11

Sharing Mindful Talk and Understanding

The following are guidelines in gathering and sharing information in response to an identified need. Since communication is the *heart* of understanding, then the content of a conversation may be likened to its *mind*. It is necessary to focus on the broad scope of where a conversation is going while selectively taking in each part at one level, and consciously processing to the next.

The Developmental/Contextual Health Assessment – First, determine the developmental foundation of a child and his or her family, then suggest ways to build upon the existing levels. The assessment becomes a process of discovering the balance between risks and protective factors embedded in the child's niche and uncovering his or her level of developmental experience. While some learning and language deficiencies may stem from a disordered brain, with many disorders and conditions, which are biological resulting in psychological responses of distress coming from severe insults and mismatched within an environment.

Stress and Trauma – The negative impact of excess stress and trauma on relationships, thinking, and other developmental levels can be significant. Both secure attachment and a person's development of critical thinking are very sensitive and vulnerable to stress and adversity in the social environment. Life is naturally unpredictable, and presents many challenges and losses, ups and downs, and periods of grief that often trigger resentment, disappointment, fear and anger. Much of biology and psychology stem from the social environment, and much of psychopathology and secondary impairments of genetic disorders have their origin in losses, abandonment, fear, rejection, victimization and powerlessness. Severe stress can actually impede brain functioning; however, recent research findings provide hope that such neurological deficits can be modified by promoting optimum experiences.

Coping – Much of a person's mind includes a brain, subjective life and experience, and skills in coping and adapting. Thus, the mind is a healing machine. Illnesses, breakdown and congenital catastrophes happen, but generative assets are available in the mind within given contexts or optimal spaces. The mind's healing process is dependent on new connections and pathways that can be formed in the process of life.

Stories – Individual perceptions differ, but perception can be altered by new interpretations. Coping abilities based on newly-acquired perspectives and interpretations are critical. Healthful reactions to individual stressors can greatly assist a person in dealing with life's problems. Coherent and self-expressive narratives using such language as is promoted through therapeutic storytelling, can modify pathological progression. The grist for a story comes from what the family says at a distance from the problem, when the problem has less influence on their lives. They may talk about times, beliefs, events, thoughts, feelings,

actions or ideas outside of an awareness of a problem's influence. These subsequently become openings for discovery of new and different stories. Such alternative stories often uncover competencies, commitments and skills to solve the very problems. Articulating these new stories assists people in reconnecting with their preferences, hopes and ideas. Eliciting and identifying a client's skills and abilities through alternative stories will likely modify the client's physiology, as well as affect and improve his future functioning.

Example

"Revising the Story"

After we attuned ourselves with the family through many conversational exchanges around the family's values, interests and significant experiences, we made discovery of the family's background and history through many valuable contexts. For our practice, we have reduced these multiple areas of influence down to eight areas from which we draw both understanding of the problems as well as strategies of seeing them as related resources and assets. Taking the role of an ethnographer, questions are asked for gathering information as well as for generating a new experience from the interchanges. These experiences regard interaction between the demands of the social-emotional environment, as well as that of the physical environment.

As we surmised, the EK family was under a great deal of stress and conflict in coping with both parents' previous life trauma, such as abuse, loss, violation, current remarriage, conflicts, job stresses, bills, medical bill collectors while having no health insurance, hassles from school and numerous moves. The measured stress was 10/10 with a coping effectiveness gap of 5/10. We asked Ella to give a name to all of the trauma as though it was a plot that was driving the conflict. She thought of "down-and-out feelings". We encouraged her to describe the impact of these feelings on her life, and she tearfully expressed her sense of being gobbled up and depleted, being unable to express her desired lifestyle, feeling criticized by teachers and feeling shamed. The ***Relative Influence*** *questions were seen as a way to map the influences of the problem as well as measure the impact of Ella's life on the problem. We externalized or put the problem outside the person so that the whole family could position themselves together against the "oppressor" or the problems. We wanted to open space with examples of unique outcomes where events from the past, present or even the hypothetical future might be found as exceptions to the problem to levy against oppressive forces. The question was asked, "So in the last week or so, the conflict continued, but were there times when some hope was still around? What ideas, habits, or feelings came to perhaps supplant some of the problem? What about times when arguing could have pushed you further into "down-and-out feelings" but didn't?" Such exceptions seemed to connote continued commitment to the marriage, taking the initiative to look for help, and continuing to keep up some good times together.*

In revising a problematic situation, it's important to seek out special moments called sparkling events and fill in details from various sensory modalities. For example, questions could be asked such as, "What was the situation when you first decided you needed help?" "Where were you?" "What was the first step you took?" "Was there someone in your mind who encouraged you?" Remembering an example from an earlier "crossroads experience" often brings forth a similar example to "thicken" the present event wherein you reached for help. Such reviewing and researching of memories gives a richer story-line construction and development aside from the problem story, where Ella now sees herself more in control, and better knows what to do as an active agent in enacting a more preferred pathway.

Of course a story is more than just what happened. After eliciting the "what, where, when, and how", we are interested in assessing the more personally-subjective opinions of the narrator and by reflection in bringing forth new meanings from what was performed. This aspect of re-storying explores making new sense of the actual lived experience in relation to one's purpose, desire, preference, motivations, thoughts, and feelings. Ella's actions now magnify more of her life, who she is, and her sense of identity as a wife, mother, sister and granddaughter. Such questions of story meaning and identity might include, "Having made this happen for you, what does this say about your hope for Adam?" "Now that things are a little better, what about renewed confidence for the future?" "Where does this take you now?" "Acting on this decision the way you have, what does this say about your commitment to keeping the family together?"

Solutions-focused interventions are another practice we use to transform newly discovered strengths and assets into something more compelling and richer for our clients. We present this now, after the restoring phase, because it is still a part of collecting information in a way that converts problems and deficits into needs and eventual goals. These goals are defined by alternatives to the problem and what people do instead of focusing on the problems, in finding ways to start dealing with the realities so that the client can become useful in managing and coping with them. We start taking a solution approach right away so that by the time we are actually writing goals in Part III, preparation has already been devoted in defining the goals in measurable, specific and concrete ways. A brief introduction with references for getting started is included in the appendices for this section. Much of what Solution-Focused Therapy is, has given us important ways to convert a pathology-based approach to something more life giving, motivational and sustainable. ***[Click here for Utilizing Focused Brief Practice as an Assessment for Intervention, Appendix A]***

Protective Factors – With a holistic and comprehensive approach, we look into each of the eight levels of historical experience for complementary strengths, talents and exceptions to disorders. If done appropriately, resilient resources are found, and old stories are re-told in a newer, more encouraging way. And, though the disorder may persist, its effects may begin to become background with new adaptations from the client's own arising foreground experience.

-Eight Levels of Transactions-

The following are a few questions on critical developmental levels to ask the child and family which include links to our philosophy. On one end of the spectrum is the child with his or her constitution, maturation and temperament. At the other end are the family and community. But all are within the context of the child or client's genetic and cultural heritage. The development of the child and the child's mind comes from both his or her chemistry as well as the socio-cultural environment. Energy and information flow both ways and each part affects every other part. If we make sufficient interventions along the flow, we achieve positive outcomes.

In one of our examples, Adam's parents got right into this by completing a 1-10 *Assets* questionnaire which includes the above (Eight Levels of Transactions). The parents give him plenty of credit (7/10), but in the areas of *physical and temperament reactivity*, he gets a score of 0 or less than 1. The helpers completed a more holistic and interdependent 1-10 scaled version, and felt the same way. Our experience is that when comparing these two evaluations, we see a remarkably close assessment of child-environment features.

[Please click on *Child Assets Scale*, and *Parent Summary of Child Health Assets* to view these forms, Appendix B and C]

1. Physical and Bodily States. Conventionally, this describes what is understood as health today, but is quite different from our view when working with complexity. Our Euro-American culture takes a narrow view, assuming a biological objectivism that reduces health and medicine to an excellence at "fixing the plumbing and reassembling the wires." On the other hand, ABLE uses the ancient meaning of health, *e.g.,* from the Old English, "haelth (heal)," which is broader and subsumes the collective and systemic as well as the biological and medical. The ABLE health provider uses a biopsychosocial-cultural context that connects bodily states to social and cultural narratives.

A genogram may be helpful to elicit genetic conditions in understanding how family members get along with each other over generations, and to learn the dates of family historical events. Pedigree sketches show squares as men and circles as women. Horizontal lines indicate marital and parent-child relations. Dates of marriages, separations and divorces are written above a slashed line. Many themes of experience as marriage, death, birth, graduation, losses, illnesses, roles, and resilience can be noted. These patterns can give insights leading to changes in attitudes and beliefs. Old and renewed stories can be told, and family trees then become a powerful way to explore these systems and improve understanding of people, things and events. *[Click here to view a genogram, Appendix D]*

Some questions asked from this particular genogram include: "What are the patterns of uniqueness, belonging, power, and role models in the family?" "Who are the heroes, heroines, as well as possible scapegoats or 'black sheep'?" "What about employment, career, academic performance or financial success?" "Where might we find traits of leisure or

hobbies?" "Can we find evidence for spiritual expression or other religious identity?" "Who might be regarded as sick or ill or with alcohol or substance use or mental illness?" "In spite of these afflictions, who seemed to bounce back and deal a winning hand in spite of the odds?"

It is appropriate here to have a nurse obtain the weight, height, head circumference, blood pressure and pulse of the client, and to chart them on a graph to show the child's stage of growth. [Click here on *Nursing Checklist and Child Development and Family Life Experience* (ABLE), Appendix E] to view these forms. [Click here on *Pediatric Assessment, Guidelines for Physician Evaluation* (ABLE), Appendix F.] The Nurse may also be available to help summarize, assess needs and act as a liaison among many possible health providers. He or she may also facilitate an *Individual Health Care Plan*. (See part III, appendix E)

The following are reminders of some of the biological systems we attempt to assess in evaluating special-needs children. This may be most helpful for the "health" person consulting with the team.

Growth and Hormones: Short stature and failure to thrive, growth failure, prematurity, small and large for gestational age puberty, and systems review. Possible pediatric referrals for screen: U/A T4/TSH, Lead, CBC/Diff, IGF-1, IGFBP-3, Bone Age, Lytes/BUN.

Unusual Physical Features: (Beyond family resemblance): small head, skeletal, spine, face, limb, especially hands, and skin abnormalities. Genetic syndrome. Pediatric referral. Fragile-X. Fetal Alcohol Syndrome.

Neurological Status: Responsiveness, strength, coordination and balance, tremor or tics, vision and hearing, headaches, head injury, seizures, and cerebral palsy.

Mental Status: Orientation, arousal, alertness, over/under focus, mood-anxiety, thoughts, feelings and behaviors, suicidal/depression, perceptions or hallucinations, memory and speech.

Autonomic Nervous System: Regulation, gas, constipation, sweating, flushing, belching, drooling, arousal, attention and diurnal rhythms.

Immunity: Sickness*es,* regressive coping with stress, fever or rash, hospitalizations, allergies, rheumatoid symptoms, and other immune diseases. Are immunizations up to date? What about school attendance? Is there herbal use?

Confirm Nutrition: Appetite, eating from a variety of food groups? Chronic vomiting or diarrhea, food sensitivity, obesity (weights, lipids and cholesterol, pulmonary function, apnea, BP) calories, mid-morning and afternoon snacks, breakfast, water bottle on desk, multi-vitamin supplements and special diets.

Bodily Functioning: Dental (brushing, preventative flossing, flouride,) toileting, sleeping (apnea, disruption), enuresis, encopresis, energy, activity menu, vitality, stamina, safety habits, exercise, stress control, relaxation, meditation and yoga.

