Clinical Review: Max Verstappen

Assessment, Formulation and Intervention Processes

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Master in Clinical Psychology

Child Clinical Psychology

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PART I

FOUNDATION

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FORMULATION

1.1 Preface

The referral for Max, a 5-year-old child of Aboriginal Australian and Irish heritage, warrants systematic evaluation for neurodevelopmental conditions. Two primary diagnostic considerations emerge: Autism Spectrum Disorder (ASD; F84.0) as provisional diagnosis, and Intellectual Developmental Disorder (IDD; F70.0-F79.0) requiring further clarification.

1.2 Autism Spectrum Disorder

1.2.1 Social Communication and Interaction Dynamics

Max's presentation suggests potential ASD, pending comprehensive assessment. Regarding Criterion A (persistent deficits in social communication and interaction), several concerning features emerge (American Psychiatric Association, 2022). Social-emotional reciprocity deficits include lack of shared enjoyment, failure to seek comfort when hurt, and apparent preference for solitary engagement. Nonverbal communication shows inconsistent eye contact and joint attention (skills typically emerging by 12 months (Elsabbagh & M. H. Johnson, 2010)), alongside reliance on leading his mother to desired objects rather than pointing or gestures. This protodeclarative communication delay represents a core early marker distinguishing autism from other developmental conditions (Mundy et al., 2009). Relationship deficits manifest through parallel play preference, absence of friendships, and limited peer engagement despite regular preschool attendance.

1.2.2 Restricted and Repetitive Behaviour Dynamics

Criterion B features include stereotyped motor behaviours showing as repetitive lining up of cars and fascination with spinning wheels, occurring in approximately 70% of young children later diagnosed with ASD (Leekam et al., 2011). Insistence on sameness shows as rigid morning routines (requiring rice bubbles and grapes specifically) and significant distress when routines disrupted, intensifying during preschool years (Rodgers et al., 2012). Restricted interests show as abnormal intensity focus on vehicles with possessiveness and rejection of alternatives. Sensory hyper-reactivity shows as pronounced auditory distress (hairdryer, vacuum cleaner, lawnmower) and tactile sensitivities during tooth brushing requiring physical restraint, aligning with

findings that 69–95% of children with ASD demonstrate atypical sensory processing (Tomchek & Dunn, 2007).

Criterion C (early developmental onset) appears met through concerns from infancy, including speech regression after initial word acquisition at 15 months. Criterion D (clinically significant impairment) appears satisfied across peer relationships, self-care, and adaptive functioning requiring teacher aide support. Criterion E (not better explained by IDD) requires careful evaluation, as cognitive functioning may substantially contribute to presentation.

1.3 Intellectual Developmental Disorder

Max's GMDS-ER assessment at 29.9 months yielded General Quotient of 69 (below first percentile), suggesting mild global developmental delay. However, this two-year-old assessment requires contemporary evaluation using age-appropriate measures examining both verbal and nonverbal abilities (American Psychiatric Association, 2022). Cognitive profiles in young children with ASD demonstrate instability (Munson et al., 2008), and language-based measures may underestimate nonverbal reasoning in children with limited verbal output (Charman et al., 2011).

Adaptive functioning shows documented difficulties across conceptual domains (limited vocabulary, word combinations rather than sentences at age 5), social domains (peer interaction difficulties, absence of reciprocal friendships), and practical domains (lack of toilet training indication, self-feeding regression, substantial preschool support required) (Tassé et al., 2012). Systematic assessment using Vineland Adaptive Behaviour Scales, Third Edition (Sparrow et al., 2016) would provide essential quantitative data across contexts.

1.4 Predisposing, Precipitating, Perpetuating, and Protective Factors

1.4.1 Predisposing Factors

Prematurity (35 weeks, 3 days) and low birth weight (2645 grams) may have contributed to neurological vulnerability, though good condition at delivery suggests resilience. Late preterm infants show elevated neurodevelopmental difficulty rates (S. Johnson & Marlow, 2011). Neonatal jaundice requiring phototherapy and severe infant gastroesophageal reflux represent early biological stressors potentially affecting neurodevelopment and early parent-child interactions.

