DIR® Assessment

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DIR Assessment

- Dependent on Context:
  - your discipline,
  - setting,
  - reason for assessment
  - amount of time,
  - funding
- Each clinician has a personal way of conducting an evaluation

General Principles: Developmental

- 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.

General Principles: Developmental

In this model, there are six functional developmental levels.

- 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.

General principles: Individual Differences
Constitutional-Maturational Patterns

- Sensory modulation/ reactivity, including hypo- and hyperreactivity in each sensory modality (tactile, auditory, visual, vestibular, and olfactory). and overall profile, consider time, context, impact on function [regulatory capacities]
- Sensory discrimination/ processing in each sensory modality (e.g., the capacity to decode sequences, configurations, or abstract patterns)
  - visuospatial processing,
  - auditory processing [auditory receptive/auditory expressive],
  - tactile discrimination.

- 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).
- Sensory-motor, muscle tone, stability. [postural controls]
- Motor planning and sequencing. [praxis] [perceptual-motor]
- Executive functions (?)-attention, memory

General principles: Relationships

- In the developmental functional approach, the evaluations go beyond the assessment of skills to the assessment of functioning within relationships

General principles: Relationships

- 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.

{Need to be aware of your own profile, history, 'ghosts', and boundaries}

General principles: The team- consultation with specialists

- *Physicians-Biomedical Evaluations*
- *Speech and Language pathologists*
- *Occupational therapists*
- *Physical therapists*
- *Developmental Vision specialists*
- *Audiologists*
- *Teachers, psychologists, neuropsychologists*
- *Mental health professionals*

General format

- History and observation: Sequence is not critical.
- 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).
- We watch as each parent plays with the child in an unstructured way for about 15 or20 minutes
- Information about relevant contexts (e.g., at home with caregivers and siblings, with peers, in educational settings)
- Review and/or observation of educational programs and peer interaction

History: rapport

- 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.
- Therefore, we strive to be unstructured; ask facilitating, elaborative questions rather than yes-or-no or defining questions;

History: rapport

- 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.

History: developmental history

- In the second session, we construct a developmental history for the child.
  - Include prenatal history
  - Consider developmental progression, rate
  - Past experiences
  - All current interventions
  - Current functioning, behavior, interaction patterns

History: caregiver and family

- The next session focuses in greater depth on the functioning of the caregiver and family at each developmental phase.
  - Strengths
  - Vulnerabilities
  - Personalities
  - Family and cultural patterns

Family and Caregiver Functioning

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.

History- parents, marriage, family

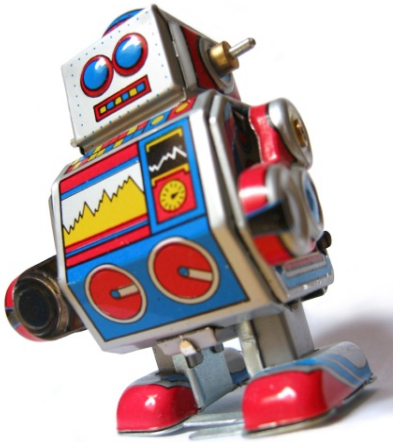
- Sometimes clinicians who are only beginning to work with infants and families feel reluctant to talk to the parents about any difficulties in the marriage. However, we use an open and supportive approach to elicit relevant information. We might ask, "*What can you tell me about yourselves as people, as a married couple, as a family?*"
- Each parent also has specific fantasies that may be projected onto the children and interfere with any of the levels

History- family history

- 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.

