The Open Journal of Occupational Therapy

Volume 10
Issue 3 *Summer 2022*

Article 3

July 2022

Occupational Therapy's Psychosocial Role for Young Children Transitioning out of Foster Care

Patrick J. Walker
University of Mary, Billings MT – USA, pjawalker17@gmail.com

Bryan M. Gee
Rocky Mountain University of Health Professions – USA, bryan.gee@rmu.edu

Sharon Leonard
Rocky Mountain University of Health Professions – USA, sharon.leonard@rm.edu

Recommended Citation

Walker, P. J., Gee, B. M., & Leonard, S. (2022). Occupational Therapy's Psychosocial Role for Young Children Transitioning out of Foster Care. *The Open Journal of Occupational Therapy, 10*(3), 1-15. https://doi.org/10.15453/2168-6408.2003

Occupational Therapy's Psychosocial Role for Young Children Transitioning out of Foster Care

Abstract

Background: Unmet needs for children in the foster care system lead to hardships with social participation, healthy relationships, and occupational engagement. Despite an understanding of these needs, there is minimal research on occupational therapy's role for young children transitioning from foster care back to their biological parents.

Method: A single case report was completed via occupational-based interventions focused on psychosocial development, such as emotional regulation and appropriate social skills. All nine interventions were intended to be provided via 45-min individual treatment sessions followed by biological parent coaching for 15 min with strategies such as role-playing, sensory techniques, and trauma-informed care. Emotional regulation and appropriate social skills were tracked through Goal Attainment Scaling, the Canadian Occupational Performance Measure, the Developmental Assessment of Young Children- Second Edition, and a parent interview.

Results: All assessments provided significant results in the improvement of child engagement in social participation, education, and play. The parent interview demonstrated increased biological parent knowledge and decreased stress.

Conclusion: Overall, the child's occupational engagement and biological parent's satisfaction enhanced their skill sets to improve their quality of life, occupational participation, and relationship quality. Through a coaching strategy, the biological parent gained confidence to take on social-emotional challenges during the child's transitional phase.

Comments

The authors declare that they have no competing financial, professional, or personal interest that might have influenced the performance or presentation of the work described in this manuscript.

Keywords

psychosocial concerns, trauma-informed care, mental health

Credentials Display

Patrick J. Walker, OTD, MOT, OTR/L; Bryan M. Gee, PhD, OTD, OTR/L, BCP, CLA; Sharon Leonard, OTD, MOT, OTR/L

DOI: 10.15453/2168-6408.2003

The foster care system is a temporary service for children who, for many reasons, cannot live with their immediate family and are placed with either relatives or unrelated foster parents (American Academy of Pediatrics, 2016). Children in foster care are four times more likely to attempt suicide. Around 70% of youth in the justice system have experienced the child welfare system, and 50% of foster children will not graduate high school on time (Foster America, 2022). Occupational therapists working in pediatric settings may see the obstacles children face when transitioning out of the foster care system. When children from foster care go through transitions, whether to a new foster home or back to one of their biological parents, there is a potential for various setbacks and psychosocial concerns, such as social-emotional dysregulation and behavioral difficulties. Understanding occupational therapy's (OT's) role in mental health sets a perfect stage to meet this unmet need for numerous young children and youth returning to their biological parents. Even though OT's scope of practice may fill this void during the transition period, there is little to no evidence of OT's approach in this practice area. This case report will enhance the understanding of practicing occupational therapists addressing psychosocial concerns for children who have experienced trauma. The case report offers a unique approach to OT evaluation and intervention with children transitioning out of foster care and back to their biological parent.

Background Literature

Prevalence of Social-Emotional Disturbances in Children in Foster Care

According to Turney and Wildeman's (2016) analysis of the 2011–2012 National Survey of Children's Health in the United States (US), there is a significant difference in health outcomes of children in foster care compared to children in the general population. It was found that children in the U.S. foster care system were twice as likely to have learning disabilities and/or developmental delays; three times as likely to have ADHD and/or ADD; five times more likely to have anxiety; six times more likely to present with behavioral difficulties, such as difficulties with conduct; and seven times more likely to have depression (Turney & Wildeman, 2016). Turney and Wildeman's (2016) findings represent poor mental and physical health for children in the foster care system.

These alarming statistics are further deleterious when paired with those of the American Academy of Pediatrics (2016), which mentions that foster children's mental health does not receive meaningful support. Zlotnick et al. (2012) noted this need when they found few promising interventions to assist with the psychosocial issues of children and youth in foster care systems and homeless individuals. The study revealed almost all approaches used for these populations focused on decreasing experienced trauma, such as separation from their parents, and environmental instability, such as difficulties with maintaining the same structure or routines in the child's home.

Need for Services in Mental Health and Managing Behaviors

In addition to examining the prevalence of social-emotional disturbances in children in foster care, Jacobsen et al. (2020) completed a longitudinal study to determine if foster children would have more significant difficulties with social-emotional functioning than their peers. According to female caregivers, male caregivers, and teachers there is a statistically significant difference between foster children and their peers in internalizing behaviors, externalizing behaviors, and total problem behaviors (Jacobsen et al., 2020). Externalizing behaviors reported by foster mothers at 2 and 3 years of age predicted externalizing behavior when the children were 8 years of age, a statistically significant rate (Jacobsen et al., 2020). The study also revealed externalizing behaviors reported by foster fathers at 3 years of age significantly predicted foster children's externalizing behavior when the children were 8 years of age. Seeing these

behaviors continue throughout foster children's lives demonstrates a need to address how to understand these behaviors when these children are transitioning back to their biological parents.

Hiller et al. (2020) completed a qualitative study on supports and barriers for emotional development in children in the foster care system via focus groups with 21 caregivers in the United Kingdom. The study resulted in themes including difficulties of caregivers managing behaviors, a lack of support and training in mental health, and a lack of access to mental health services (Hiller et al., 2020). It also found only half of the sample felt profoundly capable of managing the child's emotional needs. These results correlate with Bellamy et al. (2010), who mentioned that half of the youth in foster care need psychosocial assistance, and only 26% of these children receive these services. This demonstrates a need for increased mental health services for children who have experienced foster care, a need that OT can fill.

