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# A Perceptual Motor Intervention Improves Play Behavior In Children With Moderate To Severe Cerebral Palsy

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Provisional

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Running head: Motor intervention and play in children with cerebral palsy

A Perceptual Motor Intervention Improves Play Behavior In Children With Moderate To Severe Cerebral Palsy

Provisional

**1 Abstract**

2 For children with moderate or severe cerebral palsy (CP), a foundational early  
3 goal is independent sitting. Sitting offers additional opportunities for object exploration,  
4 play and social engagement. The achievement of sitting coincides with important  
5 milestones in other developmental areas, such as social engagement with others,  
6 understanding of spatial relationships, and the use of both hands to explore objects. These  
7 milestones are essential skills necessary for play behavior. However, little is known about  
8 how sitting and play behavior might be affected by a physical therapy intervention in  
9 children with moderate or severe CP. Therefore, our overall purpose in this study was to  
10 determine if sitting skill could be advanced in children with moderate to severe CP using  
11 a perceptual motor intervention, and if play skills would change significantly as sitting  
12 advanced. Thirty children between the ages of 18 months and 6 years who were able to  
13 hold prop sitting for at least 10 seconds were recruited for this study. Outcome measures  
14 were the sitting subsection of the Gross Motor Function Measure (GMFM), and the Play  
15 Assessment of Children with Motor Impairment (PACMI) play assessment scale, which  
16 is a modified version of the Play in Early Childhood Evaluation System (PIECES).  
17 Significant improvements in GMFM sitting scores ( $p < 0.001$ ) and marginally significant  
18 improvement in play assessment scores ( $p = 0.067$ ) were found from pre- to post-  
19 intervention. Sitting change explained a significant portion of the variance in play change  
20 for children over the age of 3 years, who were more severely affected by CP. The results  
21 of this study indicate that advances in sitting skill may be a factor in supporting  
22 improvements in functional play, along with age and severity of physical impairment.

23

24

1 The Effect of a Perceptual Motor Intervention on Play in Young Children with Cerebral  
2 Palsy

3 **Introduction**

4 “The work of children is play”. This often repeated saying encapsulates the idea  
5 that the active engagement of a child in exploring, investigating, experimenting, and  
6 experiencing the world, also known as “playing”, contributes to the development of  
7 physical, emotional, social and cognitive development. Engagement in play, particularly  
8 complex exploratory and pretend play, is a central activity of early childhood and is  
9 linked to the development of cognition, language, problem solving, and social skills  
10 (Bagnato, 2007; Farmer-Dougan & Kaszuba, 1999; Fewell & Rich, 1987; Hughes, 1991;  
11 Orr & Geva, 2015; Piaget, 1951; Russ, 2003; Singer et al., 2006; Singer & Singer, 1990).  
12 Sitting, on the other hand, is an essential motor skill that allows the infant to view and  
13 interact with the world in a completely different way and promotes more complex play  
14 activities. In the present study, we were interested in the relationship between the  
15 development of play and the development of sitting in children with motor impairments.  
16 Specifically, we explored whether improvements in a child’s ability to sit influences  
17 his/her ability to engage in play.

18 Spontaneous, self-directed play in early childhood, as traditionally characterized  
19 (Piaget, 1951; Vygotsky, 1980), requires the use of the hands to reach and interact with  
20 objects and toys. The emergence of sitting in typically developing infants at  
21 approximately 6 months of age coincides with many skills necessary for play, including  
22 improved accuracy in reaching (Harbourne et al., 2013a; Rochat, 1992), increasing  
23 understanding of the spatial properties of objects (Soska, et al., 2010), and greater  
24 efficiency in visual attention to the environment (Harbourne et al., 2014; Surkar et al,  
25 2015), among others. Sitting stability frees the arms for exploration and object  
26 manipulation, and allows the head and trunk to freely move and orient to important  
27 information in the environment (Rochat & Goubet, 1995). Sitting posture during  
28 reaching appears to rely more on anticipatory processes (Hadders-Algra, 2013). In  
29 addition, muscle activation patterns at the onset of sitting are highly variable, and as  
30 sitting and reaching develop, these patterns become gradually refined for both tasks  
31 (Hadders-Algra et al., 1996; Harbourne et al., 1993; Harbourne et al., 2013a). Studies  
32 investigating the development of sitting postural control while reaching suggest that  
33 reaching may serve as a perturbation for the maintenance of postural control in infancy  
34 (Hadders-Algra, 2013; Harbourne et al., 2013a), although hand use clearly increases as  
35 sitting develops (Rochat, 1992; Rochat & Goubet, 1995; Harbourne et al., 2013a). Thus,  
36 evidence from research with typically developing infants indicates that emerging postural  
37 control serves to support the development of environmental exploration such that an  
38 infant’s ability to play and engage in the world improves, which may, in turn, lead to  
39 further cognitive advancement.

