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Family Dynamics in Early Intervention: Case Study Insights on Communication Development

*Ana Poposka**

**PHI Centre for rehabilitation of pathology in verbal communication –Skopje, Republic of North Macedonia*
**Heimerer Coledge, Veranda D4, Hyrja C dhe D, Lagja Kalabria, (Rruga për Veternik) 10000 Prishtinë, Republika e Kosovës*

ABSTRACT

Early speech and language intervention is implemented through various models and approaches. Comparative analysis of the benefits of early speech and language intervention compared to other types of early age rehabilitation treatment represents a significant field of research. Family involvement is crucial for positive results, and families are simultaneously considered service recipients. Emphasizing parents' understanding, and engagement in their child development contributes to better lifelong experiences for the child and parents. The specific purpose of this study is to establish the developmental outcomes of two children with developmental language disorders in comparison of the level of parents' involvement due to resolution of state of mind (by implementing Reaction of Diagnose Interview). This research empirically validates the impact of parental involvement, showing that a resolved and proactive parental mindset is associated with favourable outcomes of child development. At the same time, this case report calls for a paradigm shift in intervention approaches so that therapist-guided, parent-implemented models become the norm. This research also reduces the gap between scientific knowledge and real-life applications, providing practical insights for policymakers, therapists, and educators.

Keywords: Early intervention, Reaction of Diagnose Interview, child development, parental support

Introduction

Children with developmental disorders are at risk of numerous issues that begin at birth and continue into later stages of life. The conditions affecting these children, making them candidates for early intervention, include developmental delays, socioeconomic deficiencies, and poverty(Anderson et all, 2003)y. Early intervention is based on the assumption that children from impoverished environments, as well as children with any developmental disorders, can achieve significant improvements in cognitive, academic, and social areas. Recently, significant progress has been made in our ability to provide effective early intervention for children with behavioral issues and impaired abilities. Diamond, et all (2013) emphasize that early intervention is intended not only for children with diagnosed pathological conditions and developmental delays but also children growing up in unfavorable conditions.

The concept of family-centered care first emerged in the 1950s within medicine and social work. At that time, it marked a significant shift in perspective, moving away from a purely patient-focused approach to one that also prioritized treatment outcomes for the patient's family (Jolley, Shields, 2009). This approach emphasized the importance of considering not only the patient's needs but also those of their family in the healing process. Schaefer, in 1969, expanded this concept within early intervention, pioneering a model that involved both the child and their parents. His work highlighted the value of integrating parents into early intervention practices to achieve more effective and holistic outcomes. Building on this idea, Urie Bronfenbrenner in 1974 introduced the term "family-centered," signaling a move from child-centered approaches to those that place the family as a whole at the core of care. Bronfenbrenner's concept recognized that the well-being and development of the child are deeply connected to the support and involvement of their family, thus redefining early intervention practices to embrace a more comprehensive, inclusive approach.

Data of interest of the topic

Rather challenging aspect are parents approaching the role they are given to be part of program involvement in early intervention practices. Once parents face the reality they are having special needs child, there are a lot of challenges to overcome, from accepting the diagnose to actively participate in the early intervention program (Sapiets, Totsika, Hastings, 2021). First challenge is copying with the diagnose, and accepting it in terms of resolution with the situation. The second challenge is change of introspection of the child and them as parents, once the diagnose is confirmed. Parental resolution of diagnosis is essential for the successful adaptation to raising children with disabilities, as well as meeting the requirements of the parental role (Krstic, T., et all, 2013). For that purpose in 1992 Pianta and Marvin establish a concept of guiding a semi-structured interview which will confirm the state of parent mind. So called Reaction of Diagnosis Interview (RDI), was structured to establish previous experiences correlated with their child's diagnosis as well as their accompanying emotions. When parents have supportive attitude towards the diagnosis, they are focused on action, enabling them to concentrate on addressing their child's current needs. Indicators of resolution include parents are expressed in a sense of moving forward in life, and being oriented towards the present and future in their thoughts and actions.On the other hand, parents who are considered "unresolved" often exhibit signs of disorientation and mental confusion, which can manifest as feelings of grief, confusion, and incoherence. These parents may appear to be mentally preoccupied with the past rather than engaging with the emotional and cognitive realities tied to the diagnosis. They tend to show cognitive biases concerning their experience, focusing on previous events and often displaying feelings of being overwhelmed, depressed, or angry (Krstic, T., et all, 2017). Negative emotions—feelings of guilt, shame, and emotional breakdown; thoughts—fear of stigma and concern for the child's future; actions—concealment, seeking support, and attempts to reject the results of the diagnosis, are the most frequent manifestations (Barak-Levy, Y., Paryente, B. 2023) Parents' resolution of their child's diagnosis is associated with parental sensitivity and secure child attachment. The Reaction to Diagnosis Interview (RDI) is the accepted measure for assessing resolution (Sher-Censor, E. et all, 2020). Aditionaly, as confirmed by Yirimya et all, in 2014, using the *Reaction to Diagnosis Interview* (RDI), when resolution with diagnosis was examined among parents of children with various disabilities and disorders including ASD, strong association with better outcomes for children was revealed.