Barriers to Healthy Foster Care Experiences

To understand the difficulties in receiving proper health care, Moyer and Goldberg (2020) completed a qualitative analysis through an ecological theory on the perspectives of teachers, foster parents, and former foster youth on the supports and barriers in the microsystems (youth-school relationship) and mesosystems (foster parent-school relationship) of children in foster care. Through semi-structured, one-on-one interviews, the authors identified themes that appeared in the microsystem, including differential treatment and lower expectations, differential treatment and pity, teacher misunderstanding and lack of a trauma-sensitive approach, and school is not (and cannot be) a top priority (Moyer & Goldberg, 2020). These themes centered around wanting the same expectations as other students and not advancing students when they are not ready, pity from teachers causing students to not trust educators, teachers using discipline on behaviors that are out of the student's control, and the demand of having an unstable environment must come before schoolwork for these children. These themes further resulted in teachers, foster parents, and former foster youth all agreeing that the strained relationship between the foster child and the school system created academic barriers. The results also included the emerging themes in the mesosystem, including the complexity of accommodations, foster parents' strained relationships with teachers, and teachers' lack of home-school partnership (Moyer & Goldberg, 2020). These themes centered around intimidation from the complex special education system, educators not efficiently communicating with foster parents because of their lack of respect and knowledge for foster parents' roles, and difficulties from educators getting foster parents to follow through with recommendations at home. These themes resulted in teachers and foster parents agreeing that the disconnect between foster parents and the school system created academic barriers for foster youth (Moyer & Goldberg, 2020). These barriers must be addressed during the transition period back to the biological parent to increase success with transitioning and to gain trust between the biological parent, teachers, and their child that has been in the foster care system.

To further understand foster parents' needs, perceptions, and satisfaction with their training, Kaasboll et al. (2019) completed a systematic literature review that included 13 articles relative to parent training for children in the foster care system. These findings included (a) user satisfaction of these training programs was high from the quantitative data; (b) less satisfaction of these programs was noted in the qualitative data, in one study only 34% of the participants thought the information was understandable; (c) there is a need for more information on assisting with mental health needs and children's behaviors from the effects of trauma; and (d) training completed online was effective and well-liked by participants

(Kaasboll et al., 2019). Understanding these barriers allows room for new and beneficial interventions to occur through OT with the biological parent during the transition period to regain custody.

Family Involvement

Hurley et al. (2020) completed a phenomenological qualitative study via semi-structured interviews with 20 parents and with seven children 13 to 24 years of age in hopes of decreasing some of the known barriers to unstable environments. This study centered around parent and child participation in interventions for the child's mental health challenges. The intervention was a family-based therapeutic group for families with younger children having difficulties with mental health challenges. The investigation resulted in three themes: improved parent-child relationships, understanding and being understood, and multi-generational perspectives (Hurley et al., 2020).

The theme of improved parent-child relationships was demonstrated with the children stating that they could see a decrease in negative parenting and an increase in positive parenting resulting in more functional and positive relationships. This included parents approaching behaviors in a calmer manner and parents increasing the time spent with their children. This theme is also mentioned by Smith (2022) and the important role of OT in the foster care system to rebuild relationships between the child and caregivers to enhance the ability of the child to trust again. The second theme, understanding and being understood, focused on emotional intelligence and open communication. Parents saw flaws in their own communication styles, which allowed them to focus on listening and self-reflecting on the interactions with their children. This, in return, allowed for an increase in open communication with their children. The last theme, multi-generational perspectives, looked at the effects of intergenerational trauma and how it effects both parents and children. This allowed parents to understand trauma better and potentially change themselves before changing their child. Overall, it was found that family involvement resulted in successful therapeutic relationships between the parent and child demonstrating a need to include the biological parent in interventions during the transitional phase back to the biological parent.

Trauma-Informed Care

It is essential to understand the stance that the American Occupational Therapy Association [AOTA] (2017) has on mental health promotion, prevention, and intervention with children who have experienced childhood trauma (Petrenchik & Weiss, 2015). Trauma-informed care is defined as services that are screening for trauma exposure, using culturally appropriate assessments, providing resources on trauma, strengthening resilience, addressing the impact of trauma on the entire family, and addressing secondary traumatic stress (Petrenchik & Weiss, 2015). According to Petrenchik and Weiss (2015), children who have faced an adverse childhood experience may present with difficulties in social participation, education, play and leisure, rest. and sleep, work, and activities of daily living. These occupations are essential to overall childhood and social development. Through interventions focusing on these occupations, children can continue to participate in age-appropriate tasks and occupations. Strategies supported by AOTA include creating safe environments for learning, creating predictable routines, pairing sensory approaches with cognitive approaches, providing frequent direct instruction and modeling to create competence, and creating relationships (Petrenchik & Weiss, 2015). All these strategies should be used during educational sessions with the biological parent working on regaining custody of their child.

Deutsch et al. (2015) noted the mental, behavioral, and developmental difficulties that youth in the foster care system experience. Children who have experienced the foster care system have a higher chance of facing both trauma and neglect, which may lead to the inability to emotionally regulate. When a child presents with the inability to emotionally regulate, there is an increase in the need for parenting skills.

Even though there are recommendations to approach intervention with a trauma-informed lens, the role for OT in the transition back to biological parents is scarce in the literature. An approach that is based in OT literature is to develop parenting skills to address difficulties with both physical and mental development (Lynch et al., 2017). What is known is the use of a trauma-informed lens and parenting tactics and strategies, as listed above, can be taught to fit the needs of this vulnerable population, especially during the transitional period back to the biological parent (Deutsch et al., 2015).

Model of Human Occupations (MOHO)

The MOHO guides occupation therapy practice based on an individual's volition, habituation, environment, and performance (Park et al., 2019). According to Park et al. (2019) the MOHO provides an understanding of old habits and routines to change to a new, expected habit or routine. Allowing the child to understand expectations for daily routines will allow the child to feel more safe and secure in their new environment.

Lee et al. (2012) found that 92.1% of occupational therapists working in mental health stated the MOHO was their primary model in practice. Lee et al. further mentioned that 92.2% of the sample indicated that using the MOHO as a part of their plan of care had an impact on the therapeutic outcomes. In addition to this, Prior et al. (2020) found that interventions based on the MOHO demonstrated a 63% rate of return to previous occupations for individuals suffering from mental health difficulties, such as mood and delusional disorders.

Through these studies, it is evident that the use of the MOHO gives promising results in overall client satisfaction and higher-quality services. Using the MOHO allowed the occupational therapist (first author) to fully understand the child's environment and the parent's concerns to increase the success of targeted interventions on the most challenging areas for occupational engagement.

Social Participation Frame of Reference

The social participation frame of reference (SPFR) assesses the power of emotion on the engagement of children in social participation (Olsen, 2020). This frame of reference further investigates emotional regulation, family habits and routines, environmental support at home, environmental support at school, environments for peer interaction, and peer interaction (Olson, 2020). It also supports intervention for the child and caregiver through occupation (Olson, 2010). Through the SPFR, the pediatric client may increase their knowledge of emotions and overall emotional regulation to increase success in all areas of occupation, including social participation, while decreasing difficulties with psychosocial concerns.