40 Although improving postural control may be related to increasing upper extremity  
41 skill, a causal relationship is not necessarily evident (Harbourne et al, 2013a). Evidence  
42 to date reveals contradictory findings regarding the effect of postural control on reaching  
43 or play behavior in typically developing infants and infants with developmental delays.

1 Investigations of the specific relationship of proximal (or postural) control to distal (or  
2 hand) control do not support the tenet that improving postural control must precede  
3 advances in hand skill in the developing child (Loria, 1980; Fetters, 1991). A recent  
4 analysis of gross motor function to upper extremity control in children with CP  
5 concluded that there was a poor overall correlation between the two, and that the  
6 relationship varied between subtypes of CP (Carnahan, et al., 2007). In infants with  
7 neuromotor impairments, the short-term effect of using a supportive seat to control  
8 posture led to no immediate improvement in object manipulation (Washington et al.,  
9 2002). On the other hand, providing support at the pelvis in typically developing infants  
10 that cannot achieve sitting independently enhanced the coordination between trunk  
11 control and reaching (Rochat & Goubet, 1995). Reports from parents have indicated that  
12 specific adaptive seating enabled their children to participate more in play activities and  
13 address their self-care needs (Rigby et al., 2009) whereas the absence of these devices led  
14 to negative outcomes (Ryan et al., 2009). However, a recent systematic review suggested  
15 that there are more studies needed to investigate the linkage between sitting postural  
16 control and every day life activities (Angsupaisal et al., 2015). Thus, the relationship  
17 between sitting postural control and object exploration with the upper extremities cannot  
18 be considered as causal, although researchers have identified the co-emergence of the two  
19 skills.

20 Even if postural control influences reaching behavior in typically developing  
21 infants, little is known about the specific relationship between the development of sitting  
22 and play in children with motor disorders, particularly those with a moderate to severe  
23 condition. Poor postural control is associated with limitations in the attainment of  
24 functional skills such as mobility and manipulation during the developmental process.  
25 However, therapeutic intervention also targets postural control in order to affect upper  
26 extremity skill. Research has linked qualitative improvement in reaching with  
27 responsiveness to intervention of overall motor skill in children with severe CP (Fetters  
28 & Kluzik, 1996) as well as in typically developing infants (Rochat & Goubet, 1995; Out  
29 et al., 1998), but the nature of the connection between upper extremity function and  
30 postural control is still poorly understood. Adolph and Berger (2006) refer to the  
31 'centrality of posture' as a necessary condition for looking and interacting with the  
32 environment around them. However, there are no studies that investigate how the  
33 development of sitting postural control would affect play behavior and interaction with  
34 objects in children with cerebral palsy who have not developed sitting independence.  
35 Thus, it is important to understand how improvements of sitting postural control ability  
36 might influence play behavior in children with cerebral palsy because play skills reflect  
37 the problem-solving skills necessary for independent function.

38 The prevailing method in physical therapy intervention of children with cerebral  
39 palsy is Neuro-Developmental Treatment (Bobath, 1971). This method emphasizes the  
40 reduction of abnormal muscle tone and the facilitation of normal postural reflexes.  
41 Assisted movement in specific patterns is encouraged to normalize muscle tone.  
42 Facilitation of more normal movement is a primary focus, and it is done through graded  
43 stimulation at certain key points of the body (Trahan & Malouin, 2002). Normal postural  
44 alignment is emphasized in this approach. A recent review of the body of evidence  
45 regarding this intervention approach found little support for its effectiveness in promoting



1 normal motor milestones in any type of condition (Butler & Darrah, 2001; Novak et al,  
2 2013). For this reason we chose a different intervention for the present project.

3 An alternative approach that is based on perception-action theory is the perceptual  
4 motor intervention of Ingrid Tscharnuter (Tscharnuter, 1993, 2002). This method  
5 emphasizes the ecological approach and spontaneous movement based on environmental  
6 affordances. Self-initiated, functionally-directed movement drives the focus of  
7 intervention. This intervention consists of activities that include handling, which gently  
8 calls the child's attention to the support surface, and sets up the environment for small  
9 increments of movement that the child can utilize to solve a movement problem. Passive  
10 movements are not used in this approach. Increased variability of active movement is  
11 encouraged, and movements that may be considered abnormal in other approaches are  
12 not blocked or discouraged. This perceptual motor approach was used as one of the  
13 interventions for a previous project, with preliminary evidence of effectiveness to  
14 improve postural control over and above a home program (Stergiou et al., 2006;  
15 Harbourne et al., 2010).