Research methodology

The aim of this research is to compare the developmental outcomes of two cases of children with developmental language disorders who were involved in early support processes, in corelation with the parents' resolutiion of the child diagnosis.

In this study, the subject of research is the involvement of parents in different types of support and the impact of the active involvement of parents on their relationship with the diagnosis and the results of the child's rehabilitation.

During the research the Descriptive method and Comparative analysis were used. The methods are to support an thorough overview of the initial situation with the parents diagnosis resolvment in correlation with the development of selected children, as well as comparison of the status of resolvment and development outcome in two selected cases of a children with developmental disability. Tests used in this research were Reynel Language Comprehension Development Scale, edition number 3 (58), from 1995, and Koralje - Communication Development Scale (59). Also RDI (Pianta & Marvin) interview and documentation analysis of the Support Team Assessment Reports, Individual Family Support Plan, and Individual Rehabilitation Treatment Plan.

Case Study 1

A. M. is a 2-years and, 8 months old boy. He was brought for an initial speech therapy evaluation at the initiative of his mother. The parents state that the only reason for their concern is that their child does not speak like his peers.

During spontaneous observation, he is interested in objects, but not in people. He likes to play with toys, but this activity lacks creativity and a longer course of play. He often throws the toys, and he still does not know how to share and participate in joint activities. He does not join in playing with peers. Verbal communication is not his first choice and he uses it only when there is an extreme need. He mainly communicates with one word, a noun, and even less often uses words that indicate an action. In communication, he rarely uses a 2-word sentence, and these are learned sentences whose purpose he knows. He understands verbal commands that are unambiguous and situational. Although he understands commands, he often decides not to carry out requests, and he shows this by ignoring them or expressing strong disapproval. His mother constantly supports him, without assessing whether he can complete the activity on his own or not.

His parents say that they treat him with concern and overprotection and that they often tolerate unwanted behavior. His mother speaks to him warmly and always goes out of her way to accommodate him.

Assessment achievements

During the initial review, as well as during the follow up, several procedures, both standardized and informal, were implemented to assess the degree of developmental achievements.

Table 1 – Quantitative achievements of child A.M. during early intervention follow up

Type of assessment	Age 2,8 y	Age 3,4y
Reynell Language Comprehension Scale (1995)	20 months	24months
Developmental Scale for Communication (Words and gestures) Koralje	18 months	25 months
Psychomotor achievements	21 months	26 months
Audiometry	Normal hearing	

From the chart shown, it is noticeable that the child shows a significant delay in the development of all segments of his psychomotor skills. From the applied tests, it is noted that the level of language comprehension is equivalent to a developmental age of 20 months, the results of the development of communication, words and gestures are equivalent to 18 months of developmental age, while from the obtained developmental assessment developmental age of motor skills are 21 months. The child has good listening ability.

During the second month of service support an RDI was performed, with both parents. Parts of the conversation were with questions like when they first met with the information, how both of them felt when diagnose was received. Mother admitted she was shocked at first, because of not having any previous information about that diagnose, and how it will affect their future. For the father it has been a challenging time with many questions on their minds, if they would manage, what about schooling and making friends with other kids. What helped most of all to the parents was information about the disorder, therapy, and that a positive development is possible. Father stated they had talked to other parents with similar experiences "Meeting them and listening to them encouraged and comforted us, and it seemed to make it not such a big problem for us alone". Mother is aware of having obstacles, but developmental challenges, but felt satisfied by small steps every day, by focusing on what they can do. From the moment of facing the diagnose, their life changed and actually, they became lot closer, with a lot of dialogue, feelings, and shared decision-making as well as more patient presence in the home surrounding.

An early intervention plan was established and agreed with the parents in terms of support in the natural environment as well as service support within the institution. It was agreed that the parents bring the child for regular speech therapy treatment twice a week. The parents readily accepted that a meeting with the speech therapist would be held once a month, in a natural environment, outside the institution. The purpose of the visit was to support the family during daily activities, provide family counselling, and provide guidance for improving the child's functional abilities.

