Infant behaviours and the tests used to assess development all embody their own developmental content. The following story borrowed from AA Milne (1926) reflects a behaviour that could equally well be a developmental test. ‘It was Eeyore’s birthday. Pooh decided to give him a pot of honey but regretfully felt a little peckish on the way to the party, and subsequently, after he had checked that it all tasted as good as the first mouthful, he arrived with an empty jar! Piglet’s present was a balloon but he tripped on the way bursting the balloon. After initial disappointment Eeyore was seen gloomily but contentedly putting the remains of the balloon in and out of the empty jar.’

Q In terms of human development which level, of which sequence and in which domain was Eeyore exhibiting and what developmental age would this represent?

Two-component level – structural relationships – non-symbolic cognition – 11 to 12 months.

The manipulative and visual components are at much lower levels than the cognitive, so in a test situation non-spoken cognition is the primary target.

Development of the neurological substrate

The infant brain at term has a full complement of neurons, and its morphology mirrors that of the adult with respect to structure. Basic neuronal links between sensory, high-
Developmental Assessment: Theory, Practice and Application to Neurodisability

er (cognition, language, memory, attention, behaviour etc.) and motor topographic areas of the brain are present but require elaboration and refinement for development to progress – the two go hand in hand. Neurones are small and immature but ready at all levels to be ‘buzzing’ in response to the host of novel sensations and experiences that follow birth. Initially, neurons of the sensory pathways and their corresponding cortical areas respond by growth in size and increase in dendritic spines and in synapse formation within and between their own, other sensory, higher and motor domains, leading chain-wise to the establishment of sophisticated, well-integrated and functional networks and coding templates. After the initial exuberant growth of links between areas of the brain, pruning to adult levels occurs. This process is described as neuronal connectivity or networking, and developmental progress, in all areas, is dependent on its functional integrity and capacity; the process is influenced by both pre- and postnatal genetic factors and experiences. Timetabling of networking in different domains is far from fully established, but evidence suggests that it is to some extent biologically programmed, in some areas spanning many years and in others particularly active during the early months.

Connectivity is not confined to cortical areas but is also forged with sub-cortical nuclei, the basal ganglia and the cerebellum. The importance of the cerebellum in the development and smooth execution of movement has long been recognised; its role in the subconscious execution of higher cognitive, emotional and attentional functions is becoming increasingly so (Koziol et al. 2014). At behavioural level babies are observed initially to actively attend to and visually monitor every new movement sequence; with practice the movement is given less and less attention and becomes increasingly automatic, rapid and stereotyped. At neurological level the cerebellum appears to learn to recognise the context in which a particular pattern of movement is required and to decode signals from the premotor cortex that trigger the total motor response earlier and earlier. A body of evidence from primate and patient research and fMRI studies is accumulating in support of these ideas. Thus, two-way disturbances of cortical–cerebellar connectivity may play a role in the genesis of attention-deficit hyperactivity, specific language, autistic spectrum and developmental coordination disorders.

Developmental domains traditionally used for assessment; how well do they serve us?

The purpose of dividing early development into domains that embody their own developmental sequences should be to clarify the thinking and facilitate the task of the assessor – testing, interpreting, diagnosing and formulating a plan of action. Developmental domains and our way of using them in the assessment of babies and preschool children are fashioned on thinking current in the middle of the twentieth century. Skills are grouped into ‘umbrella’ domains such as social adaptation and play, hearing and lan-
guage/speech, vision and fine movements/eye–hand co-ordination and locomotion. The importance of the special senses in triggering the networking process was emphasised earlier. Although vision facilitates the development of hand movements, it also tutors and promotes most other aspects of development – social communication, cognition, language, locomotion etc. So why was vision tied to hand skills when it contributes as much if not more to so many other areas? Why in the past was locomotion selected out for status as the only motor domain, when manipulation and speech production – the two that best demonstrate advances in intellectual processing – were engulfed into ‘umbrella’ domains (eye–hand co-ordination and hearing and speech/language)? Why deprive the development of fine hand skills (manipulation) status as a motor domain when it too possessed clear-cut sequences in the development of reach, grasp, fine finger control and release? The question is equally applicable to the development of the motor aspects of speech. Thus the special senses, particularly hearing and vision, and fine motor systems (manipulation and speech apparatus) like the intellectual and behavioural domains follow their own developmental sequences, which deserve recognition, testing and recording space in their own right.

