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## Developmentally Based Approach to the Evaluation Process<sup>1</sup>

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Infants and young children are very direct. An 8-month-old or 3-year-old doesn't disguise his true feelings; he is either engaged and related or aloof and withdrawn. There are, however, many factors influencing a child's behavior and many aspects of development that relate to one another. For example, an aloof and withdrawn child will be influenced by his own physical tendencies (e.g., auditory processing problems and/or over- or under-sensitivity to sound or touch), as well as his relationship with his caregiver and by the dynamics within his own family. He will also be influenced by the relationships between the different aspects of his development, including his sensory, motor, language, cognitive, affective, and interpersonal capacities.

The evaluation of emotional and developmental disorders in infants and young children, therefore, requires the clinician to take into account all facets of the child's experience. A model that looks at how constitutional-maturational (i.e., regulatory), family, and interactive factors work together as the child progresses through each developmental phase is necessary.

It is also necessary to distinguish this developmentally based evaluation model from other approaches. This developmentally based evaluation model is grounded on a theoretical

framework of functional developmental capacities and processing abilities that unfold as the infant grows and interacts with others. Using this model requires a clinician to assess each child's relative strengths as well as challenges as they simultaneously impact functional capacities at each developmental level. The assessment provided by using this model contrasts with that of the typical deficit model, through which teams using standardized instruments, and often working in a single-session arena style, independently evaluate the developmental domains of fine motor, gross motor, speech, language, and social skills. The deficit model typically presents assessment results in terms of deficits within each developmental domain, with general recommendations, and frequently omits critical areas of interactive relationships and emotional functioning.

The following model is distinguished by its emphasis on multiple observations and

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<sup>1</sup>Adapted from *The Assessment and Diagnosis of Infant Disorders: Developmental Level, Individual Differences and Relationship-based Interactions* (Greenspan & Wieder, 1999); *Infancy and Early Childhood: The Practice of Clinical Assessment and Intervention with Emotional and Developmental Challenges* (Greenspan, 1992); *The Child with Special Needs: Intellectual and Emotional Growth* (Greenspan, & Wieder, 1998), and *The Clinical Interview of the Child* (Greenspan, 1981).

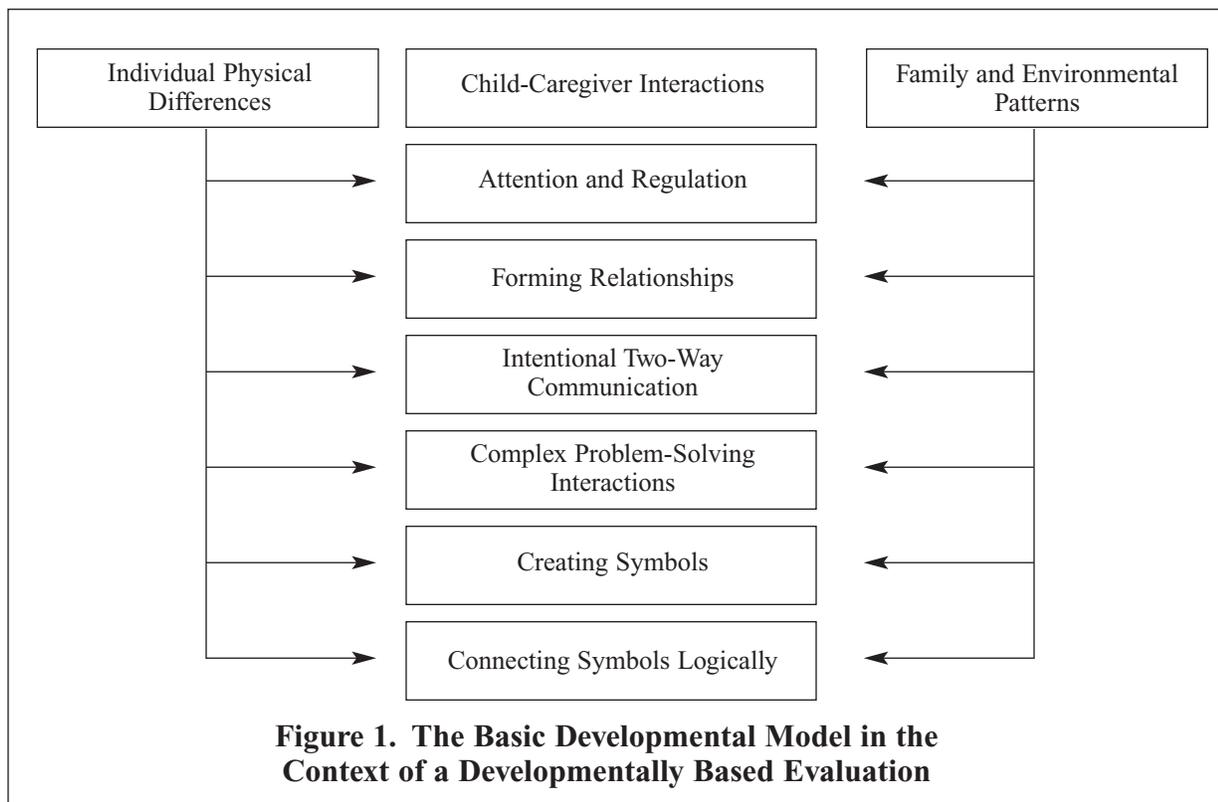
in-depth interviews over time in both the natural environments and in child-centered settings. In the developmental functional approach, the evaluations go beyond the assessment of skills to the assessment of functioning within relationships. Standardized tools are used for strategic purposes rather than as the core assessment. The evaluations always include multiple observations of the child and parent/caregiver in interactions and play, as well as their interactions with the evaluator, whose relationship with the family affects the evaluation, interpretation, and implementation of the intervention plan.

