Clinical Review: Max Verstappen

Assessment, Formulation and Intervention Processes

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School of Psychology

Master in Clinical Psychology

Child Clinical Psychology

Kingswood, New South Wales, October 2025

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PART I

FOUNDATION

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FORMULATION

1.1 Preface

The referral information for Max Verstappen, a 5-year-old child of Aboriginal Australian and Irish heritage, presents developmental concerns warranting systematic evaluation for neurodevelopmental conditions. Based on Dr. Smith's referral, two primary diagnostic considerations emerge: Autism Spectrum Disorder (ASD; F84.0) as a provisional diagnosis, and Intellectual Developmental Disorder (IDD; F70.0-F79.0) as a differential diagnosis requiring further clarification.

1.2 Autism Spectrum Disorder

Max's presentation suggests he may meet criteria for ASD, though comprehensive assessment remains necessary. Regarding Criterion A (persistent deficits in social communication and social interaction), several concerning features appear documented. Max demonstrates deficits in social-emotional reciprocity, evidenced by his lack of shared enjoyment, failure to seek comfort when hurt, and apparent preference for solitary engagement (American Psychiatric Association, 2022). His nonverbal communicative behaviours appear atypical, with inconsistent eye contact and joint attention, skills typically emerging by 12 months in neurotypical development (Elsabbagh & M. H. Johnson, 2010). His reliance on leading his mother to desired objects rather than conventional pointing or gestures suggests delays in protodeclarative communication, which Mundy et al. (2009) identify as a core early marker distinguishing autism from other developmental conditions.

1.2.1 Social Communication and Interaction Dynamics

Max demonstrates deficits in social-emotional reciprocity, evidenced by his lack of shared enjoyment, failure to seek comfort when hurt, and apparent preference for solitary engagement (American Psychiatric Association, 2022). His nonverbal communicative behaviours appear atypical, with inconsistent eye contact and joint attention, skills typically emerging by 12 months in neurotypical development (Elsabbagh & M. H. Johnson, 2010). His reliance on leading his mother to desired objects rather than conventional pointing or gestures suggests delays in protodeclarative communication, which Mundy et al. (2009) identify as a core early marker distinguishing autism from other developmental conditions.

1.2.2 Restricted and Repetitive Behaviour Dynamics

Regarding Criterion B (restricted, repetitive patterns of behaviour, interests, or activities), Max exhibits characteristic features including stereotyped motor behaviours evident in his repetitive lining up of vehicles and fascination with spinning wheels, behaviours that Leekam et al. (2011) suggest occur in approximately 70% of young children later diagnosed with ASD. His insistence on sameness manifests through rigid morning routines and significant distress when routines are disrupted, consistent with research by Rodgers et al. (2012) indicating that such rigidity often intensifies during preschool years. His hyper-reactivity to sensory input, particularly regarding auditory stimuli, aligns with findings by Tomchek & Dunn (2007) that 69-95% of children with ASD demonstrate atypical sensory processing across multiple modalities.

1.3 Intellectual Developmental Disorder

The differential diagnosis of IDD warrants systematic evaluation. Max's GMDS-ER assessment at 29.9 months yielded a General Quotient of 69, suggesting mild global developmental delay (American Psychiatric Association, 2022). However, this assessment occurred over two years ago, and research by Munson et al. (2008) indicates that cognitive profiles in young children with ASD can demonstrate instability, with some children showing improved scores following intervention. Contemporary evaluation using age-appropriate measures becomes essential, particularly given that language-based measures may underestimate nonverbal reasoning capabilities in children with limited verbal output (Charman et al., 2011).

1.3.1 Cognitive Functioning Considerations

Max's GMDS-ER assessment at 29.9 months yielded a General Quotient of 69, suggesting mild global developmental delay (American Psychiatric Association, 2022). However, this assessment occurred over two years ago, and research by Munson et al. (2008) indicates that cognitive profiles in young children with ASD can demonstrate instability, with some children showing improved scores following intervention. Contemporary evaluation using age-appropriate measures becomes essential, particularly given that language-based measures may underestimate nonverbal reasoning capabilities in children with limited verbal output (Charman et al., 2011).

