An Innovation in Infant Assessment and Intervention:

THE INFANT BEHAVIORAL ASSESSMENT AND INTERVENTION PROGRAM

IBAIP

©

Vigeland Sculpture Park, Oslo, Norway, 2000

A listening heart,
A holding presence,
Together they speak within the moment.

Hedlund, 2008
THE INFANT BEHAVIORAL ASSESSMENT
AND INTERVENTION PROGRAM
IBAIP©

An Education and Training Program for Health Care
& Early Intervention Professionals

Training is offered in the following components:

- Infant Behavioral Assessment
- Neurobehavioral Curriculum for Early Intervention
- Self-Regulatory Competence Scales
- Holding Parents Holding Their Baby
- Individualized Record of Neurobehavioral Facilitation
- Becoming an IBAIP Trainer

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“Each baby is from the start a person and needs to be known by someone. No
one can get to know a baby as well as the baby’s own mother and father can.”

Winnicott, 1964/1987, p. 86

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I. SIGNIFICANCE

“What happens during the first months and years of life matters a lot, not because this period of development provides an indelible blue print for adult well-being, but because it sets either a sturdy or fragile stage for what follows.” This is the unequivocal conclusion of the National Research Council’s Committee on Integrating the Science of Early Childhood Development (Shonkoff & Phillips, 2000, pg 5).

Of National Concern: Low Birth Weight, Incidence and Sequelae. Advances in neonatal intensive care technology and an increased understanding of neonatal pathophysiology has supported many more premature low birth weight infants to survive and return home with their parents than ever before. Of the 4 million live births annually in the United States (Bennett, 2002); approximately 12.1% are born prematurely (National Center for Health Statistics, 2002). Of these, approximately 7.5% are born with low birth weights (≤ 5 lbs., 8oz.) (Center for Disease Control, 2002), and about 1.5% are born with very low birth weight (≤ 3 lbs., 5 oz.) (Guyer et al., 1996) with a reported survival rate of at least 90% (Als, 1999; Hack, et al., 1999). These figures translate to about 300,000 low birth weight infants born each year in the United States. “Ninety per-cent and higher survival rates are currently the expectation for those infants born down to 2 pounds, 3 ounces (28 weeks gestation); with survival rates for extremely low birth weight infants (< 2 lbs., 3 oz.) estimated between 75-85%; and almost 50% survival rates are expected for those infants born with birth weights as low as 1 pound, 2 ounces (24 weeks gestation)” (Bennett, 2002, pg. VI). The decrease in mortality rates, however are associated with increased prevalence of children with poor long-term neurodevelopmental outcome related to low birth weight (Luciana et al., 1999; Perlman, 2001). Serious disabilities associated with this population are: cerebral palsy; mental retardation; seizure disorders; sensorineural hearing loss and visual impairment, often in combination; and progressive hydrocephalus (Pinto-Martin et al., 1999; de Haan et al., 2000). As with serious disabilities, the prevalence of “mild disabilities” (e.g., consistently lower intelligence quotients, attention deficit disorders, concentration difficulties, visual motor and sensory integration dysfunction, language comprehension, speech problems, social incompetence, and ultimately diminished school performance) increases with decreasing birth weight and gestational age (Bennett, 2002). In fact, it is estimated that 40-50% of the very low birth weight survivors, and 60-70% of the extremely low birth weight survivors, will experience some combination of these “minor disabilities” (Inder et al., 2003). At 8 years of age 50% of children born prematurely, with very low birth weight, require special assistance in the class-room; 20% are in special education; and 15% have repeated at least one grade in school (Aylward, 2003, Bhutta, et al., 2002). Even medically low-risk preterm infants appear to show significant school performance deficits and have increased need for special education services (Pinto-Martin et al., 1999; Shonkoff et al., 2000).

Traditional Early Intervention Approaches. The past two decades have seen an increase in both the number of clinicians involved and the number of early intervention programs aimed at optimizing developmental recovery following neonatal hospitalization and at preventing or
ameliorating associated neurodevelopmental morbidities (Bennett, 2002; Guralnick, 1997). Most home-, center-, community-based early intervention programs continue to take a stimulus/environmental deprivation approach to intervention, helping the child to “catch up” by introducing him/her to various modes of sensory stimulation and instruction in age appropriate developmental skills (Brooks-Gunn et al., 2000; Gomby et al., 1999; Johnson-Martin et al., 1991). Campbell (1991), as well as Guess et al. (1988) have observed that early intervention professionals involved with educa-tional programming are often inattentive to the child’s neurobehavioral state and readiness for interaction. Further, when the child is presented with a developmental task, the effect is more often a response of disengagement rather than of engagement. These findings have been support-ed by others (Als et al., 1979; Als, 1999; Crnic et al., 1983; Hedlund, 1992; Koldewijn et al., 2005, 2009b, 2010, 2011; Shonkoff et al., 2000) who have observed that efforts to stimulate these infants to compensate for developmental deficits may in fact cause overstimulation and force them into coping at the expense of their physiologic function and stability.

II. An Innovation in Infant Assessment and Intervention: The Infant Behavioral Assessment and Intervention Program (IBAIP)

The IBAIP is a proven (Hedlund, et al., 1998; van Hus et al., 2012, Koldewijn et al., 2005, 2009b, 2010, 2011; Meijsen et al., 2010; Verkerk et al., 2011a/b, 2012; Wolf et al., 2002, 2005) comprehensive assessment and intervention model which supports the developmental and neurobehavioral integrity of premature infants born with low to extremely low birth weight, or disabilities. The focus of the IBAIP is not “what to teach” (content curricula) but “how to teach,” a process oriented approach. By focusing on how to facilitate learning and social interaction, the IBAIP adds a critical individualized, relationship-based, family-centered, and neurobehavioral dimension to early intervention, often lacking in traditional approaches. As Papousek & Papousek (1992, pg. 38) state, “the capacity of the infant to learn requires an alert state, a graded presentation of stimuli, and a sensitivity to feedback signals indicating limits of tolerance.”

The IBAIP trains early intervention professionals:

*First, to recognize and interpret the infant’s behavioral communication system.* The theoretical framework underlying the IBAIP is the Synactive Model of Newborn Behavioral Organization and Development (Als, 1981, 1982, 1986, 1992, 1997a/b, 1999). The Synactive Model focuses upon the infant’s intra-organism subsystems (i.e., autonomic, motor, state, attention/interaction) and the continuous interaction of these systems with each other, and with the environment, across time. From each subsystem the infant may express a continuum of behaviors, running from signs of approach or engagement (Als, 1999; Barnard, 1978; Hedlund, 1989a/b, 1998, 2003); through self-regulatory behaviors utilized by the infant to assist her to concentrate, cope, or console herself (Hedlund, 1989a/b, 1992a/b, 1995, 1998); to signs of stress or disengagement (Als, 1999; Hedlund, 1989 a/b, 1992a/b, 1995, 1998). If the level of input and information that is offered to the infant is currently appropriate for her, one would expect to see
behaviors of approach and self-regulation expressed by the child. If however, the level and/or intensity of the environmental input are currently inappropriate, too complex, or poorly timed, signs of stress or disengagement would be observed (Als, 1999; Hedlund, 1986a/b, 1990, 1992a/b). The IBAIP trains early interventionists in the administration of the Infant Behavioral Assessment (IBA©) (Hedlund et al., 1988/1998; Appendix A). The IBA assists the early interventionists to evaluate the infant’s neurobehavioral organization, self-regulatory competence, and needs for co-regulatory support (i.e., neurobehavioral strategies that the adult may utilize to support the infant’s self-regulatory efforts).

Second, to provide the infant with appropriate neurobehavioral support during an assessment, intervention, or caregiving session. “The growth of self-regulation is a cornerstone of early childhood development that cuts across all domains of behaviors” (Shonkoff et al., 2000, pg. 3). Researchers (Als, 1982, 1986, 1988, 1999; Hedlund, 1989, 1998e; Koldewijn et al., 2005, 2009a/b, 2010; Papousek et al., 2005) have come to recognize the critical role that self-regulatory behaviors play in the infant’s development. These self-regulatory behaviors assist infants to acquire the behavioral, emotional, and cognitive self-control that is essential to competent functioning throughout life (Bronson, 2000; Kopp, 2000). Infants born with low to extremely low birth weight or disabilities, however, are often unable to effectively utilize self-regulatory behaviors (i.e., to concentrate, cope, or self-console) that normally support the typically developing infant to progress to higher developmental tasks (Brazelton et al., 1997; Greenspan, 1998).