Medications or Herbal Preparations: These may either help or interfere with learning. Consider what the benefits vs. side effects might be? *(Click here for web address on medical interventions. And discussion of team management of children's psychotropic medications under "Muses on Medication", under* ***Special Topics*** *in the Web Menu).*

Presence of Medical Assets: Health provider, health insurance, and a possible school health plan.

Chronic Conditions Screening: Diabetes (control, HgA1C, fasting Sugar, oximetry), allergies, asthma, accident-proneness.

Exposure: Drugs/alcohol, sex, violence, or harsh discipline.

Summarize: How do these medical/physical features influence other levels of functioning?

Adam's early history confirmed premature smallness for date of birth as described above. His early history evidenced difficult temperament with dysrhythmia in biological sleep and feeding rhythms, high activity, intensity, and slowness to warm up. He seemed sick a lot as an infant with otitis and asthmatic illnesses. He has always been a picky eater and worrying his mother. We had to keep encouraging her by showing her his current growth chart with height and weight being exactly in the middle—demonstrating how well she got Adam to grow. Vision and hearing were normal, and in fact, he heard too well, being sensitive below the 0 baseline and was distressed at spoken sounds above 70db. There were all those doctor visits paid for out of pocket (no insurance), and vitamin drops. Mother liked Valerian drops (herbal) too for soothing him from time to time.

It was pointed out to the mother how well she and her husband had both helped Adam. "You have worked together. Dad has worked hard to earn the money for food and doctor appointments, and you have prepared well and taken him to the appointments."

He was immunized and eventually was well with a sense of vitality. Too much so! Along with a family history for ADHD, Adam was also impulsive, distractible, and hyperactive. We actually felt he had mixed attention disorder with a bit of over-focused periods—making transitions hard and exhibiting some anxious OCD features. These were further explored with the school's contribution later.

2. Somatic and Sensory-Motor Experience (Temperament and capacity for self-regulation).

Sensory Maps. We must assess the way the body organizes itself into sensory and perceptual systems with underlying precognitive and motivational tendencies, because this comprises state of mind. The body processes the elemental experiences at organismic levels before integrating them into whole gestalts and larger schemas. This physical processing forms neuron maps in which outputs are assembled digitally into motor ideas, and thus praxis or planned motor output is achieved.

An Occupational Therapist (OT) or Physical Therapist (PT) may help assess the integrity of the motor-sensory system, including motor planning and sequencing, in order to accomplish goals. The OT/PT may also assess strength, activity, tone, coordination, fine motor skills and posture. In addition, the OT assesses the sensory-processing system, its sensitivities and soothing capacities, and its regulation or modulation of the system to attain a calm, alert state. Some of these dimensions include tactile, visual (acuity), proprioceptive, vestibular, auditory (hearing, sensitivity, processing), taste and olfactory elements.

Self-Organization. Self-regulation is reflected in sensory-motor strategies to achieve and maintain an organized and regulated state in dynamic situations. Arousal, alertness and attention are on a continuum with basic arousal and alertness at one end of modulation, and attention and curiosity at the other end. Some children fail to orient and have poor registration and under-responsivity, and may be sensation seeking. On the other hand, some children may over-orient with over-sensitivity to fight-or-flight, or may be avoiding sensation with freezing or sensory avoidance.

Temperament. The attributes above, along with individual differences, suggest a child's temperament, or learning style, which is a constitutional quality of the favored ways the child responds to his or her environment. Temperaments include innate attributes such as high or low activity, intensity of mood, self-control, adaptability, threshold for being ticked off, persistence (or single-mindedness) and regularity of such physical functions as sleep and appetite cycles. These constitutional features are precursors of nature and personality, depending on how the environment reinforces behavioral styles. "The Sensory Profile" (1999) by Winnie Dunn, *The Psychological Corp.,* is an excellent scale to evaluate traits of sensitivity of touch, smell, movement, vision and hearing. It describes low-tone, low-energy, sensation-seeking and over-responsive children.

Direct Experience. Concentration on what one sees, feels and hears tends to embed one in direct experience, which offers better coping and managing of extremes. "The Out-of-Sync Child," by Carol Stock Kranowitz, is about sensory processing disorder, includes many interventions, and is popular with parents. Specific experience supporting these physical foundations potentiates developmental progress, the origins for Erikson's early stages, and Piaget's sensory-motor and circular reactions, which elicit ideas and early emotional thinking. The sensory experience is lived in the moment, in the here-and-now, although it is fragmentary and fleeting. The ego and self are intertwined in the experience. Thinking may be magical and disjointed, as it includes impulsive and inattentive thought or sensory streams. Although focus is on bodily and sensory explanations, it is recommended to ask questions about meaning. How does the client make sense of these experiences? Logical, sequential thinking comes later when, in story-fashion, you speak about what happened.

Finally, *Goodness of Fit* becomes the bottom line in this part of the assessment between Adam and his social and physical environment. The worker might ask himself, "What is the match between the client's sensory motor characteristics, biological rhythms and individual learning style, and the environmental demands made upon him by his parents, teachers, and physical requirements? Before any clinical conditions can be diagnosed, hunches, observations and descriptions of his bodily reactivity are required, as well as understanding about what's required by those around him. What is Adam's adaptability in negotiating these constraints? We have seen problems almost dissolve since last year, solely due to the greater congruence between the child's temperamental style and those of the teachers at this time.

Team member: " It is important that Adam's way of learning is understood by all of us."
Parent, "Oh, now you are telling me he has even more problems. We have a noisy house and now I find out that that bothers him."
Team member: "I can tell you are growing in understanding Adam's unique and individual needs."

3. Attachment and Engagement. A child's ability to discover the world is dependent on healthy relationships with family caregivers, siblings, peers and teachers. Psychologists and social workers make assessments of the degree of security, comfort and safety of shared relationships, which are primary. The attachment behavioral control system is biologically based and strategic——motivating us toward survival and protection of our evolutionary heritage. The system consists of protective and nurturing behavior from caregivers in response to signals from children, which include vocalizing, smiling, crying, yearning, and approach behaviors.

Disorders. For some children, developmental conditions and their secondary psychiatric sequelae interfere with attachment security and with the child's achieving proximity behaviors. Professionals ask about the three basic attachment functions: *proximity, seeking a safe haven in stressful, dangerous situations, and having a secure base from which to explore the world*. Attachment disorders include the following: *having no attachment status (rare); indiscriminate and inhibited attachments; and aggressive-angry and role-reversal types*. Some of the behaviors that express these syndromes may include: *showing no or little caregiver preference; accident-proneness and recklessness; lack comfort-seeking; no boundaries, dysinhibited; anxious-clingy; non-compliant; oppositional and over-controlling; and ignoring and avoidant.* These latter characteristics may be a part of "secure-base distortions."

Righting of Disruption. The question of whether severe early deprivation and disruption can be overcome depends on its duration and severity, as well as the age and developmental level at which deprivation occurred. It also depends on external resources, understanding attachment resolution, the availability of emotionally sensitive caregivers and caregiver support. There is strong biological pressure to alleviate disruption and form multiple attachments. Recent research suggests a category of "earned secure" status. Examples show that after intervention by healthy caregivers, distressed, anxious and attached-disordered

children may gain a secure outcome. We contend that a child's attachment security can change from anxious to secure by inclusive practices, nurturing transactions and support over time. Primary and secondary caregivers (important extended kin, teachers, and mentors) can accomplish this through constructing alternative, coherent narratives of meaningful experiences with the child. Cooperation in dialogue means defining a coherent narrative. This can be done by fulfilling Grice's maxims of quality of truthfulness, namely, having evidence for what you say with sufficient examples, being succinct in quantity, being complete in relation to the topic, offering enough information and, finally, speaking understandably, with order and clarity through time.

Predicting Attachment by Telling Stories. Since we all listen to and tell stories, assessment of attachment is a responsibility of each team member, as a hunch or a feeling from our own attachment experience may come to mind. Some questions from the *Adult Attachment Interview* are offered in subtle ways and may predict the secure attachment of the offspring wherein parents narrate coherent texts about their own lives. Such non-probing questions may include: "Give me five adjectives to describe your relationship with your mother as far back as you can remember." "To which parent did you feel closer, and why?" "When you were upset or sick as a child, what did you do, and what would happen?" "Describe significant separations from your parents." Ask questions about rejection, threat, illness or loss. "How did your certain experiences influence your adult personality, or cause setbacks?" "Why did your parents behave the way they did?"

Out of these hunches and questions, four categories of attachment may come forth: 1. *secure*, (balance of avoidance and ambivalence in safety and comfort, with information processing in two modes), 2. *avoidant*, (avoiding closeness and emotional connection; dismissing, flat affect, with more logical, objective or reality-based left mode processing), 3. *anxious/ambivalent* (more anxiety, uncertainty, preoccupied, rambling, right mode, subjective processing) and 4. *disorganized*, (dissociation, freezing, fragmentation, unresolved fears, trauma). What best fits the child you are seeing? Are elements of other patterns overlapping? Can the child have a different attachment with alternative caregivers? Is contingent communication enhanced or hindered in the interactions?

Adam has an enmeshed style with his Mother, and an avoidant style with his step-dad. These can be described as adaptive forms of anxious attachment health requiring further accommodating for those working with him. The teacher and school psychologist are now secondary caregivers and have become important sources of security and help toward righting these insecurities. (different than last year where he felt so unsafe that he had to have a knife, and the typical responses were punitive.) Although we did not diagnose an attachment disorder, (only Reactive Attachment Disorder is available in DSM 1V), we did feel there was some disturbance of the secure base (anger, anxiety, ambivalence, and oppositional and controlling behavior). Attachment health is so important and can lead to much understanding of the case as well as attempts to stimulate "righting" toward an "earned secure" base over time with steadfast pervasive social connection, emotional acceptance with strong boundaries, and limit setting. This can be initiated with the child and fostered in the parents, providing the domino effect, if you will.

Team member: "It will help Adam feel safe if he has firm family rules and consequences."
Parent: "We have tried that, but he doesn't listen."
Team member: "Are the family and the family therapist working on making family rules?"
Parent: "Yes, we are working on his cleaning his room, but it is not going well."
Team: "What rewards does he earn….what is the cost?"
Parent: "Explain the program."
Team member (with gentle yet serious affect): "Every time you follow through with this program, each day that you give his consequence, you show that you care enough to be consistent, which is hard to do. This will help Adam feel safe, and that he can count on calm, consistent parents."

4. Social-Emotional Contingent Communication.

Wants, Desires and Preferences (requirements for a higher order of thinking and achievement). It is recommended that psychology, a language pathologist, a social worker and a health provider initiate inquiry into the strength of this function. We believe this aspect of attachment is a major feature to further developmental levels.

This level is a step above attachment and engagement, previously described. Now the dyad can engage in mutual, back-and-forth, non-verbal as well as verbal communication. Each responds to the other and gains the satisfaction of being heard, seen and felt. This process is enabled by having satisfied the other person's behavior-control systems of exploration, affiliation beyond attachment security, and in having a secure base. This acquisition enables an elaborate cooperative interaction to occur, involving two-way circles of communication. It is a mutual process.

We assessed the ABC's of Contingent Communication in the attachment mode as it applied to Adam. We looked for attunement, or the vital sense of the way he connected and engaged with another mind. Adam and his mother were very close, but over involved in each other's sense of separateness, which created angry eruptions. Attuned, back and forth exchanges seemed to be missing with his many interactions. A balance between the biological, psychosocial, and cultural elements all within his multiple states of mind suggested a sense of incoherence, integration and lacking in meaning.