1.3.2 Adaptive Functioning Considerations

Regarding Criterion B (deficits in adaptive functioning), Max demonstrates difficulties across conceptual, social, and practical domains. His limited vocabulary and use of word combinations rather than sentences at age 5 suggests delays in the conceptual domain, while his peer interaction difficulties and lack of toilet training indication suggest impairments in social and practical domains respectively (Tassé et al., 2012). Systematic adaptive behaviour assessment using standardized instruments such as the Vineland Adaptive Behaviour Scales, Third Edition (Sparrow et al., 2016) would provide essential quantitative data regarding functioning relative to same-age peers.

1.4 Predisposing, Precipitating, Perpetuating, and Protective Factors

1.4.1 Predisposing Factors

Max's prematurity (born at 35 weeks, 3 days) and low birth weight (2645 grams) may have contributed to neurological vulnerability. Research by S. Johnson & Marlow (2011) indicates that late preterm infants demonstrate elevated rates of neurodevelopmental difficulties, particularly when combined with other risk factors. The family history of ASD (maternal nephew) suggests genetic vulnerability, with heritability estimates for ASD ranging from 37% to over 90% depending on methodological approaches (Tick et al., 2016; Bai et al., 2019).

Stephanie's postnatal depression following Max's birth potentially affected early attachment formation during critical developmental windows. Research by Feldman et al. (2009) suggests that maternal depression can influence parent-infant interaction quality, though effects vary considerably based on severity, duration, and treatment access.

1.4.2 Precipitating Factors

The referral does not identify specific recent precipitating events intensifying Max's difficulties. However, his impending transition from preschool to primary school (High Street Primary School) represents a significant environmental change potentially affecting his functioning. Transitions between educational settings often challenge children with neurodevelopmental differences, particularly those who rely on predictable routines and familiar environments.

1.4.3 Perpetuating Factors

Max's ongoing sensory sensitivities continue to create distress during routine daily activities (tooth brushing, household appliance noise exposure), potentially maintaining heightened stress responses and limiting participation in typical childhood experiences. His reliance on rigid routines and distress when these are disrupted may inadvertently receive reinforcement through parental accommodation, potentially maintaining inflexibility. His limited communicative repertoire (word combinations rather than sentences) constrains his ability to express needs, preferences, and emotional states, potentially contributing to frustration and behavioral dysregulation manifesting as tantrums.

The current pattern where Stephanie feeds Max, despite his demonstrated capacity for independent feeding at 18 months, may reflect parental accommodation of his difficulties while simultaneously limiting opportunities for developing autonomy. The requirement for teacher aide support at preschool, while appropriate given his needs, may inadvertently limit peer interaction opportunities if support is delivered primarily through one-on-one adult interaction rather than facilitation of peer engagement.

1.4.4 Cultural Considerations

Max's Aboriginal heritage requires respectful acknowledgment and integration into assessment and treatment planning. Aboriginal Australian children experience disparities in accessing developmental services, with research by Bourke et al. (2016) reporting that intellectual developmental disorder prevalence among Aboriginal children in Western Australia was 39 per 1,000 compared to 16 per 1,000 for non-Aboriginal children, differences likely reflecting systemic barriers and social determinants of health rather than genetic factors. Cultural sensitivity and knowledge of sociostructurally conditions prove essential during assessment (American Psychiatric Association, 2022).

1.4.5 Protective Factors

Max demonstrates several strengths suggesting resources for development. His acquisition of some pretend play skills through speech pathology intervention indicates capacity for symbolic representation and responsiveness to targeted teaching. His good sleep pattern (8pm-7am) represents a significant strength, as sleep difficulties frequently complicate neurodevelopmental presentations (Maski et al., 2011). Both parents' completion of TAFE diplomas indicates educational engagement, while Charles's active involvement in his Aboriginal community suggests access to cultural support networks.

PART II

METHODOLOGY

2

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 Detailed Strategy: 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.

3.3 Conclusion

Max's case shows the complexity inherent in neurodevelopmental assessment for young children presenting with concerns for autism spectrum disorder and intellectual developmental disorder. Comprehensive evaluation employing multiple assessment methods and professional perspectives will enable accurate diagnostic formulation while identifying Max's unique profile of strengths and needs (Ozonoff et al., 2005). Evidence-based interventions such as naturalistic developmental behavioral approaches offer promise for supporting his development when implemented with appropriate intensity, cultural responsiveness, and family partnership (Rogers & Dawson, 2010).

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