The Neurobehavioral Curriculum for Early Intervention (NCEI©), (Hedlund, 1998e; Appendix D) provides specific co-regulatory supports or strategies to assist these infants to learn and gradually take over the process of their own self-regulation. These strategies are divided into three sections (i.e., Environmental, Handling and Positioning, and Cue-Matched strategies) and have been classified into four levels of support (i.e., Minimal, Low, Moderate, High). The degree (i.e., quantity of neurobehavioral strategies to offer the infant) and intensity (i.e., Minimal, Low, Moderate or High Facilitation) of co-regulatory support that is requested by the infant is assessed through the administration of the Self-Regulatory Competence Scale (SRCS©) (Hedlund, et al., 2005). The IBA, NCEI, and SRCS provide a curriculum-based and linked approach to assessment and intervention and thus ensure the “goodness of fit” between the application of the neurobehavioral strategies and the infant’s own self-regulatory competence and needs (Blanchard et al., 2000; Losardo et al., 2001; Neisworth et al., 1995). Thus, the IBAIP assists early intervention professionals to offer, on the basis of the infant’s “behavioral story,” a supportive and individualized neurobehavioral intervention plan with caregiving recommendations. In addition, an Individualized Record of Neurobehavioral Facilitation (IRNF©; Hedlund, 1998f) is developed to chart the degree and intensity of neurobehavioral strategies needed by the infant over time, during an assessment, intervention or caregiving interaction. Over the course of an intervention period the degree and intensity of the neurobehavioral facilitation is expected to decrease as the infant learns to take on more of the role of self-regulation; with decreasing needs of co-regulatory support (Hedlund, 1995, 1998e, 2001).
Third, to facilitate and validate parental perceptions of the behavioral cues of their infant. “Virtually every aspect of early human development, from the brain’s evolving circuitry to the child’s capacity for empathy, is affected by the environments and experiences that are encountered in a cumulative fashion, beginning early in the prenatal period and extending throughout the early childhood years” (Als et al., 1997; Shonkoff et al., 2000. pg. 6). Early experiences have a decisive impact on the architecture of the brain, the nature and extent of adult capacities, and directly effects the formation of the brain over the course of the child’s first three years of life (Als et al., 2004, Chugani, 1997; Rakic, 1996; Shore, 1997). These early experiences take place in the context of supportive and nurturing relationships between infant and parent, and are formed through a process of mutual social regulation between partners in the infant-parent dyad (Brazelton, et al., 2000; Bronson, 2000). Parental responsiveness to infant communication signals, plays a central role in mediating infant cognitive and linguistic development, as well as infant sociability, and a sense of “security of attachment” (Brazelton et al., 1997; Laucht et al., 2001; Stern, 1995). Furthermore, “the infant’s sense of security may result from adequate homeostatic regulation within the caregiving relationship, with the earliest form of security of attachment encoded physiologically in the experience of non-disruptive and need-satisfying neurobehavioral regulation of early states” (Lyons-Ruth & Zeanah, Jr., 1993, p.20). Infants born prematurely or with disabilities may not be able to control and/or respond to their environment appropriately and therefore fail to provide the clear behavioral cues that would normally enable parents to respond in a manner that supports the changing needs of their baby (Blanchard et al., 2000; Perlman, 2001). Parents need help in recognizing and interpreting the unpredictable behavioral cues expressed by their infant as well as in modulating stimulation in response to their infant’s physiological and neurodevelopmental status (Hedlund, 1989a/b, 1992a/b; Kelly, 1996; Kelly et al., 2000; Kopp, 2000; Meijsen et al., 2010, World Health Organization, 2004). Heeding the critical importance of the developing parent-infant relationship, Holding Parents Holding Their Baby© was developed by Hedlund & Notari-Syverson (1997, Appendix E) to assist early intervention professionals to support parents as they continue to explore ways to adjust and adapt themselves to the neurobehavioral, psychological, and neurodevelopmental needs of their ever changing and growing infant. Holding Parents Holding Their Baby recognizes and respects the parent’s natural capacity to love and care for their baby (Als, 1999; Hedlund, 2008, 2009; Hedlund & Vittner, 2009; Papousek et al., 2005) while assisting early intervention professionals in supporting the parent’s engrossment with their child and the child’s neurobiological based expectations for nurturance from the family.

III. Historical Overview: Development of the IBAIP

The IBAIP, assessments, curricula and all associated IBAIP training materials were developed by Hedlund (1985-2006) with assistance from his colleagues Mary Tatarka, PhD† and Angela Notari-Syverson, PhD in Seattle, Washington over the course of the past twenty-one years. This work was conducted through the support of five US Department of Education, Early Childhood Special Education Grants, and one private foundation grant, which were submitted through the University of Washington and Washington Research Institute, Seattle, Washington (1985-2006). Hedlund developed, trained and served as the Project Director for each of these grants.
Developmental work on the Infant Behavioral Assessment (IBA) began in 1985. This work continued with the support of The Transactional Family Systems Model Demonstration Project, H056C546001, USDE (1986-1989). This project developed and demonstrated a model of home-based intervention program for severely disabled infants, 0-24 months, and their families. It assisted NICU staff to develop a comprehensive home transition plan for parents and infants at discharge, as well as assist community early interventionists to implement the hospital transition plan and provide individualized home-based intervention that supported the neurobehavioral integrity of the infant. During this time period the Infant Behavioral Assessment (IBA), IBA Operational Definitions and the IBA Training Manual were developed by Hedlund and Tatarka† (1988,1998,2003).

The IBA and its associated operational definitions are based on the work of four infant assessments including:


In addition to the behaviors that originated from the assessments above (these were also modified by Hedlund and Tatarka†, 1988 edition of the IBA), “universal behaviors” (e.g., smile, reach, etc.) were also added. The format and organization of behaviors of the IBA were based on the work the Synactive Model of Newborn Behavioral Organization and Development (Als, 1982, 1986), the Manual for the Naturalistic Observation of Newborn Behavior (Als, 1981), and the NIDCAP Scan Sheet (Als, 1981). Work continued on the development of the IBA and the IBA Training Manual from 1986-2003.

Training in the administration of the IBA and implementation of neurobehavioral support continued from 1989-1995 with the support of the US Department of Education. The NICU Transition Project, H033R655400, USDE (1989-1992) and The NICU Follow-Through Project, H566B500200, USDE (1992-1995) provided training to hospital NICU staff in the New Born Individualized Developmental Care and Assessment Program (NIDCAP®; Als, 1981); and training to community early intervention staff in the administration of the Infant Behavioral Assessment (IBA). These two types of training assisted both hospital and early intervention professionals to recognize the infant’s behavior as truly communicative and provide appropriate neurobehavioral support to the infant during caregiving and intervention sessions. The NICU Follow-Through Project also provided training in “Team Building for Transition,” that assisted both hospital NICU and early intervention professionals to develop a transition plan that would ease the transition from hospital to home for infants and their families. From 1989-1995 over 125 early intervention professionals from 48 Early Intervention Programs, across 24 states were trained in the IBA and neurobehavioral facilitation. In addition, a videotape entitled “Infant
Behaviors: A Communication System” was developed through the support of The Forrest Foundation, Tacoma, Washington (1987-1990) to assist in the training of early intervention professionals in the IBAIP and to introduce parents to the infant’s communication system and self-regulatory competence.

In 1995, Hedlund received six years of funding for the Infant Behavioral Assessment and Intervention Program: Supporting the Neurobehavioral Organization and Development of Infants with Disabilities, HOH0244B500-20, USDE (1995-2001). This project was developed and field tested over a six-year period through a model demonstration grant. Fifteen certified early intervention professionals, and 120 children from three sites, participated in the field testing and evaluation of the following products: Infant Behavioral Assessment, the Neurobehavioral Curriculum for Early Intervention, IBAIP Program Guide, IBAIP Data Entrance Manual (1998d), Individualized Record of Neurobehavioral Facilitation (IRNF;1998f) and Holding Parents Holding Their Baby (Hedlund with Notari-Syverson, 1997).

The IBAIP website was created in 2000 (www.ibaip.org). In 2003 Hedlund further articulated the self-regulatory behaviors into three distinct categories: concentration, coping, and consoling (IBA revised edition, 2003). In 2005 the Self-Regulatory Competence Scale (Hedlund et al., 2005) was developed to assist the early interventionists in the selection of appropriate degree and intensity of neurobehavioral support best suited for the infant.

In 2003, Hedlund received funding for the implementation of the Infant Behavioral Assessment and Intervention Outreach Project: Supporting the Neurobehavioral Organization and Development of Infants with Disabilities, H324R020041, USDE, (2003-2006). This project provided training to early intervention professionals, paraprofessionals and parents on a validated intervention model designed to support the neurobehavioral organization and development of infants with disabilities.

In 2008, the first international IBAIP Training Center was, established in The Netherlands. Karen Koldewijn, PhD and Marie-Jeanne Wolf, PhD, Academic Medical Center, University of Amsterdam, The Netherlands, were certified as IBAIP Trainers. IBAIP Training and/or training in components of the IBAIP have also been conducted in Canada, Saudi Arabia, England, and throughout The Netherlands over the course of the past fifteen years.

IV. Evaluating the Effectiveness of the IBAIP

The original model, the Neurobehavioral Curriculum for Early Intervention (NCEI) upon which the IBAIP is based, was developed and field tested over a six-year period (1995-2001) through a model demonstration grant funded by a US Department of Education, Early Childhood Special Education grant. During Years 2, 3, and 4 the NCEI was field-tested at a center- and home-based intervention program as well as at a hospital to-home transition program (Hedlund, 2001). Results of this field-testing included: Infants’ progress over time; Significant gains (p<.05) were
found for both mental (MAE) and psychomotor (PAE) age equivalencies on the Bayley Scales of Infant Development (BSID-II) (Bayley, 1993), and for the age equivalencies in all six developmental domains of the Early Intervention Developmental Profile (Shafer & Moersch, 1981). Significant improvement in neurobehavioral organization for the autonomic and motor subsystems was found using the Infant Behavioral Assessment (IBA) (Hedlund et al., 1988/1998), reflecting greater infant competence and reduced stress during interactions. A significant increase in occurrences for approach behaviors and a significant decrease in occurrences for stress behaviors were also found following intervention. Data on infants’ progress on Individual Family Service Plan (IFSP) goals and objectives and degrees and amount of neurobehavioral supports were collected on a quarterly basis (interventionists completed a project developed IFSP Record). Infants’ progress on IFSP goals was significant for all six developmental domains. Decreases over time in degree and amount of neurobehavioral facilitation were also significant for cognitive, gross motor, communication, and fine motor goals indicating that as a result of the neurobehavioral intervention offered, the infants learned to manage their own self-regulatory needs (see Hedlund, 2001: Final Report, The Infant Behavioral Assessment and Intervention Program: Supporting the Neurobehavioral Organization and Development of Infants with Disabilities 1995-2001, H0244B50020, USDE, submitted to the US Department of Education, 2001).