Team member: "Adam, you're a growing boy with many interests. Does your family know about your interest in frogs?"(Team member smiles, beholding and admiring Adam.)
Adam: "Frogs creep my mom out"
Team member: "That's a way the two of you are different. This is a way you are your unique self, Adam."
Team member (smiling, and with direct eye contact to mother and child): "Do you have a place to go to see frogs?"

Mutual Process. "Goal-corrected partnerships" assure an admixture of minds between the child and the mother so that each shares and enjoys the other's determination and goals. Co-constructed and collaboratively planned ideas for mutual action come from more than one

mind. When the child heads toward his or her preferred pathway, although somewhat altered and modified from original plans by the mother, the mother too has an altered state of mind as well as a different outcome from the transaction. The child assimilates the mother's feelings and motives as well as having his or her own. This level is a lynchpin, enabling further relations, and having empathy as well as language horizons. Intention and inter-subjectivity—or the desire to experience the other--and early theory of mind is formed. Large memory structures take in the social, subjective experience and form a template for representations of intimacy and wellbeing, which are foundations for later milestones in development.

In summary at this point, with a much more concrete developmental level, and where action and doing are anxiously expressed, we see Adam making great progress. He is moving away from a less optimal fit between constitutional regulatory problems and maturational development, as well as from an early history that included harsh home and community environmental contexts. These latter conditions can interfere with integration of attachment and contingent communication dimensions—contributing to attachment distortions.

Click here for the *Child Health Assets* form)

Emotional Communication. Through a contingent attachment relationship, basic emotional and social needs are met, leading to themes of security, trust, acceptance of self and others, pleasure, a sense of control, empathy and shared power. These emotional themes are part of implicit memory processes and may initially be entirely non-verbal. These emotional themes are reflected in the child's face, body posture, tone, and gestures. Working memory is promoted. These emotions are also an energy system and so contribute to motivation, and also promote action.

These communicative gestures are multiple and involve long chains of interactive shared exchanges. These loops of sequential communication now start to depend on motor planning modules in both parties. This is a pre-language skill and is mastered before higher cognitive capacities are developed. They are the foundation for building interventions that promote readiness to master academic skills later on. We initially target self-regulation and control, cooperativeness, relatedness, confidence, curiosity and interest, intentionality, and capacity to communicate. These are the emotional themes and patterns upon which language builds. The child is now ready for language and symbol infusion—amplifying communicative ability.

Our focus on social-emotional strengths provides ways to get through the ordinary day, which is our way to embrace methods to connect children such as Adam to the "here and now". We offer several methods of inquiry, evaluated by the caregiver and helper, using the Daily Strength Scale (See part I). This scale was validated or confirmed by a similar instrument "How Well Do I Get Through the Day."(See part I), which the child filled out using his own perceptions. We matched fairly well around 7/10, higher than we thought, so in spite of assessed difficulties earlier, Adam was now seen as more functional through-the-day. The specific elements comprising coping, self-direction, relationships and creative play are elaborated fully on the Child Strengths Checklist (See part I), and are broken down into those categories. They are completed by teachers, parents, other kin and friends, and

eventually become the grist for intervention on the Family Health Promotion Plan (See part III).

Team member: "Let's look at what Adam said about, How Well Do I Get Through the Day. Is that okay with you, Adam?"(Team member looks at Adam seriously with eye contact and a questioning look.

Adam: "Sure"
Team member: "This says you are getting through the day quite well, and the Child Strength Checklist says you are good at creative play. You are getting stronger and more sure of yourself. (smiles at Adam and then to the parents.) And I notice you had said you had many fun things to do during the day. (smiles) Your Mother told us you were very good at creative play. Have you been creating some fun things since we last saw you?" (smile at Adam)
Adam: "I have made a Frog Play with my friends.
Team member: "There you go, now is that good creative play. I don't think I have ever heard of a frog play. What a good idea."
Adam: "Yes, I wrote and .....(expounds on his strengths).

A number of maturational concerns are now assessed, and we have diagnosed over-focused inattentional behaviors. Thereafter, once an alliance was achieved with the parents, they gave us permission to use a more appropriate stimulant, which clearly gave a jump start so Adam could begin to self regulate better and control his impulses. These several child-centered developmental infrastructures also give us a clear view of protection factors along with the established risks. These have been enumerated sufficiently in part 1A describing many interests and aspects of Adam's strengths and motivations, along with activities that rewarded him and helped manage his behaviors as well.

Team member: "I think now that your body is calmer, your good mind is shining through. I know your parents are proud of you. Who is most proud of you at school or with the Scouts? Have they been good at noticing you?"
Adam: "Yes, my Scout leader said I could work on a Nature badge for my frog stuff."

Although there were initially a number of interventions aimed at molecular and bodily systems, relationships, soothing and calming, to help Adam start to have academic success using his good cognitive potential, much of our thrust will now take on family, school and cultural intervention which is described in the last half of the eight transactional influences.

5. Mental Processes and Symbolic Representation.

Types of intelligence, such as Attention, Perception, Memory, Thinking and Reasoning, Visual, Spatial and Auditory Language, Non-Verbal Language, Executive Functions, and others are generally explored by a referral to Special Education, along with Psychology and/or Language consultation.

It is a miracle when everything in a human being operates as it should. It is difficult to believe we can be creative, use symbols, reason intelligently, invent new things, figure out problems, cope in effective ways, and survive—sometimes even thrive. Our potential is vulnerable, but also has powerful biological and innate origins.

Mind-Making. Once we feel secure, achieve self-regulation, and engage in nurturing two-way relationships in which we communicate our wants and needs, we can separate and further reflect and explore our world and create symbols. Symbols make up our thoughts and ideas in myths, stories, art, science, religion and humanities, and they represent our lives. We communicate ideas—expressing them by using gestures, images and pictures, play, music, words and numbers. We look, hear, feel, smell, taste and attend to our environment,, and perceive its precepts in objects, things and events. We learn by holding on to meaningful memories and by making associations and links to them with symbols. On the workbench of memory we see things again from a different view. We sort them out and reason them into new ideas and new meanings. In this way, our mind is formed, in part, from our brain, wherein information and energy are taken in and new knowledge and adaptive outputs are formed, making us who we are.

Conserving Functions. The child transacts through his or her biology and environment using emotional behavior, imagination, play, language, and emotional thinking all in the service of development. Higher levels of thinking and being also include the lower functions; therefore, exceptional abilities are constructed and conserved into newer forms of thinking and doing. Earlier emotional ideas (e.g., using dolls fighting each other) bridge to other themes (dolls making up and hugging) and, by using many circles of communication to express desires, a child negotiates the balance between pretend and reality, giving a coherent story to his or her unfolding drama.

First Things First. Traditionally, developmental science has made evaluations explicit, promoting standard testing that is separate from the whole person. Traditional developmental science assesses language, cognition, behavioral functions, and academic achievement, which has uncertain relevance to the unique life-space of a child within his or her family, community and culture. Clearly, the organization of life experience and learning abstract concepts can not come before building a firm foundation for self-regulation, curiosity and interest, attention, trust, engagement and intimacy, secure attachment, intentionality, inter-subjectivity, initiative, empathy, imagination and play.
*(See Child **Assessment,** web menu)*

Clinical Example:

So far the dynamic model we have worked from is exemplified by an interaction of multiple interdependent variables represented by the biology and strong evolutionary forces being influenced by the social-physical environment. The EK family, primarily profiled by mother and child through a case discussion, is characterized by many of these risk and protection factors enumerated.

Team member: "Do your parents know about your interest in frogs?"
Adam: "I don't know."
Team member: " Mom, did you know this wonderful energy Adam has around frogs?"
Mom: "Sort of. He talks about them and wants to have one as a pet—which would mean I'd be taking care of it."
Team member: "Well, I'm noticing how Adam's eyes light up, and he's so focused when we talk about this". Dad, with your enjoyment of the outdoors, do you remember when you were a boy and first noticed frogs?"
Dad says, "yeah", and smiles. "I liked them."
Team member, "So you like them, too. I see you are kind of like a frog: being good at moving and liking to be outside: like your own mom and dad also like to be outside."

To a degree, we have also discussed the impact of two-way talk in which salient aspects of the family are highlighted within a balance of foreground and background information and the back-and-forth dialogue is captured by our metaphor of the child developing within the family culture in transactional ways, wherein the exchange from both sides interacts contingently. Such is exactly how a conversation proceeds and changes what is generated and influenced by both mutual parties toward a surprise ending, though within the expected goals, and not necessarily ending or being defined unilaterally.

Our model also appreciates and gives vision to the growth and developmental nature of childhood, beginning at a level of physical and physiological growth. The model is circular with the elemental and more experiential linking up with multicultural complexity showing sequential and hierarchal growth. These early foundations describing Adam are built upon each other so that "higher" levels are comprised of all earlier "stages." Knowledge of these levels may lead to greater understanding where the child or parent-family may be located in the sequence and what interventions might be helpful. For example, Adam's regulatory disorder is described best within the first couple of dimensions, as it may also involve parts of emotional-communication at the fourth level. We envision the flow however to be bi-directional so intervention could be conceived within the environment and culture which may impact lower levels as well as directly focus at the child's physiology and attachment dynamics.

6. Family Functioning and Shared Story-telling and Enactment.

Healthy Functioning. Children grow and develop in family groups that have broad diversity in composition. If our parenting is only good enough, our children will likely survive with a variable quality of life. However, if the transaction between children and families is closer to optimum, mostly satisfying daily needs, with healthy family function, satisfaction of economic, domestic, recreational, spiritual, socialization and self-identity features, then children may gain resiliency. Our hope is that children will have outcomes that include wellbeing, security, affection, acceptance and understanding, as well as boundaries, confidence and a sense of discipline in their transition into the larger world. What more could a parent ask? Experts from teams with experience in this area must surely include the family itself: parents, child, siblings and extended family. The school may also have a social worker

or other family-oriented social science worker who can mediate and elicit a family's preferences and desires. A family advocate representing community support might also be called upon.

Infusion of Multiplicity from Higher Sources. The family funnels biology, genetics, physical health, culture, customs and norms to a child. It comes together from either a traditional two-parent family (70% of the U.S.) or alternative social groupings composing of step- and blended, bi-racial, gay/lesbian, single, grand-parented and other families. A child's development comes from these social-cultural systems. More complex contexts or social groupings likely establish additional niches that may stimulate development beyond the usual dyadic care-giving to other levels of caretakers in the group, and to triadic levels from varying parental-sibling-extended family sub-systems. Additional relationships contribute geometrically to non-shared experiences and affect the way stories are organized at family levels.

Several remedial family interventions were tried following enhanced motivation. The voices of Adam's parents were heard regarding his safety and protection in going back to school. Thereafter, many resources opened up for him which enabled buffering of the realities of his home. Further outreaches from school temporarily offered a lynch pin, as usual sources of help would have come from mental health, couple counseling, career development and parent skill-building. (See Health Plan—part I11 and 1V) At times, it is necessary to mobilize less desirable formal support systems, including the school, health department, housing, workforce services, etc. to jumpstart critical care areas until informal extended family and friends can be organized, while the others can hopefully be weaned off. We identified a minimal family network as well as a reluctance to depend on state agencies, due to the strong sense of family self-determination.

Team member says: "Adam, now that you are becoming more focused at school and learning your math in an after-school program, I wonder if you and your brother could help remind each other to do math at home. If the two of you work together and finish your math homework, what could be a reward each night for the two of you?"

Day-to-Day Communal Stories. Family stories are concrete and describe everyday reality--what, where, when and how--with emphasis on action. When stories are told in fellowship, they are valued and shared. Stories are drawn from life's multi-faceted backdrop and, in retelling, offer children significant advantages in understanding the world. This narrative process is like the lens of a camera: family stories select and focus on specific content while filtering less-meaningful experiences. Stories draw from formal and post-formal developmental thinking and shape a person's perspectives. Family stories shape life differently for different family members.

