren, 96) the interaction between specialist and child is mainly based on the principles of following the child, creating a specially organized milieu, where teaching through some promptings and requests may take place in situations that the child creates himself. Parents are in this approach cooperators in the process, getting instructions as the session proceeds (naturalistic procedures are in fact based on the models of natural parenting behavior).

Mitya was not in contact with the specialist, on the contrary, he demonstrated a conscious withdrawal from her. In the monotonous and scanty play situations where Mitya preferred to be alone, in his means of getting his wish, we also saw no basis for the usual parent-centered use of naturalistic

methods in the initial stages of working with the child. Nor were the parents able to understand and to maintain this form of teaching the boy. In this case to achieve an interaction process with the family it was first necessary to create a time-and-space context, that is, establish some framework, boundaries, and rules, to serve as guidelines for the subsequent development of the relationship. The child's age, his communicative pattern, his aggressive manifestations, the apparent helplessness of the parents all pointed towards this way of establishing relations with the family.

The teacher chose an approach combining clealy set boundaries and following the child's lead within the framework of the game chosen (a semi-structured approach). It was a difficult decision, since as far as the teacher knew after talking to parents and making observations in the first few visits, it was clear that nobody had ever placed Mitya in conditions where he could begin learning self-regulation. The strategy suggested by the teacher in the next two sessions was as follows:

- A small-sized room was chosen, where all the toys could be hidden in the cupboard. Thus the teacher was determining the conditions of the child's play.
- Mitya was allowed to play with any one toy, but only one at a time, replaced by another only after he had put the previous one back. This was additionally important because at home Mitya had a lot of toys in a place easily accessible to him, and treated them in the following fashion: in the morning he threw them all on the floor where they lay about in a heap all day, until in the evening the mother put them back to there places. She did not involve Mitya in tidying up the toys.
- In the study room Mitya was told to play only sitting at a table, which the teacher thought should also help him to learn regulating himself better and was conducive to concentrating his attention on whatever activity he was busy with at the time.

The idea of organizing Mitya's sessions in this way came from the overall impression of the boy's disorganized state and of the family supplying no conditions for him to overcome it.

These rules were so novel and unexpectedly complex for Mitya that it took about 45 minutes of struggle before Mitya realized that the conditions will not be changed (which always happened immediately at home in situations where thw boy showed the slightest displeasure). The parents, to there surprise, saw that Mitya understood rules and was capable of following them. At the end of the session Mitya sat at the table quietly for 15 minutes, played happily, asked for a new toy to be taken out of the cupboard when he was tired of the previous one.

The teacher observed how difficult it was for the parents to live through those 45 minutes. In their educational toolkit the only means to deal with mitya's frustration were either to withdraw their demands at once, or to punish him. The teacher's suggestion that one can actively express sympathy and compassion for the boy, yet to go on insisting on the rules being kept, was a new experience for them of overcoming situations difficult for the child together with him.

More or less the same happened also in the next session, but Mitya did not protest quite as long or as intensely as the first time. But the teacher was aware that using this new experience might prove difficult for the family unless the parents themselves got additional help. The contribution of the conditions prevailing in the family into Mitya's current state became obvious – it seems that it was enough for the boy to use primitive means of expressing his needs (tantrums) and ways of dealing with frustration (rocking). The parents appeared unable to help him learn to do this in a more mature way. The teacher decided that subsequently this family should be worked with by a teacher-psychologist tandem. Another decision made was that the family should periodically consult the neurologist as well, since the version of organic reasons for Mitya's disturbance had not been abandoned yet, and he might have needed medication. This was another step in forming a strategy to help Mitya and his family.

The new strategy – teacher and psychologist working jointly.

The aims of the teacher were:

- To go on working on the better contact and dialogue with Mitya;
- To consistently present and keep up rules, thus creating the conditions necessary (under the circumstances) for the child to acquire age-appropriate skills, including speech.

The aims of the psychologist were:

- To help the parents to become aware of what is happening in the session and how it helps Mitya's development;
- To help parents to implement the same principles of establishing and maintaining rules at home;
- To support parents in working out their own ways of helping Mitya to regulate himself, fitting the family context.