A pilot study demonstrated the efficacy of IBAIP training in Amsterdam, The Netherlands (Koldewijn et al., 2005). Significant gains (p<.05) were found for both mental (MDI) and the psychomotor (PDI) developmental indices on the BSID-II as well as demonstrating clinically significant differences in neurobehavioral competence in favor of the intervention group.

More recently Koldewijn and Wolf, Academic Medical Center, University of Amsterdam, conducted a randomized controlled trial of 176 very low birth weight infants (2004-2009). This study compared the effect of IBAIP to standard follow-up care, with respect to infants’ behavioral regulation, psychomotor and cognitive development, the well-being of the parents, and parent-infant interaction (Wolf et al., 2005). All the physical therapists that provided IBAIP intervention to infants and families in the experimental group (RCT) for both the pilot study and the studies reviewed below, were trained and certified in the IBAIP by Hedlund. Follow-up results include the following:

- At six months corrected age (CA) the IBAIP improved the infant’s motor development (PDI, BSID), mental development (MDI, BSID), behavioral development (BRS, BSID), self-regulatory competence (IBA), (Koldewijn, et al., 2009a) and mother-infant interaction (Meijssen, et al., 2010).

- At 24 months CA, the IBAIP improved the infant’s motor (PDI, BSID) development (Koldewijn, et al. 2009b, 2010).
• At 24 months CA, the most vulnerable infants profited most from intervention, affecting interactive, behavioural, mental and motor aspects of development: infants with BPD, GA < 28 weeks, abnormal cranial ultrasound, a combination of social and biological risks, male sex, and infants with low educated mother (Koldewijn, et al., 2010).

• At 24 months CA, children that received intervention needed significantly less paramedical support (Koldewijn et al., 2011a).

• At 44 months CA, the IBAIP improved independency in mobility (PEDI) and sensory processing (oral/tone; SP-NL), (Verkerk et al., 2011b).

• At 44 months CA, the most vulnerable infants profited most from intervention, affecting interactive, behavioural, mental and motor aspects of development: infants with BPD, GA < 28 weeks, abnormal cranial ultrasound, a combination of social and biological risks, male sex, and infants with low educated mother (Verkerk et al., 2011c).

• At 5.5 years CA the IBAIP leads to improvement in intelligence, ball skills and visual-motor integration (van Hus et al., 2012; soon to be published in the Journal of Pediatrics).

V. Ease of IBAIP Replication

The IBAIP contains several features that optimize replication in a variety of settings: 1. All training and products were designed to complement, not to replace current curriculum. The IBAIP improves and expands upon early intervention instructional procedures/methods, curricula, and services that are currently available for infants with disabilities. 2. The Neurobehavioral Curriculum for Early Intervention is referenced to the Infant Behavioral Assessment (IBA) and it provides guidelines for infant responsive neurobehavioral strategies for assessment, intervention, and caregiving sessions; 3. The Self-Regulatory Competence Scale (SRCS) is referenced to the Neurobehavioral Curriculum for Early Intervention, it guides the interventionists in the selection of appropriate degrees and intensity of neurobehavioral strategies best suited for the infant; 4. The Neurobehavioral Curriculum for Early Intervention provides for generalization of neurobehavioral strategies across a variety of contexts, settings, and users; 5. The IBA, Neurobehavioral Curriculum for Early Intervention, and Holding Parents Holding Their Baby provides recommendations and examples for the integration of neurobehavioral assessment/intervention into the goals/objectives of an Individual Family Service Plan (IFSP); and 6. The Individualized Record of Neurobehavioral Facilitation (IRNF) that charts the degree and intensity of neurobehavioral strategies needed by the infant across time during assessment, intervention or caregiving interactions and is referenced to both the Self-Regulatory Competence Scale and the Neurobehavioral Curriculum for Early Intervention. The IRNF thus provides a recorded trajectory of the neurobehavioral competence of the infant across time and is evaluated by the interventionists to highlight the strengths and needs of infant’s self-regulatory competence.
VI. Implementation of the IBAIP

Infant Population

The IBAIP may be implemented with infants from birth through twelve months of age who are medically fragile, high risk, developmentally delayed, neurologically impaired, or drug-/alcohol-exposed. In the case of infants who were born prematurely, the observation is based upon the infant's corrected or adjusted age (one month corrected age). The IBAIP may also be useful with older infants whose neurological impairment or developmental delay suggests associated CNS functioning within the birth-to-twelve month age range (Guess et al., 1988), due to the mediating influence of the central nervous system in human behavioral responses (Lipsitt, 1986).

Early Intervention Professionals

IBAIP Training is offered to all of the following professions: special educators, infant developmental specialists, pediatricians, neonatologists, physical/occupational therapists, communication disorder specialists, nurses, social workers, psychologists, or NICU Follow-Up professionals. Experience with newborns or young infants is required. Knowledge of neonatal medicine, infant development and standardized testing is helpful. IBAIP Training is most well-suited for clinicians who are already skilled in their own particular pediatric specialty and whose current practice includes interventions with high-risk, medically fragile infants, or infants born prematurely or with disabilities.

VII. IBAIP Training:
A Training Program for Health Care & Early Intervention Professionals

Pre-Conference Workshop

Prior to Workshop I the IBIAP Training Materials and required readings are sent to the Site Coordinator for distribution to the IBAIP Trainees approximately four months before Workshop I. A detailed description of the IBAIP homework that is to be accomplished prior to the arrival of the IBAIP Trainer is provided for in the IBAIP Program Guide (see: www.ibaip.org). The IBAIP Trainer meets with the Trainees via phone conference/Skype to discuss the Trainees’ homework assignments and answer their questions and/or reflect upon and discuss their concerns.

Workshop I: Five-Day IBAIP Training Course

The first day of this workshop consists of a half-day lecture followed by a half-day introduction to the IBA and the IBA Operational Definitions. The lecture is open to all community health care and early intervention professionals. During Days Two-Five the Trainees are instructed in the administration and implementation of the: Infant Behavioral Assessment, Neurobehavioral
Curriculum for Early Intervention, Self-Regulatory Competence Scale, Individualized Record of Neurobehavioral Facilitation, and Holding Parents Holding Their Baby.

**Written Critique of IBA Write-Up and SRCS**

Approximately three-four months from the completion of Workshop I, each Trainee sends one IBA, IBA behavioral report, and SRCS to the Trainer. The Trainer reviews each IBA, IBA report, and SRCS. A written critique is then sent to each Trainee (usually consisting of six-ten type written pages). After each Trainee has received their written critique, the Trainer follows up with a conference call/Skype to answer questions that each Trainee may have with regards to this homework assignment.

**Workshop II: Three-Day IBAIP Follow-Up Workshop**

Approximately six months following Workshop I, the Trainer returns to conduct a follow-up workshop with the Trainees. Trainees participate in a three-day workshop to check trainee progress on the administration of the IBA and development of the IBA behavioral report, as well as the implementation of the Neurobehavioral Curriculum for Early Intervention, the Self-Regulatory Competence Scale, Individualized Record of Neurobehavioral Facilitation and Holding Parents Holding Their Baby. The Trainer also reviews the requirements involved in the development of the IBAIP Case Study.

**Workshop III: Four-Day IBAIP Certification Workshop**

The IBAIP Trainer returns to conduct IBA and SRCS reliability sessions with the Trainees and assess implementation of the Neurobehavioral Curriculum for Early Intervention, Individualized Record of Neurobehavioral Facilitation and Holding Parents Holding Their Baby during the first three days of the workshop. On the fourth day of this workshop the Trainees meet together with the IBAIP Trainer to present their Case Studies to the entire group.

**VIII. Fidelity of Implementation of IBAIP Assessments and Curricula**

To ensure the fidelity of implementation of the IBAIP assessment and curricula the following safeguards have been built into the IBAIP training:

**Workshop I: Infant Behavioral Assessment (IBA) Inter-Rater Agreement:** During Workshop I, Trainees will attain IBA inter rater agreement of at least 85% with the IBAIP Trainer, on 8 DVD behavioral interactional segments (1-5 minute) over the course of this training, and on one “live parent-infant interaction” on the fifth day of training. **Self-Regulatory Competence Scale (SRCS) Inter-Rater Agreement:** For each of the 8 DVD behavioral interaction segments and live parent-infant interaction (described above) each Trainee will score within a .5 range of the SRCS five point scale with the IBAIP Trainer.
Critique of Behavioral Narrative: The IBAIP Trainer critiques (usually a 6-10 page report) the IBA, IBA behavioral report, and the SRCS that each Trainee has sent in for review. The Trainer then follows this up with a phone conference/Skype to answer any questions or concerns that the Trainees may have after receiving their critiques.