Family history of ASD (maternal nephew) suggests genetic vulnerability, with heritability estimates ranging from 37% to over 90% (Tick et al., 2016; Bai et al., 2019). Speech regression (acquiring "cat" at 15 months, then ceasing verbal output) suggests atypical language trajectory. Sensory sensitivities across auditory and tactile modalities may have contributed to affect regulation difficulties.

Stephanie's postnatal depression following Max's birth potentially affected early attachment during critical developmental windows. While maternal depression can influence parent-infant interaction quality (Feldman et al., 2009), effects vary considerably based on severity, duration, and treatment access (details unspecified in referral).

Max's Aboriginal heritage through his father requires respectful acknowledgment and integration into assessment and treatment planning. Aboriginal Australian children experience service access disparities, with IDD prevalence of 39 per 1,000 compared to 16 per 1,000 for non-Aboriginal children (Bourke et al., 2016), differences likely reflecting systemic barriers rather than genetic factors. Cultural sensitivity and knowledge of sociostructural conditions prove essential (American Psychiatric Association, 2022). The family's Parramatta residence on Darug land suggests active connection to Charles's cultural identity, representing both protective factor and consideration for culturally responsive service provision.

1.4.2 Precipitating and Perpetuating Factors

Impending transition from preschool to primary school represents significant environmental change potentially affecting functioning, as educational transitions often challenge children with neurodevelopmental differences relying on predictable routines.

Ongoing sensory sensitivities create distress during routine activities, potentially maintaining heightened stress responses. Rigid routine reliance may receive inadvertent reinforcement through parental accommodation. Limited communicative repertoire constrains expression of needs and emotional states, potentially contributing to frustration and behavioral dysregulation. Current feeding patterns where Stephanie feeds Max, despite his demonstrated capacity for independence at 18 months, may reflect parental accommodation while limiting autonomy development. Teacher aide support, while appropriate, may inadvertently limit peer interaction if delivered primarily one-on-one.

1.4.3 Protective Factors

Max demonstrates pretend play skill acquisition through speech pathology intervention, indicating symbolic representation capacity and responsiveness to targeted teaching. Good sleep pattern (8pm–7am) represents significant strength (Maski et al., 2011). Language re-acquisition following regression demonstrates neuroplasticity. Strong vehicle interests could serve as motivational engagement tools.

Both parents' TAFE diploma completion indicates educational engagement. Charles's active Aboriginal community involvement suggests access to cultural support networks. Stephanie's part-time employment provides financial stability while enabling parental availability. Current ABC preschool attendance with teacher aide support indicates access to educational services with appropriate accommodations. Family connection to Darug land and Aboriginal community provides cultural anchoring and potential access to culturally responsive support services.

PART II

METHODOLOGY

2

ASSESSMENT

2.1 Assessment Framework and Rationale

Comprehensive evaluation for possible ASD and IDD requires systematic integration of multiple information sources and professional perspectives. The gold standard assessment involves multidisciplinary collaboration including paediatrician, psychologist, and speech-language pathologist (Ozonoff et al., 2005), serving several functions: specialized expertise enabling comprehensive evaluation, cross-validation reducing diagnostic error, and integrated assessment facilitating coordinated treatment planning (Charman & Gotham, 2013).

For Max, multidisciplinary collaboration proves particularly valuable given that approximately 45% of individuals with autism also have intellectual developmental disorder (Mefford et al., 2012), necessitating careful evaluation to determine whether social communication difficulties exceed what would be expected based on nonverbal cognitive abilities alone.

2.2 Clinical Interview and Information Sources

Comprehensive assessment requires systematic information gathering from Stephanie and Charles (detailed developmental history and current functioning observations), ABC preschool teacher and teacher aide (functioning in structured settings with peers through systematic behavior rating scales), Dr. Smith (medical history and longitudinal perspectives), speech pathologist (language development trajectory and intervention response), and direct observation of Max through structured testing, unstructured play, and ideally preschool observation.