The specialists decided for the teacher and the psychologist to have regular weekly discussions of session material, as well as monthly discussion of the process of the teacher, the psychologist and the neurologist.

The roles for each of the specialists were set: the teacher works with the boy, the psychologist and the parents being present but not participating actively. The task of the psychologist was to discuss with the parents what they were witnessing in the session, their feelings, considerations as to how useful these sessions were for Mitya, and the chances of doing something similar at home.

In the next few sessions:

- Mitya would again protest against the rules established, but less intensely, and for a shorter time;
- Managed to keep eye-to-eye contact more often;
- Happily repeated the actions that had elicited approval from adults. Repeated also the gestures of approval (clapped hands, showed thumbs up, as the adults had done when saying “Great!”

It seems when the situation became more predictable and therefore more safe for him, he felt more interest in what was being offered him.

The specialists noted that Mitya did not excel in games that needed reciprocity and following simple suggestions given by adults (i.e., rolling a car down a slant), that is, activities needing close contact with a partner. Yet he was successful enough in simple constructive activities (putting together a simple puzzle of 3-5 parts) and in simple imitation with tactile material (i.e., tried to imitate the motions of rolling plasticine into a “sausage”).

Such a level of play activity development specifics of speech development (could imitate sounds and words, but was practically never using them on his own; the level of speech comprehension was low and defied objective assessment), left open the issue of grave problems possibly existing in the boy’s intellectual (cognitive) development.

Parents started mentioning the changes in Mitya’s behavior at home: he became more docile, obedient, began to repeat more words. The mother said she “now loved him more”.

Yet the main problems of the child persisted: he would periodically rock, did not speak, was aggressive, and the parents were still unable to follow the style of interaction with Mitya decided on together with the specialists. The parents found it hard to manage even the now very small and complete home assignments, and were clearly oscillating over their acceptance of the changes in Mitya (the mother would at times enthuse over “striking” changes in Mitya’s behavior, then say that this was as it always had been, that nothing new was happening). There was still a great difference between what was required of mitya by father, mother and grandmother. They obviously needed more help and support, which could not be achieved with this strategy. It had to be changed again.

We started preparing for the change by collecting a more detailed history than in the initial stage, from both parents[9]. Apart from yielding extra data, this also brought them closer to the family in order to start thinking together of the sources and reasons for Mitya's problems. At our request the parents filled in questionnaires revealing the specifics of their relationship with the child (ACB – Eidemiller, Warge-Stolen). We got to see a video recording made by the parents when Mitya was 3 months old. The data from the questionnaires ("symbiotic relations between father and son, and the mother's rejection[10], as well as the mother projecting her own negative qualities on the child) and the analysis of the video[11] (we again noted that the developmental problems that Mitya had had from birth, were being exacerbated by the sort of parenting he got) made us again reconsider the contribution into Mitya's present problem coming from the boy's biological endowment and the family style of parenting. In spite of being still unable to answer that question, we were aware that the parents' contribution was so great that no intervention could be achieved, unless help was soon given to parents as well.

The final strategy – changing the style of working with the parents

Mitya's parents had to have help not only to find out what the boy needed for normal development, but also be assisted along that difficult developmental path together with him. It also had to be taken into account that this was a family, with definite established attitudes (i.e., the mother's love for immaculate orderliness in the house, which came into conflict with the little child's needs), and an unconsidered change in those attitudes could adversely influence the very existence of the family system. We stood in need of finding a step-by-step consistent support of the family along to necessary changes. Because, on the one hand, there were now new demands on the family itself (from the point of view of the information given by the specialists on the needs of a developing child), while on the other hand, Mitya himself, changing, was now jerking the family out of the accustomed ways (i.e., demanded of the fairly withdrawn mother to get more involved, as he was becoming more communicative). Mitya's father was increasingly manifesting irritation at the mother's parenting style.

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[9] For the history see above pp.4-5.

[10] Assessment interpretation on the scale of «symbiosis\rejection" of the Warge-Stolen questionnaire.

[11] The literature of the recent years discusses the question of how far can retrospective information be relied on, including the videos of the first months of the child's life presented by parents. There have been cases when qualified experts would make diagnoses on the basis of such material which proved to be wrong. We are certainly conscious of the danger of forming a "diagnosis" resting upon retrospective video material, and believe that such information should be used carefully, always in conjunction with other data.