Furthermore, according to Olson (2020), the theoretical base of this frame of reference is the development of social skills and the importance of early relationships on a child's overall skill and habit development. According to the SPFR, dysfunction occurs when a child cannot focus; does not adjust to home, school, or community daily routines; and does not exhibit the capacity to control emotional expression. By providing an understanding of dysfunction, this frame of reference will assist in skill development for psychosocial concerns, such as emotional regulation and appropriate social skills, to increase overall occupational participation for pediatric clients transitioning out of the foster care system and back to their biological parent.

Literature Review Conclusion

Through the literature review, numerous gaps were found supporting the need for literature on OT's role for children transitioning out of foster care and back to their biological parent. The literature also guided the application of trauma-informed care by demonstrating the importance of feeling secure

and providing the child with a predictable routine in their environments. The literature also identified family involvement as a substantial need for this population during all transitional stages to increase the success of healthy relationships. By combining these techniques, this case report uniquely contributes to the literature on OT by describing OT's role in increasing occupational engagement for children transitioning out of the foster care system and back to their biological parent.

Method

Case Report Design

This single case report consisted of quantitative and qualitative measures. The aim was to discover the potential benefits of a unique treatment approach with an emerging OT area of practice to address psychosocial concerns for a pediatric client who had experienced the foster care system and was transitioning back to their biological parent. The pediatric client participated in nine outpatient pediatric OT sessions for 3 months, focusing on psychosocial development in the occupations of social participation, play, and education through a trauma-informed lens. Psychosocial development focuses on skill development of self-regulation, emotions, and social behaviors. The biological parent also participated in one coaching session with the occupational therapist during each intervention date, resulting in nine coaching sessions. The biological parent participated in assessments and a follow-up interview based on the interventions and outcomes. The biological parent provided signed informed consent. The Rocky Mountain University of Health Professions Institutional Review Board approved this case report.

Client Background

The pediatric client was a 3-year 6-month-old male who presented at OT with increased concerns with externalizing behavioral problems observed by the biological parent and daycare staff in the occupations of play and social participation during the transition back to the biological parent. This client had been seeing an outpatient occupational therapist for approximately 1.5 years while living with two different foster families because of an initial referral for developmental delay and poor coordination. The child presented with excellent outcomes with fine motor control, gross motor control, social skills, and coordination through the first 1.5 years of OT. However, when the biological parent regained custody, the pediatric client presented with an extreme increase in externalizing behaviors, such as biting, hitting, and kicking caregivers and peers. These externalizing behaviors resulted in the client's removal from two daycares, additional biological parent stress, and decreased ability to participate in age-appropriate occupations.

Outcome Measures

To determine the main areas of dysfunction in occupational performance, three assessments were used. These assessments included Goal Attainment Scaling (GAS) (Hurn, 2006), the Canadian Occupational Performance Measure (COPM) (Law et al., 2019), and the Developmental Assessment of Young Children (DAYC-2) second edition, social-emotional domain (Swartzmiller, 2014).

Goal Attainment Scaling

Outcomes from GAS are found through individualized goals scored in a standardized method (Hurn, 2006). Goals are individualized based on the patient and are used to track progress, not identify dysfunction. GAS is found to have a high test-retest reliability (Koski & Richards, 2015). These goals are scored as -2 to 2, with 0 being the expected outcome, positive numbers representing better outcomes, and negative numbers representing worse outcomes. The goals for this single case report were created at the initial assessment and included decreasing externalizing behaviors, increasing attention, increasing

appropriate peer play, understanding social participation skills, and successfully expressing emotions. The goals were reassessed post intervention with the biological parent. Harpster et al. (2019) completed a systematic review on the use of GAS in pediatric rehabilitation. The review consisted of 52 studies in four different databases. Most studies were considered low-level research. Even though they were lower-level research studies, the results demonstrated that GAS could detect a meaningful change among pediatric clients and can be used across diverse populations in pediatric interventions, but it does not identify dysfunction. Even though it was found that GAS should be used with consideration for standardization, this is a successful tool to see meaningful change in this vulnerable population.

Canadian Occupational Performance Measure

To fully assess occupational performance, the COPM was used. The COPM measures self-care, productivity, and leisure through a semi-structured interview that lasts 15–30 min (Law et al., 2019). Per Eyssen et al. (2005), the COPM has adequate test-retest reliability (ICC = 0.67 performance and ICC = 0.69 satisfaction). This assessment is based on a 1–10 scoring system, with 10 indicating the best outcomes. The assessment was administered at the initial start of the intervention and post intervention to detect overall occupational change based on the client's satisfaction and performance of the occupation. This assessment found that the biological parent's most significant areas of occupational concern included social participation, play, and education, as they were all rated 10 for importance.

Supporting the use of these two assessments (GAS & COPM), Doig et al. (2010) used both GAS and the COPM to measure progress in OT. The results of using both the COPM and GAS demonstrated client-centered goals and goal attainment from both a subjective and objective measure (Doig et al., 2010). Working with a trauma-informed lens, it was essential that all goals and interventions were client and family centered.

Developmental Assessment of Young Children- Second Edition

GAS and the COPM assessments implemented with the DAYC-2, specifically, the social-emotional domain, were used to increase the understanding of social-emotional development for this pediatric client. The DAYC-2 is a standardized caregiver questionnaire that asks questions on caregiver perspectives of their child's overall social-emotional development, such as does your child ask for help when they have difficulties. This tool is highly recommended and used to ensure that children are thoroughly assessed in how they are doing in this domain. The scoring is based on a 0 (child does not exhibit this behavior) or 1 (child shows this behavior most of the time) rating (Swartzmiller, 2014). The DAYC-2 is known to have a test-retest reliability for the social-emotional domain of 0.70 (Swartzmiller, 2014).

While completing the assessments, there were some difficulties in understanding the meaning of the assessment questions. To address this area of concern, the occupational therapist read through the questions with the biological parent on the DAYC-2 to enhance understanding of each question. There were no cultural or financial difficulties noted. Following the scoring of the assessments, there was evidence suggesting significant problems with overall psychosocial development with emotional regulation and social skills, but a good prognosis was evident because of contextual supports and biological parent buy-in.

