

The Developmental, Individual Differences, Relationship Model (DIR)

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The Developmental, Individual Differences, Relationship Model (DIR)

“The overriding, conceptual framework (pg 13) is a comprehensive, developmentally based model for assessment and intervention with children with special needs, rather than restricted approaches limited to selected surface behaviors and cognitive processes. For complex syndromes, in addition to exploring underlying etiological mechanisms, it is essential to work with the different functional developmental areas, including their deficits and strengths and the relationship among them.

Components of a Functional Developmental Approach

Functional emotional development capacities, which identify how the child integrates all her separate abilities (e.g., emotional, language, sensory modulation, spatial, and motor skills) to relate to the social and cognitive world in a purposeful and emotionally meaningful manner. Children with complex developmental and learning problems, including autistic spectrum disorders, often only learn skills in an isolated, unpurposeful or nonmeaningful way (e.g., memorizing scripts). They tend to have a harder time integrating these different capacities meaningfully. More and more studies are identifying these capacities for shared attention, intimate relating, affective reciprocity, and the emotionally meaningful use of actions and ideas as the building blocks for logical and abstract thinking, including higher levels of empathy and reflection.

Individual differences in the functioning of the central nervous system, with a special focus on how these differences are expressed in the way a child reacts to an processes experiences, as well as how he/she plans and organizes responses. This area typically includes sensory modulation (e.g., over- or underreactivity in each sensory modality, such

as touch, sight, and sound); sensory processing (e.g. auditory [receptive language], visual-spatial, tactile, vestibular, and proprioceptive); motor planning and sequencing.

Child-caregiver interactions and family and service system patterns, particularly as they mobilize developmental progress by working with the child's individual differences at the child's functional developmental level. The tendency of most approaches today, is to work with isolated behaviors or processes (e.g., compliance, aggression, or matching shapes or colors), with insufficient attention paid to the child's emotional relationship to his/her caregivers, his/her ability to engage in a continuous chain of back-and-forth affective and gestural interaction, or the capacity to generate creative idea.

A *team approach* (pg 15) to an individualized, comprehensive functional program that works with each child's unique pattern of functional deficits and strengths and often includes, as needed, speech therapy, occupational and /or physical therapy, special education, biomedical interventions, and mental health or developmental work with the child, and child-caregiver interaction sand/or family patterns—with all team members working together.

These important areas (pg 18) of developmental functioning can be systematized clinically into six basic functional developmental capacities, which also have support from the normative child development literature (Greenspan, 1992; Greenspan & Lourie, 1981). These six functional developmental capacities are:

Shared attention and regulation.

Engagement

Affective reciprocity and gestural communication.

Complex presymbolic, shared social communication and problem solving, including imitation, social referencing, and joint attention.

Symbolic and creative use of ideas, including pretending play and pragmatic language.

Logical and abstract use of ideas and thinking, including the capacity for expressing and reflecting on feelings and having insights into self and others.

A review of 200 cases of children with autistic spectrum disorders demonstrated that there were individual differences (i.e., variations) in these functional developmental and processing capacities among the children, further supporting the importance of working with them in the unique configuration that characterizes a given child and family (Greenspan & Wieder, 1997). There also is considerable support (pg 19) for focusing on *child-caregiver interactions and working with the family* (McCollum & Hemmeter, 1998; Krauss, 1998; Turnbull & Turnbull, 1982). In addition, two other elements appear to have importance. One is employing *a very intensive approach to working with children and their families*. It also appears *the one-on-one child-caregiver interactions*, especially for children who are not yet social and interactive, is essential for significant progress (Dawson & Osterling 1997; Powers, 1992). Additionally, as children become available for social interaction, it appears that balancing adult-child one-on-one work with peer-to-peer and small-group work is also quite helpful (Hoyson, Jamison, & Strain, 1984; strain & Cordisco, 1994).

The promising elements just identified can be conceptualized as part of comprehensive developmental model (Greenspan, 1992; Greenspan & Wieder, 1998, 1999) by

systematizing the elements into the three broad categories describing in a previous section. These broad categories are:

D—developmental capacities that integrate the most essential cognitive and affective processes. These are the six functional developmental capacities described above
I—individual differences in motor, auditory, visual-spatial, and other sensory processing capacities.

R—relationships that are part of child-caregiver and family interaction patterns and which provide:

Ongoing nurturing support;

Orchestration of the specific educational and therapeutic elements incorporated in 1 and 2 above’;

Provisions of ongoing interactive learning opportunities geared to the child’s individual differences and current functional developmental capacities throughout most of the child’s waking hours (at an appropriate intensity); and

A balance between on-on-one caregiver-to child interactions and peer-to-peer interactions appropriate to the child’s individual differences and functional developmental capacities.

In the Developmental, Individual Differences, Relationships-based (DIR) approach, functional developmental capacities, individual differences in processing capacities and relationships embedded in the child-caregiver and family patterns are utilized together in clinical decision making to create an individualized program for a given child and family.

Screening (Functional Developmental Grown Chart)

If at any time during the early years (pg 39), a child experience a loss or lack of progress in developing long chains of emotional cueing—regardless of other symptoms—proceed to a **full, functional developmental evaluation**. Most commonly, the loss of lack of progress in developing a continuous flow of reciprocal emotional cueing is seen between 8 and 18 months of age.