Neither the protocols nor recording sheets of most test schedules encourage the assessor to observe, record or analyse beyond the given pass/fail criterion. By emphasizing the peripheral points in the domain title, e.g. eye–hand co-ordination, a trainee assessor is

• left to guess which domain (eye or hand) is the primary focus/main objective of tests in the scale and may assume that both the special sense (vision) and the motor area (manipulation) mentioned are tested at age level when that is not the case.

Presentation of a Smartie (M&M; 1.25cm discoid sweet) on a table top is a typical eye–hand task for a 9-month-old; the ‘eye’ component – fixation of a Smartie – is a 5- to 6-month-old visual behaviour (near detection vision): the ‘hand’ component – index finger approach and closure of the thumb to the side of the index finger – is a 9-month level of manipulation. So, at 9 months, the main objective is manipulation, not near detection vision.

• not encouraged to give any thought to the cognitive processes that underpin and fire the emergence of hand skills; during the first year the size of the object that arouses cognitive interest in looking, and subsequently in manual exploration gradually decreases, so the size of the object that arouses interest carries important cognitive information that needs to be noted.

Q If the primary test objective is ‘eye’ (near detection vision) what size of spherical sweet should the assessor have chosen for a 9-month-old and how would this affect the cognitive and manipulative components?

*The appropriate size would be a 1.2mm spherical cake decoration known as a hundred and thousand in the United Kingdom. The level of the manipulative component would*
be raised above the competence of most 9-month-olds, so the test is no longer suitable for looking at the emergence of the pincer grasp; however, visual fixation and visual interest in such a small object are visually and cognitively definitive at 9 months.

So changing the size of the object completely alters the areas of the test that are definitive.

**Q** If the baby were 6 months old what would the main objective/s be of presenting a Smartie/M&M?

*At 6 months all three domains – ‘eye’, ‘cognition’ and ‘hand’ – can be definitively explored. A Smartie is an appropriate size for all three – near detection vision, visual interest and manipulation.*

**Q** For which domain would the goal posts need moving?

*The manipulative endpoint needs to be adjusted to a 5- to 6-month level, i.e. a raking attempt to pick up the Smartie. The other two would be the same – fixation and visual interest.*

No clinician would diagnose the nature of a circulatory problem without considering the functional integrity of the heart. The brain (central processor) is the heart of development. The heights of intellectual development attained by humans is the main feature that sets *Homo sapiens* apart from the rest of the animal kingdom, so surely the cognitive implications of visuomotor tasks warrant active consideration in the mind of the observer of a human baby. The real excitement of seeing a 16-week-old swipe at a hanging toy on her baby gym is the confirmation that her cognitive interest in the toy has been aroused and that she has taken a conceptual leap into realisation that she has arms and hands at her command. This is emphasised because when participants attending a developmental course are asked which domains they are testing for items on eye–hand scales, they usually respond ‘hand skills’ and/or ‘vision’ or even ‘colour vision’.

All skills involve the three main categories of developmental domain – sensory, intellectual/higher-level processing and motor – often more than one of each category. Thus test items have the potential to yield information about a baby’s development in all three categories, and in so doing, expand the assessor’s construct of a baby’s development laterally across domains as well as linearly within the main/target domain. The ability to engage with and process the breadth of this information ‘online’ throughout an assessment is professionally rewarding, informative and enabling and could become a goal for every professional and a major feature of training.

Thus the domains highlighted in the scheme of developmental examination in this book are in the three categories mentioned earlier. Of the sensory domains, vision and hearing are selected as they impact more than smell, touch and taste on early ‘intellectual’ development. The intellectual domains highlighted are social cognition/communica-
Chapter 1  A developmental approach to the examination of preschool children

Photographs that depict children in everyday rather than assessment situations are chosen in order to

• emphasize the importance of a warm embrace of family and a secure environment to development (Fig 1.1),

• capture facial expressions and interactions that reflect the intellect at work – ‘wheels

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1 NSC is sometimes referred to as non-verbal cognition or performance abilities; NSpSC refers to the understanding of non-verbal symbols such as pictures and miniature toys, and SpSC refers to the understanding of language – verbal comprehension and expressive language.