### THE BASIC MODEL

The basic developmental model guiding the evaluation process, which was also described in earlier chapters, needs to be re-emphasized in the context of the evaluation

process. This model can be visualized with the child's (or infant's) constitutional-maturational patterns on one side and the child's environment—including caregivers, family, community, and culture—on the other side. Both of these sets of factors operate through the child-caregiver relationship, which can be pictured in the middle. These factors and the child-caregiver relationship, in turn, contribute to the organization of experience at each of six different developmental levels, which may be pictured just beneath the child-caregiver relationship (see Figure 1).

Each developmental level involves different tasks or goals. The relative effect of the constitutional-maturational, environmental, or interactive variables will, therefore, depend on and can be understood only in the context of the developmental level to which they relate. Thus, influencing variables are best understood as distinct and different



**Figure 1. The Basic Developmental Model in the Context of a Developmentally Based Evaluation**

influences on the six distinct developmental and experiential levels and not, in the traditional sense, as general influences on development or behavior. For example, as a child is beginning to engage in a relationship, her mother's tendency to be very intellectual and to prefer talking over holding may make it relatively harder for the child to become deeply engaged in emotional terms. If, constitutionally, the child has slightly lower than average muscle tone and is hyposensitive to touch and sound, her mother's intellectual and slightly aloof style may be doubly challenging because neither the mother nor the child is able to take the initiative in engaging the other.

### Functional Developmental Levels

In this model, there are six functional developmental levels. They include the child's ability to accomplish the following:

1. *Attend to multisensory affective experience* and, at the same time, organize a calm, regulated state and experience pleasure.
2. *Engage with and evidence affective preference and pleasure for a caregiver.*
3. *Initiate and respond to two-way, presymbolic gestural communication.*
4. *Organize chains of two-way communication* (opening and closing many circles of communication in a row), maintain communication across space, integrate affective polarities, and synthesize an emerging prerepresentational organization of self and other.
5. *Represent (symbolize) affective experience* (e.g., pretend play or functional use of language), which calls for higher level auditory and verbal sequencing ability.
6. *Create representational (symbolic) categories and gradually build conceptual bridges between these categories.* This ability creates the foundation for such

basic personality functions as reality testing, impulse control, self-other representational differentiation, affect labeling and discrimination, stable mood, and a sense of time and space that enables logical planning. This ability rests not only on complex auditory and verbal processing abilities, but on visual-spatial abstracting capacities as well.

