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Research Paper

Investigating the Effectiveness of Eye to I© Intervention in Online Format

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ABSTRACT

During the COVID-19 pandemic, restrictions on in-person interaction were put in place throughout the world. In India, these restrictions were implemented overnight making it crucial to rapidly execute therapy in an online format. At Potentials Therapy Centre in New Delhi, India this was done using the Eye to I© early intervention model. This therapeutic model targets core developmental skills provided the framework to deliver online therapy during the ongoing pandemic. This paper explores the effectiveness of this implementation through a case study on three students who attended online therapy with Potentials Therapy Centre. Semi-structured interviews were conducted with parents and therapists to explore the effectiveness of the online implementation of the Eye to I© therapy model from their perspective as well as to understand the experiences, and challenges faced by students with social communication difficulties who access online therapy. A thematic analysis reflects that Eye to I© effectively enhances the life skills for students diagnosed with Autism and Social Communication difficulties when implemented online during COVID-19 and highlights the role of technology in delivery of therapeutic interventions.

Keywords: *Autism, Social Communication, Online Therapy, COVID-19.*

Autism, or Autism Spectrum Disorder (ASD), is a complex neurodevelopmental disorder that compromises function in multiple developmental domains including communication and social interaction and its increased prevalence is documented both globally as well as in India (Arora et al., 2018). The onset of COVID-19 and widespread restrictions on in-person interaction made it crucial to execute therapy in an online format as well as explore the effectiveness of this online therapy format. Online

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therapy, also called 'teletherapy', is viewed as any type of therapeutic intervention that uses the Internet to connect qualified professionals and their clients (Rochlen et al., 2004). Eye to I© is an early intervention therapeutic model targeting core developmental skills such as joint attention, affect sharing and pre-linguistic functions. The Eye to I© therapeutic model has been used as a framework to deliver online therapy during COVID-19, beginning April, 2020. The documented increase in telehealth services during COVID-19 (Statista, 2021) warrants further study. This paper demonstrates the efficacy of the Eye to I© model in the online format. Specifically, it indicates increased social communication skills and parent-child interaction, and documents the generalization of those skills to non-therapeutic interactions. Further, this research provides a previously unrecorded view into the parent and therapist experience of online play-based therapy in India.

REVIEW OF LITERATURE

Online therapy and Autism

The benefits of online therapy are well documented. For instance, online therapy frequently has lower costs, and provides increased convenience and scheduling flexibility (Feijt et al., 2020). Therapies like Applied Behaviour Analysis (ABA) that addresses behavioural issues prevalent in ASD have been found to be effective in the online format as well (Awasthi, 2021, Lindgren et al. 2016). Additional benefits of teletherapy addressing ASD needs include parent satisfaction and fidelity to the treatment program (Hao et al. 2020, Ingersoll & Berger 2020). Further preliminary investigations show that parent engagement and sense of competence can improve social communication skills and the overall perceived efficacy of parent-mediated online intervention for ASD (Ingersoll & Berger 2020, Narzisi 2020). Further investigation into online therapy for ASD reveals parent training to be a crucial aspect to various forms of intervention. From robust play-based therapy to programs using only parent coaching, parent training has resulted in increases in daily living skills, requesting and labelling skills, and increases in parent's ability to initiate interaction.

Online Therapy in the South - Asian Context

Teletherapy has existed for decades in developed countries yet is relatively new in South-Asia. However, over the past decade online therapy has become more accessible and prevalent in India as availability of affordable smartphones and internet connectivity increased (Keelery, 2021). While use of technology for academics is the most prominent use in the South Asian home (Soysa & Mahmud (2019), Indian parents report training programs for caregivers of children ASD to be effective and practical (Sivaraman et al. 2020). For example, a parent-mediated program NDBI for young children with ASD was shown to be feasible for parents to implement while also resulting in improved social communication, engagement and play (Ingersoll & Dvortcsak, 2010; Sengupta, Mahadik, & Kapoor, 2020).
Existing literature suggests that teletherapy for Autism is most effective when parents are involved in therapy sessions or training of young or school-aged children. However, research exploring the perspectives, benefits and challenges faced by caregivers and therapists during online implementation is underrepresented. This paper aims to add to the literature of online therapy for ASD in two areas: First, by demonstrating the effectiveness of Eye to I© therapy online for students of varied age and developmental skill levels; Second, by documenting and analyzing parent and therapist experiences as they implement the play-based Eye to I© model online.