A comprehensive developmental interview following established frameworks such as the Autism Diagnostic Interview-Revised (ADI-R; Lord et al., 1994) provides systematic coverage of areas essential for ASD diagnosis. The 93-item interview (1.5-3 hours) addresses pregnancy and birth history, early feeding and sleeping patterns, motor milestone attainment, language acquisition including pre-linguistic communication and regression, social development (early social responsiveness, attachment, imitation, joint attention, pretend play, peer relationships), play development across types, restricted interests and repetitive behaviours, clinically relevant behaviours, and current functioning across daily living skills and family participation.

Given Max's Aboriginal heritage, the interview should explicitly address family's connection to Aboriginal community and culture, cultural practices relevant to child-rearing, family's understanding of Max's difficulties within cultural framework, and preferences for involvement of

Aboriginal Health Workers (Daniels & Mandell, 2014). This exploration should be conducted with cultural humility, recognizing that families' cultural identification exists on a continuum.

2.3 Measures and Psychometric Assessment

The Autism Diagnostic Observation Schedule, Second Edition (ADOS-2; Lord et al., 2012) represents the gold standard observational assessment for ASD. For Max, Module 2 (designed for children with phrase speech who are not yet verbally fluent) provides standardized contexts for eliciting social communication behaviours through developmentally appropriate activities. However, the ADOS-2 is not independently diagnostic (Charman & Gotham, 2013). Diagnosis requires integration of ADOS-2 findings with developmental history, parent reports, and clinical judgment. The instrument demonstrates strong psychometric properties (Gotham et al., 2007), though cultural considerations require acknowledgment that it was developed and normed primarily on Western populations.

Screening measures provide useful supplementary data. The Social Communication Questionnaire (SCQ) is a 40-item parent questionnaire (10-15 minutes) providing screening across autism symptom domains. The Social Responsiveness Scale, Second Edition (SRS-2) offers 65-item questionnaires completed by parents and teachers (15-20 minutes each), measuring social communication and restricted/repetitive behaviours dimensionally. Obtaining both ratings enables comparison across contexts, potentially revealing environmental variability in symptom expression.

The Wechsler Preschool and Primary Scale of Intelligence, Fourth Edition (WPPSI-IV; Wechsler, 2012) assesses intellectual functioning across Verbal Comprehension, Visual Spatial, and Fluid Reasoning domains. Given Max's speech delays, careful interpretation of Verbal Comprehension scores is essential, as language-based subtests may underestimate nonverbal reasoning abilities. The WPPSI-IV's structure enables examination of discrepancy between verbal and nonverbal abilities, potentially revealing uneven cognitive profiles common in ASD (Charman et al., 2011). If verbal abilities significantly limit valid administration, the Leiter International Performance Scale, Third Edition (Roid et al., 2013) could provide alternative assessment.

IQ scores in ASD may demonstrate instability in early childhood (Munson et al., 2008), making reassessment across developmental periods essential. Standard cognitive tests may underestimate abilities due to social communication demands, reduced motivation, anxiety, and difficulty comprehending instructions. Profile analysis examining scatter across subtests provides more useful clinical information than global IQ scores alone (Flanagan & McGrew, 1997). Careful observation during testing illuminates problem-solving approaches, frustration response, sustained attention capacity, and social referencing behaviours.

The Vineland Adaptive Behaviour Scales, Third Edition (Vineland-3; Sparrow et al., 2016) evaluates functioning across Communication, Daily Living Skills, Socialization, and Motor Skills domains through semi-structured interview with parents. For differential diagnosis between ASD and IDD, examining the pattern of adaptive scores can illuminate whether deficits are global (consistent with IDD) or whether social communication deficits are disproportionate to

other adaptive domains (consistent with ASD; Klin et al., 2007). Additional assessment through preschool teacher report enables comparison across contexts.

Given Max's reported sensory sensitivities, the Sensory Profile-2 (Dunn, 2014) provides parent and teacher questionnaires (15-20 minutes each) assessing sensory processing patterns across multiple modalities. Research indicates that 69-95% of children with ASD demonstrate atypical sensory processing (Tomchek & Dunn, 2007). The Child Behaviour Checklist for Ages 1.5-5 (CBCL/1.5-5) completed by parents provides broad-band screening for emotional and behavioural problems, as anxiety disorders and attention-deficit/hyperactivity disorder frequently co-occur with ASD.