Workshop II: Inter-rater Agreement Homework: At the beginning of Workshop II, each Trainee must turn in ten IBA behavioral reports with recommendations that indicate: a) attainment of an inter-rater agreement of at least 85% with another trainee on ten “real time” IBA observations following Workshop I, and b) attainment of a score within a .5 range of the SRCS with another trainee on these ten “real-time” observations as described in “a)” above. Inter-Rater Agreement: Each Trainee will also attain an IBA inter-rater agreement of at least 85%, on one “live parent-infant interaction” and score within a .5 range of the SRCS five point scale with the IBAIP Trainer. The Trainees are also introduced to the expected content, organization, and format of the Case Study that they will develop over the course of the next six months and then present this at Workshop III.

Workshop III: Certification in the IBAIP. During Workshop III, trainees will: a) attain IBA inter-rater agreement of at least 85% with the IBAIP Trainer on a “live parent-infant interaction,” b) score within .5 range on the SRCS, c) receive the Trainer’s approval of each of the trainees’ ten written neurobehavioral reports and recommendations that were submitted during Workshop II; and d) present their individual Case Study to the IBAIP Trainer and the entire group of Trainees thus ensuring fidelity of implementation over time. Upon successful completion of the requirements discussed above, the IBAIP Trainee is certified in the administration and implementation of all IBAIP assessments, curricula, and additional training materials.
IX. **IBAIP Goals of Neurobehavioral Assessment & Intervention**

1. Support the infant’s subsystem functioning.

2. Support and facilitate the infant’s self-regulatory strategies and competencies.

3. Facilitate infant’s optimal attention and interaction.

4. Minimize infant stress and disorganization to:
   - Promote brain organization and development.
   - Decrease expenditure of excessive energy; much needed to grow and develop.
   - Facilitate the developing parent-infant relationship.
   - Increase the infant’s exploratory interest and desire to participate in the “outside world” (facilitating a “sense of self”).
   - Increase opportunities for learning.
   - Decrease the need (degree/quantity) of early intervention services over time.

5. Build and support developmentally appropriate skills.

6. Support, validate, and facilitate parental perceptions of their infant’s communicative and developmental abilities.

7. Support parental facilitation (i.e., co-regulation) of their infant’s self-regulatory competence.

8. Facilitate the ever evolving parent-infant relationship.


10. Improve clinical skills and practice of the professional care giver:

    By learning to read and interpret the infant’s individualized neurobehavioral communication system and thus offer appropriate neurobehavioral support (i.e., graded support) during an assessment, intervention, or care giving interaction.

11. Facilitate the clinician’s integration of the reflective process into their daily interactions with infants their families, and other caregivers and professionals.

12. Move from a curriculum based, agenda oriented intervention to a process/relationship-based, family centered approach to early intervention.
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APPENDIX A

INFANT BEHAVIORAL ASSESSMENT (IBA)
### Infant Behavioral Assessment (IBA)

**Observer:**

**Child:**

**Birthdate:**

**Gestational Age:**

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INFANT BEHAVIORAL ASSESSMENT (IBA)

TRAINING MANUAL

Rodd Hedlund, MEd
Mary Tatarka, PhD, PT

The Infant Behavioral Assessment and Intervention Program©

1986/2003

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IBA TRAINING MANUAL

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EXAMPLE OF IBA BEHAVIORAL REPORT
IBA © Behavioral Narrative Example

Jonathan’s Behavioral Story

Child’s Name: Jonathan Smith      Date: September 30, 2012

Introduction

Jonathan was observed in his home today as part of a scheduled developmental visit. This observation was conducted to support Jonathan’s continuing development and to meet the requirements of the training provided by the Infant Behavioral and Assessment and Intervention Program (IBAIP©). The observation took place on September 30, 2012 between approximately 10:30-11:30 AM, while Michelle Jones, an infant developmental specialist, engaged Jonathan in several social and toy games. Mrs. Smith, and Mary Darcy, a physical therapist, were present during the observation.

The Observation

Background Information

Jonathan was born on June 22, 2012 at approximately 25 weeks of pregnancy to his 22 year old mother. He has one sister, Beth, who is now four years of age. Mr. and Mrs. Smith live in Yakima, Washington. Jonathan’s expected birth date was October 1, 2012. Four weeks prior to delivery Mrs. Smith reported intermittent spotting and cramping. Approximately one week prior to delivery Jonathan’s mother reported premature contractions. She was given a drug (Brethine) to help stop preterm labor and this appeared to be effective. On June 21, 2012 Mrs. Smith reported increased bleeding and severe cramping. Upon vaginal exam at Yakima County Hospital, Mrs. Smith was completely dilated and delivery was imminent. Once Jonathan was born, the family was advised that he would not live and resuscitation efforts were not attempted. Approximately four and one-half hours later Jonathan was still breathing and moving. His parents insisted that he be transferred to Children’s Hospital in Seattle for further evaluation and care. Jonathan was transferred via mediflight to Children’s Hospital. He was placed under a plastic dome shaped hood (oxygen hood) and received 30% oxygen as well as antibiotics (Gentamicin, Ampicillin), to treat the possibility of a general infection in his blood (Sepsis). After a few hours, pauses in his breathing (apnea) were observed. Additional oxygen was delivered to him through clear plastic tubes (nasal cannula) that were positioned within his nostrils and held in place with soft plastic tape. A drug (Caffeine) was also given to Jonathan to assist him in his breathing efforts and heart rate. A small plastic tube was inserted into a vein in Jonathan’s naval (umbilical venous catheter). This tube delivered nourishment and medication to Jonathan. He was also placed under special bright lights (bili lights) to treat jaundice, a liver condition that causes the skin to have yellowish tinge.
Jonathan’s APGAR scores, a measure of infant well-being at birth, were 3 at one minute, 3 at five minutes, and 4 at ten minutes; out of a possible score of 10. At birth Jonathan weighed approximately one pound and five ounces (582 grams); he was about 13 inches tall (32 centimeters); and his head measured about eight inches around (21 centimeters). This means that for every 100 infants born at 25 weeks of pregnancy, Jonathan weighed more than 9 of them (at about the 10 percentile) was taller than 48 of them (just under the 50th percentile); and his head was smaller than all of them (under the 3rd percentile).

Jonathan was discharged from the hospital on September 2, 2012. Prior to going home a special x-ray (head ultrasound) showed that some blood had seeped into his brain (grade III IVH). An eye exam on August 29 revealed that Jonathan has Stage I, Retinopathy of Prematurity (ROP), in both of his eyes. This is a disease that affects the retinas of the eyes and involves the rapid and irregular growth of blood vessels in the retina. Jonathan is enrolled in a special ROP study at Children’s Hospital and will be assessed on a regular basis by his doctor in Yakima. Jonathan and his family were referred to the Yakima Valley Birth to Three Early Intervention Program just prior to his discharge home. He began receiving services from this program two weeks after his arrival home.

Jonathan is now 14 weeks and two days old, which is 39 weeks, 2 days of pregnancy. At his last visit with the pediatrician on Thursday, September 27, 2012, Jonathan weighed five pounds and four ounces which is less than the 3rd percentile of growth. This means that for every 100 babies born at approximately 39 weeks, he currently weighs less than all of them. Mrs. Smith reports that Jonathan’s breathing monitor alarmed two times during the past day. Jonathan receives two medicines to help with his digestion (reglan and bethanichol). A recent eye exam revealed that Jonathan’s eye disease (ROP) has remained stable and may be improving. Mrs. Smith reports that she is becoming more comfortable with Jonathan’s care and nightly feedings. Mr. Smith is participating in some of the night feedings. Mrs. Smith says that her husband is very good at helping Jonathan return to sleep after these early morning feedings, as he often sings and gently rocks Jonathan in his arms. This appears to help Jonathan drift back down into sleep. According to his mother, Jonathan has several periods of wakefulness during the day. Usually after his feedings he likes to engage in brief social interactions (i.e., looking up into his mothers face as she softly speaks to him) and appears to be interested in looking around at all the people and things in the room. Mrs. Smith has expressed some concern over Beth’s adjustment to Jonathan’s recent appearance within the home. Mrs. Smith reports that she and her husband are working on ways to help Beth have her own “special time” with her mother and father.

The Environment

Jonathan’s home is located in a quiet neighborhood, shaded by large maple trees. Mrs. Smith greeted us at the door, inviting us to come in. From the entryway we entered the living room, a rectangular room comfortably furnished with a couch, large overstuffed chairs, and tables at each end of the couch. The coffee table in front of the couch held some of Jonathan’s toys and medicine. The house was quiet when we entered, with soft music coming from the radio in the
kitchen. Occasionally the barking of a neighborhood dog could be heard outside in the distance. Mr. Smith and Beth had gone to the store. The living room was softly lit, with two small table lamps and indirect lighting streaming in from a window at the far end of the living room. The room was comfortably heated and the smell of the morning’s breakfast lingered in the air. Jonathan’s soft comfortable day-bed was positioned at one end of the couch. Jonathan was sleeping comfortably on his back. A small blanket roll was positioned at the foot of his bed. Mrs. Smith reports that Jonathan actively pushes up against this with his feet. This appears to support Jonathan’s efforts to help him transition down into sleep. Jonathan wore a hat and one piece outfit. A soft blanket rested upon him. Two soft discs on his chest were attached to two wires that led to a machine next to his bed. This machine monitors Jonathan’s breathing and heart rate.