Current Study

Challenges faced by caregivers and therapists while implementing online therapy, are not highlighted in the current body of research. In India, challenges posed by the small number

of trained professionals are documented (Naskar, Viktor, Das & Nath, 2017). However, many challenges remain that have not been formally identified or researched including the availability of internet connection and gadgets, play and study materials needed for therapy, and difficulties in training parents. Covid-19 may have further exacerbated these impacting factors. This paper explores these challenges and demonstrates how the online implementation of Eye to I© therapy provides tools to address them.

For this study, the Eye to I© model was used to deliver online therapy during COVID-19. This model focuses on parent training and skill-based therapy, sensory integration and play especially for students with autism and social communication difficulties. The model encourages the use of commonly available household items for therapeutic interactions and play, thereby empowering caregivers to implement therapy activities in the home environment. Eye to I© is founded on in-depth theoretical understanding of cognitive and social stages of play. This allows for rapid and accurate creation of individualized therapeutic and training goals. The current research aims to understand the effectiveness of the Eye to I© therapy model from parent's and the therapist's perspective, and to understand their experiences. This study explores improvements in social communication skills of students ranging in age from 7 - 23 years who attended Eye to I© therapy at Potentials Therapy Centre, in New Delhi, India.

METHODOLOGY

The present study attempts to answer the question: Is Eye to I© therapeutic intervention delivered online effective enough to inculcate social communication skills in students previously diagnosed with ASD. The study also aims to understand the experience of the parents and the therapists with the therapy being delivered online.

This research presents case studies of three students who were receiving online Eye to I© therapeutic intervention. The researchers employed a convenient sampling. The study utilized a qualitative design whereby in-depth data was collected between April 2020 and July 2021, over Zoom application using semi-structured interviews. Thematic analysis was used to identify major themes of experiences reported by the participants about online implementation of Eye to I© therapy.

Participants

Primary caregivers (mothers) and the therapists of three students of online Eye to I© therapy. Parents were trained 1:1 by therapists to moderate sessions or act as a co-therapist, depending on requirement for individual cases. The therapist trained the parent, instructed the parent during therapy sessions if required, and led the child and parent in goal-based therapy sessions. The demographic details of the individuals are as follows:

Note: Names have been changed to maintain confidentiality of the individuals.

- Kartik, a 7 year old student, with a well-established relationship with in-person Eye to I© therapy at Potentials Therapy Centre. He started online therapy with Potentials during the pandemic.
- Ananya, a 23 year old student, had just begun therapy prior to the pandemic but not with Potentials Therapy Centre. She started therapy online at Potentials during the pandemic.
- Rishab, an 18 years old student, had extensive previous experience with in-person therapy, and started Eye to I© therapy with Potentials online during the pandemic.

Procedure

On a prearranged and mutually agreed day, the participants were interviewed by the researchers over a Zoom call. Interviews used a semi-structured guide with a loose scaffolding that allowed for exploring the topics of interest using further probes. The questions centered on the perceived effectiveness of online implementation of the Eye to I© therapy model and understanding the positive and negative experiences of parents and therapists with the model. Interviews were transcribed and coded by two researchers independently and the inter-rater reliability was found to be 85% for the six interviews analyzed. Thematic analysis was used to identify central themes of the parent's and therapist's experiences with the online delivery of the Eye to I© therapy model.

The specific components of Eye to I© therapy varied according to each case as determined by the students' developmental stages and corresponding individual needs and goals. These variations included differences in frequency of sessions, as well as frequency and duration of parent-therapist interactions. Table 1.1, 1.2 and 1.3 briefly note how the therapy process was individualized for each case.

Table 1.1. The format of therapy provided to Kartik as per his needs.

Student Name	Therapist Role	Parent Role	Activities
Kartik	Trained parent to do activities with child. **Structured** session to be detailed and easy for the parent to follow. Modelled play activities and interaction for parent and child. Supervised parent.	In person engagement. Received hands-on training in implementing goal-based activities.	Activities were parent and explained in advance by the therapist. After a few months of online therapy, mother was able to implement therapist-designed activities appropriately with narrations and pauses.

Table 1.2. The format of therapy provided to Ananya as per her needs.

Student Name	Therapist Role	Parent Role	Activities
Ananya	Trained parent, created rapport with student and modelled interaction. Acted as **prompter** for activities involving parent and child.	Learned from therapist through instructions and modelling. Acted as a co- therapist.	Ananya and mother engaged in activities together with guidance of therapist. Guidance, practice and review with therapist helped mom smoothly transfer skills from therapeutic to general setting.