2 For practical reasons phonology is presented in the chapter on speech sound production rather than language.
going round', interest, confusion, triumph, achievement, drive,
• stress the importance of observation (structured or informal) in the developmental assessment of young children,
• hone the reader’s ability to interpret and logically think through the developmental content of the scene depicted,
• build the qualitative aspects of the reader’s gestalt of normality.

The developmental content of tests
The next paragraphs illustrate how a three-category domain approach expands an assessor’s insight into the developmental content of the tests he uses and of the responses he observes. The skill of ‘reaching for a toy’ and design of a test for it are thought through

The target domain is motor (manipulation). The main sensory, cognitive (intellectual) and motor components are as follows:

Sensory
• Sufficient vision to see the target and their own hands
• Visual, kinaesthetic and proprioceptive (feedback) from eye musculature to direct gaze and fixate on the target
• Kinaesthetic and proprioceptive feedback mechanisms from core, arm and hand musculature – control of arm movements

Intellectual/higher processing
• Cognitive interest in the target aroused by its visual percut
• Processing coordinates of the position of the target relative to self (parietal processing)
• Concept of arms and hands as prehensile organs that the owner can direct

Motor
• Eye and head movements to focus and fixate target
• Locomotor: head and trunk control and shoulder stability
• Arm and hand movements enacting a reach
Thus when a baby reaches for a toy the level of integration and functional maturity of the
networks and coding templates within and between all of the above are being observed. When designing a test for reaching, the following also need to be taken into account:

**Quality of the endpoint criteria**

Reaching for a visual target emerges around 12 weeks as bilateral dabbing/swiping movements by supine babies. By 27 weeks the movements are smoother, more coordinated and direct with one hand leading\(^3\) in babies sitting well supported on the parent’s lap. This is too wide a time frame and too much variability in quality of movement for ‘reaches for a toy’ to be age defining under 6 months. How can it be rendered more so? Two variables – positioning of baby and quality of arm movement – could be broken down to define narrower age brackets (see Table 1.1).

<table>
<thead>
<tr>
<th>Positioning of baby</th>
<th>Quality of arm movement</th>
<th>Average age range (wks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supine</td>
<td>‘Grasp with the eyes’ +/− tensing of arms</td>
<td>12 to 15</td>
</tr>
<tr>
<td></td>
<td>(small excited movements)</td>
<td></td>
</tr>
<tr>
<td>Supine</td>
<td>Incoordinate swiping movement</td>
<td>16 to 19</td>
</tr>
<tr>
<td>Supine</td>
<td>More coordinate and more direct movement</td>
<td>20 to 23</td>
</tr>
<tr>
<td>Sitting supported on parent’s lap</td>
<td>‘Grasp with the eyes’ +/− general tensing of arms</td>
<td>16 to 19</td>
</tr>
<tr>
<td>Sitting supported on parent’s lap</td>
<td>Incoordinate swiping/dabbing movement</td>
<td>20 to 23</td>
</tr>
<tr>
<td>Sitting supported on parent’s lap</td>
<td>More coordinate and more direct reach</td>
<td>24 and &gt;</td>
</tr>
</tbody>
</table>

\(^3\) The rate at which the bilateral movement subsides and the arms act independently varies; but a leading hand should be apparent by 6 months.

**Q** Why does positioning make such a difference between 17 and 23 weeks?

_A supine baby does not have to give attention or motor effort to maintaining posture and is free to concentrate on organising arm and hand movement; a baby-sitting well supported on the parent’s lap still needs to give attention to postural control and maintenance of shoulder stability under 24 weeks._
Grasp with the eyes, rather than arm movements, is described in two stages in Table 1.1 (see also Figs 1.2 and 1.3).