Return to the Attachment Narrative, which becomes the Family Narrative. Physical and psychological wellbeing is supported by the social environment, as well as secure attachment, which is manifest in coherent narratives. Such narratives are truthful and have credibility. They are succinct, yet complete. Conversations are relevant to the topic at hand and are clear and orderly. Shared family stories that lead to action will promote a child's

development toward greater logical awareness of experience, and will organize experience in the concrete of the here-and-now, offering a simple causality and problem-solving approach, as well as the beginning of empathy-building.

Family stories co-enacted through members during intervention are transformative of older, marginalized stories of the individual members independently trying to shape their own destiny by pulling themselves up by their own bootstraps. Coherent and integrated stories told by family members ultimately have health-related outcomes supported by attachment-related research literature. Getting a family to revise their accounts has a life-giving effect. Systematized case management, with the coordination of helping community agencies, has been able to help move thinking from pre-operational or magical-egotistical thinking to more concrete strategies, then on to more relational, reflective and flexible coping.

Father says: "We have always been a family with many hardships. I never learned to read. I flunked out of school and the school didn't care."
Team member: "Look how you are changing this story for Adam. You and your wife have cared, have worked with the school, and have cleared the path for Adam's success."

7. Meanings from School-Achieved Sense of Self.

School experience creates new meanings through accomplishment and successful management of the peer experience. The school encounter is a source of formal, abstract and reflective thinking and feeling resulting from the attainment of a sense of self. The team is augmented by the child's teacher and, perhaps, other members of the school's various interdisciplinary groups. Many groups we participate in have included the school principal who takes responsibility in assuring positive outcomes for his/her children and their families.

Child's Personal Experience. Paulo Freire says, "Teachers should attempt to live part of their dreams within their education space." A classroom can be a space for hope, where students and teachers glimpse the more perfect society that is possible, and where they gain the skills needed to make social improvement a reality. Children have an innate curiosity, sense of wonder, and a capacity to learn that is closely related to their unique experiences. What is taught should come from personal experience in order to promote reflection and self-awareness.

We seek ways to transition children from home to school. Although the family is a collective resource for early development and will always exert strong influence, it will many times yield to the impact of schools where dominant cultural values prevail. Value conflicts, peers and alternative interests will come between family and child. The first day children leave for school they expose themselves to new ideologies, to peers with different expectations, and to different systems of conflict resolution.

Dealing with a Complex Environment. A child has to cope with much. Consider a child's multiple settings: walking or taking the bus to school, the school halls, playground, lunchroom, classroom and the library. Then he or she goes home again. The mini-settings in school are also various: seatwork, teacher and peer-directed groups, recitations, sharing time, independent work, computer time and worksheets. Following rules and transitions for all these settings, tuning out countless distractions, being aware of who is top dog, and

negotiating social hierarchies and gender issues are quite a feat.

We expect kids to show up for school bright and spunky, and we expect them to be punctual and prepared. They must have their homework finished, have pencils and a daily planner, sit still, and keep their hands to themselves, except when raising a hand to give a correct answer. They must be intelligent about reading, writing and arithmetic, have friends, but don't push or shove, and ask for help yet don't rock the boat. Above all, they must protect their self-esteem from taunting and humiliation. Mastering these extraordinary demands has a significant effect on developmental milestones.

Life's complexity increases for children as they grow older. They must adapt to puberty and major physical changes. They may encounter gender stress, racial and ethnic differences, peer stress, mood-altering substances and sexual activity. If they are disabled or have a health condition, they especially need substantial support at this time.

Accomplishments. Besides the major task of achieving social and academic competence, other school-developed accomplishments include higher problem-solving skills, decision-making, development of an internal sense of control and positive self-concept, orientation, morality, handling multiple choices, and a higher sense of empathy. Successful experience with and mastery of these tasks are great milestones. Developed levels include: greater causal and attribution thinking with less black-and-white literal concreteness, understanding from greater reflection, and being able to stand apart from a situation and separate feeling from thinking. More of a sense of self is achieved by seeing one's self in relation to a problem, which allows development of formal operations, and seeing patterns by observing similar behaviors over time. Comparisons to others are sometimes painful, but they help develop an internal sense of measurement and standards. Later, school development forms personality and a sense of the future, including goals, occupation, a sense of independence, and deepening intimacy. Many of these tasks are social, related to self-development, and not necessarily academic.

Accelerated Development. To sum up the crux of the matter, the school experience broadens a child's roles and expectations by integrating successful coping with the demands of a precocious culture of new lessons, skills and knowledge, while bringing an influx of friends and family-school interfaces. All of these experiences create exposure to more sophisticated multidimensional realities and encourage rapid development. Cognitive and social capacities are experienced earlier with abstract and formal abilities unleashed at a younger age.

The optimal school experience shapes not only an achieved sense of self, but consolidates other self-determined needs of creativity, adequate coping, feeling worthy and having a sense of bodily intelligence in relation to the social aspects.

The goodness-of-fit between the school environment and the child, in other words, the balance between school demands on the child and what the child can give, determines the child's success. We must witness this goodness-of-fit, or lack of it, and stand with families who make requests of the school. Better goodness-of-fit can be accommodated with support for higher expectations, extra help, mentoring, incentives and rewards, opportunities for

recognition and responsibility, connection to a caring person. Other help for goodness-of-fit include providing alternative ways to achieve, alternate protective factors supporting positive development, encouragement of hope and a sense of importance, as well as preventive options for promoting stress-resistance.

Clinical Example:

*A premise of our work is that screening for **protective factors** and resources as well as risk-**reduction strategies** within the school environment highlights our belief in the cultural knowledge of the community and school, distilled through a healthy receptive family, can mediate established risks in the child. EK's family experienced high stress from realities of a poor working class, economic pressures of low income, budget problems, a lack of health insurance, and unresolved past traumas. The result was depletion, strained relationships, and shame-based functioning. Although at the same time we saw a strong commitment, endurance, legacy from past generations, spiritual orientation, a sense of humor and willingness to ask for help. See previously "Tell us about the influence this has played out in your life."(part I) See also "School Conferencing" in part III.*

Mother says: "Our family came from Europe being poor. Things have always been hard and we have done it all on our own. "
Team member: "Given that past, it is so impressive that you are hard working and working with the community for your son."

8. Multiculturalism and Relational Identities.

Thinking About Culture in Two Ways. Culture is the total of who we are. In its abstract and largest sense, culture is a universal template for a body of people's methods for coping and figuring out the world. Culture helps people understand themselves and others, and it is thought that if we go by our culture's rules and assumptions as we grow up, everything makes sense. Culture gives coping skills that satisfy the need to acquire resources. Culture imparts customs, norms, patterns of thinking, behavior and learned prescriptions for identification with a group. Culture defines problems and specifies solutions to them.

In its most personal way, culture is funneled through families and temperaments—giving us our own stories and creating our individuality. Singleness of agency is part of that identity. Identity is likely constructed from multiple social sources and is much influenced by context and changes in its facets. The ABLE Program model takes an inductive, ethnographic approach to determine the impact of culture on family. Our approach is bottom-up. We do not stereotype cultures onto people and impose exotic universal principles from top-down. We prefer to help people draw forth their own preferred cultural life-stories rather than to adopt oft-repeated, problem-saturated stories from a predominant culture.

Culture-Centered Stories Integrate Levels. Culture-centered narratives bring together various developmental experiences of biology and body awareness linking family, school and community. We seek ways to draw all layers together with multiple levels of information processing. We may ask a patient for an image at the sensory-motor experience level, or

draw out a story through a concrete, linear narrative. We work on reflection and the way a patient relates to situations with thoughts, feelings and actions, as well as the way the patient relates to multiple issues within the context. A culture-centered treatment and family plan comes from this involvement, which results in seeing patterns from family and culture of origin and finding new meaning from several points of view. We add community resources as dialectical systems to integrate a plan that includes support for sensory-physiological concerns, medication, relaxation training, a cognitive behavior plan for distorted thinking, and reflection on information about a problem on the patient's sense of self.

ABLE also takes a position that culture is not unitary in its expression. Culture comes from many sources: ethnicity, race, gender, class, age, ability, religion, language, nationality, family history, education and occupation. As multicultural beings, we define our roles in relation to all that we experience, which contributes to the whole question of who we are. Of course, we continue becoming who we are as our stories unfold.

Cultural Competence. Multicultural assessment becomes sensitive and competent by using tools and ideas from developmental and family-systems medicine, as well as from social-constructionism and language-determined systems. These tools provide proactive ways to unpack the dominant cultural discourses and to re-author the parts back into a whole that is more in keeping with the world of our multicultural patients. Competent assessment practices include knowledge and respect for other lifestyles, including healing folkways and their practitioners. We must also be aware of our own Euro-American culture, especially its subtle and covert misappropriation of power and prejudice (racism). Sometimes we oppress out of ignorance. For example, sometimes our ethnocentric beliefs assume the relative superiority of our ways of life, which leads to the assumption that our beliefs are good for all. Be aware of the tendency to stereotype and prejudge people. Learn the secondary mal-effects of cultural diffusion, which is when two cultures meet in unequal contact, there is resulting acculturation and cultural loss from the minority client's perspective. Awareness helps circumvent exploitation and injustice and helps find respectful ways to render assistance. Examples of cultural sensitivity include asking how the patient understands a given problem and how they would solve it in their own culture. The truth is, a helper can't know all the cultures of the world, so transparency and humility is essential. Ask the patient to tell you what solutions they see. Other culture-centered ideas include: family networking, case management, communal teams, balance in confidentiality, consulting an ethnic resource, using outside witness groups, working with a religious leader, seeking ethnic health remedies, suggesting ceremonies or constructing rituals, applying the power of music and dance, and suggesting a genogram. Some of these ideas may elicit family support and community activities.

Seeking Fitness Again. Additional mutuality between parties with dialogic and reflexive two-way thinking brings out many perspectives. Diversity is systemic, multiple and complex contexts, with many storied accounts and an acknowledgment of other voices. Relational thinking stirs co-construction of vital understanding.

Coming from our biological-environmental and cultural transactions, the dialectical processes of reciprocity and mutually respectful turn-taking helps sort out and select

elements that offer the most advantageous solution. Good fit leads to novel adaptabilities and alternative identities, new levels of agency and renewed power, reconnection, appreciation for contexts, new awareness and consciousness, and a sense of coherence, vitality and wellbeing─all of which serve to enhance developmental progress.

Clinical Example:

Originally, when the idea of multiple contexts was brought forth from the work of Greenspan et al., Ivey and O'Hanlon and Bertolino, (Constructvism, Developmental Therapy and Ericksonian Therapy) the intention was to enumerate a variety of contextual influences, all of which moderate their effects on each other. We hope we have described Adam's different settings which have multiply contributed to his progress and development. There is greater credibility in this idea of multiple causality in understanding what happens to him, as well as likely many solutions in helping him. Seeing many solutions to a single problem. (Different than the prevailing medical mode.) Single cause and effect thinking leaves open the child-EK family to be embedded within the person with having oppressive politically dominating consequences from society──centering blame and guilt within the self, whereas it should be situated in the problem, with its source in the larger culture.
Examples of this abound in the many "isms" around children, they to be seen but not heard, so called economic truths of pulling yourself up by your own boot straps, or Adam "should" do what he is told. Finally these two opposing organizing systems of child-environment holds the metaphor of "fit". We've previously described this under temperament and sensory features. It becomes another therapeutic tool to look at these two entities from their congruent or incongruent positions. It's likely that our continued conversation to bring together pertinent information from the outset wherein we have a chance to accommodate and negotiate the two sides with mutual appreciation produces a "goodness of fit" where the environmental demands are in synch with the child-family's abilities and challenge capacities in a way that makes for "flow." This is also worthy curative space for family healing. Hopefully these several model advantages speak to their benefits on behalf of Ella and Adam, his teacher and other relationships so that everyone is just a little bit better off.