Table 1.3. The format of therapy provided to Rishab as per his needs.

Student Name	Therapist Role	Parent Role	Activities
Rishab	Therapist gave agency to student and respected client-therapist relationship by maintaining privacy and confidentiality.	Gave space to son, respected privacy. Parent took feedback and was updated after taking permission from Rishab. Parent met with therapist and expressed concerns, observations, needs.	Sessions focused on developing social communication skills required to begin and sustain the foundation of friendship: sharing interests, experience, and emotion.

RESULTS

***Case* 1**

Kartik: Kartik was a 7 year, 2 months boy at the time of data collection. Kartik previously attended Eye to I© therapy in-person at Potentials Therapy Centre up to thrice weekly. He started Eye to I© therapy online with Potentials immediately after in-person restrictions were announced as mother reported that he was having difficulty adjusting to isolation at home. This difficulty manifested in the form of hyperactivity, aggression and unmanageable behaviour. In the initial online therapy sessions, Kartik could sustain attention for limited periods of less than 3 minutes and he struggled to communicate his intentions. He quickly showed irritation through whining, wriggling, and avoidance of interaction. Additionally, he displayed signs of emotional dysregulation such as crying, laughing, and shouting all within the same few minutes. During the first five sessions of online therapy Kartik did not interact directly with the therapist on screen. He did not gaze towards the therapist or do actions in reaction to therapist actions or voice. In this case the parent mediating the therapy was directed to engage with Kartik during session activities.

As the therapist adapted existing goals and identified new goals specific to the isolation of Covid-19 and the home environment, she also trained the mother to begin parent-mediated therapy. To address communication difficulties the therapist introduced a picture-based communication system the parent could store in the gallery section of an old mobile phone the family had on hand. Kartik began to direct his gaze to the screen and to interact directly with the therapist online, as well as with mother in person simultaneously. He sustained engagement in activities and interactions for periods of 5 - 10 minutes when sensory breaks between activities were part of the routine. Kartik could also use the picture-based communication system to communicate with parent and with therapist. He used one and two-word picture phrases to indicate his functional needs and desires for objects and actions involved in interactive activities as well as independent self-engagement. These communication skills were easily generalized to home interactions outside of the online therapy sessions as Kartik and parent were using the same device in the same physical environment in which therapy took place. Gradually, over a period of several months, with continuous therapy, mother reported more ‘manageable’ behaviour at home as Kartik showed less hyperactivity and vocal and physical aggression as well as a reduction in swings of emotion. Furthermore, the parent reported that Kartik’s academic participation also improved when Kartik gained the discussed communication and sustained engagement skills.

Table 2.1. Depiction of Kartik's case

Student's Name	Therapist-client relationship	Parent-child relationship	Social Communication improvements
Kartik	Initially child depended on parent for instruction. Gradually interactions with therapist increased. Parent and therapist interacted more in online mode about activities, feedback, progress of sessions etc. Parent shared positive changes and concerns about behaviour	Through training from therapist and session participation, parent gained in-depth knowledge of child's development, resulting behaviours and needs. Thus, parent modified own strategies in parenting.	During online therapy, child became efficient in using picture - based communication. As skill acquired in home environment very little transition needed to generalize skill to non- therapy interaction.

***Case* 2**

Ananya: At the time of data collection, Ananya was a 23 years old female. Parents reported that Ananya experienced great difficulty in adjusting to the restrictions on in-person interaction brought on by Covid -19. Her mood fluctuated rapidly and she unexpectedly expressed anger, frustration and irritation by shouting at her mother and manipulating family members by refusing to cooperate or participate in household interaction. Ananya struggles with social anxiety and avoids interaction with unknown and lesser known persons thus her only social interaction was the negative actions reported above.

Anaya began online Eye to I© therapy twice a week in May of 2020. The format of screen-based interaction was new and she needed several sessions to adjust and build rapport with the therapist. Goals focused on increasing communicative gaze, finding topics of mutual interest, and involving mother in positive interactions with Ananya. In time, consistent therapy sessions, involving parents and other family members facilitated successful communication and interactions. As the therapist guided the family to find topics of common interest and developmentally appropriate skill levels Ananya's relationships improved such that Ananya's mother now says that they "both are best friends". In another example, Ananya began to visit her aunt often, and learnt embroidery from her indicating increased social communication skills like the ability to generalize skills across persons and settings. Anaya's emotional regulation skills increased and As a result of knowing more shared actions and interests the therapist reported that Anaya's emotional regulation increased and aggression reduced over the course of this research.