Therapeutic Intervention

The therapeutic intervention used was based on occupational engagement through a lens on trauma-informed care (Petrenchik & Weiss, 2015) and psychosocial development (Cahill et al., 2020). The unique approach differed from traditional approaches in outpatient OT as three consecutive

interventions were implemented to enhance skills in one area of occupation, followed by biological parent coaching on each session (see Table 1). This approach is also backed by Paul-Ward and Lambdin-Pattavina (2016), suggesting that OTs role in foster care is to promote participation in occupations at all levels of intervention by meeting unmet physical and mental health needs. This strategy was used as typical outpatient pediatric OT plans of care may focus on a large variety of deficits including visual motor integration, social-emotional skills, fine motor precision, or gross motor control. When the plan of care has numerous goals, it is easy for parents to get lost in caregiver education and lose sight of the overarching occupational goals. This approach focuses on one occupation to allow the pediatric client and biological parent to fully understand the strategies and techniques that are used for each occupation to ensure that carryover occurs at home during the transition period back to the biological parent. This approach also supports using occupations as a mean of relationship building, which is needed for this population. The three occupations that were focused on for three sessions each were social participation (with a client-centered focus on Zones of Regulation [Kuypers, 2021], waiting/requests, expressing emotions with choices), play (with a client-centered focus on turn-taking, sharing/communication, problem-solving/understating others' emotions), and education (with a client-centered focus on attention, following commands, and classroom rules). These occupations were used to enhance overall psychosocial development of emotional regulation and appropriate social skills as these occupations were the biggest areas of concern for the biological parent.

To ensure intervention effectiveness, the occupational therapist (first author) used the MOHO as the supporting model for the case report. Using the MOHO provided an understanding of old habits and routines to elicit change to a new, expected habit or routine for the child and the biological parent. Allowing the child to understand expectations for daily routines allowed the child to feel more safe and secure in their new environment, which is a goal of trauma-informed care. Along with the MOHO, the SPFR was used to address the high level of difficulties with social relationships, routines, and emotional regulation. This frame of reference was used throughout to increase success with the development of psychosocial skills with peers, such as emotional regulation and social skills.

All intervention sessions in the plan of care lasted for 45 min with the occupational therapist. Each intervention was then supplemented with approximately 15 min of biological parent coaching to enhance carryover at home and continue building the child's social-emotional skillset. Parent coaching is defined by a professional providing support to a parent to promote successful parenting skills for their child. Since this child was being unified with the biological parent, coaching sessions focused on developing parenting skills, which is supported as the OT's role with a child in this circumstance (Lynch et al., 2017). Coaching sessions included education on deep breathing and joint approximation for calming strategies, role-playing, sensory integration, therapeutic breaks, routines, visual aids, positive and encouraging voice, and encouraging a safe and secure environment. Before starting the plan of care, the plan was to complete 4 weeks that focused on improving participation and performance in each occupation. However, because of illness, cancellations, and everyday life challenges for the family, each occupation was addressed via three consecutive intervention sessions (once per week), resulting in 9 weeks of intervention sessions. The focused interventions for the occupation of play (the third intervention in the plan of care) were not completed because of client illness, but the biological parent concerns for the week and the coaching session still occurred via phone conference to enhance the overall well-being of the pediatric client. The full intervention plan, coaching sessions, and reasoning for occupation sequence are detailed in Table 1.

Table 1

Overview of Therapeutic Intervention

	Intervention	Coaching Session	Reasoning
Session 1 **Social Participation** **Zones of Regulation**	Interventions provided through social stories of being a good friend for social skills development. Role playing was used for green and red emotions to increase emotional awareness of self and others (Kuypers, 2021). This approach was used to demonstrate modeling of emotional management for this child (Petrenchick & Weiss, 2015).	Coaching was given via calming sensory strategies, such as deep breathing, and when to use these calming strategies. Education was provided on allowing the child to express emotions as either green or red and giving the child time to express his emotions.	Social participation was the first occupation to be addressed as all these skills will be needed throughout every occupation. This child was also demonstrating the most concerns in social participation because of external behaviors, such as biting and hitting other children in his classroom. These concerns were addressed in social participation through development of psychosocial skills, such as emotional regulation and emotional understanding. These strategies were carried over to all interventions and were used on Sessions 1 through 3.
Session 2 **Social Participation** **Waiting and Requests**	Intervention included role playing interventions with a game of the child's choice. Intervention focused on waiting for others and requests for needs during any task. Allowing more opportunities to understand the need to wait and the proper way to request needs.	Coaching was provided during a hands-on session with the pediatric client. The focus was on how to play at home with a concentration on allowing the child to properly request needs and waiting. Coaching was also provided on positive language during play with high praise when proper waiting or requests are made. This supports trauma-informed care by allowing the parent to provide frequent modeling for the child to become competent in social participation skills (Petrenchick & Weiss, 2015).	
Session 3 **Social Participation** **Social Skills with Peers**	Intervention planned for appropriate social skills with peers but was cancelled because of illness.	Coaching occurred via phone conversations on consequences that are used. Discussed the importance of allowing emotions to be expressed when a behavior has occurred. Following the behavior use positive language and provide security and emotional understanding. Parent also educated on the importance of peer relations and allowing the child to become active in sports and activities in the community, which is supported by Cahill et al. (2020).	
Session 4 **Play** **Turn Taking**	Intervention consisted of play via child's game of interest. Play was focused on turn taking and the emotions that come with turn taking or not turn taking with peers. Elongated turns were taken to increase overall carryover of taking turns with peers. High praise was given following	Coaching on using the term "ready hands" when taking turns starts to become difficult, demonstration of this strategy given and fielded all questions related to playing at home. Another trauma-informed approach, helping the child be in control with some choices during play, was provided	Because of the main concern being social skills and play skills with peers, the occupation of play was the second occupational focus for Sessions 4 through 6. This occupational focus surrounded biological parent's questions. Demonstrations and hands on teaching were provided

	small wait times, which resulted in an increased time for waiting. Intervention also included working on transitions through sensory regulation.	during this coaching session (Petrenchick & Weiss, 2015).	throughout all coaching sessions as this was a high concern area for the parent.
Session 5 **Play** **Communication and Sharing**	Intervention included social stories of sharing using communication instead of actions, such as asking for a toy instead of looking and then taking a toy. Peer play then focused on sharing and communicating with peers using words instead of immediate actions. Worked on painting tasks with sharing colors and utensils with occupational therapist. Occupational therapist expressing high levels of being green when proper sharing was given.	Demonstration given on transition periods using an auditory timer followed by a decompressing sensory strategy, such as joint approximation, deep breathing, or belly breathing. This was then followed by an age-appropriate tabletop task. These strategies promote trauma-informed care by allowing the child to participate in predictable routines and pairing sensory with cognitive interventions (Petrenchick & Weiss, 2015).	
Session 6 **Play** **Problem-Solving and Peer Emotions**	Play was focused on problem-solving and understanding peer's emotions. The child and occupational therapist took turns on their game of choice to demonstrate that everyone likes different toys and games. The occupational therapist expressed high levels of green, blue, or red emotions (Kuypers, 2021) to demonstrate how other children would feel during play with the choices that the child made. There were great results in understanding what makes a child sad (not playing the other child's game of choice) or red (taking toys away from the other child).	Coaching reiterated the importance of red and green emotions and allowing emotions to be expressed to help the child to feel secure in his environment at home. Coaching was provided on word choice, discussing using "what happened" instead of "what is wrong," positive language, such as "please do this" instead of "do not do that" and getting down to the child's level when giving requests or discussing emotions. This trauma-informed approach is supported by providing numerous positive reinforcements (Petrenchick & Weiss, 2015).	
Session 7 **Education** **Following Commands**	Participation in tabletop tasks, such as puzzles, pre-writing tasks, and other fine motor control tasks were used. While completing these tasks short, quick commands were given. Increased success with following commands was noted when short verbiage was used, commands were given at eye level, and when observational commands were given, such as "I think I need someone to draw a circle," instead of demanding requests.	Coaching surrounded parent's questions on how to get the child to follow more commands. Education provided on making questions and tasks fun instead of demanding; examples given throughout role playing.	Education was the final occupation to be addressed in Sessions 7 through 9. This was placed last in the sequence order because at this child's age both social participation and play skills are needed to successfully participate in educational tasks.