16 Because infants and children with severe motor impairments such as CP are often  
17 limited in their ability to manipulate objects (Arnould et al, 2008; Duff & Charles, 2004),  
18 measuring and assessing play is a challenging task. Prior to this study, no play-based  
19 assessment system had been adapted for use with severely motor impaired children. In  
20 the present study, we used a new scale, the Play Assessment of Children with Motor  
21 Impairment (PACMI) Scale (see <http://www.plaisuno.com>). The PACMI is a modified  
22 version of the Play in Early Childhood Evaluation System (PIECES) developed by Kelly-  
23 Vance and Ryalls. The PIECES has been empirically documented to be both a valid and  
24 reliable measure of play in typically and atypically developing children (Kelly-Vance et  
25 al., 1999; Kelly-Vance & Ryalls, 2005; Kelly-Vance et al., 2002). As described in the  
26 Materials and Methods section, the coding scheme used in the PIECES was expanded in  
27 order to capture basic play manipulation behaviors at a fine-grained level. These play  
28 behaviors included both successful and unsuccessful child-initiated attempts to  
29 manipulate toys.

30 In summary, the primary goal of the present study was to help fill a gap in the  
31 literature by directly examining the relationship between improvements in sitting and a  
32 child's ability to engage in spontaneous play after a perceptual motor intervention in  
33 children with moderate and severe CP. We had two specific questions. First, we  
34 examined if sitting skill could be advanced in children with significant motor  
35 impairments using an intensive perceptual motor intervention. Second, we questioned if  
36 children's play skills would change as sitting ability advanced and whether improvements  
37 in sitting would be associated with improvements in the complexity of play. Our  
38 hypothesis was that the intervention would improve sitting and play ability and that the  
39 changes in sitting ability would explain a significant proportion of the variance in the  
40 change of play scores.

## 41 **Materials and Methods**

### 42 *Participants*

1 Participants were 30 children with moderate (N=12) to severe (N=18) Cerebral  
2 Palsy (CP). All children were between the ages of 18-months and 6-years (11 female, 19  
3 male). Children were recruited from a group of children who participated in a previous  
4 study, from the University of Nebraska Medical Center community, and by word of  
5 mouth.

6 To be included in this study, children were required to have a diagnosis of CP and  
7 be unable to sit independently. In order to assess the distribution of children with  
8 moderate and severe CP, we used a scale created in a previous study of infants with CP  
9 (Harbourne et al., 2010). Beginning sitting skills were required for entry into the study.  
10 We defined beginning sitting as: the ability to prop sit while floor sitting for at least 10  
11 seconds when placed; the ability to hold the head in line with the body (not falling  
12 forward) while prop sitting; when supported by another person in the sitting position, the  
13 child is able to move the arm toward a person or toy, but does not need to grasp the toy.  
14 Children were excluded from participation in this study if they had a diagnosis of  
15 blindness, a diagnosed hip dislocation or subluxation of the hip over 50%, or an  
16 additional diagnosis that affected his/her neuromuscular system (e.g., Down syndrome or  
17 spina bifida).

## 18 *Measures*

### 19 *Play Assessment of Children with Motor Impairment (PACMI).*

20 Assessing the play skills of young children with severe motor impairments, such  
21 as CP, is challenging because of their limited ability to manipulate objects (Arnould et al,  
22 2008; Duff & Charles, 2004). Several measures exist but none are tailored to the unique  
23 needs of these children. Therefore, an expanded version of the PIECES was used to  
24 assess the participants' play skills (Kelly-Vance & Ryalls, 2014). The PIECES was  
25 developed based on thorough research and theory on play across developmental stages  
26 and has been shown to have high psychometric properties with an interrater reliability of  
27 90% for typically developing children and as high as 100% for children with  
28 exceptionalities and moderate test-retest correlations for each population ( $r = .48$  and  $r$   
29  $= .58$ , respectively) (Kelly-Vance & Ryalls, 2005). The PIECES is an observation of a  
30 child's free play with toys that results in a description of exploratory and pretend play  
31 skills. The scale has been used with children who have a variety of exceptionalities  
32 including motor impairments, autism spectrum disorder, and speech/language  
33 impairments (Kelly-Vance & Ryalls, 2014). It was selected as the play measure because  
34 of its flexibility in adapting it to the needs of the children included in this study.

35 The expanded version of the scale is called the Play Assessment of Children with  
36 Motor Impairments (PACMI). It was derived from the exploratory play scale of the  
37 PIECES that included an assessment of a child's ability to explore toys by mouthing,  
38 manipulating, and discovering their function (see <http://www.plaisuno.com>). Due to the  
39 limited motor ability of the participants in the present study, most of the children were  
40 unable to play with toys in the same manner as typically developing children. Typically  
41 developing children use their hands to explore toys, but due to the limited motor skills of  
42 children with CP, a more general definition of toy manipulation was used. Children could  
43 initiate exploratory play by successful manipulation, proximal manipulation, or

1 unsuccessful manipulation. Successful manipulation (SM) includes using any body part  
2 to manipulate a toy, such as pressing a play piano key with one's finger or forehead and  
3 resulting in an audible note. Proximal manipulation (PM) involves using a body part in  
4 close proximity to the toy without any attempt to manipulate the toy. This would occur if  
5 the child puts a hand on the piano but does not press an individual key. Unsuccessful  
6 manipulation (UM) is when the child makes an attempt to manipulate a toy but is not  
7 successful. An example of unsuccessful manipulation is when a child puts a finger on a  
8 piano key but is unable to press it down.