The theoretical, clinical, and empirical rationale for these developmental levels is discussed in *The Development of the Ego* (Greenspan, 1989) and *Intelligence and Adaptation* (Greenspan, 1979).

To make a developmental assessment of the functional level, the clinician should evaluate each of the six developmental levels in terms of whether or not the child has successfully negotiated the level, and whether there is a deficit at any level that the child has not successfully negotiated. A *deficit* occurs when the level has not been mastered at all. Sometimes a child may have successfully negotiated a level, but not for the full range of emotional themes. For example, a toddler may use two-way gestural communication to negotiate assertiveness and exploration by pointing at a certain toy and vocalizing for a parent to play with him. The same child may either withdraw or cry in a disorganized way when he wishes for increased closeness and dependency instead of, for example, reaching out to be picked up or coming over and initiating a cuddle. This behavior would indicate that a child has a *constriction* at that level. Sometimes a child is able to negotiate a level with one parent and not the other, with one sibling and not another, or with one substitute caregiver but not another. If it should reasonably be expected that a particular relationship is secure and stable enough to support a certain developmental level, but that level is

not evident in that relationship, then the child has a constriction at that level as well.

If the child has reached a developmental level, but the slightest stress, such as being tired, having a mild illness (e.g., a cold), or playing with a new peer leads to a loss of that level, then the child has an *instability* at that level.

A child may have a deficit, constriction, or instability at more than one level. Also, a child may have a deficit at one level and a constriction or instability at another. Therefore, the clinician should make a judgment based on how fully each child has negotiated each developmental level. It is also useful for the clinician to indicate which areas or relationships are not incorporated into each developmental level. Consider the following areas of expected emotional range: dependency (closeness, pleasure, assertiveness [exploration], curiosity, anger, empathy [for children over 3½ years]); stable forms of love; self-limit-setting (for children over 18 months); interest and collaboration with peers (for children over 2 years); participation in a peer group (for children over 2½ years); and the ability to deal with competition and rivalry (for children over 3½ years). A Functional Emotional Developmental Scale was developed for research purposes and includes reliability and validity studies (DeGangi & Greenspan, 2000; Greenspan, 1992).

### Constitutional-Maturational Patterns

A child's constitutional-maturational characteristics are the result of genetic, prenatal, perinatal, and maturational variations and/or deficits. These characteristics can be observed as part of the following patterns:

- Sensory reactivity, including hypo- and hyperreactivity in each sensory modality (tactile, auditory, visual, vestibular, and olfactory).
- Sensory processing in each sensory modality (e.g., the capacity to decode sequences, configurations, or abstract patterns).
- Sensory-affective reactivity and processing in each modality (e.g., the ability to process and react to degrees of affective intensity in a stable manner).
- Muscle tone.
- Motor planning and sequencing.

An instrument to clinically assess aspects of sensory functions in a reliable manner has been developed and is available (DeGangi and Greenspan, 1988, 1989a,b).

Sensory reactivity (hypo- or hyper-) and sensory processing can be observed clinically. Is the child hyper- or hyposensitive to touch or sound? How does the child react in terms of vision and movement in space? In each sensory modality, does the 4-month-old “process” a complicated pattern of information input or only a simple one? Does the 4½-year-old have a receptive language problem and is, therefore, unable to sequence words she hears together or follow complex directions? Is the 3-year-old an early comprehender and talker, but slower in visual-spatial processing?

If spatial patterns are poorly comprehended, a child may be facile with words and sensitive to every emotional nuance, but have no context. Such children have difficulty seeing the “forest” and get lost in the “trees.” In the clinician's office, this child may forget where the door is or have a hard time picturing that mother is only a few feet away in the waiting room. In addition to lacking straightforward “pictures” of spatial relationship (i.e., how to get to the playground), such a child may also have difficulty with “seeing” the emotional big picture. If the mother is angry, the child may think the earth is opening up and he is falling in because he cannot

comprehend that his mother was nice before and she will probably be nice again.