Team member says: "Adam, all these grown-ups are getting better at understanding all the different parts that come together to make you up."

The End, and Adam looks down at his Frog Book, smiling.

Appendix A

Utilizing Solutions-Focused Brief Practice as Assessment for Intervention by Richard Besenhofer

INTRODUCTION

Solution-Focused Brief Therapy (SFBT) was developed by Steve DeShazer, Insoo Kim Berg and their colleagues in the 70's and 80's. SFBT is a practice-based model of helping people, families and children finding solutions or methods that can help them achieve a more satisfactory future. The process is not a problem-solving strategy because it is about co-constructing goals, exploring exceptions (those times when clients', families', and children's' lives are going the way they want them to go)—identifying strengths and resources, while maintaining a future orientation, i.e., "What will you be doing when you don't need to come here anymore? Or "What will your children be doing when you don't have as many concerns about them?" DeShazer and Berg's work suggest a number of underlying principles:

1. **Emphasis on mental health, not pathology:** In all SFBT sessions, client, family, or children successes, strengths, resources and abilities are emphasized vs. their limitations and deficits (Berg and Miller, 1992). Clinicians utilizing this view are more interested in discovering what works and what is right, rather than exploring what is wrong and trying to fix it. They become very curious about how strengths can be built upon.

2. **Utilization:** This is a method of accepting the family frame of reference. Their existing resources, skills, motivation, behavior, symptoms, social network, circumstances and personal idiosyncrasies are used to lead them to their desired outcomes (O'Hanlon and Wilk, 1987).

3. **An atheoretical/nonnormative/client-determined view:** Few assumptions are made about the "true" nature of the child or family problems. The family is viewed as the expert about their solutions, and the clinician is more of an apprentice whose job is to learn about the unique ways the family has conceptualized their complaint(s) that brought them into the clinic (Berg & Miller, 1992).

4. **Parsimony:** Solution-Focused therapists prefer the simplest and most straightforward means to a desired outcome. DeShazer often quotes the 14th Century philosopher, William of Ockam, "What can be done in fewer means is done in vain with many (DeShazer, 1985 in Berg & Miller, 1992). So, the clinician wants to keep things simple without introducing complex theories or explanations about problems and their resolution. For example, solution-focused advocates would never say that symptoms are "just the tip of the iceberg", preferring to view symptoms as things that come and go. Such an approach is more interested in the times that symptoms go, or aren't present, and what is different about those times. This positive orientation does much to reframe the family's view of the "problem".

5. **Change is not only possible but inevitable:** SFBT clinicians believe they have yet to come upon a problem that is absolute, or in other words, a problem that happens all the time. They believe that change for the better has no lesser odds of happening than change for the worse. So, they are constantly looking for these changes toward the better and want to

highlight them to the client, family, or child as perhaps a "difference that makes a difference."

6. Present and future orientation: SFBT is not particularly interested in exploring the past, with the exception of reviewing past successes. Their focus is on what is working now and what needs to happen for a satisfactory future adjustment. This process fits very well into family resiliency goals.

7. Working what works: The approach suggests that if something isn't broken, don't fix it. It also suggests that when a family knows what works they should do more of it. Finally, the approach endorses the idea that, if something isn't working, do something different.

PROCESS

With these as guiding principles, the clinician facilitates conversations around five kinds of questions: goal, scaling, miracle, coping, and exception/instead questions. Each type involves inquiry about individual or family goals and identifying successive steps for those goals.

1. Goal questions: All sessions are begun with the following types of questions: "What has to happen here today for you to later think that coming in was worth it?" These questions help people decide what they want to work on—the clinical staff not presupposing the family's goals. Some examples follow:

'How can we be most helpful to you?"
"What would you like to accomplish as a result of coming here, so that one day you can look back and say, 'That wasn't a terrible waste of time'?"
"How will you know that coming here was helpful for your child or family?"
"When all is said and done, what will tell you it wasn't a waste of time?"

2. Scaling questions: It is the view of SFBT clinicians that language and conversation are the only true "tools" of therapy, but this is a potential problem inasmuch as language can be very vague and uncertain. Numerical language is useful in helping clients, parents, and even small children clarify vague ideas and goals by the use of scaled symbols such as degrees of smiley faces. Basic Scaling question may be like the following:

On a scale of 1 to 10, where 1 is, "perhaps the worst things have been for you" and 10 is "considering where you would like your life to be, where do you see yourself today?"

Note: Many clinicians misunderstand scaling questions as an assessment question, as if the scale of 1 to 10 is based on normative standards and the answer "4" has some analytical meaning.

To this end, scaling questions have little value. In this model the questions are used to facilitate movement, identify successive steps (goals), measure perception, motivate and to encourage.

Sample Follow up:

"You see yourselves or your family at a 4. O.K., this is good. What will be different as you begin to see yourself or your family at a 5?"
"As you leave here today, what small things will your family be doing differently when you are at the next step on the scale?"

3. Miracle questions: A clinician may ask the parents and adolescent the following question to help them identify their goals:

"I have a strange question for you, one that you have probably never thought about. Suppose you leave here today, go about your business, and get ready for bed. And let's suppose that when you go to bed and fall asleep, that a miracle occurs. And let's say that this miracle occurs in such a fashion that these problems that you are coming in with today are solved. O.K., now here is the tricky part. Since the miracle happens while you are sleeping, there is no way for you to know that the miracle did indeed happen."

"What, then, do you suppose will be the first small signs you will notice in the morning that will tell you a miracle occurred?"
(to the child) "What will your parents/siblings notice/ or do?" -
(to the parent) "What will your children notice or do?"
(to the spouse) "What will your spouse notice or do?"
(to the child or parent)"What will your friends notice or do?"
(to the adolescent or parent) "What will your employer notice or do?"

33. Exceptions and Instead questions: SFBT practitioners feel that they have yet to come upon a problem that is "absolute." In other words, one that is evident all of the time, 24-hours-a-day and seven days a week. While the relevance of the problem may be rather significant to the individual or family, the "times" of the problems are often in the minority (but unfortunately, less relevant to those individuals involved). So, we continue to look for "exceptions", that is, those times that the problem does not occur. Practitioners have noted that it is often too easy to identify instances of things that don't work because they stand out, are irritating, frightening, make one feel helpless, etc. Things that work tend to be less obvious and thus need greater focus.

Exception questions:

"Tell us about the times when your family members were considerate to each other. What were you all doing when this occurred? What was different about these times?"
"When confrontation is less of a problem, what will you be doing instead?"

Instead questions:

People experiencing difficulties often talk about "not doing" one thing or another. The problem with "not doing" something is that it leaves a void. It is much easier for people to find a viable replacement behavior. People don't behave in a vacuum, they typically have

very good reasons for their actions and quite often it is to meet basic needs. It is important to find alternatives to the unsuccessful strategies in helping to meet those needs:

"When your child is not depressed, what will they be doing instead?"
"When you stop fighting with your husband, what will you/he be doing instead?"

***Coping questions*:** Many times clients and families come to us and are in very dire straits, discouraged, helpless, hopeless and feeling that their lives can't improve. They have often been dealing with very difficult circumstances within a multiplicity of problems (serious poverty, homelessness, criminal activity, substance abuse, physical and emotional barriers, etc.) and we are sincerely interested in why things aren't even *worse*—what are they doing? So, we ask, for example:

"O.K., you're at a 1 – what are you doing to keep things from getting to a zero?"

"What have you done to cope with these very difficult circumstances?"

"Can things get worse? What are you doing to keep things from worsening?"

We use coping questions to highlight strengths, resources and what families are doing that is helpful. These inquiries can provide much needed hope by identifying the things that they *are* doing right? Often, clients will tell us that it is good to hear that, "At least I'm doing something right." Remember that these families usually have a long history of hearing about all the things they do wrong. So, this kind of feedback can be encouraging while instilling a sense of hope.

This brief overview should have been helpful in increasing your understanding about the nature of our work. We believe in looking for resilience, strengths, resources and protective factors, such as those times when the family or child problem(s) either wasn't present or was less of a problem, and when positive family goals are focused upon, instead of compulsively placing emphasis on problems.

Appendix B Child assets Scale

Child Assets Scale
(A Global Health domain Scale)
Child_____ Age_____
School_____ Date_____

Child supports for Regulatory Function

_____Biophysical Integrity reflects the balance of such factors as genetic endowment, temperament features (activity levels, positive emotionality and sociability), constitutional sensitivities, and sensory-motor abilities. Medical, neurological as well as sleep-wake patterns, growth, and nutritional factors also affect integrity.

_____Functional Physical State modulates and controls energy, stamina, arousal, mood attention, and impulse.

Developmental and Identity Functions

_____Information Processing mediates verbal and non-verbal intelligence, perception, language, sequential and simultaneous learning, generalization, and appreciation of time, space and context.

_____ Functional Identity Development is impacted by beliefs, expectations, attributions, and behavioral and explanatory styles.

_____Attachment bonding produces child-parent goodness of fit physical-emotional connection, nurturance, mutual responsiveness, protection
support, guidance and safety.

_____Functional-Emotional Growth generates action tendencies and motivation around meeting sufficient basic needs. The growth includes
security, self-soothing, trust acceptance of self and other, curiosity, and pleasure in living. It also maintains continuity in a sense of goodness, self worth and esteem, spontaneity, shared power. "ability to do", and of caring for others.

Family

_____Care-giving Resources, such as food, shelter transportation, telephone, income, insurance, medical-dental care, education, employment
and leisure activities are available.

_____Functional Family is promoted by a healthy parent and supportive partner with alignment and cohesive boundaries, roles and rules, disciplinary skill, flexible coping, problem-solving, helpful communication, sibling and other relation-building, balance between dependence and independence, and appropriate relation to time, attention, routines, rituals and transitions.

Community/School/Friendship Resources

_____Collaboration with empathic outside resources is available to individually and comprehensively address eco-socio-political equity. Religion-cultural empowerment is respected and valued. Resources such as health, recreational opportunities and respite are also available to link extended family, peers, friends, mentors and other supports.

_____Functional School Plan (or daycare plan for preschoolers) linking family and community with a supportive adult, expectations with unique opportunities that foster achievement, and meeting such basic needs as comfort, esteem, attendance, personal health, and development.

Sum____

Appendix C
Parent Summary of Child Health Assets

Child_____ **Parent Summary** Date_____
(of a Child's Health Assets)

Instructions: Please rate each of the entries below by encircling one of the three following scores: **1**=agree, **½**=partially agree, **0**=disagree.

Child's Physical Qualities

1 ½ 0 My child was born with a physically healthy body and continues to enjoy basically good health.

1 ½ 0 My child is alert, focused, easy going and even tempered.

Developmental Growth

1 ½ 0 My child learns quite easily as in school.

1 ½ 0 My child is forming a positive sense of who he/she is as a person.

Emotional Bonding

1 ½ 0 My child is quite easy to love and connects with me.

1 ½ 0 My child usually feels a sense of trust, security, self control and joy.

Family Strengths

1 ½ 0 Our family provides the basic needs of food, clothing, shelter, transportation, etc.

1 ½ 0 Our family listens and talks to each other, gets along well, and shows respect for each other.