9 The overall result of the play assessment conducted in this study was a Self-  
10 Initiated Play Composite (SIPC) score, which was computed by adding all SMs, PMs,  
11 and UMs and then dividing the total number by the overall time spent with the toy. High  
12 inter-observer reliability was found on the PACMI (see Procedure section) which is  
13 consistent with findings on the overall PIECES.

14 *Gross Motor Function Measure-88 (GMFM).*

15 The GMFM was used to evaluate changes in sitting skill over time. This measure  
16 was designed for use with children with cerebral palsy, and evaluates motor skills in five  
17 areas: lying and rolling, sitting, crawling, standing, and walking/running/jumping skills.  
18 It took approximately 20 minutes to administer the test, with time varying according to  
19 the ability level of the child and his/her cooperation and understanding. This scale has  
20 been validated in children five months to 16 years old (Russell et al., 1993). We utilized  
21 only the sitting subsection for this study.

22 *Procedure*

23 Each child received 45 minutes of physical therapy intervention twice a week for  
24 12 weeks. The intervention received by the children was performed by therapists trained  
25 in perceptual motor techniques that are based on the approach of Ingrid Tscharnuter  
26 (Tscharnuter, 1993, 2002). In general, the approach utilizes environmental forces during  
27 self-initiated goal-directed movements to change function and postural control. The  
28 specific techniques used during intervention were dependent on the skill level of the child,  
29 and the interests of the child. Overall, activities were aimed at teaching the child to attend  
30 to significant environmental information, such as pressure against the support surface,  
31 which can be correlated to forces useful for controlling posture and movement, and all  
32 activities were related to interaction with objects of interest to the child. We allowed the  
33 child to choose the movement strategy even if the movement appeared atypical, thus  
34 allowing for child-initiated movement. The therapist presented an environmental  
35 modification requiring a small movement or postural challenge to the child, and waited  
36 for the child to solve the problem, giving very light cues or assistance. The focus was on  
37 helping the child utilize forces to obtain a functional goal through problem solving.  
38 Fidelity of the approach was maintained by having only three therapists who were trained  
39 in the approach provide the intervention, under the supervision of a primary therapist.  
40 (For more information on the perceptual motor intervention refer to Harbourne et al.,  
41 2010).

1           Sitting (GMFM) and play (PACMI) data were collected at the Infant lab at the  
2 Munroe-Meyer Institute of the University of Nebraska Medical Center. This lab is  
3 designed to look like a home living room, with carpeted floor and living room furniture  
4 (e.g., a couch and end tables). Data was collected at two different times during the child's  
5 participation in the study. The first session was at pre-test, prior to the child receiving any  
6 intervention sessions. The post-test session was conducted after the completion of the  
7 intervention, approximately 12 weeks later. For all data collection sessions, the children  
8 were allowed time to adjust to the setting.

9           Both play and sitting data were collected on the same day. The play assessment  
10 was conducted before the sitting assessment. Cameras were set up to record both sessions  
11 and all sessions were coded from the videotapes. To ensure consistency across sessions, a  
12 specific toy set was utilized. The toy set included a baby doll, a piano, a pop-up toy, a  
13 pull-toy, a telephone, pretend food items, a jack-in-the-box, and a toy car with people. A  
14 set of four to eight toys was used in each session, and four toys were set out for the child  
15 at a time. The goal was for the child to use all eight toys, but some children did not have  
16 the hand skill or interest level to play with all of the toys. The parents/caregivers were  
17 asked if the child would be interested in playing with a specific toy, and if the response  
18 was negative, that toy was eliminated from the set. A minimum of four and a maximum  
19 of eight toys were presented, per child, and the same toys were used at the post-test as at  
20 the pre-test. The examiner asked the child which toy she/he wanted to play with and the  
21 child was allowed to make the selection by scooting toward the toy, gazing at it, or  
22 reaching for it. If the child did not select a toy, the examiner did, one at a time, and  
23 presented it to the child. During the play assessment, most children were seated on the  
24 carpeted floor with a therapist seated behind them. The therapist provided the support  
25 needed, depending on the child's sitting skill. Only as much support as needed was  
26 provided. One child, with severely limited sitting ability, was seated in her wheelchair for  
27 the pre- and post-test play assessment because the parent thought it was the best option  
28 for her. The play assessment took approximately 15 minutes.

29           To code the play assessment, two graduate assistants watched the session  
30 videotapes and provided a running description of what the child and the examiner did  
31 with the toys. These behavioral descriptions were then coded using the SIPC scale of the  
32 PACMI coding scheme. The percent of time that the child spent engaged with the toy was  
33 also calculated. Inter-rater reliability was calculated on 20% of the tapes, and an inter-  
34 observer correlation was found ranging from .97 to .99.