A child with a lag in the visual-spatial area may become overwhelmed by the affect of the moment. This reaction is often intensified when the child also has precocious auditory-verbal skills. The child, in a sense, overloads and does not have the ability to see how it all fits together. Thus, at a minimum, it is necessary for the clinician to have a sense of how the child reacts in each sensory modality, how the child processes information in each modality, and—particularly as the child gets older—a sense of the child's auditory-verbal processing skills in comparison to visual-spatial processing skills.

It is also necessary for the clinician to look at the motor system, including muscle tone, motor planning (fine and gross), and postural control. Observing how a child sits, crawls, or runs; maintains posture; holds a crayon; hops, scribbles, or draws; and makes rapid alternating movements will provide a picture of the child's motor system. Her security in regulating and controlling her body plays an important role in how she uses gestures to communicate and her ability to regulate dependency (being close or far away), aggression ("Can I control my hand that wants to hit?"), and an overall physical sense of self. Other constitutional and maturational variables have to do with movement in space, attention, and dealing with transitions.

### **Parent and Family Contributions**

In addition to constitutional and maturational factors, it is important to describe the family contribution in terms of each developmental level. If a family system is aloof, it may not negotiate engagement well; if a family system is intrusive, it may overwhelm or overstimulate a baby. Obviously, if a baby

is already overly sensitive to touch or sound, the caregiver's intrusiveness will be all the more difficult for the child to handle. We see, therefore, the interaction between the maturational pattern and the family pattern.

A family system may throw so many meanings at a child that the child is unable to organize a sense of reality. Categories of me/not me may become confused, because one day a feeling is yours, the next day it is the mother's, the next day it is the father's, the day after it is little brother's; anger may turn into dependency, and vice versa. If meanings shift too quickly, a child may be unable to reach the fourth level—emotional thinking. A child with difficulties in auditory-verbal sequencing will have an especially difficult time (Greenspan, 1989).

The couple is a unit in itself. How do husband and wife operate, not only with each other, but in negotiating on behalf of the children in terms of the developmental processes? A couple with marital problems could still successfully negotiate shared attention, engagement, two-way communication, shared meanings, and emotional thinking with their children. But the marital difficulties could disrupt any one or a number of these developmental processes.

Each parent is also an individual. How does each personality operate vis-à-vis these processes? While it may be desirable to have a general mental health diagnosis for each caregiver, one also needs to functionally observe which of these levels each caregiver can naturally and easily support. Is the parent engaged, warm, and interactive (a good reader of cues)? Is he or she oriented toward symbolic meanings (verbalizing meanings) and engaging in pretend play, and can the caregiver organize feelings and thoughts, or does one or the other get lost between reality and fantasy? Are there limitations, in terms of these levels, and if so, what are they?

Each parent also has specific fantasies that may be projected onto the children and interfere with any of the levels. Does a mother see her motorically active, distractible, labile baby as a menace and therefore overcontrol, overintrude, or withdraw? Her fantasy may govern her behavior. Does a father, whose son has low muscle tone, see his boy as passive and inept, and therefore pull away from him or impatiently “rev” him up?

In working only with the parent-child interaction, and not the parent’s fantasy, a therapist may be dealing with only the tip of the iceberg. The father may be worried that he has a overly passive son, or the mother may be worried that she has a monster for a daughter (who reminds her of her cognitively delayed sister). All these feelings may be “cooking,” and they can drive the parent-child interactions.

## **THE PROCESS OF CLINICAL ASSESSMENT**

Each clinician has a personal way of conducting an evaluation. However, any assessment should (1) encompass certain baseline data, (2) organize data by indicating how each factor contributes to the child’s ability to develop, and (3) suggest methods of treatment. A comprehensive assessment usually involves the following elements: presenting “complaints,” developmental history, family patterns, child and parent sessions, additional consultations, and formulation. Chart 1 presents a brief outline of a formal assessment, followed by a discussion of selected elements.

### **Presenting “Complaints” (Overall Picture)**

Therapists frequently spend an entire session on the presenting “complaints” or overall picture, which includes the development of the “problems,” the child’s (or infant’s) and his

family’s current functioning, and preliminary observation of the child both with the caregiver(s), or, in the case of a child over 3 years old, without them as well.