Case Study: S.R.

S. R. is a 3year and 8 month old boy (44 months) who was included in early rehabilitation medical model. S.R.'s developmental progress was primarily guided by structured therapy sessions with professionals, while parents played a consultative role rather than an active one. During observations in outpatient room, S.R. showed expected interest in toys and limited interest in people. While he displayed an ability to manipulate objects, his play was mostly repetitive, and imaginative or symbolic play was not observed. His challenge was interaction and required adult prompting. Functional communication was not his first choice and mostly used single words. S.R. relied heavily on non-verbal cues and only occasionally used two words to request or label objects. His initiation was prompted by a situation of need. His expressive vocabulary was significantly delayed compared to peers, and he showed difficulty spontaneously establishing two-word combinations. He understood situational gesture supported commands but often refused to preform activity.He relied heavily on adult intervention for task completion and rarely exhibited independent problem-solving behavior. S.R.'s parents provided extensive support but with little structured reinforcement of therapy strategies at home. Each of his parents expressed different level of concern about his developmental delays and felt dependent on therapists to guide progress. Parents asked for receiving advisory guidance. During the initial review, as well as during the implemented support, several procedures, both standardized and informal, were implemented to assess the degree of development achievements.

Table 2 – Quantitative achievements of child S.R. during early rehabilitation follow up

Type of assessment	Age 3,8 y	Age 4,4y
Reynell Language Comprehension Scale (1995)	26 months	30 months
Developmental Scale for Communication (Words and gestures) Koralljе	24 months	29 months
Psycho-motor achievements	27 months	31 months
Audiometry	Normal hearing	

From the chart shown, it is noticeable that the child shows a significant delay in the development of all segments of his psychomotor skills. From the applied tests, it is noted that the level of language understanding is equivalent to a developmental age of 26 months, the results of the development of communication, words and gestures are equivalent to 24 months of developmental age, while from the obtained developmental assessment developmental age of motor skills are 27 months. The child has good listening ability.

During the second month of service support an RDI was performed, with both parents, applying the same questions by the protocol for RDI, as mentioned in the previous case of the first family. The mother emphasized she was overwhelmed and surprised, while the father was not clear why he is even there, since his child was a little slow, but "plenty of kids develop a little later and manage".The mother is mostly concerned about the future, an the ffather claimed nnothing's wrong since his nephew had taken four years, and afterwards he hade become a chatty one. "Doctors overdo diagnoses".Considering a speech therapy support parents showed different attitudes, mother was willing to try, and the father did not think it was necessary to obtain such, since "kids develop at their own pace and will speak when they're ready".

Parents stated different opinion for the point of learning about early intervention for support, not labels, could be beneficial.While the mother simply didn't want to miss a significant problem and have regrets about it, the ffather believed that it was beyond needs.

An early rehabilitation plan was agreed with the parents in terms of support in the institution a. The parents showed no availability to be active participants, but only to take the child to sessions and receive information from the therapists.

Discussion

Through a comprehensive examination this analysis compares two cases, A.M. and S.R., who were included in different intervention models—a family-centered approach (A.M.) and a traditional medical rehabilitation model (S.R.). Both of them were followed in their developmental progress, language skills, self-feeding, and socialization. One of the most critical aspects of early intervention is language development. Both A.M. and S.R. were assessed using standard tool, and their results indicate that both children exhibited delayed comprehension and expressive abilities compared to their peers. Despite intervention, neither child fully closed the developmental gap. Expressively, both children struggled with forming sentences, relying mostly on single words or gestures. Despite these minor differences, both approaches resulted in comparable language progress, indicating that both interventions accelerated speech production with the same pace of 4 months developmental improvement. Language progress is direct consequence of in home strategies and family implementation (Crawford and Weber, 2014). The Developmental Psychomotor Assessment shows that both A.M. and S.R. made steady progress, but A.M. achieved a slightly greater increase in developmental months. A.M. improved from 21 to 26 months (+5 months), while S.R. improved from 27 to 31 months (+4 months). Although S.R. maintained a higher overall developmental level, A.M. demonstrated a greater rate of progress. This suggests that home-based reinforcement and parental engagement may enhance psychomotor development just as effectively, or even slightly more, than professional therapy alone. A sstudy of Bernabe Zuniga et all, in 2024, confirms that early interventions incorporating parental participation result impacts motor and cognitive positive outcomes in children with developmental delays. It found that children receiving both professional therapy and parental guidance at home displayed stronger fine motor control and problem-solving skills compared to those relying solely on clinical interventions.Language acquisition and socialization require consistent engagement, practice, and reinforcement, all of which depend on both structured therapy and everyday communication opportunities (Tosh et all, 2017).