Functional Developmental Evaluation

Developmental history

Observation of family patterns

Biomedical assessment

Review of current functioning

Observations of child-caregiver interactions

Reviews and/or observation of educational program and peer interactions

Assessment of auditory processing and functional language skills

Assessment of motor and perceptual-motor functioning

Assessment of sensory modulation

Assessment of sensory processing

Monitoring Development, Prevention, and Early Intervention: The Functional Developmental Growth Chart and Questionnaire

By: Stanley I. Greenspan, M.D.

“One of the most important components (pg 45) of a functional approach to intervention is for clinicians to initiate the interventions at the earliest possible time. Many children who are diagnosed between ages 2 ½ and 4 with autistic spectrum disorders began evidencing a subtle deficit in affective reciprocity and complex, preverbal, interactive problem-solving patterns between 12 and 16 months of age (Greenspan & Wieder, 1997) and by 18 months of age often are unable to engage in joint attention tasks, purposeful pointing, and early forms of pretend play (Baron, Cohen, Frith & Leslie, 1988).

Historically, clinicians (pg 46) have approached children’s development in terms of isolated areas, such as motor development, the functioning of the senses, aspects of language and cognition, spatial problem solving, and social functioning. When looking at separate areas of development, a child can operate at a relatively advanced level in one area (e.g., motor development), and yet have significant challenges in another area (e.g., language development). Although specific aspects of development are very important to identify and assess, it is more useful for monitoring purposes to look at the full range of a child’s functional developmental capacities and the way in which the child uses all her abilities together.”

*Clinical Practice Guidelines—Redefining the Standards of Care for Infants, Children, and Families with Special Needs (pg 13-19;45-46;
2000 The Interdisciplinary Council on Developmental and learning Disorders (ICDL)*

Infant Mental Health and DIR™

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“There are three essential aspects of intervention that are unique to family work that bind the principles of infant mental health with those of DIR™. The first one is a shift in how we do treatment. We used to focus treatment on individuals. The individuals reported their memories to us, and their observations of themselves, based on their experiences.

In all of our work in the DIR™ model, the Floor Time is focused on development through relationships. We see the relationships as the primary force, the central function in helping children to develop in all domains.

The second important shift in the way we do treatment is the highlighting of the importance of the individual differences and the constitutional and maturational patterns of a young child.

In the DIR™ model, the “D” is for Developmental, and the “I” is for the individual differences, so two-thirds of the model are about the importance of these individual

differences in the baby. In the DIR™ model we have an emphasis on these components and a well-articulated process and structure for observing and thinking with caregivers.

The third shift from the traditional psychodynamic therapies that focus on representations and earlier experience is the use of representation in the service of what we witness as real-life interactions. Now, we're treating the family members in the moment of a heightened emotional climate. Floortime provides a way of making a stage set for real-life interactions

Through this process we begin to help them notice the nuances of small, interpersonal exchanges and to find the meaning in them to enhance the development of the relationship.”

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Mindblindness:

An Essay on Autism and Theory of Mind By: Simon Baron-Cohen

“Some people (pg 1) were aware of physical things but were blind to the existence of mental things. Mindreaders (pg 2) have the capacity to imagine or represent states of mind that we or others might hold. It is our natural (pg 3) way of understanding the social environment. Our mindreading (pg 28) fills in the gaps in communication and hold the dialogue together.

The other way in which mindreading (pg 29) is held to play an essential part in successful communication is in the speaker's monitoring the informational needs of the listener—that is, in the speaker's judging what the listener may already know or be ignorant about, and what information he or she should supply so that the listener will be able to understand the message. The speaker must monitor whether the meaning for an utterance has been received and understood as he or she intended it to be, or whether rephrasing is required to resolve ambiguity. A final sense in which language and mindreading are intimately related rests on the idea that language functions principally as a “printout” of the contents of the mind. Mindreading (PG 30) is good for a number of important things, including social understanding, behavioral prediction, social interaction, and communication.

Stern (1985) point out that an infant's control (pg 42) over its visual system is precociously mature, enabling the infant to make or break eye contact and thus regulate the degree of eye contact and the amount of physiological arousal that the infant can cope with at that time. Too much might be uncomfortable; too little might be understimulating. Since what constitutes a comfortable level of arousal is likely to vary from one infant to another, it makes good sense that the infant should have its own regulatory mechanism to control this. There is mounting evidence that infants have a drive to maintain an optimal level of stimulation (Maurer 1993). Furthermore, as all parents know, infants and toddlers love to play peek-a-boo, which is all about occluding

the eyes and then revealing them. This innocent little game may be quite important (Bruner 1983).

The Theory-of-Mind Mechanism (ToMM)

ToMM (pg 52) is a system for inferring the full range of mental states from behavior—that is, for employing a “theory of mind.” The first thing that is still needed is a way of representing the set of epistemic mental states (which include pretending, thinking knowing, believing, imagining, dreaming, guessing, and deceiving). The second is a way of tying together all these mental-state concepts (the volitional, the perceptual, and the epistemic) into a coherent understanding of how mental states and actions are related.

Regarding ToMM’s first function of representing epistemic mental states, Leslie’s suggestion (Leslie and Thaiss 1992; Leslie and Roth 1993) is that ToMM processes representations of propositional attitudes of the form. Around the age (pg 54) of 18-24 months (Leslie 1987; Dunn and Dale 1984) the mental state “pretend” is probably one of the first epistemic mental states that young children come to understand. Second, from 36 to 48 months, children show evidence of understanding additional epistemic states, such as “knowing,” and demonstrate that they understand the principle that “seeing leads to knowing” (Pratt and Bryant 1990)”

Baron-Cohen, S. (1999). Mindblindness: An essay on autism and theory of mind. Cambridge, Massachusetts: MIT press.