What is the developmental explanation for ‘Grasp with the eyes’ in each place? For the supine 12- to 15-week-old ‘grasp with the eyes’ signifies cognitive interest but not yet realisation of the functional potential of his hands. The sitting 16- to 19-week-old actually has the latter concept because he makes a swiping movement in supine; however, he is unable to demonstrate his conceptual understanding in sitting as so much of his motor effort is given to postural control of his head/trunk and shoulder stability.

The influence of the contributory domains (cognition and gross motor) is evident in Table 1.1. Row 1 emphasises that cognitive realisation of the functional potential of the upper limbs underpins the development of reach. Rows 4 and 5 illustrate the constraint on reaching imposed by the gross motor domain on the quality of movement. Rows 2, 3 and 6 define three age levels between 16 and 27 weeks that could be used as endpoint criteria in the assessment of upper limb development.

Figure 1.2 Grasp with the eyes in supine 2½-month-old; note tension in arms and hands.
Developmental level of the supporting domains

It is important to ensure that the developmental level of the supporting domains (vision and cognition) is well within the abilities of the age group and not at the ceiling or above; if set too high they will interfere with the interpretation of failure – this was illustrated in the discussion of the hundred and thousand and the Smartie/M&M (mentioned earlier). For the assessment of reach a test item and a mode of presentation that spans the time frame are needed. Assuming the test item is a ball, we need to consider:

- Size – the ball needs to be of a size that arouses cognitive interest in looking and in manual exploration, rather than the smallest that babies can see at the age defined by the test. To be sure that a very young baby is seeing, parents and professionals alike rely on the look of intense interest that accompanies direct gaze and fixation, i.e. upon a functioning visual-cognitive link. In fact the visual acuity of a newborn term baby is sufficient to see a ball of smaller than 1cm, but such a small target is

Figure 1.3 Grasp with the eyes of 4½-month-old in supported sitting; arms and hands are similar to those of baby in Figure 1.2. In supine this baby makes a visually directed swipe.
unlikely to arouse cognitive interest until 5 to 6 months. However a 6.25cm ball should arouse visual interest by 6 weeks, so for exploring the development of reach between 16 and 27 weeks a target of that size or larger would be appropriate.

- **Mode of presentation** – as reaching is dependent on arousing cognitive interest the visual allure of the target is important. A ball of uniform colour dangling limply does not have anything like the visual allure of either a multi-coloured one or one with holes in (to produce light effects) spinning ‘on the spot’. Interest can be aroused in a ball on a tabletop by spinning the ball gently. For a sitting baby a squeaky toy of similar dimensions could be substituted as reach, not vision, is being tested.

- **Distance from the baby** – mobility of babies in this age bracket is limited so the ball is best presented ‘within baby arms’ reach’, i.e. between 30 and 40cm.

- **Position in the visual field** – the visual field is full at birth but most babies alert and direct their gaze more promptly to a lure introduced within 45 degrees of centre rather than in the extremes of the peripheral field. Spatial processing of visual targets should certainly be adequate by 16 weeks.

- **Control of eye movements** advances rapidly over the first few weeks, reflecting rapid networking and functionality across the cortical cerebellar circuits that process the visual, spatial and motor aspects of eye movement. Eye movement control should therefore be more than adequate by 16 weeks.

Test procedure/instructions, primary observation and pass/fail criteria evolve directly from the earlier considerations. For each of the three age levels between 16 and 27 weeks test instructions will be the same except for positioning of the baby and mode of presentation of the ball. For a baby of 24 or more weeks:

**Test instructions**

The baby sits supported on the parent’s lap up to a table. Attract his attention to a multi-coloured woolly ball or toy (12.5cm) positioned in his central visual field at a distance between 30 and 40cm.

**Primary observation:** Reaching movements and the level and quality of the arm movement.

**Primary pass/fail criterion:** Reaches for the ball with a moderately well-co-ordinated swipe/dab.

**Primary record**

Reached for ball Yes  No

If Yes, then the developmental level of the arm movement
Interpretation

If Yes and Moderately well-coordinated have been circled the baby has achieved the main objective of the test (motor domain – manipulation) at age level. This is the moment to think, ‘Was everything appropriate in the supporting domains – vision and cognition?’ Match what is observed to what would be expected; in this child – fixation and age-appropriate eye movements of normal quality; cognitive interest in looking (6-week level) and ‘hands are for reaching’ (12- to 17-week level): age-appropriate and normal quality sitting posture.