Socialization as crucial part of early childhood development, influencing both communication and behavior.Here, in this research, both children struggled with peer engagement. From the follow up A.M. showed a slightly higher tendency to engage socially, likely due to the family-led reinforcement of social skills. However, neither model fully addressed social independence.A.M.'s parents were overprotective and may act as obstacle for his ability to develop independent social skills, as his parents frequently adjusted to his needs instead of challenging him to manage social situations on his own. In contrast, S.R.'s parents were less involved in reinforcement in natural setting, leading to a greater reliance on structured therapy sessions. This lack of continuous practice outside professional settings may have contributed to his more profound difficulties in engaging with peers. Both children struggled with developing peer relationships, limited social motivation, and neither was able independently to participate in shared activities. Beyond socialization, self-care skills such as self-feeding, dressing, and managing daily activities are crucial for a child's functional independence. In this area, both A.M. and S.R. exhibited significant challenges, but their progress was influenced by the differences in their respective intervention approaches. Both children also faced challenges with other self-care routines, such as dressing and following structured daily activities. A.M. showed some initiative, attempting to put on shoes or pull up his pants, though he struggled with dressing a jacket. However, his parents' tendency to immediately step in and assist limited his opportunities for practice. S.R., on the other hand, waited passively for adults to complete tasks for him, displaying greater dependency than A.M. This comparison suggests that A.M. had slightly more functional independence than S.R., but his progress was interrupted by over-accommodation from his caregivers. Meanwhile, S.R.'s lack of motivation and reinforcement at home resulted in even slower self-care skill acquisition. These findings are similar to th conclusion by Allias et all in 2024, a research where collaboration among occupational therapists, parents, educators and health professionals in home programmes enhances self-care intervention outcomes.

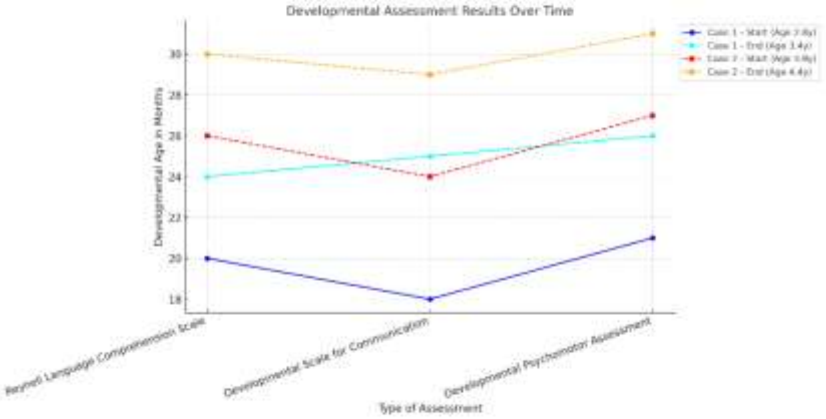

Chart 1 Correlation between developmental improvement and age between two cases

Comparing the developmental progress of the first case (A.M.) and the second (S.R.), different patterns of growth in the key areas are noticeable.

From 20 months in the Reynell Language Comprehension Scale A.M. ended with 24 months developmental age, while S.R. began at 26 months and improved to 30 months on the same scale. Despite S.R. starting at a higher level, both cases had an equal rate of progress (+4 months).

Developmental Scale for Communication showed a measure of opposite performance. Case 1 progressed 7 months (18 to 25), while Case 2 progressed just 5 months (24 to 29). This indicates that the intervention had greater effects on the communication development of Case 1.

Once again, the Developmental Psychomotor Assessment showed comparable results with A.M. gaining 5 months 21-26 while S.R. gained 4 months 27-31. Even though S.R. was always at a higher level, Case 1 made up for that in equal growth comparative of developmental months. Our research corresponds with the of Kellar-Guenter et all. In 2014 where higher parental involvement, particularly in home-based settings, significantly enhances developmental outcomes. It further highlights that children whose parents are actively engaged in reinforcing therapy at home demonstrate greater progress in language and cognitive development than those who rely solely on external interventions. Further on, Fereirra et all, in 2020 confirmed early intervention focused on the family has a positive effect on the developmental mlestones of preterm infants. The effect on motor development was lower, possibly due to the emphasis on interventions in family-child interaction. The effect of interventions on the development of children at social risk and on the language domain was inconclusive, due to the scarcity of studies in the area.