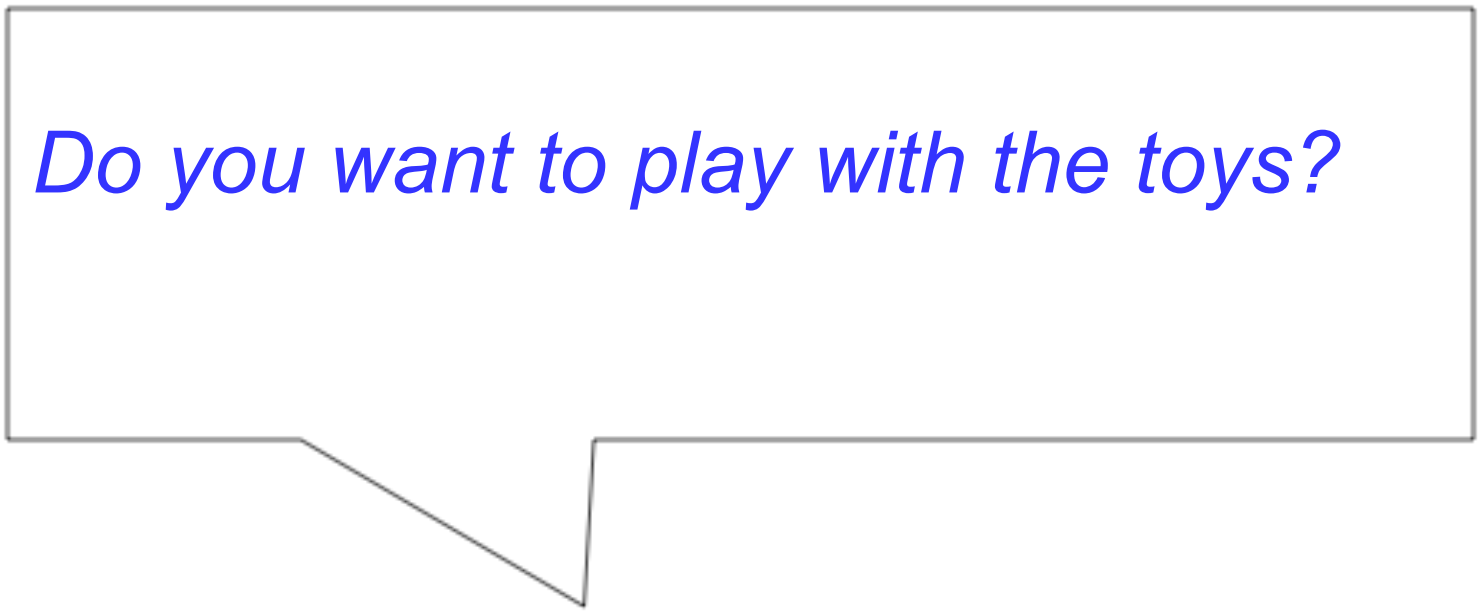
The Play room

- Setting up the environment
- Familiar vs novel
- Sensory, gross motor, fine motor, problem solving, pretend
- Number of options
- *We offer the use of the toys in the office or tell them they may bring a special toy from home.*



Invitation: woo and entice

- What the child does with behavior or has to say <u>without us saying too much</u> can be very valuable.



Show me how you like play with your child

What do you want me to do?

Anything you like

Tips

- Consider where you are in the room in relation to the parent and child
- Make a plan: Have parents take turns
- Give the other parent a supportive role
- If needed, talk about what you are thinking, seeing

Observation of caregiver-child interactions and family patterns

- 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.

Coaching and Direct Interaction

- Later, we will join them to do some coaching and/or start to play with the child.
- 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.
- In addition, we want to determine how to bring out the highest developmental level at which the child can function.

Coaching

Affect!

Wonder..