Before the Observation

Mrs. Smith said that Jonathan had been sleeping for the last three hours. She indicated that it was time to wake him up so that we could play with him, and then it would be time for his bottle. She gently lifted Jonathan out of his bed as she softly spoke to him. Jonathan began to awaken as he yawned and began to briefly peek out at his mother from underneath his semi-closed eye lids. He then began to squirm and stretched his arms and legs out away from his body as Mrs. Smith positioned him within the warm comfort of her arms. Mrs. Smith continued to softly speak to Jonathan as he became increasingly awake, looking up into his mothers face and then, at times, briefly looking away. Jonathan stretched his legs out away from his body and Mrs. Smith quite intuitively readjusted her cradling position so that he could push his feet in to the inside portion of her arm (Jonathan’s mother reports that he often searches for support to brace his feet against). Jonathan, now awake, made some mouthing movements and his mother quite naturally offered him a pacifier, which he immediately accepted. Mrs. Smith sat down on the couch with Michelle who had spread a soft blanket out upon her lap, and had arranged several infant toys next to her. Jonathan’s mother then gently laid Jonathan down on his back in Michelle’s lap. Jonathan’s cheeks were slightly pale and a purplish-blue tinge appeared around his mouth and eyes as Jonathan gave a big sigh. Michelle loosely swaddled the blanket around Jonathan with his arms and hands free. Jonathan began to stretch his arms out away from his body. Michelle gently contained Jonathan’ hands within one of her own and positioned them down upon his chest. Jonathan began groping onto his clothing with his hands and then finally held on to his one-piece outfit. Michelle then repositioned Jonathan so that he could push his feet against her upper body. He effectively made use of this support. Jonathan made a few soft grunting sounds and then looked up into Michelle’s face. Michelle smiled at him. Jonathan briefly looked away and then returned her gaze. His breathing alternated between a slow to moderate rate.

During the Observation

Michelle began to smile and softly speak to Jonathan. He at first, gazed up into Michelle’s face, and seemed to be focusing his attention upon her mouth, as she spoke to him. Jonathan then looked up into Michelle’s eyes. He raised his eyebrows and a small fleeting smile appeared across his mouth. Jonathan then looked away, but after a brief moment, returned her
gaze as she continued to speak to him. Michelle reported that she could feel Jonathan pushing with his feet against her body. Jonathan then turned his head to the side and stretched both of his arms up into the air. His breathing rate seemed to increase as he began to squirm. He pulled his arms back with his hands coming to rest up near his head. Jonathan became increasingly red as he grimaced and made low grunting sounds of protest. Mrs. Smith indicated that Jonathan sometimes had difficulty making transitions from one position to the next. Michelle placed a blanket roll at Jonathan’s feet to provide a firmer bracing support. She then brought his hands down to his chest and gently maintained them there with her hand. Jonathan, began to settle, and again returned his gaze to Michelle’s face. Michelle, without speaking, slowly moved her head and face from the center of Jonathan’s body to his left side. Jonathan followed her face with his eyes, briefly looking away, but then visually recapturing her face. Michelle then moved her face to Jonathan’s right side and he again briefly followed it with his eyes. As Michelle returned her face to the midline of his body, Jonathan again began to squirm and arch his back; his breathing rate increased; and his face became increasingly pale. Michelle picked Jonathan up and cradled him in her arms. Jonathan began to settle and nuzzle into the support offered by this cradled position. Mrs. Smith commented that this was Jonathan’s favorite position: “It seems to offer him more of sense of security, to have the boundaries provided by your arms and body.” As Michelle continued to support Jonathan in this manner she asked Mrs. Smith to show Jonathan a rattle. Jonathan looked up at the rattle as his mother softly shook it, he then looked at his mother, and then returned his gaze to the rattle. His hands were open with his fingers slightly flexed. Jonathan appeared at times to make attempts to grasp onto the blanket that he was swaddled in. Michelle placed one of the blanket edges into his hands and Jonathan held on. Jonathan continued to look between the rattle and his mother. Mrs. Smith began to gently shake and move the rattle from one side to the next as Jonathan attempted to briefly follow these excursions. Mrs. Smith set the rattle down and softly spoke to Jonathan. Jonathan looked up into his mother’s face and made soft sounds of pleasure. Both he and his mother appeared to be enjoying this time together. As Mrs. Smith continued to smile and speak to Jonathan he seemed to become more animated. As he raised his eyebrows and cheeks, two brief smiles appeared across his mouth. He then began to make mouthing movements and his mother offered him his pacifier. Jonathan began to suck on it. It then fell from his mouth. This seemed to upset him as he began to squirm, arch his back, and firmly push with his feet into the inner part of Michelle’s arm. Mrs. Smith commented that she thought he may be hungry and left the room to prepare his bottle. Michelle offered Jonathan the pacifier and gently held it at his mouth. Jonathan latched on to it and began to suck vigorously. Jonathan then grasped onto Michelle’s hand, and held on. He breathed more regularly and appeared to relax as a more pinkish color returned to his cheeks. Michelle held Jonathan quietly in her arms, as his mother returned with his bottle.

After the Observation

Michelle gently placed Jonathan into Mrs Smith’s arms. Mrs. Smith sat down on the couch, removed the pacifier from Jonathan’s mouth and offered him the nipple of the bottle. Jonathan latched on to the nipple and began to suck. He closed his eyes as if he were concentrating on the task of drinking from his bottle. His cheeks became somewhat pale and a
bluish tinge appeared around his eyes and mouth. He appeared to breathe unevenly at times, sometimes fast and at other times slow. After a few minutes Mrs. Smith removed the bottle from his mouth, softly dabbed his mouth with a soft cloth, and then positioned Jonathan over her shoulder to burp him. Jonathan made some soft grunting sounds, squirmed, and then brought his hand up to his face, as he expelled an audible burp. Mrs. Smith gently rubbed his back and commented on the fact that he was, for the most part, “a pretty good eater.” Towards the end of the feeding, lasting approximately 20 minutes, Jonathan’s forehead and cheeks were pale and he continued to make soft grunting sounds. His arms lay at his sides with little energy as he drifted down into sleep.

**Behavioral Summary Statement and Identified Goals**

From this behavioral observation, Jonathan appears to be quite comfortable in his new home environment and is well supported by the natural, intuitive care that is provided by his mother and father. He makes many efforts to support himself during social and care giving interactions, including: bracing with his feet into a supportive surface; sucking upon his pacifier; grasping and holding on to his blanket and or a proffered hand/finger. He is very much interested in engaging in brief social and toy interactions. At times these may become somewhat challenging for him. His sensitivity is expressed in: the paling of his cheeks/forehead and the appearance of a purplish-blue tinge around his eyes and/or mouth; his breathing pattern, as at times, it becomes somewhat uneven (at times fast, at other times slow); the stretching of his arms and legs out away from his body; and the occasional arching of his back. Feeding seems to continue to require much of Jonathan’s energy, as observed by his pale face and lack of energy in his arms at the conclusion of his feeding. Jonathan appears to be working toward more robust and steady breathing; conserving and maintaining energy for the duration of feeding; graded social and toy play; and increasingly effective use of self-comforting/consoling behaviors (i.e., bringing his hands to his chest/tummy, grasping, holding on, foot bracing efforts, sucking, and occasional efforts to bring his hands to his mouth). Mrs. Smith quite naturally provides Jonathan with the support that he requests through the expression of his own special “body language.” Both mother and child appear to be completely attuned to each other and enjoy their daily interactions.

**Recommendations**

The following recommendations are made to continue to support Jonathan development and behavioral organization:

1. Continue to provide a quiet area for Jonathan to rest. This may help to support his efforts to conserve energy.

2. Continue to provide Jonathan with a deep, softly made bed. The blanket rolls placed at the end of his bed appear to support his foot bracing attempts and help him settle into sleep.

3. Continue to dress Jonathan in soft comfortable clothing.
4. Continue to support Jonathan’s desire to hold on to an object (i.e., the blanket he may be swaddled in; his own clothing) or a hand/finger that is offered to him. He appears to use this to “organize around,” or self-comfort/console.

5. Continue to be aware of Jonathan’s cues that signal that he may need a break or “timeout” from a social/toy interaction or care giving event (i.e., the stretching of his arms/legs out away from his body; color changes to pale; the arching of his back; or squirming).

6. During feeding time, continue cradling Jonathan in your arms, up close to your body. This may assist him to maintain energy and support his efforts to engage you in social/toy play.

7. Continue to speak softly to Jonathan and introduce one form of social input at a time (i.e., your face, or voice, or a toy). Little by little Jonathan will be able to take in, or process more, from the great, big world around him. At this time, however, it appears that he depends upon you to gradually introduce things to him at his own pace. Continue to read his “body language” to guide you in your interactions with him.

8. Continue to offer Jonathan a pacifier or consider supporting his hands to his mouth to suck on. This appears to assist him to self-console and/or comfort himself.

If you should have any questions or concerns with regards to this behavioral report please do not hesitate to contact us at (526) 487-9787 or at our email addresses listed below.

Sincerely,

Michelle Jones, MEd
Infant Educator
Yakima Valley Early Intervention Program
mjones@yakimavalleyeip.org

Mary Darcy, MEd, PT
Physical Therapist
Yakima Valley Early Intervention Program
mdarcy@yakimavalleyeip.org
Plan

1. Share the above report with Mr. and Mrs. Smith.

2. Inquire how their plan to provide Beth with her own “special time” is working out.

3. Continue to support Mrs. Smith’s natural interaction style and intuitive consoling responses to Jonathan’s signs of distress.

4. Re-assess with the IBA in two weeks to monitor Jonathan’s neurobehavioral organization and self-regulatory competence; and to evaluate the effectiveness of the co-regulatory strategies suggested under the Recommendations of 9/30/2002.