We will usually suggest that the parents bring the child with them to the first session. Even though we spend most of the time talking to the parents, we have our eyes on the child and we watch spontaneous interactions between them. If a verbal child is involved, we will have the parents leave the child at home the first time, if possible, so the parents can talk more freely.

We begin by asking the parents, “How can I help?” We encourage the parents to elaborate about the child’s problem, whether it has to do with sleeping, eating, or being too aggressive or too withdrawn. If we ask a question, it is usually to clarify something they have said, such as, “Can you give me some examples of that?” “How is this different now from what it was 6 months ago, and when wasn’t it a problem?” We try to find out when the problem started, how it evolved, and its nature and scope. For example, if a 2<sup>1/2</sup>-year-old is aggressive with peers, we want to know whether it is with all peers or only certain children. We are interested in what precipitated the problem and what may be contributing to it. Was there a change within the family, such as the father getting a new job? Was there marital tension? Were new developmental abilities emerging which paradoxically were stressful to the child?

When the parents say, “Well, I think we have told you everything about the problem,” then we will ask, “Is there more to tell about Johnny or Susie that would help fill out the picture?” We find it much more helpful to ask open-ended questions than to ask specific questions about cognitive, language, or motor development at this point. We can gather together more relevant information when the parents elaborate spontaneously. Parents also

### Chart 1. Formal Assessment

- I. Review of current challenges and functioning**, including
- Each functional developmental capacity (e.g., from attention and engagement to thinking)
  - Each processing capacity (e.g., auditory, motor planning and sequencing, visual-spatial, and sensory modulation)
  - In relevant contexts (e.g., at home with caregivers and siblings, with peers, in educational settings)

- II. History**, including history of the preceding review items, beginning with prenatal development

- III. Two or more observational sessions of child-caregiver interactions** with coaching and/or in interactions with clinician (each session should be 45 minutes or more). These observational sessions should provide the basis for forming a hypothesis about the child's functional emotional developmental capacities, individual processing and motor planning differences, and interactive and family patterns

- IV. Family and caregiver functioning**

- V. Biomedical evaluations** (e.g., as needed, EEG, metabolic work-up, genetic studies, and nutrition)

- VI. Speech and language evaluation**

- VII. Evaluation of motor and sensory processing**, including
- Motor planning
  - Sensory modulation
  - Perceptual-motor capacities
  - Visual-spatial capacities

- VIII. Evaluation of cognitive functions**, including neuro-psychological and educational assessments

- IX. Mental health evaluations of family members, family patterns, and family needs**

NOTE: The evaluations listed in under Roman numerals V– IX should be carried out only to answer specific questions which arise from the history, review of challenges, and current functioning and observations of the child-caregiver interaction patterns and family functioning

reveal their own feelings and private family matters if the therapist is empathetic in helping them describe their child. Therefore, we strive to be unstructured; ask facilitating, elaborative questions rather than yes-or-no or defining questions; and never be in a hurry to fill out a checklist.

We use the initial session to establish rapport with the family and child to begin a collaborative process. Our experience is that the developmental process discussed earlier in relation to the child—mutual attention, engagement, gestural communication, shared meanings, and the categorizing and connecting of meanings—may occur between an empathetic clinician and the parents. How the clinician relates to the parents reflects how they will be encouraged to relate to their baby. If the therapist asks hurried questions, with yes-or-no answers, he or she sets up an untherapeutic model. It usually takes parents a long time to decide to come for help; they should be able to tell their story without being hurried or criticized.

As part of this presenting picture, we find it is important to learn about all the areas of the child's current functioning. If the primary focus is initially on aggression and distractibility, we want to know the child's other age-expected capacities. We consider if the child is at the age-appropriate developmental level and if so, the full range of emotional inclinations. Is the 8-month-old capable of reciprocal cause-and-effect interchanges? Is a 4-month-old wooing and engaging? Is a 2<sup>1/2</sup>-year-old exhibiting symbolic or representational capacities? Does the child do pretend play? Does she use language functionally? How does the child negotiate needs? At each of these levels, how is the child dealing with dependency, pleasure, assertiveness, anger, and so forth?