35           All statistical analyses were performed with SPSS software (version 16.0). The  
36 alpha level was set at .05. Paired t-tests were performed for the GMFM scores and the  
37 PACMI play scores between pre and post intervention. We also performed Pearson r  
38 correlations to identify linear relationships between the changes in the variables of  
39 interest, as well as severity, and age. Lastly, we performed a stepwise multiple linear  
40 regression analysis to investigate the percentage of variance of the change in SIPC play  
41 scores that could be explained by the change in the GMFM scores and by the play scores  
42 pre-intervention.

## 43 **Results**

1 Descriptive data of the children's age, GMFM and SIPC scores pre and post  
2 intervention are presented in Table 1. The children's scores for sitting and play both pre-  
3 and post- test can be found in Figures 1 and 2. As can be seen in Figure 1, all children's  
4 GMFM sitting scores improved from pre- to post-intervention. Statistical analysis  
5 indicated that the change was statistically significant ( $t(30) = -6.317$ ,  $p < .001$ , effect size  
6  $r: 0.761$ , Cohen's  $d: -2.346$ ). As can be seen in Figure 2, a majority of children (18)  
7 showed improvements in their SIPC scores from pre- to post-intervention, although the  
8 effect was only marginally significant ( $t(30) = -1.903$ ,  $p = .067$ , effect size  $r: 0.333$ ,  
9 Cohen's  $d: -0.706$ ). Moreover it is important to note that seven children, although very  
10 delayed in motor skills, played in a cognitively advanced way. Different play strategies  
11 were noted that would be considered higher level, such as pretending the baby doll was  
12 real with hugs and kisses, rather than poking at the baby's face. These advanced play  
13 strategies usually resulted in less repetitious behavior (counts of manipulation) but more  
14 social interaction with the parent, examiner, and toy item. By group consensus after  
15 viewing the play videotapes, we agreed that the scoring for the lower functioning children  
16 did not accurately represent the play behavior of the children who were more cognitively  
17 advanced. In those seven cases, we carried forward the pre-play score and made it their  
18 post-play score.

19 Gender initially appeared to be a significant factor. However, there was 25% of  
20 girls in the moderate CP range, which appears as if gender was significantly related to our  
21 outcome measures. The primary composition of the moderate group was male. Although  
22 we know that a disproportionate number of males are diagnosed with CP  
23 (<http://www.cdc.gov/ncbddd/cp/data.html>), there is no data on gender differences by  
24 severity for the diagnosis of CP. We judged severity of CP to be more influential than  
25 gender by the composition of our groups, and verified our assumption with correlation  
26 and regression analysis. Finally, we used only severity and age in the regression models.

27 Bivariate correlations (Table 2) revealed that severity level was positively  
28 correlated with age ( $p=.004$ , older children were more severely affected by CP), and  
29 negatively correlated with GMFM pre ( $p=.005$ ), post ( $p<.001$ ) and change ( $p<.001$ )  
30 scores and SIPC pre ( $p<.001$ ) and post ( $p<.001$ ) scores. Age was negatively correlated  
31 with the SIPC pre ( $p=0.036$ ) and post ( $p=0.041$ ) scores. In addition, GMFM pre scores  
32 were positively correlated with the GMFM post ( $p<.001$ ) and SIPC post ( $p=.018$ ).  
33 GMFM post scores were positively correlated with the GMFM change ( $p<.001$ ), SIPC  
34 pre ( $p=.015$ ) and SIPC post ( $p=.002$ ) scores. This result suggests that younger children  
35 had greater SIPC pre and post scores. The GMFM change score was positively correlated  
36 with the SIPC pre ( $p=.042$ ) and SIPC post ( $p=.016$ ) scores while the SIPC pre scores  
37 were positively correlated with SIPC post ( $p<.001$ ) and negatively correlated with the  
38 SIPC change ( $p=.014$ ) scores.

39 Because age was positively correlated with severity, and after careful visual  
40 observation of the data we identified that 45% of children under age three were classified  
41 as severe, whereas 100% of the children over or equal to three years of age were  
42 classified as severe. Thus, we conducted an ad hoc stepwise linear regression analysis  
43 using age as the selection variable. We selected 3 years of age as our cut-off based on  
44 visual observation of the data. In addition, 3 years of age is the usual division in age for

1 special services mandated by the Individuals with Disabilities Education Act; Part C  
2 differentiates services for children under the age of 3 (infants), from children over the age  
3 of 3 (school age) (Adams et al, 2013). Thus, we ran two stepwise multiple linear  
4 regressions: One on children under three and one on children over three. First, we  
5 examined the proportion of variance explained by GMFM change, and SIPC pre scores  
6 on SIPC change scores in children less than age three (22 children). No significant  
7 relationship was found for these moderately delayed children. Second, we examined the  
8 proportion of variance explained by GMFM change, and SIPC pre scores on SIPC change  
9 scores in children greater or equal to age three (8 children). A significant proportion of  
10 the variance was explained ( $F(1,7)=7.786$ ,  $p=0.027$ ) with an  $R^2$  of 0.527 with only the  
11 GMFM change scores included in the model. Therefore, more than 50% of the variance  
12 in the SIPC change score was explained by the change in the GMFM scores for these  
13 older, more severely delayed children.