Session 8 **Education** **Attention**	Interventions focused on tabletop activities with visual timers to increase understanding of continuing until we are done. A great increase in attention was noted with visual timers even when the task was nonpreferred.	Coaching surrounded the use of a visual timer when needing the child to attend to a task when the biological parent needs to cook, clean, etc. Coaching was also given on the importance of a sensory break for regulation when asking the child to be in one spot for an extended period of time. Strategies used included obstacle courses that have direction, heavy lifting of items, or parent-guided gross motor play.
Session 9 **Education** **Classroom Rules**	Intervention included classroom rules, such as quiet feet, paper tasks, and listening ears. Fun verbiage, such as turn on your ears with a key turn and motion over the child's ears was used. Higher compliance noted when sneaky gestures were made for quiet feet and when funny gestures were made for turning on ears. A visual aid of a first then board was used with even higher compliance to nonpreferred educational tasks.	Coaching was used on describing a first then board and how it is used in play with a demonstration of a variety of cards. The occupational therapist and child demonstrated the use of the board for the biological parent to increase understanding with great reception noted. This coaching session also focused on empowerment and allowing the child to predict the upcoming routine, which is supported for trauma-informed care in OT (Petrenchick & Weiss, 2015).

Data Collection

Data collection for each assessment was completed during the initial evaluation and again 1 week following the last intervention session. All assessments were used in this way to understand the pre and post test results for the psychosocial development of this pediatric client throughout the transitional period to the biological parent.

Data Analysis

Data analysis was conducted by completing, scoring, and analyzing all three assessments to determine this pediatric client's overall change in psychosocial skills. Furthermore, the semi-structured interview was analyzed for a qualitative perspective of the biological parent. The primary author copied the semi-structured interview verbatim and did a line-by-line analysis.

Results

GAS

Through GAS the pediatric client went from -2 to 2 on externalizing behaviors during peer play, -1 to 1 on education, -1 to 0 on peer play, -1 to 2 on social participation, and -1 to 2 on social-emotional development. Per the calculations of the results, there was a 42.3 change from a baseline of 31.0 to achievement of 73.2. This represents a change that was better than expected from the GAS scoring. GAS has a mean achievement of 50 with a standard deviation of 10 (Turner-Stokes, n.d.). The achievement of 73.2 results in significant change greater than two standard deviations.

COPM

Results from the COPM created an overall score change in performance of 5.5 (from 1.5 to 7), and an overall change in satisfaction of 7.25 (from 1 to 8.25) (see Figure 1). Furthermore, there was a

remarkable change in performance and satisfaction for all performance problems (play, social participation, education, and attention). These changes can be found in Figure 2. Per the COPM manual, a change of two points represents a meaningful change (Law et al., 2019). The data collected demonstrates a significant change of at least 4 points in all ratings.

Figure 1
Overall COPM Score

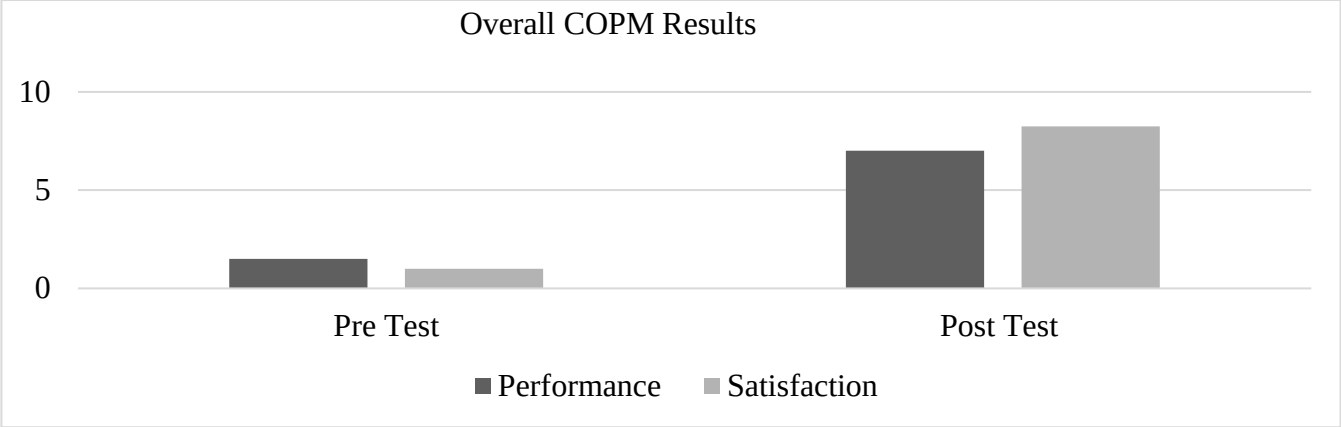
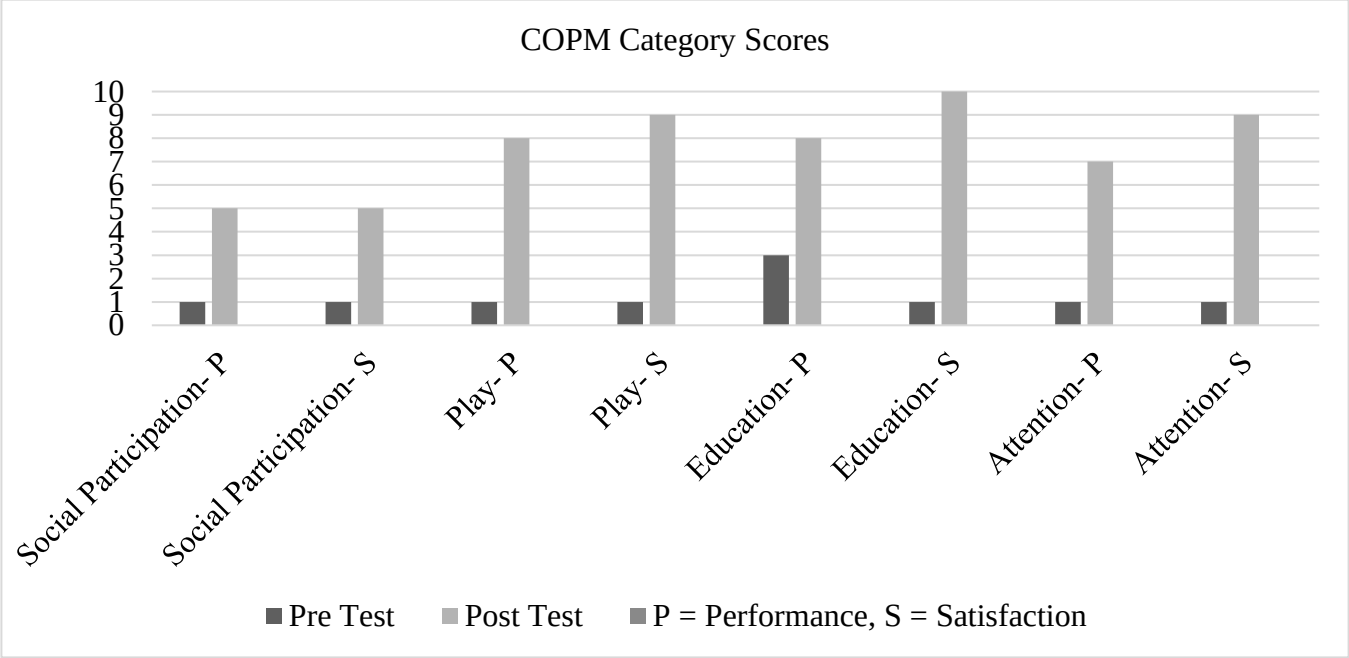