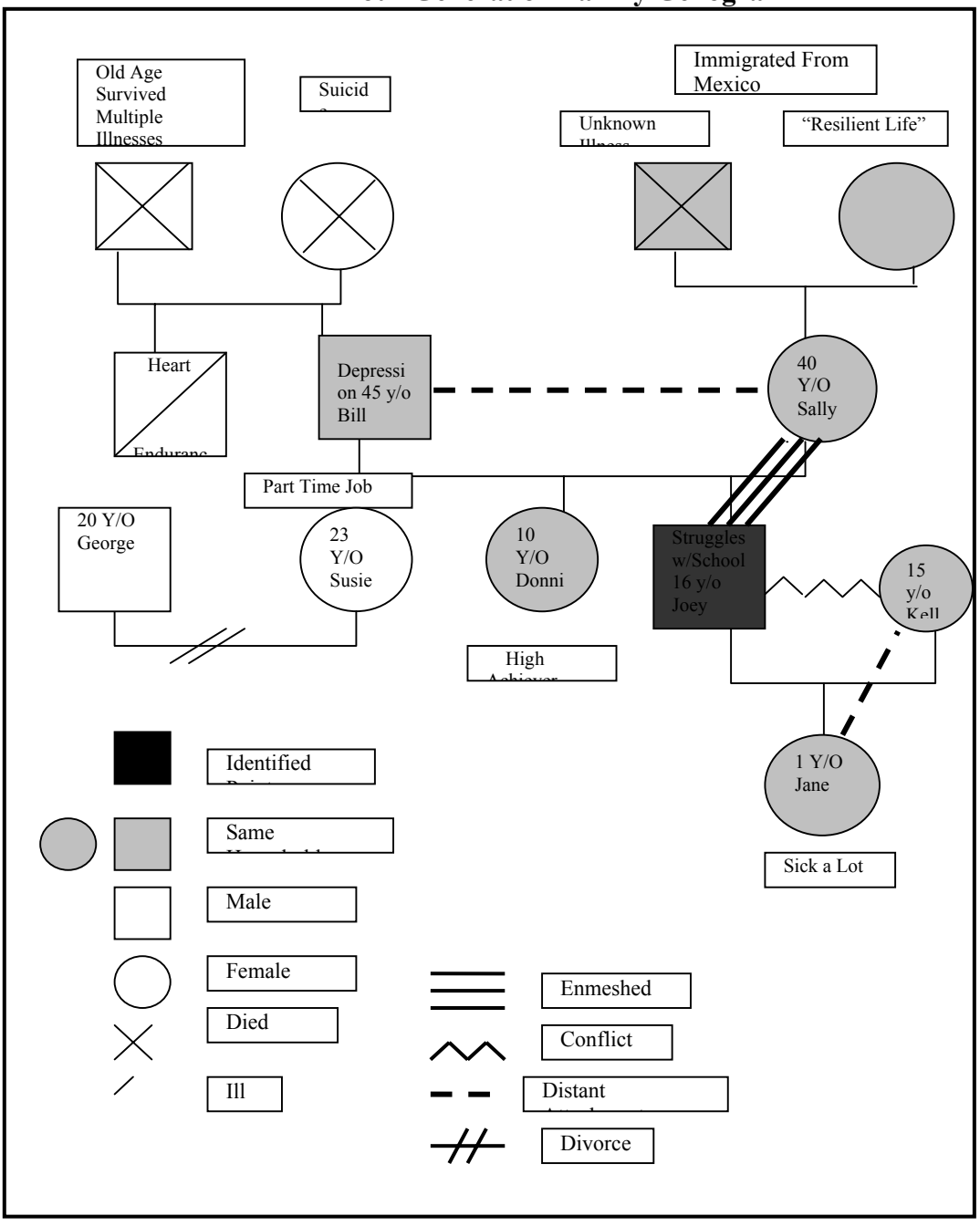
Community Support

1 ½ 0 We enjoy helpful interaction with relatives, neighbors and/or community.

1 ½ 0 The school meets my child's schooling needs.

Appendix D

Four Generation Family Genogram



Appendix E
Nursing Checklist and Development and Life Experiences form

***CHILD DEVELOPMENT and FAMILY LIFE EXPERIENCES**

Please return the completed form to: CSHCN, Box 144710, SLC UT 84114-4710 Attn.: ABLE Program.

Today's Date_____
Child's Name_____ **DOB**_____ **Age**_____
Parent(s') Name(s)_____ **Age(s)**_____
Address_____
Length of time at this address_____
Phone Number(s) Home: _____ **Work:** _____
Languages (other than English) spoken in home_____
Ethnic, cultural affiliation_____
Year Parent(s) Received High School Diploma, GED_____
Other Education_____
Years Married or Living With Present Spouse or Partner_____
Ages at start of current relationship_____
Child's Physician's Address_____ **Ph#**_____
Other Healthcare Provider_____ **Ph#**_____
Number of Other Marriages or Partner Relationships_____

In order to evaluate and address possible reasons which may be contributing to the difficulty your child is experiencing in school or preschool, we would like you to assist us by answering the following questions honestly and to the best of your ability. Some of the questions will not be applicable to your child because of never having had an opportunity to learn that task. This questionnaire will become a permanent and CONFIDENTIAL part of your child's chart. The accuracy of this history will determine the kinds of appointments and future scheduling for your child.

Please describe concerns about your child_____

_____

_____

_____

_____

Mother's Employment_____ **How long?**_____ **Satisfied?**_____
Number of Jobs Mother has had in the last three years_____
Father's/partner's Job_____ **How Long?**_____ **Satisfied?**_____
Number of Jobs Father/partner has had in the last three years_____

1. Physical Health

a. Pregnancy *(Mark with an X only if statement is true or mostly true. You may want to add qualifying information beside each statement)*

_____ I had problems with the pregnancy, labor, or delivery of my child. **(circle)**

Month started prenatal care 1-3 4-6 7-9 **(Circle)**

_____ My baby had complications after delivery; number of days (weeks) in hospital (due to prematurity, bleeding in the brain, on a respirator, infection, jaundice, other). **(circle)**

What was your child's birth weight?_____

_____ My baby was slow to gain weight as an infant.

_____ My baby didn't thrive.

Please **(circle)** the following which applied during the pregnancy: I

smoked cigarettes was depressed drank beer, alcohol

used drugs or substances was physically sick was stressed out

took medication was physically or emotionally hurt

b. Hereditary Life Events of the Parent(s)/Relative(s)--NOT the Child

Initial the following blanks as they pertain "M" to MOTHER of child, "F" to FATHER of child, or "R to RELATIVES in the family.

_____neurological condition(s)

_____seizures

_____serious illness **(Explain)**

_____receiver of harsh discipline

_____adoption

_____accidents **(Explain)**_____

_____long term medication for any condition

_____drug use

_____smoking

_____trouble with the law

_____court

_____multiple hospitalizations **(Explain)**

_____depression

_____trouble in school

_____trouble with learning

_____failure to graduate from high school

_____jail/prison

_____abuse: **(circle)** sexual/emotional/physical

_____alcohol use

_____multiple relationships, marriages

_____divorce

_____birth defects_____

_____other hereditary disorders

_____other mental or physical problems **(Explain)**

_____

Please list all adults and children in your household:

Name Age	to child	Relation Family	School	Work/Play	Friends	Health	Mental Health	Physical Health	

2. c. Child's Health *(Mark with an X only if statement is true or mostly true. You may want to add qualifying information beside each statement)*

My child...

_____has trouble with vision/wears glasses.

_____has poor hearing.

_____has history of many ear infections.

_____has/had a lot of sickness.

_____has a poor appetite, is picky, or has a feeding problem.

_____has nightmares/talks, is noisy, moves in sleep.--

_____has difficulty sleeping, going to bed, staying asleep, getting up.--

_____is overweight.

_____has/had seizures.

_____has a lot of eye blinking or redness.

_____smacks lips or blinks eyes frequently.

_____sweats too much.

_____has tics, tremors or odd movements.

_____hums; has disturbing vocal sounds.

_____is weak.

_____is often tired.--

_____isn't growing or gaining weight.

_____smokes, drinks, uses drugs **(circle)**

_____had/has a head injury of any kind.

_____has staring spells, is spacy or seems to daydream a lot.

_____has frequent headaches and/or stomach aches, or other body pain.**(circle)--**

_____has/had asthma or chronic cough.

_____soils and/or wets day and/or night.

_____has been on long-term medication.

_____has had surgeries or serious medical problems.**(Explain)**

_____

_____has allergies and/or rashes **(circle)**

_____is accident prone. (Number of serious cuts needing sutures:_____)

_____uses right/left hand over the other, or uses both hands equally. **(circle)**

_____eats a lot of one particular food such as: sugar, sodas, water, milk, salt, and wheat. **(circle)**

_____has dental problems.

_____has frequent extreme temper tantrums which aren't appropriate to the cause.

2. Temperament/Sensitivities *(Mark with an X only if statement is true or mostly true.)*

My child...

_____had/has rocked, banged his/head, or has other unusual postures or mannerisms.

_____had/has a strong choice to avoid certain

_____is irritable--

_____avoids trying new physical tasks.

food textures.

_____is over/under-sensitive to temperature, odor, touch, pain, light. **(circle)**

_____is slow to warm-up to/or change to a different activity.

_____avoids eye contact, turns away from human face, or prefers objects and toys.

_____is excited or restless when in a crowded, bustling setting, supermarket, or restaurant.

_____dislikes hair/face washed or haircuts.

_____touches everything in sight.

_____gets car sick.

_____is over/under-reactive to such noise as: loud, high, or pitched noise. **(circle)**

_____is easily startled or jumpy.

_____is slow moving/lethargic.

_____gets hyperactive or under-active. **(circle)**

_____is oversensitive to bright lights or new and striking visual images. (such as colors or shapes). **(circle)**

_____does not interact back and forth. (has few back and forth exchanges.)

_____dislikes being dressed or undressed.

_____is sensitive to certain clothes.

_____still puts things in mouth. Explores objects with mouth.

3. **Motivation & Energy** *(Mark with an X only if statement is true or mostly true.)*

My child...

_____hardly shows any facial expression.

_____is often sad.--

_____is moody (often goes rapidly from happy to sad or angry) without apparent reason

_____is over-talkative & chatty.

_____has decreased alertness.

_____spends much effort with little return.

_____has difficulty staying on or finishing assigned tasks.

_____runs out of energy.

_____is hard to reinforce with rewards.

_____goes from activity to activity without completing one.

_____is inhibited, anxious, shy.

_____seems confused--"in a fog".--

_____gets bored easily.

_____interrupts frequently

_____has few interests.

_____fails to finish things he/she starts.

_____is easily frustrated.

_____needs frequent reward changes.

_____has a short attention span (is easily distracted). **(Circle)** how long he/she can sit in the following activities:.

2 5 10 15 30 minutes playing one activity.

2 5 10 15 30 minutes watching videos or TV.

2 5 10 15 30 minutes being read to.

_____seems extremely impulsive compared to other children (doesn't think before acting).

_____is fearless--takes chances that are unsafe.

4. **Hearing & Talking** *(Mark with an X only if statement is true or mostly true.)*

My child...

_____has difficulty understanding or remembering what he/she hears.

_____doesn't ask questions.

_____needs complicated directions repeated.

_____often "tunes things out" --especially what is heard.

_____talks very loudly, even during normal conversations.

_____frequently doesn't respond when called from other rooms.

_____frequently turns the same ear in the direction of the sound.

_____confuses or misunderstands words that have similar sounds but are different (like top/tap, track/tack).

_____repeats or echoes previously heard words or phrases.

_____can't retell a short story.

_____is hard to understand (stutters, repeats words, talks fast, slow, or interruptedly). **(circle)**

_____has trouble learning words in songs, nursery rhymes, etc.

_____has unusual speech tone, rhythm, or voice.

_____struggles at putting ideas into words or finding the right words to use.

_____has difficulty using correct word arrangements. like me/I, her/she, him/he.

_____has difficulty telling about recent events

_____has little conversation ability.

5. Thinking, Remembering & Playing *(Mark with an X only if statement is true or mostly true.)*

My child...