Let's try…

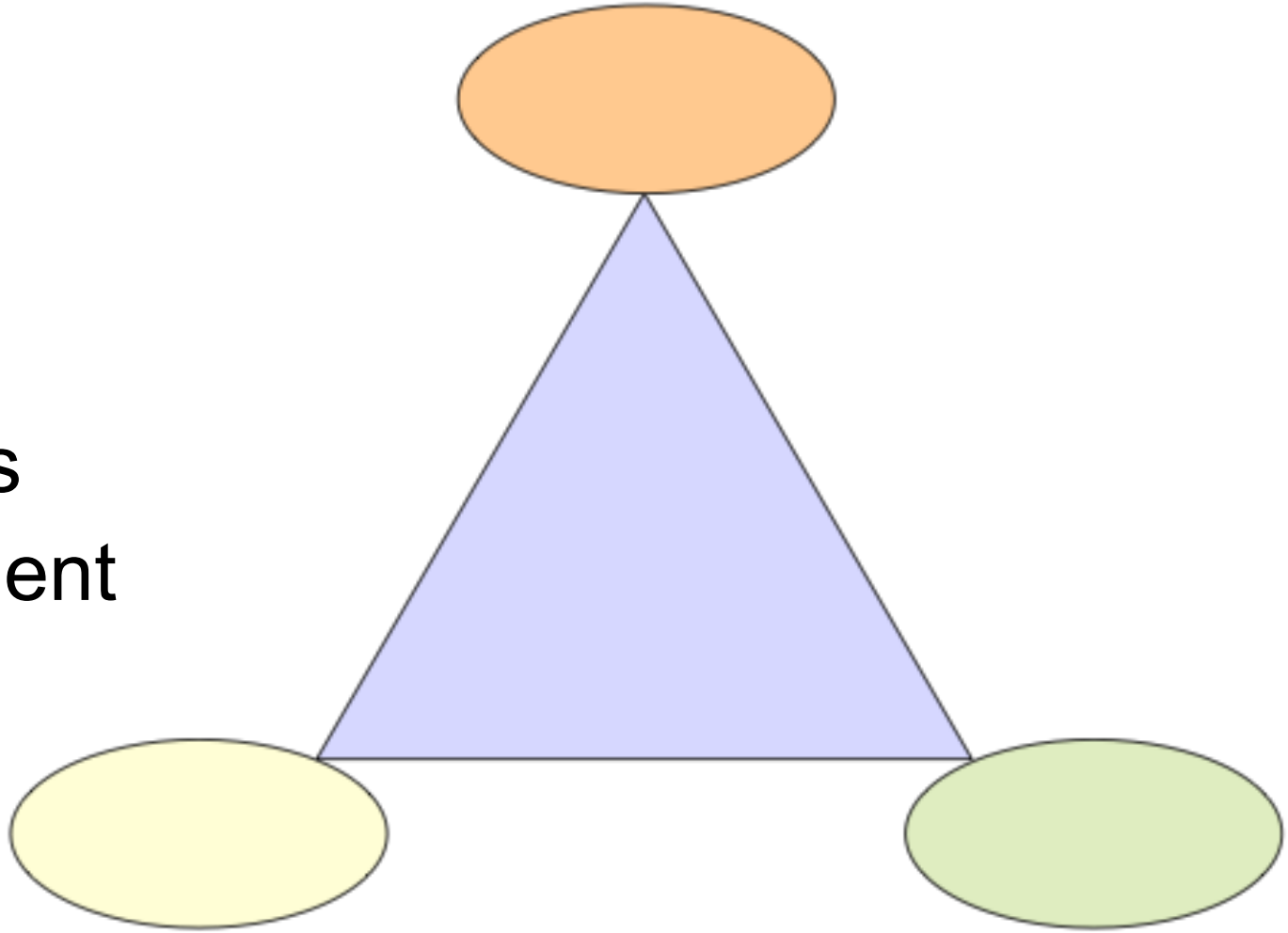
Observations

Encouragement

Questions

Pacing

Direction



Symbolic play observation

- 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.

Special considerations: Infant assessment

- Assessment is a therapeutic process
- Be cautious of not being ‘better’ than parent
- Importance of considering state regulation (deep sleep, drowsy, alert, awake, fussy, crying), state transitions and stability
- Importance of prenatal and birth experience
- Help parents find the solutions

Special consideration: The depressed parent

- Support parent-child interaction:
- You may need to be flatter, still, so child looks to parent
- Bolster parent's affect and expression- direct coaching or interacting with them
- Avoid eye gaze or direct eye gaze back to parent

Coaching the anxious parent

- Take your time, don't be rushed
- Listen and support

- For all parents, consider your disciplinary boundaries, and when consultation or referral is needed.

Videotaping

- Explain use clearly to obtain consent
- Doing it regularly makes it easier
- Use a tripod
- Be at child level
- Consider wide angle lens
- Have parent help
- Reviewing tapes is very helpful!

Standardized Tools

- Standardized tools are used for strategic purposes rather than as the core assessment.

FEAS: Functional Emotional Assessment Scale, 2001

- One part of a comprehensive clinical evaluation
- Clinical version and Research version
- Clinical version can be used to describe and/or rate (scale of 0-4)
- Intended to systematize clinical thinking

FEAS

- For 7 months to 4 years of age
- 15-30 minutes to administer
- 3 sets of toys, 5 min. each
  - Symbolic
  - Tactile
  - Large movement
- Describes some specific semi-structured ways to elicit highest levels

FEAS

- Primary emotional capacities (FEDL)
- Emotional range- sensori-motor
  (sensori-motor employed for FEDL)
- Emotional range- affective (themes)
- Associated sensory, motor, language and cognitive capacities
- General infant tendencies regulatory patterns (all ages)
- Overall caregiver tendencies (history or observation)

Impressions

- 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

Impressions: The 'Developmental Formulation or Profile'

- (1) the child's functional developmental level;
- (2) the contributing processing profile (e.g., sensory reactivity auditory and visual-spatial and motor-planning difficulties); (strengths and vulnerabilities) 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.

Constrictions

- 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.

Instability

- 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.

Impressions

What helps or hinders optimal performance ?
What interventions are suggested?

Build a Consensus

- Professionals can help parents ask the questions, but parents have to answer them. If they are unsure or if there is a difference in opinion, the professionals can observe with them until parents and professionals come to some consensus.

Only the beginning….

- Periodic updates
- How does the child respond to treatment programs?

Resources

- Clinical Practice Guidelines (online)
- Clinical Interview of the Child
- Engaging Autism
- www.icdl.com