2.4 Clinical Observation and Timeline

Systematic clinical observation throughout assessment sessions provides invaluable data complementing standardized testing. Observations should occur across structured testing situations (separation from parents, response to novel adult and environment, attention during tasks, frustration tolerance, social referencing, presence of repetitive behaviours), unstructured free-play scenarios (toy selection and themes, functional versus symbolic play, communication patterns, play flexibility), parent-child interaction (quality of social engagement, communication patterns, affective sharing), and ideally preschool setting (peer interaction quality, response to teacher instructions, transitions, behavioural regulation).

Comprehensive assessment typically requires multiple sessions distributed over several weeks (Zwaigenbaum et al., 2009). A suggested sequence includes Session 1 (2 hours): developmental interview with parents, completion of questionnaires, introduction to Max with brief play observation; Session 2 (1.5-2 hours): ADOS-2 administration, parent-child interaction observation; Session 3 (1.5-2 hours): cognitive assessment, adaptive behaviour interview; Session 4 (1-1.5 hours): supplementary assessment, preschool observation if possible; Session 5 (1-1.5 hours): feedback session presenting findings, diagnostic formulation, and recommendations.

PART III

PLANNING

3

INTERVENTION

3.1 Evidence-Based Treatment Approaches

Research on ASD intervention has expanded substantially, with systematic reviews guiding evidence-based practice (Reichow et al., 2012; Warren et al., 2011). Interventions categorize into comprehensive approaches targeting broad developmental domains versus focused interventions addressing specific skills (National Research Council, 2001).

Early intensive behavioural intervention (EIBI) based on Applied Behaviour Analysis principles typically involves 20-40 hours per week of structured teaching. Research suggests EIBI can produce improvements in intelligence, language, and adaptive functioning, though effect sizes vary and response is heterogeneous (Reichow et al., 2012). Developmentally-based approaches integrating behavioral principles with relationship-focused methods include the Early Start Denver Model (ESDM), which may produce changes in brain activity patterns alongside behavioral improvements (Dawson et al., 2012).

Focused interventions target specific developmental domains. Joint attention interventions show particular promise, demonstrating improvements in both joint attention abilities and language outcomes (Kasari et al., 2010). Social skills training programs teach specific social competencies through direct instruction, modeling, and role-play, though generalization to natural contexts remains challenging. Communication-focused interventions including the Picture Exchange Communication System (PECS) can increase communication initiations, though evidence for effects on spoken language development remains mixed (Maglione et al., 2012).

Parent-mediated interventions teach parents to implement intervention strategies during daily routines, enabling intensive intervention within natural contexts. Research shows variable results, with some studies demonstrating improvements in parent-child interaction and child communication. Parental involvement represents a critical component regardless of specific model. Interventions for co-occurring concerns address the high rates of anxiety, attention difficulties, and behavioural challenges through modified cognitive-behavioural therapy, functional behaviour assessment, and parent training in behaviour management.

3.2 Naturalistic Developmental Behavioral Intervention

For Max, naturalistic developmental behavioral intervention (NDBI) approaches represent a particularly appropriate evidence-based strategy. NDBI integrates principles from applied be-

havior analysis with developmental science, implemented within natural play-based contexts (Schreibman et al., 2015).

3.2.1 Conceptual Foundation and Rationale

NDBI approaches rest on several principles: young children learn most effectively through natural social interactions and play rather than highly structured teaching; embedding learning within child-initiated activities enhances motivation; using natural consequences produces more meaningful learning than arbitrary reinforcers; and targeting pivotal developmental skills (joint attention, imitation, affect sharing) produces cascading effects across multiple domains.

The Early Start Denver Model (Rogers & Dawson, 2010) exemplifies NDBI approaches, combining ABA teaching principles with developmental relationship-based strategies. Key features include targeting developmental skills across all domains, teaching within playful social interactions following the child's interests, using naturalistic behavioural teaching strategies, implementing intervention intensively (20-25 hours weekly ideally) across contexts, involving parents as active intervention agents, and monitoring progress through frequent data collection (Dawson et al., 2010).