5. Share the parent materials from Holding Parents Holding Their Baby with Mr. and Mrs. Smith (i.e., Holding Your Baby in Different Positions, Talking With Your Baby, Sucking).
A Neurobehavioral Curriculum For Early Intervention

Supporting the Neurobehavioral Organizational Development of Infants with Disabilities

Rodd Hedlund, MEd
Washington Research Institute
150 Nickerson Street, Suite 305
Seattle, Washington 98109

May 1996, revised November 1998

Production and design by Mary Delaney Gallien

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APPENDIX E

HOLDING PARENTS HOLDING THEIR BABY
Holding Parents
Holding Their Baby

Rodd Hedlund, MEd

with Angela Notari-Syverson, PhD

Infant Behavioral Assessment and Intervention Program (IBAIP©)

Production and design by Mary Delaney Gallien

The development of this notebook is supported by Grant # H024B50020 (CFDA 84.024B) from the U.S. Department of Education, Early Education Programs for Children with Disabilities. “Supporting Neurobehavioral Organizational Development in Infants with Disabilities: A Neurobehavioral Curriculum for Early Intervention.”
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*Estimated Trainer’s Fees, Training Materials and Travel Expenses
Infant Behavioral Assessment and Intervention Program

*Estimated Trainer’s Fees, Training Materials and Travel Expenses

The following training expenses are based on training eight professionals in the administration of the: IBAIP Program Guide
  Infant Behavioral Assessment (IBA) & IBA Operational Definitions
  IBA Training Manual
  Neurobehavioral Curriculum for Early Intervention (NCEI)
  Self-Regulatory Competence Scale (SRCS)
  Individualized Record of Neurobehavioral Facilitation (IRNF)
  Holding Parents Holding Their Baby
  One copy of IBAIP Readings

Pre-Conference Workshop

IBAIP Training Materials: $500.00 per Trainee .................................................................$4,000

Shipping Fees: Shipping of IBAIP Training Material .......................................................500

SUBTOTAL OF TRAINING MATERIALS /SHIPPING FEES: $4,500

Prior to Workshop I the IBAIP Training Materials are sent to the Site Coordinator for distribution to the IBAIP Trainees approximately four months before Workshop I. A detailed description of the IBAIP homework that is to be accomplished prior to the arrival of the IBAIP Trainer is provided for in the IBAIP Program Guide. The IBAIP Trainer meets with the Trainees via phone conference/Skype to discuss the Trainees’ homework assignments and answer questions.

Workshop I: Five-Day IBAIP Training Course

Trainer’s Fee: $1,000 per day .............................................................................................................$5,000

The first day of this workshop consists of a half-day lecture followed by a half-day introduction to the IBA and the IBA Operational Definitions. The lecture is open to all community professionals (there is no limit on the number of individuals that may attend this lecture; it is dependent upon room capacity). During Days Two-Five the Trainees are instructed in the administration and implementation of the IBA, NCEI, SRCS, IRNF, and Holding Parents Holding Their Baby.

*Trainer’s Travel Expenses: These include RT airfare and hotel accommodation. The Training Site is responsible for the payment of these travel expenses (see page 3).

*IBAIP Training within the continental United States.
Written Critique of IBA Write-Up and SRCS

Approximately four months from the completion of Workshop I, each Trainee sends one IBA behavioral report, and SRCS to the Trainer. The Trainer reviews each IBA, IBA report, and SRCS. A written critique is then sent to each Trainee (usually consisting of six-ten type written pages). After each Trainee has received their written critique, the Trainer follows up with a conference call/Skype to answer questions that each Trainee may have.

**Trainer’s Fee:** $500 per written critique.................................................................$4,000

Workshop II: Three-Day IBAIP Follow-Up Workshop

Approximately six months following Workshop I, the Trainer returns to conduct a follow-up workshop with the Trainees. Trainees participate in a three-day workshop to check trainee progress on the administration of the IBA and development of the IBA behavioral report, as well as the implementation of the Neurobehavioral Curriculum for Early Intervention, the Self-Regulatory Competence Scale, Individualized Record of Neurobehavioral Facilitation and Holding Parents Holding Their Baby. The Trainer also reviews the requirements involved in the development of the Case Study (required by each Trainee).

**Trainer’s Fee:** $1,000 per day:.....................................................................................$3,000

*Trainer’s Travel Expenses:* These include RT airfare and hotel accommodation. The Training Site is responsible for the payment of these travel expenses (see page 3).

Workshop III: Four-Day IBAIP Certification Workshop

IBAIP Trainer returns to conduct IBA and SRCS reliability sessions with the Trainees and assess implementation of the Neurobehavioral Curriculum for Early Intervention, Individualized Record of Neurobehavioral Facilitation and Holding Parents Holding Their Baby during the first three days of the workshop. On the fourth day of this workshop the Trainees meet together with the IBAIP Trainer to present their Case Studies to the entire group.

**Trainer’s Fee:** $1,000 per day.................................................................$4,000

*Trainer’s Travel Expenses:* These include RT airfare and hotel accommodation. The Training Site is responsible for the payment of these travel expenses (see page 3).

**SUBTOTAL OF IBAIP TRAINER’S FEES:** $16,000
**Estimated Trainer’s Travel Expenses**
These include RT airfare and hotel accommodation. The Training Site is responsible for the payment of these travel expenses:

Three RT Airfares X $500 .......................................................... 1,500

Twenty nights Hotel X $150.00 .................................................. 3,000

SUBTOTAL TRAINER’S TRAVEL EXPENSES: $4,500

The training site is also responsible for transportation of Trainer to and from airport, and daily transport of Trainer to and from hotel and training site.

**Estimated Total Cost of IBAIP Materials, Training Fees & Travel Expenses**

Subtotal of Training Materials/Shipping: $4,500

Subtotal of IBAIP Trainer’s Fees: 16,000

Subtotal of Trainer’s Travel Expenses: 4,500

TOTAL COST OF IBAIP TRAINING: $25,000

IBAIP Training provided to eight Trainees within the continental United States: Cost per Trainee = $3,125. This includes all training expenses (i.e., Training Materials, Shipping of Training Materials, Training Fees, Critique of IBA Behavioral Write-Up, Trainer’s Travel Expenses).

*Please note: IBAIP Training expenses quoted above are for training conducted in the continental United States. Airfares fluctuate depending upon the airline carrier chosen, date of ticket purchase, and date of travel. Training and Travel expenses outside the continental United States will vary depending upon geographical location and currency fluctuations. Payment of Trainer’s Fee is to be made in USD. Payment of Trainer’s Fees is made immediately following the completion of each workshop. Training Fees may change without prior notification.*

Hedlund R, IBAIP © 2012
Appendix G:

Trainee Responsibilities and Time Commitments
TRAINEE RESPONSIBILITIES

IBAIP Master Trainer/ Director: Rodd Hedlund, MEd

All of the requirements listed below must be successfully completed, within the timelines provided, before certification may be granted to the Trainee.

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I. Pre-Conference Workshop:
A. Attend and participate in the Pre-Workshop Conference Call
B. Read all articles and training materials enclosed in the reading packet.
   Review:
   1. The IBA© and its Operational Definitions.
   3. The Neurobehavioral Curriculum for Early Intervention©.
   4. Holding Parents Holding Their Baby©.
C. Complete the Training Registration Form (Appendix F).
D. Complete the Pre-Training Test (Appendix F). This will be collected at the beginning of the workshop. All Trainees are required to achieve a score of at least 85%.
E. Complete the Study Guide for Babies and Their Mothers (Appendix F).
F. Prepare videotape (please see Videotape Protocol, Appendix C).
G. Complete the Consent for Photography/Dissemination forms and the Trainee/Subject Identification form (Appendix F) Two consent forms:
   1. Parent/Infant Consent For Photography And Dissemination of Photographic Product.
   2. Interventionist Consent For Photography And Dissemination of Photographic Product.

One consent form is signed by the parent of the child that you choose to videotape (Parent/Infant Consent form). The other consent form is signed by yourself (Interventionist Consent form). The white copy of each consent form will be collected at the beginning of the workshop. Please give the yellow copy from the Parent/Infant Consent form to the parent. The yellow copy from the Interventionist Consent form is for your own files. These consent forms must be completed before the videotaping is begun.
II. Workshop I: Five-Day IBAIP Training Course  
A. Attend the lecture on the Synactive Theory of Development:  
Morning/Afternoon session of Day #1.  
   - Time: 4 hrs.

B. Participate in the Infant Behavioral Assessment and Intervention Program  
Workshop: Afternoon session of Day 1 through the afternoon session of Day 5.  
   - Time: 36 hrs.

III. Homework Assignments:  
The following assignments are completed in the Trainee’s respective  
developmental setting after Workshop I.

A. Ten inter-rater observations (actual or “real-time”). Each observation  
should also include written summaries and recommendations. The Trainee must attain an inter-rater agreement of at least 85% with another Trainee  
on 10 actual or “real-time” observations following the training as well as score within a .5 range of the SRCS five point scale with another Trainee. These 10 inter-rater observations should be conducted on:

   1. Five typically developing infants;  
   2. Five atypical infants (DD, CP, or infants with drug/alcohol exposure).

B. The Trainee will send a copy of one IBA, SRCS, and IBA behavioral  
report to the Trainer prior to Workshop II. The Trainer will review and critique the report and return it to the Trainee. The Trainer will follow-up with a telephone/conference/Skype to answer questions and/or address Trainee concerns.