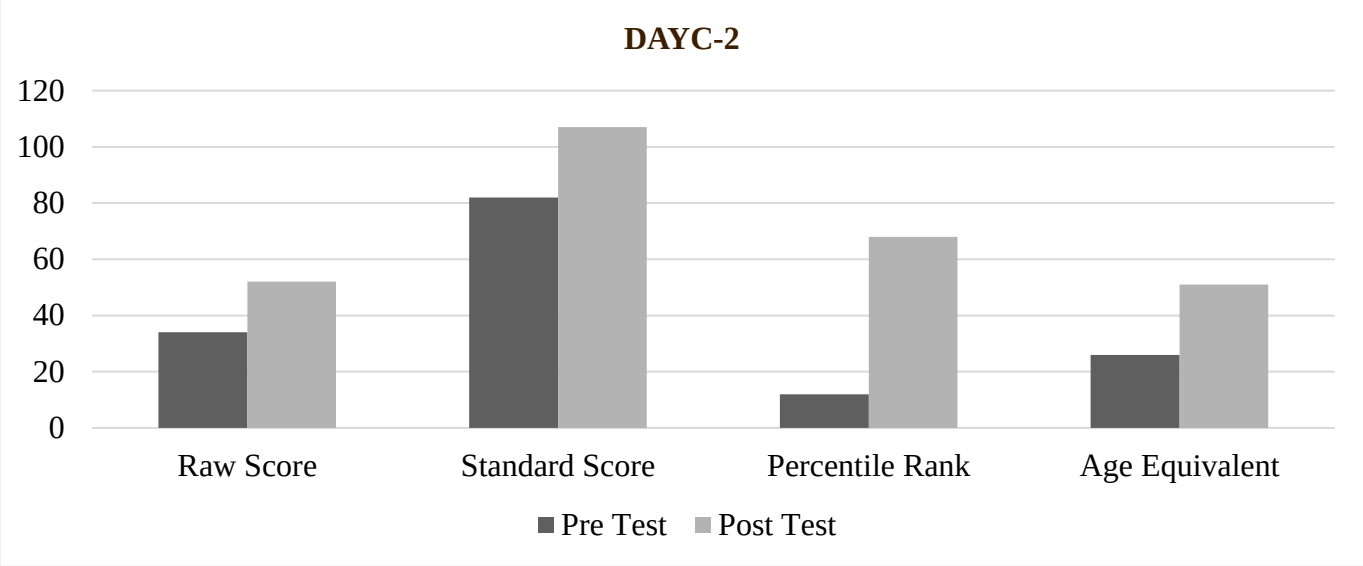
Figure 2
COPM Category Scores



DAYC-2

The results from the DAYC-2 demonstrated improvements in occupational performance as well. At the pretest, the pediatric client was scoring at a 26-month-old and in the 12th percentile, while at the posttest, the client scored at a 51-month-old and in the 68th percentile. Even though this client had only gone from below average to average in the descriptive terms, the pediatric client was on the extreme low end of the below-average category at pretest (82 on a scale from 80–89) and the high end of the average category on the posttest (107 on a scale of 90–110) (see Figure 3).

Figure 3
DAYC-2 Social-Emotional Results



Semi-Structured Interview with Biological Parent

Prior to the end of the collection period, the main author created an open ended, semi-structured interview to understand the biological parent's perspective of the interventions. Questions included: What were your overall thoughts about the program? What stood out to you in the program? and Anything that you would change about the program? The interview was recorded and transcribed verbatim by the primary author. Line by line analysis was completed to understand the biological parent's full perspective. During this 10-min semi-structured interview, the biological parent expressed her perspective of being involved in the novel intervention program. The biological parent stated, "he is now the boy that I had at the very beginning, and I do not think I would have been able to do this on my own." She mentioned that she could see massive growth in her child's overall psychosocial development in emotional regulation and peer play skills. She alluded to the fact that she had gained skills from the coaching sessions that have allowed her to continue to see growth at home and give her confidence in knowing what she is doing to assist in the psychosocial development of her child. This is demonstrated in her thoughts of "now I have the skills to, like, help transition him to new things, or if he is getting too worked up." The biological parent believed in the new program and even mentioned the name of the occupational therapist to local institutions that assist with children in the foster care system to use as a resource when psychosocial concerns occur. She mentioned "my son is like completely changed," when discussing the reasoning of telling this agency about the services provided. Through the line-by-line analysis, the main themes that formulated included perspective change, beneficial, and confidence. These themes all relate to the knowledge that she has taken forward in addressing psychosocial development for her child. Overall, the biological parent was highly thankful for the experience, knowledge, and outcomes that the client-centered program provided.