14

## 15 **Discussion**

16 In the present study we had two primary goals. Our first goal was to document  
17 that an intervention grounded in perception-action theory (Tscharnutter, 1993, 2002)  
18 would improve sitting in children with moderate to severe cerebral palsy. Our second  
19 goal was to examine whether children's play skills would change as sitting ability  
20 advanced and whether the improvements in play were directly linked to improvements in  
21 sitting. Our results were positive with regards to the first goal and partially for the second  
22 goal, with the findings concerning the effect of the intervention on sitting being more  
23 straightforward than for the improvements in level of play. Specifically, analyses  
24 revealed that children with moderate or severe CP given a 12-week perceptual- motor  
25 intervention made significant gains in sitting ability and marginally significant gains in  
26 play behavior. With respect to our second goal it was revealed that improvements in play  
27 were directly linked to improvements in sitting only for children over 3-years of age.  
28 Thus, in this study, an improvement in sitting was linked to an improvement in play only  
29 for the severely impaired and older children. Specifically the results indicated that, for the  
30 older severely delayed children, a significant proportion of the variance in SIPC change  
31 scores was due to the change in GMFM scores from pre to post intervention.

32 There are several implications that can be drawn from the results of the present  
33 study. First, with respect to our first goal, we successfully documented the effectiveness  
34 of a perceptual motor intervention on sitting ability in children with moderate or severe  
35 CP. GMFM sitting scores of all the children that received the perceptual motor  
36 intervention improved, as shown in Figure 1. The perceptual motor intervention is based  
37 on the ecological approach and emphasizes spontaneous movement based on  
38 environmental affordances. Self-initiated, functionally-directed movement is the focus of  
39 intervention. Perceptual motor intervention consists of activities that include handling,  
40 which gently drives the child's attention to the support surface, and sets up the  
41 environment to produce small increments of movement that the child can utilize to solve  
42 a movement problem. Passive movements are not used in this approach. Increased  
43 variability of active movement is encouraged, and movements that are considered

1 abnormal in other approaches are not blocked or discouraged. These results are in  
2 agreement with a younger cohort of children with cerebral palsy who received the  
3 perceptual motor intervention in the first two years of life and improved sitting postural  
4 control (Harbourne et al., 2010). This is the first study, to demonstrate that the specific  
5 perceptual motor intervention is effective in improving gross motor behavior in sitting in  
6 older children with moderate and severe CP. Fundamentally, perceptual motor  
7 experiences offer the opportunity for broad development and in other domains, such as  
8 social and cognitive development (Lobo et al., 2013, Dusing et al., 2013).

9         With respect to our second goal, the very design of the experiment presumed a  
10 link between motor behaviors such as sitting and a child's ability to engage in play. The  
11 results of the experiment can be interpreted in this manner: The sitting intervention did  
12 not directly target play, and yet, overall, children both improved at sitting and most of  
13 them showed greater ability to manipulate the toys after the intervention. In typically  
14 developing children, the attainment of motor skills like sitting and reaching are  
15 temporally linked to the development of complex play behavior (Rochat & Goubet, 1995).  
16 However, further analyses revealed that improvements in play were only directly related  
17 to improvements in sitting for the older children in the study (3-years old and above). The  
18 eight children that were above or equal to age three were in the severe CP range. With the  
19 exception of one child, all children maintained or improved their SIPC score as GMFM  
20 scores improved. However, for children less than 3-years old, improvements in play were  
21 not correlated with improvements in sitting.

22         There are two possible reasons why we only found a significant linkage between  
23 sitting improvement and play change in the older children and not in the younger children.  
24 First, all the children in the study showed very delayed motor skills; all were at least 18  
25 months of age and not yet sitting independently. Clearly, the older children were more  
26 severe simply when considering the discrepancy between their age and skill level. Thus,  
27 the more severe children had lower initial scores, and may have had more room to  
28 improve on the play scale. Second, the younger children advanced to a greater degree in  
29 motor skills, on average, during the intervention. Some of the younger children  
30 developed mobility, including the ability to get in and out of the sitting position. This  
31 new-found freedom to move appeared to take their interest rather than toy exploration, a  
32 phenomenon noted in typically developing children (Karasik et al, 2011). Infants who  
33 become mobile tend to have interest in distant objects, rather than objects close at hand,  
34 as in our play paradigm. Alternatively, the younger children with moderate CP may have  
35 had better inherent trunk and arm control, which did not show as large a degree of change  
36 during the intervention. Because we used only the sitting section of the GMFM, and not  
37 the crawling section, these children may have reached the zenith on the motor score they  
38 could achieve. This would influence the motor change scores that could contribute to the  
39 variance in the play scores. These results certainly suggest there is a complex relationship  
40 among age, severity of impairment, sitting, and the development of play, which is worthy  
41 of further study.