Several factors suggest NDBI would be suitable for Max. His young age (5 years) falls within the developmental window where early intensive intervention demonstrates strongest effects (Rogers et al., 2012). His emerging communication abilities (word combinations) suggest he is positioned to benefit from intervention targeting language expansion within social contexts. His strong vehicle interests provide natural motivators. His good sleep patterns suggest capacity to tolerate intensive intervention. The availability of both parents and his teacher aide as potential intervention agents enables intervention across contexts.

NDBI approaches can be culturally adapted more readily than highly structured ABA approaches (Schreibman et al., 2015), potentially aligning better with Aboriginal cultural values emphasizing learning through observation and participation in meaningful activities. However, explicit exploration with Charles and Stephanie would be necessary to understand their preferences.

3.2.2 Implementation and Expected Outcomes

NDBI implementation begins with comprehensive assessment using developmental frameworks evaluating skills across receptive communication, expressive communication, social skills, imitation, cognition, play, motor skills, behaviour, and independence domains (Rogers & Dawson, 2010). Goal-setting occurs collaboratively with parents. For Max, potential priority goals might include increasing spontaneous communication initiations, expanding vocabulary and phrase length, improving joint attention skills, developing pretend play schemes, reducing distress with transitions, and expanding self-feeding independence.

Core intervention techniques include following the child's lead (interventionist joins Max's activity rather than redirecting), creating communication opportunities (environment arranged to prompt communication with desired objects placed in view but out of reach, containers dif-

ficult to open, activities interrupted), modeling and expanding language (when Max communicates, interventionist responds immediately with slightly more complex language), establishing joint activity routines (predictable, enjoyable routines providing multiple opportunities for social engagement and turn-taking), and using positive reinforcement (Max's attempts reinforced immediately with natural consequences and specific labeled praise) (Dawson et al., 2010). Additional techniques include task analysis and shaping (complex skills broken into smaller steps taught sequentially), prompting and prompt fading (prompts provided at minimum necessary level, systematically faded), and generalization planning (skills taught across multiple contexts, materials, and people from the outset).

Parent coaching represents a critical component, enabling intensive intervention within daily routines. Research indicates that parents can implement strategies effectively with appropriate coaching, producing meaningful improvements (Rogers et al., 2012). For Stephanie and Charles, parent coaching sessions might occur weekly initially, focusing on embedding strategies within mealtimes, playtime, bedtime routines, and community outings.

Implementing NDBI with Max's family requires cultural responsiveness. Explicit discussion with Charles and Stephanie about their values, goals, and preferences would guide intervention planning. Incorporating cultural activities, stories, and materials into intervention would support Max's cultural identity development. Charles's Aboriginal community involvement might provide opportunities for Max to participate in cultural activities with structure supporting his learning. The interventionist would need to demonstrate cultural humility, seeking to understand the family's perspectives rather than imposing mainstream assumptions.

Research suggests that 20-25 hours per week of intervention produces optimal outcomes (Dawson et al., 2010). For Max, a combination of direct therapy sessions (5-10 hours weekly), parent-implemented intervention during daily routines (10-15 hours weekly), and preschool-implemented strategies by teacher aide (15-20 hours during preschool days) could approximate this intensity. Duration typically spans 2-3 years, with progress monitoring occurring at least quarterly.

Research on ESDM indicates that children receiving this intervention demonstrate improvements including increased language abilities, enhanced social communication, reduced autism symptom severity, and improved cognitive functioning (Dawson et al., 2012). However, response is variable (Vivanti et al., 2014). For Max, reasonable expectations might include expansion of expressive language to longer utterances, increased spontaneous communication, improved joint attention, more elaborate pretend play, reduced transition distress through visual supports, and increased self-care independence. Progress monitoring would enable evaluation of whether intervention produces expected gains and modification if progress is insufficient.

NDBI would be implemented as part of comprehensive intervention potentially including speech-language pathology services targeting specific communication skills, occupational therapy addressing sensory processing and fine motor skills if indicated, and preschool services including special education support and teacher aide assistance. Coordination across these services would ensure consistency in approaches and goals.

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