We also believe that using the data from questionnaires (CDI, ABC, etc) in working with families, amounts to rough screening, and the resultant information may only be used in a multidisciplinary team, and only in conjunction with other data.

Out of the types of psychological help available in such cases, family therapy seemed to be the most attractive, but the specialists rejected the idea. The boy needed immediate help, while family work would demand a lot of time and resources. For the same reason, and in the event that the family was not asking for anything of the kind, other techniques directed at the parents' feelings and emotions, had to be excluded. Techniques focusing on the parents' behavior in their relations with Mitya were considered more adequate and relevant. The technique the specialists chose was ICDP[12].

The framework of this educational program for parents, widespread in many countries of the world, provides them with opportunity and a place for meetings to exchange and discuss matters of bringing up children. This program is directed at developing sensitivity in the parents themselves.

The intervention consists in helping the parents recognize the positive points and abilities of their child, and at the same time to give them a deeper understanding of the parenting skills they already possess. This promotes and enhances their self-assurance as caregivers. The use of video records of parent and child interaction enables the experts to draw the attention of parents to what they do well, and why this is good for the child's development, thus supporting this behavior as part of the parents' tool-kit. The parent do not get an impression of being lectured or criticized, or ordered to do something they are unable to perform. At the same time the constant support of the specialists, who, together with the parents, look through the videotapes of the parents playing with their child, allows the parents to focus on the positive changes in their interaction with the child.

The ICDP method is rather a form of a guided reconsideration of one's own positive practice of parenting, than a direct instruction about parenting skills.

The meetings with Mitya's family at this stage (by the time of beginning to work according to the ICDP program there had already been 10 sessions) looked as follows: once a week they came to the session Mitya had with the teacher, with the parents and the psychologist present. Now that the child had learned to keep within definite behavior rules connected with setting up boundaries, we came to use even more actively the procedures of naturalistic approaches – following the child's attention, giving choice, commenting on the proceedings. Mitya always used to choose both the toy and the activity to use it for, the teacher supported the play to the extent that the child wanted it, offering but not forcing new activities on him, was actively following the play by naming, questions, praise. In addition, in every session we asked one of the parents to play with the child for 5-10 minutes and videotaped this process. Once a week we saw the parents without Mitya in order to watch and discuss the videos.

We usually selected in advance the bits of video showing those behaviors in the interactions between the parents and Mitya, which, in our opinion, were helpful for Mitya's development (following the child, naming the objects the child is playing with, regulating his behavior by means of praise, introducing a

[12] H.Rye, K.Hundeide, International Child Development Program, 1999.

plot into the play activity, etc.). Pointing out those instances to the parents on the video, we tried to explain, why such interactions were so important for Mitya. We recorded Mitya with each of the parents separately, and then invited them together to watch the video in such a way that the stronger aspevts of each could be subsequently used by both of them. Apart from that, a mutual discussion of strengths helped the family to become more attuned to their own interaction, caused their behavior in playing with the child to become conscious.

It should be noted that invitation to the first of those discussions caused severe anxiety in the parents: they were ththan 30 minutes late, and then we could not start discussion for a long time, as the mother kept talking of things unrelated to Mitya.It took a lot of our patience and empathy towards the parents in order to help them start discussing the videos.

After some time Mitya, now aged 3 years 1 month (that was after about 15 sessions), started pronouncing a greater number of separate words (about 30 now) demonstrated a clearer comprehension of speech directed at him (the parents noted about 116 words that he would understand without gesture and in any situation), became more clear in expressing his wishes, not only in session, but also at home. He would more often be interested in names of things in the street, would sometimes repeat those names after mother, (yet it resembled echolalia). But the intonations of his speech remained inexpressive and jerky, there was still no phrasal speech. Mitya enjoyed the result, which was strongly confirmed by another's response. He would watch the adult, as if searching for the appreciation of what he had done. This was judged by the specialists to be a visible achievement in contacting Mitya.