Discussion

As the management of mental health continues to be a pertinent topic in society, this single case report may be beneficial in understanding how to manage psychosocial concerns for children experiencing the transition back to the biological parent from the foster care system. Occupational therapists can foster

occupation-based interventions through a trauma-informed lens and coaching strategies to enhance the carryover of psychosocial skill development for children, such as social-emotional regulation, social participation skills, and understanding emotions. This may then impact their development and allow nurturing of their mental health to continue to develop as they age through positive engagement in occupations.

The findings of this single case report demonstrated promising outcomes based on the extended time frame to focus on one area of occupational performance at a time, incorporating psychosocial strategies during occupational engagement, facilitating biological parent coaching sessions through means of occupation, rebuilding healthy relationships during all occupations, and using a trauma-informed lens for children that have experienced trauma. This approach is highly supported by the needs that were found from caregivers in Kaasboll et al.'s (2019) study, including a lack of interactive exercise, communication in lay terms, support following placement, and real-life practice training via role-playing. By filling the needs of these caregivers, remarkable and effective outcomes were achieved.

Furthermore, it is essential to look at the overall presentation the client is exhibiting post intervention. Post intervention, this pediatric client had significantly decreased his overall externalizing behaviors in all areas of occupation. This is also seen in Van Holen et al.'s (2017) study using family involvement in intervention when the intervention group presented with statistically significant fewer externalizing problems at the follow-up data assessment. This child has made great improvements in social participation with advancements in social-emotional regulation with peers and being able to understand and acknowledge others' emotions. This is also evident in the improvements in play skills resulting from the child's newfound skill set in waiting for others, taking turns, and following directions with support from the environment, such as sensory strategies and giving the child a known routine. One of the biggest and most notable outcomes is that this child has been able to stay with the same daycare because of the decrease in emotional outbursts, resulting in increased engagement in the occupation of education. These occupational-based outcomes were easy to track by both the therapist and biological parent as all interventions were based solely on one area of occupation.

Alongside these positive outcomes, the child's biological parent had mentioned numerous times how strong their relationship had become during the interventions, especially those influenced by a trauma-informed lens during occupational engagement. Approaching interventions with this lens is also supported by Bailey et al.'s (2019) review of the Attachment, Self-Regulation, and Competency (ARC) Model. Using this trauma-informed model aims at building lasting and effective relationships, skills, competency, and self-understanding. After using this model, children presented with decreased behaviors, increased chance of permanent placement, lower post-traumatic stress disorder symptoms, and a significant decrease in biological parent's stress. Even though this model was not used in this case report, a general trauma-informed lens, supporting routines, positive reinforcement, client-centeredness, and collaboration were used, and provided significant results on psychosocial development, including social-emotional regulation, healthy relationships, and social skills (Petrenchik & Weiss, 2015).

Limitations and Future Research

This single case report was based on an intervention provided by one occupational therapist with a pediatric client in the Northwest United States. Therefore, the results may not be representative of this entire vulnerable population. There is also a limitation that the occupational therapist knew this pediatric client before the transition occurred and continued to work with the client when the program was implemented, even though this was when the change in emotional regulation occurred. The occupational

therapist did not know the biological parent before this planned intervention. During the first week of intervention, the client transitioned to a new school, which may have increased overall psychosocial skill development success. To ensure the results are based on this intervention and increase the chance of generalizability, further research is required with a larger sample size. Further research would also be beneficial to understand the differences in outcomes based on the transitional period, whether that is into foster care, back to a familiar foster family, or transitioning to a new family while already being in foster care.

Conclusion

Overall, the pediatric client and biological parent enhanced their skillsets to increase their current quality of life, participation in meaningful occupations, and social-emotional relationship with one another. In addition, it was found that the biological parent saw a significant improvement in satisfaction and child performance in the occupations of social participation, play, and education. Moreover, positive results were indicated in the development of social-emotional regulation skills throughout all three assessments. The results also demonstrate positive outcomes in decreasing the barriers noted in the research by caregivers of foster care children. Although the results cannot be generalized, occupational therapists should consider this type of approach when working with children in need of developing or enhancing psychosocial skills to increase success with their overall occupational engagement and quality of life during the transition phase back to the biological parent from the foster care system.

References

American Academy of Pediatrics. (2016). *Foster care.* https://www.aap.org/en/patient-care/foster-care/

American Occupational Therapy Association. (2017). Vision 2025. *The American Journal of Occupational Therapy*, *71*(3), 7103420010p1. https://doi.org/10.5014/ajot.2017.713002

Bailey, C., Klas, A., Cox, R., Bergmeier, H., Avery, J. & Skouteris, H. Systematic review of organisation-wide, trauma-informed care models in out-of-home care (OoHC) settings. *Health and Social Care in the Community*, *27*(3), e10–e22. https://doi.org/10.1111/hsc.12621

Bellamy, J. L., Gopalan, G., & Traube, D. E. (2010). A national study of the impact of outpatient mental health services for children in long-term foster care. *Clinical Child Psychology and Psychiatry*, *15*, 467–479. https://doi.org/10.1177/1359104510377720

Cahill, S. M., Egan, B. E., & Seber, J. (2020). Activity- and occupation-based interventions to support mental health, positive behavior, and social participation for children and youth: A systematic review. *American Journal of Occupational Therapy*, *74*(2), 7402180020. https://doi.org/10.5014/ajot.2020.038687

Deutsch, S. A., Lynch, A., Zlotnik, S., Matone, M., Kreider, A., & Noonan, K. (2015). Mental health, behavioral and developmental issues for youth in foster care. *Current Problems in Pediatric and Adolescent Health Care*, *45*(10), 292–297. https://doi.org/10.1016/j.cppeds.2015.08.003

Doig, E., Fleming, J., Kuipers, P., & Cornwell, P. L. (2010). Clinical utility of the combined use of the Canadian occupational performance measure and goal attainment scaling. *American Journal of Occupational Therapy*, *64*(6), 904–914. https://doi.org/10.5014/ajot.2010.08156

Eyssen, I. C., Beelen, A., Dedding, C., Cardol, M., & Dekker, J. (2005). The reproducibility of the Canadian Occupational Performance Measure. *Clinical Rehabilitation*, *19*(8), 888–94. https://doi.org/10.1191/0269215505cr883oa

Foster America. (2022, February 21). *The problem.* https://www.foster-america.org/the-problem

Harpster, K., Sheehan, A., Foster, E. A., Leffler, E., Schwab, S. M., & Angeli, J. M. (2019). The methodological application of goal attainment scaling in pediatric rehabilitation research: A systematic review. *Disability and Rehabilitation*, *41*(24), 2855-2864. https://doi.org/10.1080/09638288.2018.1474952