Table 2.2. Depiction of Ananya's Case

Student's Name	Therapist-client relationship	Parent-child relationship	Social Communication improvements
Ananya	Using shared screen and music while doing activities made sessions more engaging and fun, further enhancing quality of interactions between Ananya and therapist. Enjoyed interacting with therapist. Started messaging and sharing highlights with therapist. This interaction outside the session provides a space for her to practice, and for the therapist to follow up on the communication goals being addressed.	Parent learned to modify interaction, keeping in mind age and privacy of student. Parent got to closely view therapeutic sessions and participate. Observing the therapist interact with Ananya, helped Parent to understand strategies like acknowledging difficulties or discomfort, or using self-talk and parallel talk help the young adult feel at ease.	The student became comfortable talking with therapist - evident in how she - maintained eye contact therapist through the screen, -spoke with comparatively stronger volume -added content details while sharing.

Rishab: Rishab, 18 years old at the time of data collection, is a highly verbal male student, formally diagnosed with Autism Spectrum Disorder. He began once a week Eye to I© Therapy with Potentials in June 2020. He had no previous experience with Eye to I©, but had participated in multiple forms of therapeutic intervention previously. Rishab has achieved academic success at grade level. Rishab was very comfortable with the online medium and reported that he frequently engaged in google searches and YouTube videos as forms of self- engagement. When he began online therapy with Eye to I©, Rishab discussed that he had no friends, was socially bullied in the past and thus experienced anxiety in social settings. The specific therapeutic goals were to guide him in learning to choose a topic of common interest; to summarize topics precisely, giving the conversation partner a chance to speak; and to develop preliminary perspective taking skills to employ in conversation. Upon request from Rishab, and with consent form his parents, the involvement of parents was minimal, and confidentiality was maintained in order to contribute to his independent thinking and socializing skills.

The online therapy was restricted to screen-based interaction which proved to be a positive format for Rishab. The screen mitigated some of the need for body language interpretation (an area of difficulty for Rishab) and he reported feeling less pressure to maintain directed eye gaze. Therapists relied on Rishab's existing familiarity with video and online searches to introduce topics of his interest and practice conversation. As he learned to speak on topic and listen to the interlocutor's response for up to three turns at talk, Rishab gained greater confidence. Subsequently, Rishab and mother each independently reported that his relationship with his sister improved as he could engage in conversation with her on topics

of her interest, and not just his own interests. Rishab's skills were further developed as he practiced conversation and questioning skills when an additional therapist joined the therapy session from a third screen. In this situation Rishab generalized conversation skills to three persons. Rishab's skills continued to expand as the number of conversation partner's increased and changed over the course of the data collection period. Generalization of skills will further occur as in-person interaction opportunities increase post Covid-19 pandemic.

Table 2.3. Depiction of Rishab's Case

Student's Name	Therapist-client relationship	Parent-child relationship	Social Communication improvements
Rishab	Student was protective of relationship with the therapist and considered sessions as his time of learning that had to take place without parent involvement	Got trained to respect boundaries set by their son. There is no power struggle as the child is treated as an independent being.	Student takes initiative in conversations, has gained skills of listening, asking questions, staying on a shared topic, and listening to topics of limited interest

DISCUSSION

This study adds to the existing literature that indicates online therapy is a promising solution when access to in-person therapy is restricted. Continued in-depth exploration is needed to confirm efficacy of such programs (MacEvill & Brosnan, 2020). The present study attempts to understand how shifting to online mode due to COVID-19 related restrictions allowed for differences in experiences of therapists, parents and students with the Eye to I© model of therapy. We utilized a qualitative approach and used the thematic analysis technique. Through our analysis, we found four broad themes.