The teacher also started broadening the options of the structure of their sessions, that Mitya had already got used to:

- Part of the time Mitya would spend in the room where the sessions usually took place, and part in a new large office, where the situation of free play was created, and where Mitya could play, for instance, with sand, which he loved. These periods of time (beginning of the session, end of the session, transition to free play) we would separate visually, by showing Mitya the bright moving arms of a clock. We also divided the time of the session into definite periods with the help of pictures showing what it was that Mitya was doing (a boy drawing, a boy molding, etc.). This made the time structure visually reinforced, and helped Mitya understand that abstract pictures are connected with reality, which was supposed to facilitate forming generalized ideas and concepts. For the same purpose an album of family photographs was used. The use of the album had additional significance, since Mitya felt obvious difficulties over his identity. He never used the pronoun "I" (though "I" usually appears among the first spoken words with speech

delayed 3-year-olds) and almost never designated himself, by word or gesture. Speaking of himself, Mitya used verbs in the second person singular: “Find!”, “Go!’)

- Mitya was now always given a choice (Will you draw or mold?”; Will you take the big chair or the small one?)

In the new room Mitya understood the rules much easier (i.e., that one can only play with sand in a special box). Both at the sessions and at home his behavior became more easy to regulate. He started to use replacement objects more often. His mimic was becoming increasingly more expressive.

As our work progressed, the time that Mitya spent in the session room became smaller, and the time for free play became longer. We observed Mitya to become better at making contact, to support interaction or play suggested by an adult. Because of that we frequently tried to introduce routine games (constant songs or poems with gestures, playing with a car) which gradually became more variable. Now Mitya easily accepted that.

Mitya started to play longer with parents in our office. They spoke of having practically abandoned the belt, which used to be the only means of regulating the boy’s behavior. The mother said: “He has grown up and begun to understand better. And now it is enough just to show him the belt, if he gets too naughty. We no longer beat him”.

Of course, Mitya still had difficulties. His speech developed slowly, play activity was impoverished. He still needed serious help with self-regulation. – For instance, it has become increasingly difficult for him to leave the office he was playing in. When told that “it was time to go, Mitya would get into a corner, started rocking or tried to hit his parents who were trying to talk him into leaving. We suggested introducing a special ritual of leaving - Mitya blowing out a candle, which served as a special framework marking the end of session for the boy. This, as well as constantly helping the parents to understand, why structure was so necessary to Mitya, helped him learn to cope with situations difficult to him.

In our ICDP work we continued discussing with the parents their successes in playing with the boy and regulating his behavior. We try support them when they shared with us their worries about the difficulties of bringing up such a child as Mitya. We pointed out to them how wonderfully the father could uphold the framework in interacting with Mitya: he would very mildly teach the boy how to treat different toys, always responded to change of interest in M, maintaining the framework of the situation they were in. For instance, looking through a book, he would show the boy the rules of treating books: “A book is looked through from the beginning… let’s look from the beginning…”. Yet the father lacked flexibility to allow Mitya more spontaneity within this framework. The mother’s style when interacting with Mitya had

another wonderful characteristic: she would comment on Mitya's actions, helping him tie together what was happening in the game, with his past experience. For instance, as they were building a toy house together, she reminded him of the country house where they had recently been, and when Mitya started playing with a toy wolf, she reminded him of the fairy tale about a wolf she had read to him the day before. She did not, however, have adequate ability of reading Mitya's signals, would not support his vocalizations, almost never observed the direction of Mitya's attention. Also, the mother often said that she was not interested and did not want to be playing with Mitya.

We observed how slowly and day by day there appear changes in the concept of parenting this family held ("I know he has to be played with, but I do not want to, I get tired", "he is just like me – if I do not want something, I just won't"), and we did not force them on. But even such small and gradual changes proved to be a real ordeal for the family. Our regular discussions with Mitya's parents of their interactions with him obviously promoted a heightened attention to the contribution of each into the boy's upbringing. The mother started telling about rows in the family, and a big quarrel on the eve of the one planned visit of the teacher and psychologist to Mitya's home. But thanks to the strong alliance formed with the specialists, both during and after the conflict (the father who had left the family came back a week later), the contacts with the family were never broken.