IV. Workshop II: Three-day Follow-Up IBAIP Workshop  
The Trainee will turn in the ten inter-rater observations as discussed in “III A above.” Each Trainee will also attain an IBA inter-rater agreement of at least 85%, on one “live parent-infant interaction” and score within a .5 range of the SRCS five point scale with the IBAIP Trainer. The Trainees are also introduced to the expected content, organization, and format of the Case Study that they will develop over the course of the next six months and then present this at Workshop III.

   - Time: 24 hrs.

V. Homework Assignment: Case Study  
The Trainee must demonstrate a thorough understanding of the neurobehavioral concepts as demonstrated by the implementation of appropriate neurobehavioral strategies and parent materials. Specific outcomes include:

   1. The Trainee conducts serial assessments/interventions with an infant and family that is currently receiving services from the Trainee.  
   2. A Case Study is developed.  
   3. Pre/post video tapes and critique are completed. See Assessment and Intervention Protocol
VI. Workshop III: Four-Day IBAIP Certification Workshop

During Workshop III, trainees will: a) attain IBA inter-rater agreement of at least 85% with the IBAIP Trainer on a “live parent-infant interaction,” b) score within .5 range on the SRCS, c) receive the Trainer’s approval of each of the trainees’ ten written neurobehavioral reports and recommendations that were submitted during Workshop II; and d) present their individual Case Study to the IBAIP Trainer and the entire group of Trainees thus ensuring fidelity of implementation over time. Upon successful completion of the requirements discussed above, the IBAIP Trainee is certified in the administration and implementation of all IBAIP assessments, curricula, and additional training materials.

Total estimated time to participate in the IBAIP Training course, satisfy all training requirements as outlined above, and attain certification in the administration and implementation of the IBAIP assessments, curricula, and associated training materials…………………………………………..Approximately: 200 hrs.
Appendix H:

IBAIP Reading List
IBAIP 

Infant Behavioral Assessment and Intervention Program

**IBAIP Reading List**

*Articles designated with an asterisk are required reading for the IBAIP Training Course.*

**Theoretical Foundations**


Als H. *Manual for the Naturalistic Observation of Newborn Behavior (Preterm and Full Term Infants)*. 1981. The Children’s Hospital, Enders Pediatric Research Laboratories, Boston, MA.


**2010**


**2009**


2005


2002


1998


Additional Publications


**Research & Development**


**Curricula & Test Development**


*Hedlund R. The Infant Behavioral Assessment and Intervention Program. 1998* www.ibaip.org; rhedlund@ibaip.org

*Hedlund R. *Neurobehavioral Curriculum for Early Intervention*. 1988. Publication available from R Hedlund, Lawrence Kansas; rhedlund@ibaip.org; www.ibaip.org

Hedlund R. *IBAIP Data Entrance Manual*. 1998. Publication available from R Hedlund,
Hedlund R. *IBAIP Program Guide*. 1997. Publication available from R Hedlund, Lawrence Kansas; rhedlund@ibaip.org; www.ibaip.org


Lawrence Kansas; rhedlund@ibaip.org; www.ibaip.org

Appendix I:

Supporting and Sustaining the Reflective Process
Supporting and Sustaining Reflective Practice
Roddi Hedlund, MEd

Reflection

Reflection or the reflective process has been described by a number of educational theorists as: “the continuing conceptualization of what one is observing and doing.” 2,4,10 “thinking on your feet.” 3,8,14 “going toward the center of what you are doing...to invest in the present moment with full awareness and concentration.” 9,410 “knowing in action;” 1,4 “...mindfulness, allowing one to move away from habitual or automatic behavior, from familiar formulas, and from doing routine things in a routine way;” 7,9,418 and finally:

“The process of feeling, ‘seeing,’ or ‘noticing’ what it is you are doing; then learning from what you feel, see, or notice; and finally, intelligently, even intuitively, adjusting your practice.” 9,410

As Tremblay points out, to practice reflection one has to change the way one’s mind works. Reflection is an ongoing dynamic process which challenges the caregiver to pay attention to “her thoughts, feelings, inner experiences, values, and behaviors,” 7,46 as well as the thoughts, feelings, behaviors, and experiences of other caregivers, and of the most important people in the infant’s life, him or her parents.

The Role of Reflection in the Implementation of the NICCAP Approach to Care

“Reflection as a framework for practice is not typically articulated in action-oriented, intensive care work. Yes, with the move toward developmental care, reflective practice, by necessity, becomes a focus.” 7,46

The critical importance of reflection in implementing relationship-based developmental care cannot be overstated. Reflective practice provides the foundation for the alignment and connection between caregivers and the infants and families for whom they care. As Gillieson and Ali observe, the connection formed between the infant and caregiver “strengthens the capacity to nurture relatedness between parent and infant.” 39 Reflective practice also strengthens the relationship between the caregiver and the infant.
and the infant's parents, as well as other caregivers. Relationships at this level are of critical importance to the infant's growth and development. As Eggbeer and her colleagues note, "The quality of the relationship that parents and professionals establish on behalf of the child can enhance or diminish the effect of whatever technical skills and knowledge practitioners bring to their work with children and their families." 8,9

Reflection also helps us examine our own practice and the way we respond to our own work. It fully engages the intellectual and emotional work inherent in relationship-based developmental care. In addition, it assists us in implementing the NIDCAP approach to care and in "facilitating change" in the routine based, protocol driven, high-tech environment of the intensive care nursery.

"To cope with and work through the changes which affect them... professionals must deal with the emotional process of letting go." 10

Letting go of the past and moving into the future...integrating new knowledge into practice. The act of changing is more than an "event." Change for human beings is both a psychological and an emotional process. The way a caregiver typically performs a routine or procedure has psychological meaning to her; it gives her a sense of comfort, a feeling of control and a belief in being able to effect an outcome. However, when this course of change is interrupted, the introduction of a new innovation, there can be a chain of emotional responses, such as anxiety, fear, or anger. Change may produce a sense of uneasiness, a lack of direction, a sense of unfinishedness, and insecurity. As Perlman and Takacs11 state, "To cope with change effectively, organizations must consciously and constructively deal with the human emotions associated with it." 12

Als and Gilkerson13 have identified three conceptual elements of developmentally supportive care that require changes in the individual caregiver's practice, the NICU culture, and the hospital system as a whole. These elements involve viewing developmentally supportive care as process-guided, relationship-based, and systems-oriented. "A process-guided approach to care requires a flexible mind to continuously assess the infant's behavioral and physiological needs and requires flexible procedures that allow one to creatively adapt caregiving. Implementing a process-guided rather than a task or procedurally based model is a challenge in any setting, and particularly so in an acute care environment, which is focused on standard protocols and caregiving routines. Relationship-based care puts into focus the connectedness and mutuality of all involved: infants, family, and the professional caregivers in the system. Systems-oriented care is implemented within the dynamics of an existing social system. To grasp the systems perspective, it is necessary to step back from the immediate situation and examine the forces operating in the larger environment—both positive and constraining forces: taking the pulse of the system before offering solutions." 14,15

The NICU development team should have access to unit-specific training and consultation, including a process consultant and psychological support (eg, psychiatric nurse, licensed clinical psychologist, psychiatrist, or social worker) to assist them in reflecting on the process of implementation itself as well as on the emotional content of the work. 12

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The Practice of Reflection

"Developmental care is inherently reflective. There are no protocols that tell you exactly what to do. Instead, ongoing observations and continuous feedback from the baby (as well as the family) guide care (and your interactions with them)."

The successful implementation of reflection requires that reflection be practiced before, during, and after our interactions with infants, their families, and the professional caregivers who care for them. Practicing the reflective process includes the following steps:

Before the Interaction: Preparing for the Moment

Preparing oneself before an interaction requires moving from a state of preoccupation of the day’s events, to returning to “mindful awareness”; preparing oneself to invest in the upcoming interaction with full awareness and concentration. For example, in preparing for a caregiving interaction with an infant, one might consider: (1) reflecting upon the caregiving that the infant will currently be offered; (2) reflecting upon what caregiving events in the past have challenged the infant and what co-regulatory supports have been most effective in comforting and soothing the infant during necessary medical and nursing procedures; (3) reviewing past developmental reports that have been written and reflecting upon the recommendations that were made; and (4) gathering all necessary supplies that will be needed to care for the infant to ensure that the interaction is not interrupted once care has begun (e.g., leaving the infant’s bedside to search for a forgotten pacifier).

In preparation for being with parents as they come to be with their infant, one might consider reflecting upon: (1) current developmental observation reports and recommendations, including the infant’s apparent goals, strengths, and needs; (2) current medical/nursing recommendations and any new information concerning the infant’s growth and development that might be shared with the parents; (3) how one will greet the parents, welcoming them to their infant’s bedside; (4) setting up the bedside environment that will offer privacy (e.g., perhaps a screen), comfortable chairs for the parents to sit on, and a place to store their coats and personal belongings; (5) how the parents might be engaged in assisting in caregiving (e.g., feeding, bathing, diaper changing, co-regulatory support, facilitation of skin-to-skin holding, etc.); and (6) what questions the parents might have and what professionals might be available to answer specific questions pertaining to their infant’s care (e.g., lactation specialist, neonatologist, social worker).

During the Interaction: In the Moment

Delivering care in an individualized and supportive manner within a relationship-based developmental framework requires the caregiver to:

"... be here, now, to invest in the present moment with full awareness and concentration. Bringing your mind back from its many wandering to mindful awareness."