Hiller, R. M., Halligan, S. L., Meiser-Stedman, R., Elliott, E., & Rutter-Eley, E. (2020). Supporting the emotional needs of young people in care: A qualitative study of foster carer perspectives. *British Medical Journal Open*, *10*(3), 1–10. https://doi.org/10.1136/bmjopen-2019-033317

Hurley, J., Lawler, M., Bray, A., & Oeding-Erdel, N. (2020). Achieving therapeutic gains for regional youth with emergent mental health issues through parental family system-based groups: Findings from a qualitative study. *The Australian Journal of Rural Health*, *28*(2), 161–167. https://doi.org/10.1111/ajr.12610

Hurn, J., Kneebone, I., & Cropley, M. (2006). Goal setting as an outcome measure: A systematic review. *Clinical Rehabilitation*, *20*(9), 756–72. https://doi.org/10.1177/0269215506070793

Jacobsen, H., Bergsund, H. B., Wentzel-Larsen, T., Smith, L., & Moe, V. (2020). Foster children are at risk for developing problems in social-emotional functioning: A follow-up study at 8 years of age. *Children & Youth Services Review*, *108*, 1–10. https://doi.org/10.1016/j.childyouth.2019.104603

Kaasbøll, J., Lassemo, E., Paulsen, V., Melby, L., & Osborg, S. O. (2019). Foster parents' needs, perceptions, and satisfaction with foster parent training: A systematic literature review. *Children & Youth Services Review*, *101*, 33–41. https://doi.org/10.1016/j.childyouth.2019.03.041

Koski, J., & Richards, L. G. (2015). Reliability and sensitivity to change of goal attainment scaling in occupational therapy nonclassroom educational experiences. *American Journal of Occupational Therapy*, *69*(Suppl. 2). https://doi.org/10.5014/ajot.2015.016535

Kuypers, L. (2021). *Framework designed to foster regulation and emotional control.* Zones of Regulation. https://zonesofregulation.com/index.html

Law, M., Baptiste, S., Carswell, A., McColl, M. A., Polatajko, H., & Pollock, N. (2019). *The Canadian occupational performance measure* (5th ed., revised). CAOT Publications.

Lee, S. W., Kielhofner, G., Morley, M., Heasman, D., Garnham, M., Willis, S., Parkinson, S., Forsyth, K., Melton, J., & Taylor, R. R. (2012). Impact of using the Model of Human Occupation: A survey of occupational therapy mental health practitioners' perceptions. *Scandinavian Journal of Occupational Therapy*, *19*(5), 450–456. https://doi.org/10.3109/11038128.2011.645553

Lynch, A., Ashcraft, R., Paul-Ward, A., Tekell, L., Salamat, A., & Schefkind, S. (2017). *Occupational therapy's role in mental health promotion, prevention, & intervention with children and youth foster care.* American Occupational Therapy Association. https://www.aota.org/~/media/Corporate/Files/Practice/Children/SchoolMHToolkit/Foster-Care-Info-Sheet-20170320.pdf

Moyer, A. M., & Goldberg, A. E. (2020). Foster youth's educational challenges and supports: Perspectives of teachers, foster parents, and former foster youth. *Child & Adolescent Social Work Journal*, *37*(2), 123–136. https://doi.org/10.1007/s10560-019-00640-9

Paul-Ward, A., & Lambdin-Pattavina, C. (2016). New roles for occupational therapy to promote independence among youth aging out of foster care. *American Journal of Occupational Therapy*, *70*(3), 7003360010. https://doi.org/10.5014/ajot.2016.017426

Park, J., Gross, D. P., Rayani, F., Norris, C. M., Roberts, M. R., James, C., Guptill, C., & Esmail, S. (2019). Model of human occupation as a framework for implementation of motivational interviewing in occupational rehabilitation. *Work*, *62*(4), 629–641. https://doi.org/10.3233/WOR-192895

Petrenchik, T., & Weiss, D. (2015). *Occupational therapy's role in mental health promotion, prevention, & intervention with children and youth childhood trauma.* American Occupational Therapy Association. https://www.aota.org/~/media/Corporate/Files/Practice/Children/Childhood-Trauma-Info-Sheet-2015.pdf

Prior, S., Maciver, D., Aas, R. W., Kirsh, B., Lexen, A., van Niekerk, L., Fitzpatrick, L. I., & Forsyth, K. (2020). An enhanced individual placement and support (IPS) intervention based on the model of human occupation (MOHO): A prospective cohort study. *BMC Psychiatry*, *20*(1), 361. https://doi.org/10.1186/s12888-020-02745-3

Olson, L. J. (2020). A frame of reference for enhancing social participation. In P. Kramer, J. Hinojosa & T. Howe (Eds.), *Frames of reference for pediatric occupational therapy* (4th ed., pp. 461–491). Wolters Kluwer.

Olson, L. J. (2010). A frame of reference to enhance social participation. In P. Kramer & J. Hinojosa (Eds.), *Frames of reference for pediatric occupational therapy* (3rd ed., pp. 306–348). Lippincott Williams & Wilkins.

Smith, M. N. (2022). Occupational therapy's role in the foster care system. *The Open Journal of Occupational Therapy*, *10*(1), 1–6. https://doi.org/10.15453/2168-6408.1850

Swartzmiller, M. D. (2014). Test review: Developmental assessment of young children–second edition (DAYC-2). *Journal of Psychoeducational Assessment*, *32*(6), 577–580. https://doi.org/10.1177/0734282913518380

Turner-Stokes, L. (n.d.). Goal attainment scaling (gas) in rehabilitation. University of London. https://www.sralab.org/sites/default/files/2017-06/Tools-GAS-Practical-Guide.pdf

Turney, K., & Wildeman, C. (2016). Mental and physical health of children in foster care. *Official Journal of the American Academy of Pediatrics*, *128*(5). https://doi.org/10.1542/peds.2016-1118

Van Holen, F., Vanschoonlandt, F., & Vanderfaeillie, J. (2016). Evaluation of a foster parent intervention for foster children with externalizing problem behaviour. *Child and Family Social Work*, *22*(3), 1216–1226. https://doi.org/10.1111/cfs.12338

Zlotnick, C., Tam, T., & Zerger, S. (2012). Common needs but divergent interventions for U.S. homeless and foster care children: Results from a systematic review. *Health & Social Care in the Community*, *20*(5), 449–476. https://doi.org/10.1111/j.1365-2524.2011.01053.x

Patrick J. Walker, OTD, MOT, OTR/L, *Instructor, University of Mary, Billings, MT*

Bryan M. Gee, PhD, OTD, OTR/L, BCP, CLA, *Professor, Rocky Mountain University of Health Professions, Provo, UT*

Sharon Leonard, OTD, MOT, OTR/L*, Assistant Professor, Rocky Mountain University of Health Professions, Provo, UT*