Theme 1: Improved relationships

The implementation of online Eye to I© therapy was a transition that required time and effort from the therapist, the parents and students. In this study, the prominent theme in all cases was improved interpersonal relationships. The parents were an active part of the therapy process, either as a facilitator, a distant observer or both. They reported that this involvement contributed towards a greater understanding of their child's developmental needs and a deeper sense of empathy towards their own child. Kartik's parent said, "*I now have a better understanding of Kartik's needs and accept that he can be different*". Therapists reported forming a close, comfortable and reliable therapeutic relationship with the students, and their parents often as a result from intensive training parents for their involvement in sessions and communicating regular updates on the child's progress towards goals. The therapists also reported improved relationships and increased understanding of the child's "natural habitat." One therapist said "*I could observe the child in a natural environment. In offline mode, parents would share their observations* [from the home environment] *and I would not get the child's first-hand experience.*"

Theme 2: Transition Experiences

The second theme that emerged from analysis highlights how parents and the therapists experienced the transition form in person to online Eye to I© therapy. Parents reported being anxious about their supply of toys and therapy materials. However, upon attending sessions,

these fears dissipated. One of the key aspects of the Eye to I© model is that it utilizes material for therapy which is readily accessible - such as kitchen utensils like sieves or home office tools like sellotape, making it easy for parents to engage in activities with familiar supplies and skills.

For therapists, the transition to online delivery required numerous changes in techniques, goals, tracking growth and parent training. For example, therapists modified goals to the restrictions of on-screen interaction and observation and designed activities keeping in mind limited available resources. Additionally, therapists reported that they changed the way they implemented goal- based activities in order to utilize parental involvement in the session.

Theme 3: Benefits

Online therapy is an effective and a viable way to deliver therapy, without compromising safety during the pandemic. Furthermore, additional benefits reported by parents and therapists included saving time and money as the resources needed to implement therapeutic activities therapy were readily available household items. Both parents and therapists reported observing in students a reduction in anxiety, enhanced social skills, and generalizability of learnt skills. Parents reported feeling emotionally satisfied, and experiencing a sense of empowerment that came from learning about their child, engaging in therapeutic activities, and the increased interactions with therapists.

The therapists found positive opportunities for engagement with both parents and students during online therapy sessions. The intimacy afforded by conducting the sessions in -home allowed for greater insight into the child's learning by both parent and therapist. For example, one therapist reported, *"[I] could engage her after knowing her interests [at home]."* Additionally, therapists reported that parents who participated in or observed the online therapy sessions demonstrated conceptual understanding of therapist's feedback about the child's learning and skill acquisition. This was a great contrast to previous experience therapists had providing feedback to parents of clients attending in-person Eye to I© therapy.

Theme 4: Parental isolation & changes in therapeutic structure due to setting

The transition to online Eye to I© therapy was not without challenges due to the home-based setting. Parents described initially feeling apprehensive about their capacity for involvement in therapy sessions but this was overcome by training, proving to be less of a challenge than expected. In contrast, difficulty occurred in making time for sessions at home and with interruptions during therapy sessions by family members. Parents also noted that they experienced isolation and reduced connection to parents of other students with similar therapeutic needs.

The home-based setting of online therapy caused therapists to experience challenges as well. In-person therapy at a dedicated therapy environment relies, in-part, on restricted spaces, persons and times to create boundaries and behavioural expectations. One therapist reported "*Ananya's experience was challenging- expectations were not clear- emotional and behavioural issues came out." "The boundary and structure got a little loose."* In the home environment therapists struggled to establish therapeutic spaces and firm time tables as available rooms shifted according to the rhythms of the home.

CONCLUSION & FUTURE DIRECTIONS

This research explores experiences through three case studies of students receiving Eye to I© therapy online and subsequent interviews of the student's parents and therapists. Eye to I© is an early intervention therapeutic model for students with Autism spectrum disorder targeting core developmental skills such as joint attention, affect sharing and pre-linguistic functions. Qualitative analysis of the interviews produced four themes revealing unique insight into the experiences of participants. Results indicate that despite each case being unique in terms of age, developmental stages and needs, frequency of therapy, and accessibility of gadgets, therapy proved to be effective in all cases. Parents and therapists reported increased skill in student's social communication, emotional skills and family interactions. This study has crucial implications for how to better deliver therapy to clients with communication issues using telehealth means where access to in person therapy is restricted - whether that is due to a pandemic, availability, economic opportunity or other reasons. Additionally, this study shows that the use of household items in therapy and intensive therapist-parent communication can facilitate parental understanding and involvement in the online therapeutic process. Further research is needed to study a larger sample size and explore implementation of play-based therapy on both neurotypical and neurodiverse populations.

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Conflict of Interest

The author(s) declared no conflict of interest.