To be here and now for the infant during caregiving interactions: This means helping the caregiver see the experience of the care recipient and responding in a developmentally supportive manner to the infant’s behavioral story. As Gillieron observes, the reflective process is an effort to move beyond the task-oriented nature of intensive care toward relationship-based caregiving in intensive care nurseries. The caregiver must first, make a mindful effort to release her mind from the day’s past and future events so that she can truly see, hear, and feel the “humaness” of the infant; and then, intelligently, even intuitively adjust her interactions with the infant to further enhance her relationship with the baby and his or her family.

To be here and now for the family as they come to be with their baby: This involves supporting them in what comes naturally to them, to be a mother and father, to be with and for their baby. As Lawhorn observes, “relationship-based caregiving implies that the nurse makes a human connection with the infant and consequently is invested in furthering the beginning parent-infant relationship. The nurse understands and appreciates the infant’s apparent goals and not only modifies his or her approach, but supports the parents in helping their infant achieve these apparent goals.”

To be here and now for the NICU staff that may be resistant, ambivalent, questioning, or unsure of the developmental process: This involves listening and “holding” their feelings and perspectives. As Bettthelm and Rosenfeld reflect:

“... We can begin to understand another person’s behavior only if we start with the assumption that the reason or motives that lie behind his actions... seem good to him (p.107)...”

It is only through the process of “walking in the shoes” of others that we may begin to understand and reflect upon the motives, and actions of the “other.” By holding within “the mind’s eye” another person’s feelings, ideas, and concerns one can, as Belensky and colleagues reflect, “discover the experiential logic behind these ideas (feelings and concerns); the ideas become less strange and owners of the ideas cease to be strangers.”

After the Moment: Reflective Supervision

“Relationship-based developmental care requires reflection rather than action; it requires seeing connected and open to the other person’s feelings; it is system oriented and process based; and it demands suspension of judgement and focus on the life giving forces of the other person.”
Relationship-based developmental care requires changes in the individual caregiver’s practice, the NICU culture, and the hospital system. The building and nurturing of relationships at each of these three distinct levels can best be served by the creation of a Reflective Supervisor role within the NICU. As Als and Gilkerson observe: “Supervision is a relationship for learning where time is set aside on a regular basis, with an experienced and trusted professional, to explore the ‘imperfect processes’ of professional practice and one’s own responses to the work.”

Providing reflective supervision for each developmental team member as well as the developmental specialist and/or NIDCAP Trainer is of utmost importance. As Gilkerson states:

“Relationship-based work makes one conscious of one’s feelings in interactions—one’s emotional world—and that is the very place that [most NICU caregivers] have been trained to avoid. It is my belief that the greatest challenge in infant-family work across all settings is the emotional experience of the work.”

The Reflective Supervisor is available to listen, reflect, and provide the emotional understanding and regulation for those professionals involved in the implementation of this relationship-based work. As Shalom of the Reflective Supervisor, Gilkerson cites Jere Pavlov’s “platinum rule” “Do unto others as you would have others do unto others.”

Fenichel described reflective supervision as a relationship for learning between the Reflective Supervisor and the Reflective Practitioner or Supervisee. This learning relationship consists of three essential elements: regularity, collaboration, and reflection. “Regularity” involves: “just being there, at each time and on time; being fully available, without interruptions or telephone ringing.” Collaboration involves: sharing power; making sure mutual expectations are clear; communicating openly. Finally, Reflection, which is used in four ways: reflection before action, reflection in action, reflection on action and reflection for action.

Reflection before action involves preparing oneself to invest in the upcoming interaction with full awareness and concentration.

Reflection in action has been described by Schon as “thinking on your feet,” or “focusing on the present moment, simultaneously doing and learning and coming to know.”

Reflection on action refers to “slowing down the process to reflect” after the interaction or a “mode of research activity undertaken in tranquility, off-line...” as experienced through individual reflection (or inter-subjective reflection) and one’s participation in a reflective supervisory session: “stepping back in order to go forward.” Reflection on action involves integrating (1) what one has learned before and in the moment (i.e., reflection before and in action) and (2) what one has learned through individual reflection and in the course of participating in a reflective supervisory session (i.e., reflection on action). This newly gained knowledge and insight is then applied to one’s future interactions (i.e., reflection for action) with the infant, parents, staff, the NICU system, the hospital, and/or the community.

Within this framework, both the Reflective Supervisor and Reflective Practitioner function “like researchers on the scene, not searching for certainty but focusing on the present moment, simultaneously doing, learning, and coming to know.”

Gilkerson and Shalom of the Reflective Supervisor, who may not be trained in mental health, in how to incorporate the three essential elements, discussed above, as the dialogue between Reflective Supervisor and Reflective Practitioner begins. This seven-phase process consists of the following categories: (1) Preparation; (2) Greeting and Reconnecting; (3) Opening the Dialogue and Creating the Agenda; (4) Gathering Information; (5) Formulating Hypotheses; (6) Considering Next Steps; and (7) Closing (see Table, page five).

As Gilkerson observes, “In a range of settings and with practitioners from a variety of disciplines, we have found that reflective supervision effectively supports change toward relationship-based practice and sustains it over time.”

A Reflection

In summary, reflective practice is a dynamic, ongoing process that includes preparing oneself before the interaction; mindfully engaging in the interaction; and thoughtfully individual reflection after the interaction. It is a process that many of us have been introduced to, and practiced, as we were learning the NIDCAP approach to care in the following ways: through our observations of infant-caregiver interaction; through the development of our observational report and recommendations for care; through the process of sharing our report with staff and family members; through the implementation of the NIDCAP Advanced Practicum; and through learning to administer and score the Assessment of Preterm Infants’ Behavior (APIB). Each of these steps of learning called upon reflection to effectively integrate this innovative approach to care.

Just as important, however, is the mindful review and reflection of one’s work with a Reflective Supervisor. This process nurtures our ability as professional caregivers to implement relationship-based developmental care. Participating in reflective supervision helps us to maintain and further refine our reflective
skills, as well as support us in our day-to-day interactions with families and our colleagues. As Gilkerntor observes, "...one has to experience being heard, respected, and challenged within the context of safety... I do think that the quest for reflection is truly a quest... and not complete for a long, long time... if ever!"

The concept of reflection and reflective supervision supports NICU professionals to learn and grow personally and professionally as they journey toward the challenging but rewarding experiences of implementing the NIDCAP approach to care. As Alm7 reflects:

"The implementation of relationship-based developmental care is geared toward fostering nurturing relationships among caregivers and the infants and families they care for, among the caregivers themselves, and between the developmental care facilitators and the caregivers." [7]

The Supervisory Session: Regularity, Collaboration, and Reflection

| Preparation | The first step is getting ready, shifting from one’s present preoccupation to a state in which it is possible to be fully open to another and to take in the state of the other. We stress to each new supervisor that she will need some time, even if just a couple minutes, to get herself together—to clear her mind, close off her desk, put the phone on “do not disturb,” and begin to create a protected environment for herself and the supervisee. |
| Greeting and Reconnecting | The supervisor greets the supervisee in a friendly way and makes a broad, personal connection. This helps both participants prepare for what is to come. If the supervisee has just rushed from another task, the greeting helps her make the transition to the calm space of the supervision session. |
| Opening the Dialogue and Creating the Agenda | With experience, most supervisors settle upon a third way of opening the session. Their supervisor might ask, “How have your week been for you?” or simply say, “Let’s begin.” Just as new supervisors may need maps and guidelines, they also sometimes need to have suggested openings, ways to bridge the greeting and the serious work of the session. Since this can be an awkward moment for beginners, we suggest that supervisors find a few opening that feel both right and productive and use those as they gain comfort in the role. Then the supervisor’s task is to listen carefully and attentively. What is on the supervisee’s mind? What would he/she like to focus on? When the supervisee experiences, session after session, that the supervisor really is just where he/she is, a sense of collaboration and safety is created. Sometimes the supervisee will know just where to go; other times she will need the supervisor’s help. It is better to ask than to guess. “You have shared so much. What would you like us to focus on today?” |
| Gathering Information | When an issue or concern has been identified, the next step is to gather the details: what exactly happened, what was said, what the supervisee experienced, what he/she also observed the other experiencing, etc. It is tempting to rush in and seek solutions or to normalize, but we encourage details. He/she is also constructing the story of the event and perhaps becoming aware of his/her own attitudes and reactions for the first time. |
| Formulating Hypotheses | The collaboration continues as the supervisor and/or supervisor begins to share hunches about what is going on and what might be helpful. Hypotheses are generated in an open, tentative exploration. The supervisee is helped to reflect on his/her own position and to try on another person’s perspective. There should be no rush towards closure. |
| Considering Next Steps | Non-clinical practitioners come to supervision with problems to solve, uncertainties to clarify, and issues that are affecting their day-to-day work. After gathering information and formulating hypotheses, the supervisor guides the conversation toward consideration of next steps. This not only gives the practitioner direction, but also helps him/herself during the session. The supervisor might ask, “In the time we have left, given all you have shared and observed, how might you approach your next home visit? What might help you to do so well? What might be the next steps?” As with formulating hypotheses, this is a collaborative process. The supervisor’s greater experience may be a resource at this stage, as the supervisee imagines what might happen in a situation to ones the supervisor has experienced many times. |
| Closing | The supervisor ends the session with some appreciation of the work done and a confirmation of the next supervision contact. |

SUPPORTING AND SUSTAINING REFLECTIVE PRACTICE

References


