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

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 from Dr. Smith's referral: 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 (described as being "independent in his own world"). 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, sharing difficulties, and limited peer engagement despite regular preschool attendance.

1.2.2 Restricted and Repetitive Behaviour Dynamics

Criterion B features include:

Stereotyped motor behaviours show as repetitive lining up of cars and trucks, and fascination with spinning wheels. These behaviours occur 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), significant distress when routines disrupted or preferred objects removed. This rigidity intensifies during preschool years (Rodgers

et al., 2012). Restricted interests shows as abnormal intensity focus on vehicles, possessiveness toward these toys, rejection of alternatives like balls. Sensory hyper-reactivity shows as pronounced auditory distress (hairdryer, vacuum cleaner, lawnmower) producing screaming and prolonged upset; tactile sensitivities during tooth brushing requiring physical restraint. These patterns align with findings that 69–95% of children with ASD demonstrate atypical sensory processing across multiple modalities (Tomchek & Dunn, 2007).

1.2.3 Diagnostic Criteria Considerations

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

1.3 Intellectual Developmental Disorder

1.3.1 Cognitive Functioning

Criterion A (deficits in general mental abilities) warrants systematic evaluation. 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, with some showing improved scores following intervention (Munson et al., 2008). The interaction between delayed speech development and assessment performance requires consideration, as language-based measures may underestimate nonverbal reasoning in children with limited verbal output (Charman et al., 2011).

1.3.2 Adaptive Functioning

Criterion B (adaptive functioning deficits) 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 standardized instruments such as Vineland Adaptive Behaviour Scales, Third Edition (Sparrow et al., 2016) would provide essential quantitative data across contexts. Criterion C (developmental period onset) appears satisfied through concerns evident from infancy.

1.4 Predisposing, Precipitating, Perpetuating, and Protective Factors

1.4.1 Predisposing Factors

Biological: 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, particularly with additional risk factors (S. Johnson & Marlow, 2011). Neonatal jaundice requiring phototherapy represents early biological stress potentially affecting neurodevelopment. Severe infant gastroesophageal reflux may have influenced feeding experiences and early parent-child interactions.

Genetic: 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).

Developmental: Speech regression (acquiring "cat" at 15 months, then ceasing verbal output) suggests atypical language trajectory potentially reflecting neurological differences. Sensory sensitivities across auditory and tactile modalities may have contributed to affect regulation difficulties and stress responses during daily activities.

Environmental: Stephanie's postnatal depression following Max's birth potentially affected early attachment and maternal attunement during critical developmental windows. While maternal depression can influence parent-infant interaction quality and infant regulatory development (Feldman et al., 2009), effects vary considerably based on severity, duration, and treatment access (details unspecified in referral). The transition from breastfeeding to bottle-feeding at six weeks occurred during this period.

Cultural: 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 in Western Australia (Bourke et al., 2016). These differences likely reflect systemic barriers and social determinants rather than genetic factors. Cultural sensitivity and knowledge of sociostructural conditions prove essential during assessment (American Psychiatric Association, 2022). The family's Parramatta residence on Darug land suggests active connection to Charles's cultural identity and community, representing both protective factor and consideration for culturally responsive service provision.

1.4.2 Precipitating Factors

No specific recent precipitating events emerge from referral. However, impending transition from preschool to primary school (High Street Primary School) represents significant environmental change potentially affecting functioning, as educational transitions often challenge children with neurodevelopmental differences, particularly those relying on predictable routines.

1.4.3 Perpetuating Factors

Ongoing sensory sensitivities create distress during routine activities (tooth brushing, household appliance noise), potentially maintaining heightened stress responses and limiting typical

childhood participation. Rigid routine reliance and disruption-related distress may receive inadvertent reinforcement through parental accommodation. Limited communicative repertoire (word combinations rather than sentences) constrains expression of needs, preferences, and emotional states, potentially contributing to frustration and behavioral dysregulation manifesting as tantrums.

Current feeding patterns where Stephanie feeds Max, despite his demonstrated capacity for independence at 18 months, may reflect parental accommodation while limiting autonomy development opportunities. Teacher aide support at preschool, while appropriate, may inadvertently limit peer interaction if delivered primarily one-on-one rather than facilitating peer engagement.

1.4.4   Protective Factors

Max demonstrates developmental strengths: pretend play skill acquisition (feeding animals) through speech pathology intervention indicates symbolic representation capacity and responsiveness to targeted teaching. Good sleep pattern (8pm–7am) represents significant strength, as sleep difficulties frequently complicate neurodevelopmental presentations (Maski et al., 2011). Language re-acquisition following regression demonstrates neuroplasticity and learning capacity. Strong vehicle interests, while potentially restricted, could serve as motivational engagement tools.

Family resources: Both parents' TAFE diploma completion indicates educational engagement and potential understanding of learning processes. Charles's active Aboriginal community involvement suggests access to cultural support networks and identity resources. Stephanie's part-time employment provides financial stability while enabling parental availability.

Service access: Current ABC preschool attendance with teacher aide support indicates access to educational services with appropriate accommodations. Upcoming High Street Primary School transition suggests educational provision continuity. Family connection to Darug land and Aboriginal community provides cultural anchoring and potential access to culturally responsive support services.

PART II

METHODOLOGY

ASSESSMENT

2.1 Comprehensive Assessment Process

2.1.1 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 for ASD involves a multidisciplinary team approach, ideally including a paediatrician, psychologist, and speech-language pathologist (Ozonoff et al., 2005). This collaborative model serves several functions: different professionals contribute specialized expertise enabling comprehensive evaluation; cross-validation of findings reduces risk of diagnostic error; and integrated assessment facilitates coordinated treatment planning (Charman & Gotham, 2013).