Toward the end of the first session, we may fill in more gaps by asking questions about

sensory, language, cognitive, and fine and gross motor functioning. Usually, we have a sense of these capacities and patterns from anecdotes and more general descriptions of behavior. We listen for indications of the child's ability to retain information, if she does or does not follow commands, her word retrieval and word association skills, her fine and gross motor skills, and her motor-planning skills.

Some clinicians write down what parents say right after the session; others write during the session. Taking notes need not be an interference if the clinician stops throughout to make good contact. We take detailed notes during the first 15 or 20 minutes because we want as much information as we can get in the parents' words.

By the end of the first session, we have a sense of where the child is developmentally. We also have a sense of the range of emotional themes the child can deal with at his developmental level, as well as an awareness of the support, or lack of support, the child gets from his fine and gross motor, speech and language, and cognitive abilities. We also form an impression of the support the child gets from his parents. We observe how the parents communicate and organize their thinking, the quality of their engagement, their emotional availability, and their interest in the child. We have a good sense of their relative comfort or discomfort with each emotional theme. In general, we use the initial meeting to observe how the parents attend, engage, intentionally communicate, construct and organize ideas, and are able or not able to incorporate a range of emotional themes into their ideas as they relate to their child and to us as the therapists.

### **Developmental History**

In the second session, we construct a developmental history for the child.

(However, sometimes marital or other family problems burst out during the first session. The parents may be at each other's throats; the mother and/or the father may be extremely depressed. In such cases, the focus of the second session is on the individual parent problems, as well as family functioning.)

We will usually start the session in an unstructured manner, allowing parents to describe how their child's development unfolded and what they think is important. We encourage them to alternate between what the baby or child was like at different stages and what they felt was going on as a family and as individuals in each of those stages. We try to start with how (or if) the couple planned for the child and progress through the pregnancy and delivery. Next, we cover the six developmental stages previously described to organize a developmental history.

### **Family Patterns**

The next session focuses in greater depth on the functioning of the caregiver and family at each developmental phase. For example, the mother may say that she was a little depressed or angry, or that there were marital problems at different stages in the child's development.

Sometimes clinicians who are only beginning to work with infants and families feel reluctant to talk to the parents about any difficulties in the marriage. However, we use an open and supportive approach to elicit relevant information. We might ask, "What can you tell me about yourselves as people, as a married couple, as a family?" We are also interested in concrete details of a history of mental illness, learning disabilities, or special developmental patterns in either of the parents' families.

Some families will not hesitate to discuss marital difficulties or other problems.

Sometimes there will be discussion of how the "problem child" relates to the father and mother in terms of "power struggles." If they describe a pattern, for example, between mother and child or father and child, we are likely to ask, "Does that same pattern operate in other family relationships—between mother and father, for example?" Is the pattern a carryover from a parent's own family? By following the couple's lead, we try to develop a picture of the marriage, careers of one or both parents, relationships with other children and between all the children, the parents' relationships with their own families of origin, and friendships and community ties.

Sometimes the family as a whole functions in a very fragmented, presymbolic way. They gesture, "behave at" each other, overwhelm each other, or withdraw from one another, but they do not share any meanings with one another. Nothing is negotiated at a symbolic level. Even though each individual may be capable of functioning on a symbolic level, something about the family dynamics cancels out that ability. In this context, we want to know how the family handles dependency, excitement, and sexuality, as well as anger, assertiveness, empathy, and love.

For each unit of the family—the parents, each parent-child relationship, and the family as a whole—we want to find out how the different emotional themes were dealt with at different developmental levels.

### **Child (or Infant) and Caregiver Sessions**

We focus the next two sessions on the child. Many clinicians may prefer to observe the child before exploring family patterns. Sequence is not critical. We conduct the session differently with an older child (a 3- or 4-year-old, for example) than with an infant. With an infant, we may ask the parent to play

with the baby to “show me how you like to be with or play with your baby or child.” The parent may ask, “What do you want me to do?” “Anything you like,” is our response. We offer the use of the toys in the office or tell them they may bring a special toy from home.