42         One important contribution that this study makes to the literature is the extension  
43 of the PIECES system to assess play behavior in children with motor-delays. The present  
44 study is the first and only study ever conducted using the newly developed PACMI



1 instrument. Although the scale itself, assessment procedure, and coding of behavior is  
2 well-grounded in prior research (Kelly-Vance & Ryalls, 2014), additional research is  
3 needed to further document the validity and utility of this scale. The development of play  
4 has been linked to development in numerous other cognitive and social domains. Thus,  
5 interventions that improve a child's ability to play may be important to improving  
6 function in other areas. This study provides initial support for a reliable tool that can be  
7 used to measure the emergence of play skills in children with significant motor-delays.

8 This study, like most, suffers from limitations that leave additional questions  
9 unanswered. Most notably, all children were exposed to the same sitting intervention,  
10 therefore comparison with a control group is not possible. Thus, we cannot state with  
11 absolute certainty that the changes in sitting and play were not the result of maturational  
12 changes alone. However, we find this highly improbable, given the severity of the delays  
13 experienced by these children. Ultimately, however, it would be desirable to replicate the  
14 present study with a control group of children given no intervention. A second limitation  
15 concerns the fact that only a single type of sitting intervention was used. Therefore, while  
16 we can tentatively conclude that the sitting intervention was effective, we do not know if  
17 different types of sitting interventions would be more or less effective or have more or  
18 less of an effect on play. Additional research is needed comparing the effectiveness of  
19 different types of sitting interventions on both sitting and play. A third limitation  
20 concerns the lack of information about the children's cognitive level. Apart from basic  
21 demographic information, the only thing known with any certainty was each child's level  
22 of sitting ability. No data concerning level of cognitive functioning was collected or  
23 available. Anecdotally, a wide range in play ability was observed across the children in  
24 this study. Given that cognitive ability is linked to the complexity of play in typically  
25 developing children (Piaget, 1951), it would be interesting in future studies to  
26 systematically examine the relationship among motor ability, cognitive ability and play.  
27 However, measuring cognitive ability in these children is difficult, given their limitations.  
28 One potential window into cognitive ability may involve looking measures or eye  
29 tracking (Harbourne, et al., 2013; Karatekin, 2007). Finally, a fourth possible avenue for  
30 future study concerns the effect of a play intervention on motor development. While this  
31 study suggests that improvements in sitting may lead to improvements in play,  
32 particularly for severely impaired children, an interesting question not addressed by the  
33 present study is if an intervention targeting play behavior in children with CP would have  
34 positive benefits on sitting. Playing may improve sitting because reaching for toys  
35 requires children to employ variable strategies to control posture and enable interaction  
36 with the toys (Harbourne & Kamm, 2015). If children are spontaneously motivated to  
37 engage in play, then interventions designed to improve play may also naturally have  
38 positive influence on a child's ability to sit.

39 In summary, in spite of these limitations, the present study documents that  
40 emerging play-behavior can be reliably measured in motor-delayed children, that an  
41 ecological intervention can significantly improve sitting ability in children with moderate  
42 to severe CP, that these improvements in sitting may lead to improvements in simple  
43 pretend play, particularly for more severely-delayed children. This link between motor-  
44 development and play is consistent with views with ecological and systems theories that  
45 emphasize the significant influence that motor development and self-directed action can



1 have on many areas of development including perception, cognition, emotional  
2 development, and others (Campos, Anderson, Barbu-Roth, Hubbard, Hertenstein, &  
3 Witherington, 2000; Marayuma, Dineva, Spencer, & Schoner, 2014; Smith, 2005).  
4 Importantly, documenting a link between sitting and play in motor-delayed children  
5 demonstrates that such links can exist independent of typical chronological development.

6

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1 **Tables**

2 Table 1. Measures of central tendency of the main variables.

Variable	Minimum	Maximum	Mean	Std. Deviation
Age	1	6	2.43	1.49
GMFMpre	8	40	14.20	6.03
GMFMpost	10	47	23.96	11.38
SIPCpre	0.20	34.90	7.56	8.15
SIPCpost	0.40	29.10	8.69	7.31

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5 Table 2. Bivariate correlations