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

2.1.2 Clinical Interview and Developmental History

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 while gathering broader developmental information relevant to IDD consideration. The ADI-R is a 93-item interview taking 1.5-3 hours, requiring intensive training for reliable administration.

Given Max's Aboriginal heritage, the interview should explicitly address cultural considerations including family's connection to Aboriginal community and culture, cultural practices relevant to child-rearing, 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.

2.2   Measures and Psychometric Assessment

2.2.1   Autism-Specific Diagnostic Instruments

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 would likely be most appropriate, designed for children with phrase speech who are not yet verbally fluent. The ADOS-2 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/caregiver reports, and clinical judgment. Research by Gotham et al. (2007) indicates that the ADOS-2 demonstrates strong psychometric properties, though cultural considerations require acknowledgment that the instrument was developed and normed primarily on Western populations.

2.2.2   Cognitive Assessment

Evaluation for IDD requires comprehensive cognitive assessment using individually administered measures. The Wechsler Preschool and Primary Scale of Intelligence, Fourth Edition (WPPSI-IV; Wechsler, 2012) would be appropriate given Max's age, assessing intellectual functioning across multiple domains including Verbal Comprehension, Visual Spatial, and Fluid Reasoning.

Given Max's speech delays, careful interpretation of Verbal Comprehension scores is essential. 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, nonverbal intelligence measures such as the Leiter International Performance Scale, Third Edition (Roid et al., 2013) could provide alternative assessment.

Research by Munson et al. (2008) indicates that IQ scores in ASD may demonstrate instability, particularly in early childhood, making reassessment across developmental periods essential. Profile analysis examining scatter across subtests provides more useful clinical information than global IQ scores alone (Flanagan & McGrew, 1997).

2.2.3   Adaptive Behaviour Assessment

The Vineland Adaptive Behaviour Scales, Third Edition (Vineland-3; Sparrow et al., 2016) represents the gold standard adaptive assessment, evaluating functioning across Communication, Daily Living Skills, Socialization, and Motor Skills domains. 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).

2.2.4   Sensory Processing Assessment

Given Max's reported sensory sensitivities, the Sensory Profile-2 (Dunn, 2014) provides parent and teacher questionnaires assessing sensory processing patterns across multiple modalities. Research by Tomchek & Dunn (2007) indicates that 69-95% of children with ASD demonstrate atypical sensory processing, making systematic assessment valuable for intervention planning.

2.2.5   Timeline and Sequencing

Comprehensive assessment typically requires multiple sessions distributed over several weeks, enabling observation across occasions and reducing fatigue effects. Research by Zwaigenbaum et al. (2009) emphasizes that assessment quality improves when children are evaluated across multiple contexts and occasions, allowing for more valid conclusions about typical functioning patterns.

PART III

PLANNING

3

INTERVENTION

3.1 Evidence-Based Treatment Approaches

3.1.1 Overview of Evidence-Based Interventions

Research on ASD intervention has expanded substantially, with multiple systematic reviews now available to guide 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 represents one comprehensive category. Research by Reichow et al. (2012) in their Cochrane review suggests that EIBI can produce improvements in intelligence, language, and adaptive functioning, though effect sizes vary and response is heterogeneous across children. Developmentally-based approaches integrating behavioral principles with relationship-focused methods include the Early Start Denver Model (ESDM). Research by Dawson et al. (2012) indicates that ESDM may produce changes in brain activity patterns alongside behavioral improvements, suggesting neuroplastic effects.

Focused interventions target specific developmental domains. Joint attention interventions show particular promise, with research by Kasari et al. (2010) demonstrating that such interventions can improve both joint attention abilities and language outcomes. Communication-focused interventions including the Picture Exchange Communication System (PECS) provide alternative communication methods. Research by Maglione et al. (2012) indicates PECS can increase communication initiations, though evidence for effects on spoken language development remains mixed.

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

3.2.1 Conceptual Foundation and Rationale

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, and implementing intervention intensively across contexts (Dawson et al., 2010).

Several factors suggest NDBI would be particularly suitable for Max. His young age falls within the developmental window where early intensive intervention demonstrates strongest effects (Rogers et al., 2012). His emerging communication abilities suggest he is positioned to benefit from intervention targeting language expansion within social contexts. Research by Schreibman et al. (2015) indicates that NDBI approaches can be culturally adapted more readily than highly structured ABA approaches, potentially aligning better with values emphasizing learning through observation and participation in meaningful activities.

3.2.2 Implementation Process

NDBI implementation begins with comprehensive assessment using developmental frameworks, evaluating skills across receptive communication, expressive communication, social skills, imitation, cognition, play, fine motor, gross motor, behaviour, and independence domains (Rogers & Dawson, 2010). Goal-setting occurs collaboratively with parents, ensuring alignment between intervention targets and family priorities.

Core intervention techniques include following the child's lead (interventionist joins Max's activities rather than redirecting), creating communication opportunities (arranging environment to prompt requests), modelling and expanding language (responding immediately to Max's communication with slightly more complex language), establishing joint activity routines (predictable, enjoyable routines providing multiple opportunities for social engagement), and using positive reinforcement (Max's attempts reinforced immediately with natural consequences; Dawson et al., 2010).

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

3.2.3 Dosage, Duration, and Expected Outcomes

Research on NDBI approaches suggests that 20-25 hours per week of intervention produces optimal outcomes (Dawson et al., 2010). For Max, a combination of direct therapy sessions, parent-implemented intervention during daily routines, and preschool-implemented strategies could approximate this intensity.

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 to intervention is variable, with some children making substantial gains while others show more modest improvements (Vivanti et al., 2014). Progress monitoring would enable evaluation of whether intervention is producing expected gains and modification of approach if progress is insufficient.

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