We watch as each parent plays with the child in an unstructured way for about 15 or 20 minutes. We are looking for the developmental level, the range of emotional themes at each level, and the use of and support that the child is able to derive from motor, language, sensory, and cognitive skills. We are also watching for the parents’ ability to support or undermine the developmental level, the range in that level, and the use of sensory, language, and motor systems. After we watch the mother and father separately, we watch the three of them together to see how they interact as a group because sometimes the group situation is more challenging. Later, we will join them to do some coaching and/or start to play with the child (briefly in the first session and for a longer period in the second session).

During this time, we want to see the child interacting at her highest developmental level, as well as how she relates to a new person whom she knows only slightly. In addition, we want to determine how to bring out the highest developmental level at which the child can function. For example, if a child is withdrawn or self-absorbed and repetitively moving a truck, we will suggest joining her play, trying to move the truck together, put up a fence (one’s hands) or take another car and, with great joy and enthusiasm, announce “Here I come!” to entice the child into interaction. Sometimes marching or jumping with an aimless child or lying next to a passive, withdrawn child and offering a back rub or tickle will draw the child in. If a child shows signs of symbolic functioning and the parents do not support symbolic functioning (i.e., in

their 3-year-old), we will try, through coaching or directing, to initiate pretend play. If an 8-month-old is being overstimulated, we will try to introduce cause-and-effect interactions. If a 4-month-old looks withdrawn, we’ll try to flirt to pull him in. We will try to calm down a fussy 5-month-old by using visual or vocal support, gentle tactile pressure, and a change of positions. We will work hands-on with an infant to explore tactile sensitivity, muscle tone, motor planning, and preference for patterns of movement in space.

We learn a great deal through observation. By way of example, we might offer a doll to a child moving a train to see if he gives it a ride—suggesting symbolic capacities—or playfully obstruct the path of a child aimlessly wandering around the room to see if he ducks under our arms or smiles or simply turns and wanders away. We also might say to a child who is moving a train, “Oh boy, I can see that you know how to make this train go!” The child may put a doll on the train, make the doll a conductor, and add a passenger. The passenger may have a baby while the train is going through a tunnel, while, at the same time, a doctor makes sure the baby is all right. A 3-year-old who generates such a “drama” is sophisticated cognitively and evidences a rich fantasy life.

With children who can connect ideas together (e.g., hold a back-and-forth conversation), and depending on the child’s comfort in being separated from his caregiver, we may reverse the sequence. We may have the first session with the child alone to explore how he or she engages, attends, initiates intentional two-way communication, problem solves, and shares and categorizes meanings.

During this time alone, a 3½-year-old may stand in the middle of the room and look us over, while we look at him. If we don’t try to control the situation too quickly and can tolerate 10 or 15 seconds of ambiguity, the

child may become more self-absorbed and aimless or he may start to play, ask us a question about the toys, or talk about his family. What the child does with behavior or has to say without us saying too much (“Do you want to play with the toys?”) can be very valuable. A child may look around and say, “I heard there were toys here. Where are they?” Such a statement indicates an organized, intentional child who has figured out why he is there and acts on his understanding. Another child may look puzzled and withdrawn and repetitively bang a block

Some 4-year-olds will talk to us throughout the session. We might have an almost adult-to-adult kind of dialogue about school or home, nightmares or worries, or just a chat about anything, as one might have with a neighbor. Other children will behave aggressively and want to jump on us or wrestle. They become too familiar too quickly.

We observe the way the child relates to us; that is, the quality of engagement—overly familiar, overly cautious, or warm. We look for how intentional she is in the use of gestures and how well she sizes up the situation and us (without words). We try to determine her emotional range and her way of dealing with anxiety (e.g., does she become aggressive or withdrawn?). We also note, during interaction with a child, the child’s physical status, her speech, receptive language, visual-spatial problem-solving skills (e.g., can she search for a toy), gross and fine motor skills, and general state of health and mood. In general, we want to systematically describe the child’s ability to attend, engage, initiate and be purposeful with affects and motor gestures, open and close many communication circles to problem solve, create ideas (pretend play), and converse and think logically.