_____has simple, repetitive, monotonous play.

_____has little creativity or pretending as in playing with cuddly objects, or plays with toys only one way.

_____plays inappropriately with toys: throws, breaks, or uses them in the wrong way.

_____has trouble using gestures: waving, clapping, pointing or using hands when talking. **(circle)**

_____has trouble sorting or classifying similar or same things. (colors, shapes, objects, ideas).

_____is illogical or confused. It is hard to understand his/her thoughts.

_____has trouble catching on to things, or is slow to understand.

_____doesn't seem to learn from mistakes.

_____has trouble finding personal belongings or remembering where things are.

_____has trouble remembering past experiences.

_____has a "style" to help remember (repeating things, "seeing" things, talking to self).

_____prefers videos to action play.

_____plays same videos over and over.

6. Vision, Ordering & Space *(Mark with an X only if statement is true or mostly true.)*

My child...

_____has difficulty with ordering, ideas or objects, motor actions, words, &/or putting ideas in a row. **(circle)**

_____holds his/her head close to paper when writing/reading/coloring.

_____has problems organizing in the following areas: time, space, materials

_____has difficulty cutting with scissors.

_____has little interest in puzzles or such toys as "legos".

_____misjudges objects and things while reaching. Spills or has "accidents".

_____has trouble working with small objects like buttons, zippers, fasteners.

_____eats in a sloppy manner.

_____knows prepositions like behind, under, next to, in front.

_____tilts head while reading, writing, coloring, or drawing.

_____has poor memory seeing or visualizing things.

_____has a poor sense of direction--gets lost easily..

_____draws simple pictures (stick figures, with no detail).

_____has/had trouble keeping inside the lines when coloring.

_____knows right from left.

7. Motor Coordination *(Mark with an X only if statement is true or mostly true.)*

My child...

_____handles self poorly on playground as with slides, swings, monkey bars. **(circle)**

_____is unable to ride a bike or tricycle.

_____falls and trips frequently; is clumsy.

_____is awkward when running; loses balance.

_____avoids games or activities involving catching, throwing, hitting, or kicking a ball.

_____has poor timing (swings a bat after ball goes by, catches before or after ball arrives).

_____has trouble skipping or hopping.

_____has a slumped body posture--leans on a hand or an arm when doing table top activities.

_____has to have things his/her way.

_____compared to his peers he/she is not as strong, i.e. can't run as far, can't pull on monkey bars.

8. Caregiving/Cooperation *(Mark with an X only if statement is true or mostly true.)*

My child...

_____is very controlling (bossy).

_____does not respect others' privacy/crosses others' borders.

_____gets distressed when separated from parent(s).

_____argues with me/refuses to do things I expect of him at home.

_____resists efforts to stop his/her behavior.

Parent Feelings: *(Mark with an X only if statement is true or mostly true.)*

_____I have an established daily routine for eating, sleeping, play times, family time, etc.

_____No matter what I try, nothing seems to help my child's behavior.

_____I feel used up and burned out by my child.

_____My child causes me to worry excessively.

_____Toilet training and/or feeding time is horrible for both me and my child.

_____We have constant battles or power struggles.

_____It is difficult getting my child to bed and keeping him there.

_____I feel inadequate trying to comfort my child when he has been upset.

_____I tend to forget my early childhood relationships with my mother.

_____I seem preoccupied thinking how wonderful and ideal my mother is (was).

_____I feel that I am overly involved or very protective of my child.

_____My child makes me very angry; sometimes I lose control verbally or physically. **(circle)**

_____It seems there is no one to whom I can go for help.

_____Sometimes I worry about our discipline being too harsh or physical.

_____My child likes creative, imaginative play.

_____I have clear expectations for my child's social, school, and family behaviors.

_____I've been depressed or feel angry much of the time. **(circle)**

_____I remember little nurturing, warmth, or being cared-for when I grew up.

9. **Family** *(Mark with an X* only if statement is true or mostly true*.)*

My child...

_____has no pets.

_____rarely eats breakfast.

_____fights with brothers and sisters.

_____does better in a one-to-one situation.

_____is a discipline problem.

How many children in your family?_____Which number is this child?_____

As a family...

_____I have the support of a spouse or partner.

_____Our monthly income is_____.

_____Consequences or punishments for breaking the rules are given out consistently (always the same) by both parents.

_____Both parents agree on what the rules are for the children.

_____Both parents agree on what the consequences are for breaking rules.

_____Family values and child expectations are consistently supported by both parents.

_____Family rules are posted in the house.

_____Family rules are talked over clearly.

_____Friends or relatives ask us not to visit due to this child's behavior.

_____I/we live close to relatives.

_____I/we visit together and/or call often.

_____I go to the following person(s)for support:_____

_____I/we have State or other assistance. **(circle)**: SSI, Medicaid, AFDC, food stamps, legal, "reduced lunch", HEAT program, food bank, other.

_____My/our family is active in an organization. **(circle):** PTA, church, Scouts, sports, karate parent support group (list name)_____, any volunteer work, other.

_____Other agencies are involved with our family. **(Circle)** which one(s) apply: Social Services, Mental Health, court, family worker, other
Please give names and phone numbers:_____
_____There are others outside the family who care about my child, who are special, and who spend time with my/our child frequently. Name & ph#:_____
(Circle) what your family has: telephone washer/dryer, TV, VCR, Nintendo own/rent home car gun(s)

Number of moves in this child's life_____

My child... *(Mark with an X only if statement is true or mostly true.)*

_____was hurt by a psychological or physical trauma or hurtful event.

_____has brothers or sisters with serious problems.

_____has had other life experiences or stressful events which have had adverse effects on him/her.

Please **(circle)** any of the following which occurred in your family in the last 12 months:

moved to new home	parents separated/divorced	family member(s) hospitalized
child entered new school	death in family/relation to this child	financial difficulty
new child in family	job loss(es) or starting new job(s)	gang membership
serious family arguments	other siblings doing poorly in school	other catastrophes
violence in the home	violence in neighborhood	too many hassles

Please **(Circle)** family stress level: Present: Little 1 2 3 4 5 Much

Last 6 months: Little 1 2 3 4 5 Much

10. Coping-Defending Responses

My child... *(Mark with an X only if statement is true or mostly true.)*

_____lives in a fantasy/unreal world.

_____is preoccupied with hand washing,

_____is argumentative.--

_____acts passive--no initiative.

_____has poor judgment.

_____adjusts (adapts) poorly after change.

_____blames others/denies behavior.

_____is involved with drugs/alcohol.

_____runs away.

_____lies frequently.

_____is self-abusive.

cleanliness, or ordering of things.

_____is unable to take care of him/herself.

_____cries easily when scared/criticized.

_____gets sleepy or sleeps soon after being scolded.

_____overeats/undereats when stressed or disciplined.

_____acts very immaturely for his/her age.

_____has difficulty calming self when upset.

(Circle) only those self-help areas that your child **can't do**:

wash hands with soap	tie shoes	buy something with money	pour drinks
memorize street address	brush teeth	cut food with knife	help with chores
cross the street	dress self	toilet train	

When your child is upset what works to calm him/her down?

_____

_____

How does your child react to disappointment?

_____

_____

How long does it take to get calm again after disappointment? **(Circle)**

5 min 15 min 30 min 1 hr longer

11. Feelings and Social Relations

My child... *(Mark with an X only if statement is true or mostly true.)*

_____feels persecuted or picked on.--

_____feels "mixed-up".

_____feels unusually guilty.--

_____shows inappropriate affection and feeling for the situation.

_____is secretive.--

_____rarely shows feelings.

_____thinks about sex too much.

_____has many fears.--

_____is very self-conscious.

_____is critical of self—puts self down.

_____is tense, anxious or nervous.--

_____hoards or collects things.

_____has obsessive, compulsive behavior.

_____is withdrawn, likes to spend a lot of time by himself/herself.--

_____is shy, timid, has few friends.

_____has more younger or older friends than friends of own age.

_____is depressed, has low moods.

_____will go to anyone, including strangers.

_____doesn't like praise--can't accept positive feedback.

_____is aggressive.

_____sets fires.--

_____is seductive.

_____has a bad temper.

_____gets angry most of the time.

_____often destroys things.

_____gets easily frustrated.

_____thinks about sex too much.

_____acts out sex behaviors.--

_____plays with sexual body parts too much.

_____has fewer friends due to negative bossy, or annoying behavior.

_____disturbs others: teases, provokes fights, interrupts, wants attention.

_____physically strikes back at teasing peers.

_____displays physical aggression toward objects or persons.

_____speaks to others in an impatient or cranky tone of voice.

_____gets picked-on or bullied fre□uently.

12. Awareness of Others *(Mark with an X only if statement is true or mostly true.)*

My child...

_____seems to have no conscience; has little guilt.--

_____is cruel to animals.--

_____is involved with the courts/law.

_____is a gang member or associates with gang members.

_____steals things at home/store **(circle)**.

_____is unconcerned about feelings of others or seeking approval.

_____identifies with "rules" in our home (e.g., "Daddy said...", "Mommy said...").

_____can't take on others' points of view.

_____shows little empathy or sensitivity for others.

_____has difficulty following rules or staying within limits.

_____has problems sharing or taking turns.

_____lacks manners.

13. Rights & Needs

My child... *(Mark with an X only if statement is true or mostly true.)*

_____has few interests, hobbies, or talents.

_____has few outside activities:
(circle those not attended)
clubs, sports, church.

_____lacks self-esteem/self-worth.

_____feels inferior.

_____has loss of his/her spirit/enthusiasm.

_____does not respond to limit setting, controls or discipline.

_____is highly dependent/is "clingy' or "hangs on".

_____lacks confidence, needs frequent reassurance.

_____doesn't have immunizations up-to-date.

_____doesn't use a seatbelt.

(Circle) any of the following you feel the family has more need for:

religious worship

family worth & esteem

medical care, a doctor

child care

recreational outlets

discipline & limit setting

early intervention preschool

information about my child's condition

intimate friends

dental care

counseling

toys/books

needs of living (food, housing, utilities) **(Circle)**

summer program

coordinating child's care

controlling anger

money for bills

kids doing more chores

health insurance

transportation

feeling safe

parent support group

alcohol/drug treatment

SUPPLEMENT A

School
For School Age Only

Grade_____
Name of child's school_____

_____
Length of time attended this school_____
Number of different schools child has attended since kindergarten_____
Name of current school contact person (teacher, principal, etc.)_____

My child... *(Mark with an X only if statement is true or mostly true.)*

_____has difficulty with grades.

_____has difficulty with citizenship and/or study habits.

_____has problems with behavior at school.

_____gets suspended or has notes sent home due to behavior.

_____dislikes school.

_____receives reports indicating he/she is not working to full potential or ability.

_____has difficulty completing homework.

_____completes homework but forgets it or loses it before turning it in.

_____reverses such letters as b/d, numbers (6/9), or words (was/saw).

_____has messy handwriting or avoids written tasks.

_____has fluctuating or changing memory for spelling. (spells OK while studying, but forgets the next day)

_____has fluctuating memory for what he/she just read. (comprehension or understanding).

_____has fluctuating memory in math. (ordering of math functions) division, multiplication tables, carrying and regrouping)

_____has trouble reading left to right.

_____can't tell time by clock hands.

_____had trouble counting or learning ABC's.

_____has trouble with days of the week, months of the year.

_____does poorly with phonics (sounding out words) in school.

_____confuses similar letters, numbers, shapes, or words.

(Circle) what usually applies to your child on the report card:

Citizenship/study habits _____ **Grades**

NI, S, S-, H F's, D's, C's, B's, A's, NI, or below level

What do you think would be helpful solving you child's school problem?_____
_____
_____
_____

About how long has your child had this problem?_____

11

(Circle) school services you or your child needs**:**

counseling,	vocational services	meeting more with school or community
"home notes"	occupational services	understanding IEP's & due process
testing	speech/language	after school programming,
physical therapy	occupational services	vocational services or work training
speech/language	parent conference	self-management training
other (please list)	group self-esteem	transition services
legal center	resource support person	

other please list_____

_____

My child . . .