Yet we noted definite positive moves in the family: the belt was put away in a cupboard, it was no longer used to threaten Mitya, the parents' educational repertoire broadened. The parents started to talk more of their own behavior towards Mitya, frequently analyze their past behavior. (For us now the mother's phrases of the type: "I have come to punish him less, to allow him more, to put away things not needed, so as not to provoke or distract him… I used to do it before as well…", were no longer so much the evidence of hesitancy in accepting the change in Mitya, as an indicator of starting the inner work to analyze her parental behavior). At 3 years 5 months Mitya was already speaking in phrases, repeated a lot (with strong distortion of syllable structure and articulation), played games with a plot, regulated his behavior in a virtually age-appropriate manner (the tantrums and rocking were almost gone), definitely showed comprehension of speech addressed to him. Our work was drawing to a close. The parents were already thinking about sending the child to a kindergarten. Our last advice was in a discussion of the results of the latest video: we drew the mother's attention the enthusiasm and abandon with which Mitya was taking part in a game she had organized. Commenting on a close-up of the smiling, wildly and demonstratively happy Mitya, we spoke to the mother of how important it is for him to feel her attention and interest in a reciprocal game, of what a joy it is for him, and of the fact that she can elicit such emotions in him. We were addressing not the parents' logic, but their emotions, since now they could bear such treatment.

Our next and last meeting with the family half a year later, when Mitya, already 3 years10 months old, went to kindergarten. Mitya spoke fairly much, in phrases of 2-3 words, enjoyed communicating and playing, making up his own plots. And though there still remained some difficulties connected with his behavior, he became much calmer – he could now express many things with words. But the main thing was that the family was successfully managing education without recourse to the belt, emotional withdrawal, or catastrophic quarrels.

Analyzing the course of working with this family, several points come to mind. Once again we raise the question of how necessary, or possible it is to influence the parental attitudes in working with a child. Undoubtedly, the environment, particularly the parents and their ideas of parenting, are important for the process of therapy, and are sometimes such that they need to be changed, since they either provoke or exacerbate (like in Mitya's case) the child's problems. Yet these changes are a very delicate and complicated process, and caution and a lot patience are required of the specialists. As for the techniques a specialist may use in working with family members, the choice has to be dictated by the character of the parents, and by the cultural context of the family, and by the child's potential. Thinking of Mitya's family we come to a conclusion that what proved therapeutic both for him and for his parents was not only the content of the sessions or recommendations voiced in them, but also a year of regular weekly meetings that made it possible not merely to offer help to the family, but to help them make use of this help. At the outstart of our work the parents were only capable of cooperating with the specialist in one way: arrive every Tuesday at 14.00. They were simply incapable of benefiting by the recommendations, and we realized that to insist would be wrong and useless. Time and gradual steps were needed to have them reconsider the child's needs. Without the support made available the parents would simply have left, refusing help, to face their problems alone once again. The parents needed to be in a situation where they are accepted, and their ideas of themselves, their child, and parenting treated with respect and understanding.

We would also like to stress that in early intervention, where specialists are working with children having severe organic and genetic damage, the role of parents could at times be exaggerated, as relations with a child having serious developmental problems may naturally give rise to a specifically inadequate style of behavior within the family. Therefore, we are dealing with a tangle of problems where separating what is primary from what is secondary, even if possible, requires time and a meticulous dynamic assessment. This is why it is especially important to approach the process of helping a family with the greatest care, to be slow in laying stress on anything, and to be prepared to go through the painful process of change together with the family.

Postscript

When we ask ourselves, if we would have followed a different strategy is we were to learn (to suggest this only hypothetically) in the first steps of dealing with the family, what had been the main cause of Mitya's problems – the answer is, no. The strategy would have remained the same. It is, in fact, no matter what made the child to be that way, be it organic damage, disturbed relationship, or whatever. Different professionals may describe it in different language, but the important thing for every specialist is to help the child and the family to learn ways of **adaptation**: how to live with organic damage, or with disturbed regulation, in the given social environment (so long as it cannot be changed), etc.

We were helping the family to learn (and were learning with it) how to treat a child, and we were helping Mitya to learn to adapt in the changing life conditions. So the object of intervention wasneither Mitya nor his parents, but the relations between them that were slowly changing in the process of our dealings with the family.

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