		Correlations							
		Severity	Age	GMFMpre	GMFMpost	GMFMdiff	SIPCpre	SIPCpost	SIPDiff
<b>Severity</b>	<i>r</i>	1	.506*	-.500*	-.732*	-.628*	-.603*	-.681*	-.019
	<i>p</i>		.004	.005	.000	.000	.000	.000	.920
<b>Age</b>	<i>r</i>		1	-.134	-.299	-.307	-.384*	-.375*	.119
	<i>p</i>			.480	.108	.099	.036	.041	.531
<b>GMFMpre</b>	<i>r</i>			1	.687*	.212	.308	.428*	.190
	<i>p</i>				.000	.262	.098	.018	.315
<b>GMFMpost</b>	<i>r</i>				1	.856*	.441*	.550*	.130
	<i>p</i>					.000	.015	.002	.494
<b>GMFMdiff</b>	<i>r</i>					1	.374*	.434*	.039
	<i>p</i>						.042	.016	.836
<b>SIPCpre</b>	<i>r</i>						1	.917*	-.444*
	<i>p</i>							.000	.014
<b>SIPCpost</b>	<i>r</i>							1	-.049
	<i>p</i>								.799
<b>SIPDiff</b>	<i>r</i>								1

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1 **Figure Legends**

2 Figure 1. GMFM sitting scores between pre and post intervention

3 Figure 2. SIPC play scores between pre and post intervention

Provisional

Figure 01.JPEG

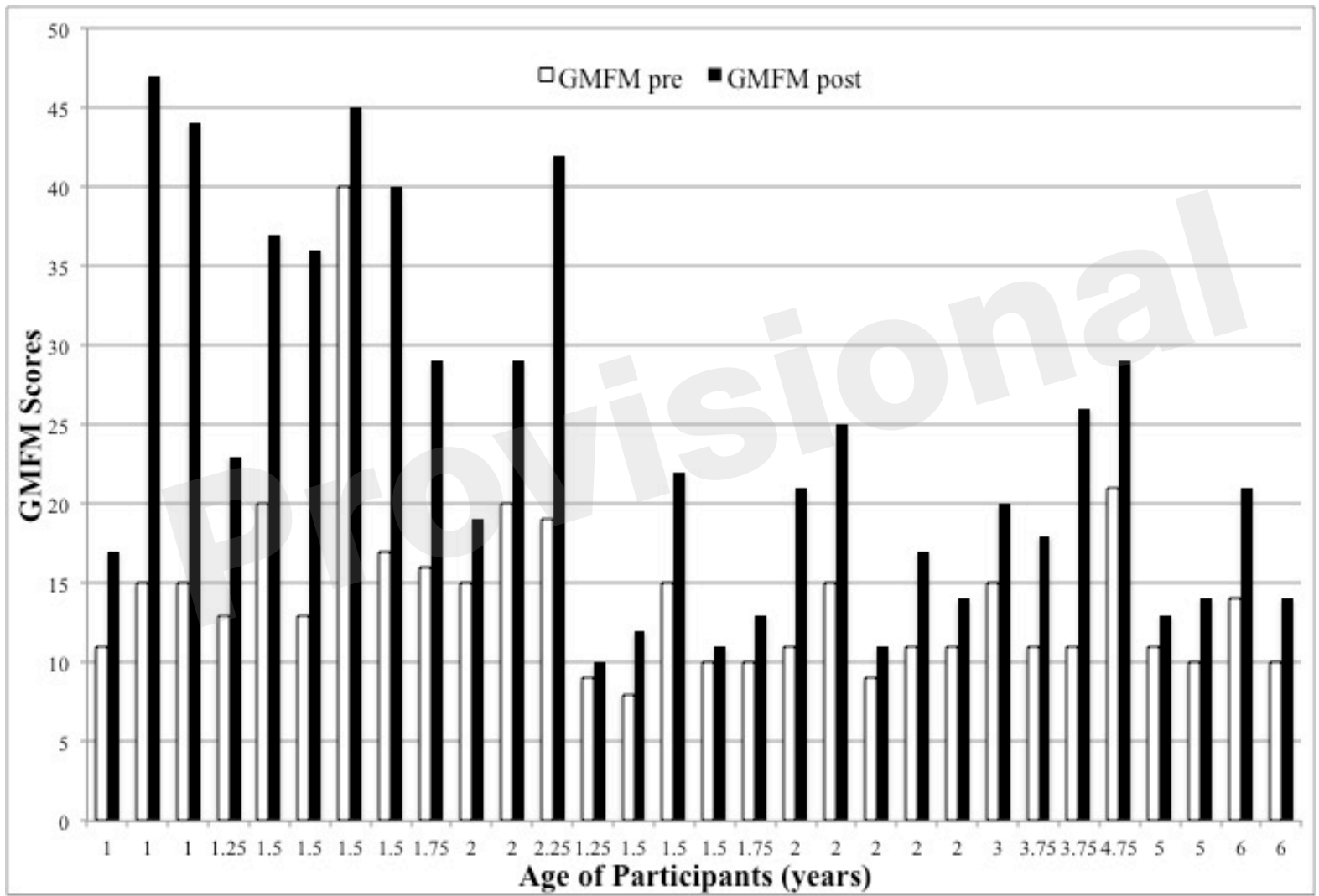




Figure 02.JPEG