_____has more problems during free, unplanned time such as the following: playground, lunchroom, hallways, before & after school **(circle)**

_____has stress in school. (little 1 2 3 4 much) **(Circle)**

_____has the following special helps: Resource pullout one-on-one class IEP computer calculator tutor social skills group scribe (to take notes) learning strategies class (TLC) tapes (talking books) support person **(Circle)**

_____has benefited mostly from which of the above resources:_____

_____has very good teachers now. Please **(Circle)** how many: none 1 2 many

_____likes the following number of school subjects: none 1 2 many **(Circle)**

_____has extreme difficulty at school with the following number of subjects: none, 1, 2, many **(Circle)**

_____fails to attend school regularly; misses many days.

_____has failed a grade. If yes, what grade?_____

_____parent-child homework frustration: How much time each night is spent on homework?**(circle)** 15 min, 1/2 hr., 1 hr. 2 hrs, more.
Rate the degree of frustration that's felt during homework times: mild 1 2 3 4 5 frantic

_____Parent(s) had negative experiences in their own school years.

SUPPLEMENT B

Preschool or Daycare

Complete only if child is under 5 and not in public school.

Name of Child's Preschool/Childcare:_____

Length of time having attended this facility:_____

My child . . . (*Mark with X only if statement is true or mostly true.)*

_____dislikes preschool/daycare or the present one. **(Circle)**

_____has had the following number of daycares or family home care facilities: life:_____

_____misses many days from preschool/daycare.

_____has transportation problems.

_____is not potty-trained.

_____is difficult for the teacher or care worker to manage.

_____often interrupts the teacher/classmates.

_____has trouble following classroom or daycare rules.

_____often doesn't play with other children or bothers teases or pokes, etc.).

_____seems more active than the other children.

_____has trouble sitting and listening during story or circle time.

_____is not liked by the other children.

_____needs testing.

If your child has had some of these problems, about how long ago did they start?_____

How much stress is your child under at preschool/daycare? **(circle)**
(little 1, 2, 3, 4, 5 much).

_____How many children per adult are in the preschool or daycare?

_____Are there others outside the family who provide care?
The child care provider or teacher doesn't seem to care about our family issues.

Appendix F

Assessment
Guidelines for Physician Evaluation

Review of Records: (Taken from "history growth" section under red tag in chart)

- Brief summary prior records:
  - Child Development and Family Experience
  - Chief Complaint
  - Nursing Triage
  - School records, psychological or educational testing, etc.
- Complete review with parent questions, focusing on:
  - Medical history: immunizations, illnesses, injuries, hospitalizations, head trauma, seizures, vision/hearing abnormalities, medications, and allergies.
  - Daily habits: eating, sleeping, waking, toileting, routines and irregularities

Behavioral Observations: (gained from direct observation of child responses to the situation, people, parents, special tasks)

- Initial Observations (Record any oddities or lack thereof in first impression)
  - Appearance: neat, relaxed, disheveled, dirty, clean, small, large, older or younger than stated age
  - Disposition: positive, negative, mixed, ambivalent, resistant
  - Mood: happy, sad, anxious, angry, blunted
    - Indicate intensity of mood
    - Emotional expression
  - Approach: relaxed, agitated, inhibited, impulsive, shy, avoidant, energetic
    - Energy level in relation to task (appropriate, inappropriate, variable, slow building)
  - Response: cooperative, submissive, stubborn, resistant, oppositional
    - Speech rate, volume, spontaneity
    - Motor responses: fidgety, lethargic, abnormal, agitated

Mental Status Exam: (does not have to be a "formal" evaluation, but can be gathered during the assessment)

- questions that might help you explore these domains with children:
  - Why are you here? Whose idea was it?
  - Tell me about your family. How well do you get along with them (easiest/ hardest)?
  - What do you like to do? What kinds of things don't you like? What are you good at?
  - Do you have a best friend? How easy or hard to make/keep friends? Do kids like you?
  - What do you do when you are sad? Mad? Happy? Does it happen a lot?
  - Have you ever thought about or tried to hurt yourself? Do you ever wish you were dead?
  - Do you get into fights? What happens when you get mad? What do others do?
  - What do you like most/ least about school? Tell me about your grades, teachers, other kids, etc.
  - What do you want to do when you get older?
  - If you could change anything in your life, so it was perfect, what three things would be different?
  - Three wishes? If your parent had a wish, what would it be?

Mood and Affect:

- Stability/ lability of mood
  - How child feels most of the time
  - Moods change a lot? Confused by feelings often?
- How child responds to negative emotions
  - Appropriateness of reactions
  - Blunted, normal, exaggerated expression of emotions
- What do others think of child?
  - How would your friend's describe you?

- Thought Content *make sure questions are developmentally appropriate
  - Suicidal, aggressive, homicidal ideation
    - Do you ever think about hurting yourself or someone else?
    - Have you ever done anything to hurt yourself on purpose?
    - Do you ever think about dying? Do you ever want to die?

- Depressive cognitions
    - Guilt, worthlessness, hopelessness, feeling unloved or unwanted
    - Obsessions, ruminations, fears
- Delusions

- Thought Processes *often hard to distinguish normal from abnormal in younger children
    - Coherence; perseveration; logical stream

- Perception and Orientation
    - Hallucinations; Depersonalization; Oriented to person, place, time, reality testing

General Physical Exam

- Growth (check under red tag in chart for what has already been recorded and measure what's left)
    - Height, weight, head circumference, pulse, blood pressure
    - Any other areas of interest
- Areas indicated by positive response in history, ROS, or by chief complaint
- HEENT/lungs, heart, etc.
- Review any dysmorphic findings from stature, cranial-facial, or hand findings
- Look for any neurocutaneous lesions and/or cutaneous scarring
- Look for any orthopedic findings
- Endocrine assessment

Neurological Screen (make sure tasks are developmentally and culturally appropriate)

- Alertness, interest, concentration
    - 1,2,3,4,5, (), 7,8,9. What number was left out?
    - When I say 5,10,15,20, what comes next?
    - Starting with the number 30, count backwards by (2,3)'s to zero. Like this, 30, 28, now you do it.
- Memory
    - Remote
        - Who is the president of the United States?
        - What are the four seasons of the year?
        - Who is the governor in Utah? The capital?

- Immediate
  - I'm going to say three (five for older child) things and I want you to repeat them: "House, tree, ball" (pen, money)
  - Now I'm going to say some numbers and I want you to listen and repeat them when I am done: 287 - 341; 2874 - 9436; 17549 – 63295
- Recent
  - Can you remember the three things you had to repeat (house, tree, ball)? (pen, money)
  - Ask the child to remember what they had for breakfast, or something you talked with them about earlier in the interview.

- Speech, Language and Cognition: (observe and record speech tone, articulation, and content, fund of knowledge, judgment, and abstraction)
  - Let's see how many different animals you can think of.
  - How are a penny and a dime alike? An orange and a pear?
  - Have the child
    (a) Repeat a 4-8 word sentence
    (b) Copy a 4-8 word sentence
    (c) Read a 4-8 word sentence
    (d) Write a 4-8 word sentence
  - Give multi-step directions (use before and after)

- Dominance ("Hand, foot, visual, auditory)

- Motor Exam
  - Involuntary movements:
    - Tics, tremor, mirror movements, self-stimulation behaviors, stereotyped movements; Assess deep tendon reflexes
  - Voluntary movements:
    - Symmetry and bulk, posture, muscle tone and strength, coordination and gait
    - Examine motor sequencing and motor planning

- Sensory Exam
  - Vision
    - Visual fields and eye movements
    - Visual-spatial integration (copying skills)
    - Visual sensitivities (brightness, etc.)
    - Cover Test, PERRLA
  - Audition
    - Abnormalities in central auditory processing
    - Auditory sensitivities (tones, amplitude)

  - Touch

- Simultaneous touch
- Touch sensitivities (to textures, pressures, hot/cold)
- Hand stereogenesis, kinesthesia, and graphesthesia

➢ Other CNS

- Cranial nerves I through XII
- Fundus and discs if appropriate
-

Summary of Findings

❖ Present findings in coherent fashion at team meeting

- What are your general thoughts about this child?
- What are the child's hopes, wishes, desires?
- What are the factors that influence the child's ability to interact with his/her environment? Learning style?
- What are distinctive strengths (weaknesses) observed in this child?
- Does the problem satisfy an adaptive function for the family?
- Is there a dominant temperament trait or emotional theme conveyed by the child?

❖ Document observations, findings, & your actions for future interactions with this family/child

- What might I have seen that would be helpful for others to know about this child?
- What language can I use to promote best fit with family or team?

Recommendations for further evaluation and/or treatment

❖ Indications for further evaluation

➢ questions/concerns arose from your assessment

➢ Findings that are inconsistent with other findings/reports

- Can you determine the reason for the inconsistencies?
- Are there any biases in reporting that may account for inconsistencies?

➢ Any ideas about other testing or laboratory assessment or imaging studies

❖ Indications for treatment goals

➢ Any ideas about effecting change on child, family, or environment, how to improve goodness of fit

➢ What protection factors can be increased?

➢ Any ideas about options that are likely to fail and why

➢ Any noticeable obstacles in treatment planning

Motivation, family functioning, information and understanding, environmental challenges

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A few resources and emphasis of opinion of important interventions: We believe the "Floortime" approach which is a component of the DIR programming (Developmental, Individual Difference, Relationship model) has important potential contributions to Special Needs Children. Especially when these kids have not responded to traditional approaches. Read about DIR on www.icdl.com. As well as at www.floortime.org. This is also a good site for parent referral. Don't forget The Special Needs Child by Greenspan.

Closely related to the Developmental-Relationship approach are the various suggestions for Attachment Related issues. Parents have told us they like, How to Talk so Kids will Listen and Listen so kids will Talk by Adele Faber. Also Raising an Emotionally Intelligent Child by John Gottman is helpful reading for anyone involved with children. Helping younger children develop a sense of empathy, social abilities, boundaries and access to building symbols—look at It Takes Two to Talk (parents guide to helping children communicate two way) by Ayala Manolson, The Hanen Center, Toronto 416-921-1073. or Thinking about you Thinking about me by Michele Winner. A little more involved, but a great social language enhancement for perspective taking for disabled child. (2002) San Jose, 408-557-8595. If you want a more scientific source substantiating for parents the brain basis for parenting that builds attachment-bonding with your child, with the brain in mind look for Parenting from the Inside Out by Daniel Siegel (2003)

There are tapes for help understanding sensory reactivity and modulation The Out of Synch Child by Carol Kranowitz, Sensory resources (2001) Buy the book by the same name.

Finally, We would like to refer those interested in how to rearthor and restory by checking Narrative Therapy on the Web especially try www.dulwichcentre.com for articles as well as solution focused therapy and check out a powerpoint at www.drugnet.bizland.com/powerpoint/sfbt.ppt

Our best practices for children with a variety of developmental disabilities is www.ddhealthinfo.org./