Discussion on the Interview

In RDI interview, the parents in the case of A.M. demonstrated resolution regarding their child's developmental language disorder diagnosis, which can be categorized as adaptive and accepting resolution. This type of resolution is characterized by a conscious acceptance of the child's condition, focusing on their abilities rather than their limitations, and taking an active role in their progress.

Their responses show cognitive resolution, as they actively sought information, connected with other parents, and learned how to navigate the challenges.

The motivation behind their resolution is information, since information they received helped understanding what the disorder is about. Moreover, the father highlighted that "we met other parents with similar experiences," demonstrating that social support was a significant factor in their resolution.

The resolution statements indicated that initial fear had been replaced with acceptance, had suggested a positive view of their child rather than fear or regret, had shown realistic expectations, focus on progress and demonstrates a conscious shift in perspective.

This interview clearly demonstrates a process of resolution in which the parents, through knowledge and support, change their perspective.

The interview with parents of S.R. demonstrated a lack of resolution regarding the child's diagnosis of developmental language disorder. The mother was still processing her emotions and was uncertain about what steps to take, while the father was in denial, dismissing the diagnosis and resisting any interventions. Marvin and Pianta, (1996) clearly analysed the same indicators of mothers resolution to the diagnose.Similar to these findings are stated in the research of Kazak et all, from 1997 year.

Indicators of non-resolution in the case of S.R. can be noticed by minimization of the problem, emotional distress, and resistance to intervention. Evident were potential barriers to resolution, like not seeking for information, fear of stigma and presence of emotional resistance.

Following are summarized difference in perspective of both families in the field of therapy

Table 3 – Influence of parents Mind-set on therapy follow up

Aspect	Case 1 (A.M.)	Case 2 (S.R.)
Initial reaction to diagnosis	Concerned but open to guidance	Denial and passive acceptance
Emotional Response	Anxiety transitioned to confidence	Mixed response—father in denial, mother overwhelmed
Willingness to Engage	Increased over time; parents became actively involved in the intervention.	Limited engagement, often citing work obligations or lack of time.
Participation in Therapy	Active involvement; attended sessions, applied techniques at home	Minimal participation; expected therapy to fix the issue
Attitude Toward Progress	Tracked progress, adjusted home routines accordingly	Relied on professionals, did not actively monitor changes
Perspective on Therapy	Believed intervention could significantly improve their child's abilities	Expected therapy to yield natural improvement without their direct involvement.

A.M.'s parents demonstrated an adaptive coping approach. Apart from the initial stages of concern over A.M.'s speech and social development, they took a proactive position, actively participating in therapy and implementing strategies in natural surroundings. This mindset played a pivotal role, as they transitioned from anxious uncertainty to an engaged, informed approach to intervention. In contrast, S.R.'s parents exhibited an avoidance coping mechanism. They struggled to integrate therapy strategies into their daily routines, relying predominantly on therapists to guide S.R.'s progress. This hands-off approach resulted in slower developmental progress, as S.R. lacked consistent reinforcement outside structured sessions, making therapy feel like an isolated event rather than a continuous learning process.

Conclusion

This study confirms a proportional correlation between parental involvement and developmental progression in children. The child whose parents have resolved state of mind, and take an active role in early intervention, has higher functional achievements. Additionally, proactive parenting improves functional abilities in daily living of their child. The independence of self-care and social development accelerates in family-oriented framework, where the child is always encouraged and interact in a structured way. Clearly, the findings stress that for maximum developmental gains in intervention, parents need to be an active voice and settled in their emotions. Continuous service support enhances the communication skills and overall developmental impact in both cases. In the case of the two families it is confirmed that both models have noticeable impact on accelerating all developmental abilities towards developmental milestones.

In general, parental involvement is prerequisite and impact factor in early intervention outcomes. Parents with a resolved state of mind are able to serve as consistent source of support by linking service support and natural environment. In fact, children whose parents put all on the therapists make slower progress in functional abilities, e.g. social and self-help skills. A holistic approach where professionals cooperate with parents to activate daily strategies results in best developmental outcomes. Family-centred models that foster the application of service support by parents in their child's daily routines provides developmental improvements The findings underscore the rationale behind shifting to parent-inclusive early-intervention methods that endure in the long run through collaborative support by professionals and families.

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