The next step is to learn what is on the child’s mind. If the child is symbolic, we look at the content of the play and dialogue, as well as

the sequence of themes that emerge from them. Often, observing how a child shifts from one activity or theme to another (e.g., aggression to protectiveness or exploration to repetition) will provide some initial hypotheses. Our role as therapist is to be reasonably warm, supportive, and skillful in engaging the child and helping him evidence and elaborate upon his capacities.

### Formulation

After learning about the child’s current functioning and history and observing the child and family first hand, we should have a convergence of impressions. If a picture is not emerging, we may need to spend another session or two developing the history or observing further.

We ask ourselves a number of questions related to the child’s assessment to determine how high up in the developmental progression the child has gone in terms of:

1. Attending and regulating
2. Engaging
3. Organizing two-way intentional communication
4. Engaging in preverbal problem-solving chains
5. Sharing symbolic meanings
6. Connecting symbols logically (or emotional thinking)

We evaluate how well a child has mastered the earlier phases and, if the child has not fully mastered a level, what are the unresolved issues? For example, does a child still have challenges in terms of his attentional capacities, the quality of engagement, and/or his intentional abilities?

Determining the developmental level tells us how the child organizes experience. To use a metaphor, it provides a picture of the “stage” upon which a child plays out his “drama.” The presenting symptoms—nightmares, waking up

at night, refusal to eat, as well as other concerns and inclinations—make up the “drama.” The “stage” may be age-appropriate. For example, a 4-year-old who can categorize representational experience has a drama of being aggressive to other children, but this drama is being played out on a stage that is age-appropriate. This child has the capacity to comprehend the nature of his aggression and use “ideas” to figure out her behavior.

On the other hand, there may be major deficits in the stage (i.e., attending, being intentional, representing experience, or differentiating experience). If there are flaws in the stage, we want to pinpoint the nature of those flaws. For example, if a child is not engaged with other people, she may be perseverative and self-stimulatory because she can’t interact or she may be aggressive because she basically has no sense of other people’s feelings. She may not even see people as human. Alternatively, another child may be aggressive because he cannot represent feelings and, therefore, acts them out. Still another child may represent and differentiate his feelings, but have conflicts about his dependency needs.

We also look at the range of experience organized at a particular developmental level. If a child is at an age-appropriate developmental level, does he accommodate such things as dependency, assertiveness, curiosity, sexuality, and aggression at that level? On the other hand, even if a child is at the right developmental level, the stage may be narrow. In other words, he might be only at that developmental stage when it applies to assertiveness, but not when it applies to dependency. When it comes to excitement, he may function at a much lower level. We also

look at the stability of the developmental organization: Does even a little stress lead to a loss of function or are the functions stable?

To continue the metaphor, if the child has major problems stemming from earlier developmental issues, we will say there are defects in the stage. If the stage is solid (no defects), it is either very flexible and wide or very narrow and constricted (e.g., it will tolerate a drama of assertiveness, but it will not tolerate a drama of intimacy or excitement). In addition, a stage is stable or unstable.

Next, we want to know about the contributing factors. One set of factors relates to observations about family functioning; the other set of factors relates to the assessment of the child’s individual processing differences (i.e., sensory reactivity, processing, and motor planning). The child-caregiver interactions are the mediating factors. The developmental formulation or profile describes: (1) the child’s functional developmental level; (2) the contributing processing profile (e.g., sensory reactivity auditory and visual-spatial and motor-planning difficulties); and (3) the contributing family patterns (e.g., high energy, overloading, and confusing family pattern), as well as the observed interaction patterns of each of the significant caregivers and the types of interactions that would be hypothesized to enable the child to move up the developmental ladder and decrease her processing difficulties.

## SUMMARY

In this chapter we have outlined the practical clinical steps involved in conducting a comprehensive developmentally based evaluation. This discussion will hopefully complement the material presented in Chapters 3 and 4. ■

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