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Appendices

Appendix A: Parent Interview questions

1. During online therapy were you able to use household items (e.g-utensils, bottles, comb etc.) to engage in play? How difficult or easy was it to arrange these items? Did you use materials that you previously did not perceive as learning materials or explore concepts that previously you did not perceive as part of play or education? (Eg.: sensory play - making up and down motions or side to side motions - both play and pre-writing horizontal/vertical line skills)
2. When shifting to online therapy, you had to make a laptop or mobile screen available for the duration of your child's therapy. Did you face any difficulties in doing that? Did you use a different medium (phone/ laptop/ iPad or tablet/ computer or PC or desktop)? Did you find one better than the other?
3. Earlier, your child interacted with other children at Potentials either in a group or in the waiting area. When you transitioned to online therapy, did you notice changes in social interaction or interaction with peers (e.g-decrease in opportunity for overall interaction)? Did you notice changes in interaction with family members (e.g-existing ongoing interactions with family)?
4. Since online therapy is/was taking place in your homes, has there been a difference in how your child could transfer skills acquired in the therapeutic setting/interaction to the other environments & interactions like home or public spaces, as opposed to therapy at the centre? (e.g- greeting others since the child started online therapy)
5. What techniques were used by therapists to engage the child especially since the medium is now online during therapy sessions on Zoom? What about you as a parent at home, how did your actions change in maintaining directed eye gaze? Did you notice a difference in this or did you use any techniques that therapists used, at home? Was the amount of time gaze was sustained greater? Or lesser? Or was eye gaze directed to other objects / action, not at screen?
6. Did you gain tools to spend more positive time in interaction and play with your child? Were there any techniques you learned as a parent? How did it affect opportunities for engagement when you were not in therapy?
7. What changes did you notice in implementation of goal-directed activities outside of therapy sessions?
   Probes:
   Activity is based on available materials,
   Activity is designed specific to environment as opposed to designed for therapy room environment
   Goals are specific not only to skills, but also to lifestyle that can only be observed by seeing into the home via video conferencing online format.
8. Earlier, you came to the centre but now since everything has shifted online, what has improved about this for you? And what do you miss about going to the centre? OR - you began therapy only online and then transitioned to in -person therapy -
   a. How you follow up at home on activities introduced in therapy session
   b. Child's approach to the therapist in terms of physical distance.
9. In the online therapy model - what is your connection with other parents? How have you connected to other parents? With in-person therapy did you connect with other parents at the centre?
10. Has there been an increased parent involvement (during COVID-19 induced lockdown) with your child? Have you noticed an increased engagement with your

child in things you do at home? Would you say it has benefitted in any way for example reduced cost, time and reduced anxiety in your child.

Appendix B: Therapist Interview questions

1. What do you think was the parent experience when Eye to I© moved online? (Probes: was there an increased parent involvement (during COVID-19 induced lockdown) that you noticed with the child? Increased engagement with child, with therapist?)
2. What were some things that benefited parents when therapy moved online? (Probes: anxiety reduced in child? Cost reduced for parents?)
3. What would you say changed about your interaction with parents in this time?
4. Changes (increase or decrease or remains same) in implementation of goal-directed activities outside of therapy sessions - why?
    1. activity is based on available materials,
    2. Activity is designed specific to environment as opposed to designed for therapy room environment
    3. Goals are specific not only to skills, but also to lifestyle that can only be observed by seeing into the home via video conferencing online format
5. Generalization of Techniques: How was therapist able to use techniques of E2I differently when we moved from offline to online, and how was that different?
6. What was the parent experience in arranging materials during online therapy?
7. What was your experience in developing understanding or awareness of the child's needs? How did the online mode either enhance or inhibit observations and insights into the child's developmental patterns, etc.?

We will explore cons, and how they overcome or counter balance

1. What would you say about targeting therapeutic goals that target lifestyle specific needs and other family members? (difficulty of therapist and therapist learning)
    1. Greater difficulty in maintaining goals due to unpredictability of space, materials, persons to interact with
    2. Difficulties therapist may have faced in implementing goal -directed therapy due to variability in space/materials/persons i.e., one time the therapy is on the balcony and next has to be taken in the bedroom with a different parent etc. And this changes the skills because we know that skills are executed differently across places people and time.
2. More difficult to engage directed gaze - what techniques have we used as therapists?
3. What would you say about restricted viewable space & shared space? - use of phone, not just laptop and increased portability - this is of particular interest to Western countries where the assumption is that therapist and client are using laptop/tablet - but there is great advantage to using a phone. This is most evident in one case in which it allows for great movement, as well as for easy access scrolling to PECS type photo gallery.