If Yes and Incoordinate swipe or dab or No is circled the main objective has not been achieved. Repeating the presentation this time with the foci of observation on the cognitive, visual (vision and eye movements) and postural components is likely to highlight potential areas of concern and indicate which, if any, areas should be examined particularly carefully. The following three scenarios are illustrative:

- Scenario 1: Suppose a sitting 22-week-old baby does not reach for the ball. When presented a second time she is noted to fixate the ball with interest; her eye movements and postural control appear age appropriate and without any overt pathological features such as squint, abnormal posturing and low tone. ‘Does she understand the potential of her upper limbs for reaching?’ should be flashing in the assessor’s head.

  Q Is there cognitive delay or simply manipulative delay; how could the assessor tell?
  Repeat with dangling ball and baby supine. If she does not attempt to reach or swipe in this position she does not possess the underpinning concept so the manipulative delay is likely to be part and parcel of cognitive delay.

- Scenario 2: A supine 19-week-old baby makes no reaching movement. On second presentation the assessor notes brief visual awareness and interest in the ball and nystagmus; general tone in trunk and limbs appears normal and symmetrical.

  Q Which domains are showing delay?
  All three domains – visual, cognitive and manipulative.

  Q Which domain would need to be examined with particular care?
  Vision and the visual system.
Scenario 3: Figure 1.4 shows a supine 11-week-old. An appreciation of the developmental content of tests also encourages active engagement of assessors in construction of a diagnostic perspective throughout their assessment in the same way as a clinician does when performing a physical examination. In turn the diagnostic pointers, together with the findings, evolve into an action plan and developmental guidance.

Assessors are advised initially to focus their attention on the target domain and gradually expand it to the supporting domains (secondary observations / bonuses). Readers wishing to hone their developmental thinking may find it useful to reflect upon the developmental content of tests and skills from different domains.

**Thinking in profiles**
At the end of a preliminary assessment the assessor has a basic construct of the child’s functioning within sensory, intellectual and motor domains, in other words a basic profile of the child’s development. Analysing the intellectual profile and subsequently considering it in the context of functioning in the sensory and motor domains facilitates diagnosis and formulation of an action plan and developmental guidance. The intellectual profile of seven children, all aged 3.0 years, is presented in histogram format in Figure 1.5.

A line drawn horizontally across the figure through the 3-year-old index on the vertical axis represents the chronological age of each child. First look for discrepancies of a third
or more in age levels achieved between domains as these provide the strongest diagnostic pointers. There are no discrepancies of this magnitude for child A, B or G; in child A age levels are all clustered around his chronological age – intellectually he is functioning normally; however in child B they are all clustered at approximately half her chronological age – she is globally delayed most likely because of learning disability; child G will be discussed later. Children C, D, E and F present with discrepancies of more than a third between some domains. The best domain to use as a reference/yardstick is NSC. Both expressive language and verbal comprehension are less than two thirds that of NSC in child D and child E, though only expressive language is in child C; with NSpSC and SoC also at chronological age level the most likely problems are specific language delay in child D and specific expressive language delay in child C. Both aspects of language are very severely delayed in child E compared to all other domains; this could represent a severe developmental language delay/disorder. However, in this child an additional small discrepancy provides a subtle clue to a more likely diagnosis; expressive language is slightly (just 2 or 3 months) higher than verbal comprehension; this should start a red light flashing ‘HEARING’ in an assessor’s head. Child F differs from the others in that SoC and NSpSC are also delayed in comparison to NSC, suggesting that the language delay is part of a more widespread disorder of communication – an autistic spectrum disorder (ASD). Note that in child F expressive language is slightly lower than verbal comprehension, like that more typical of children with specific language delays or those with global developmental delay (see children B and D). Returning to child G, his language development is a little delayed, but the language profile suggests that the cause may be a mild/moderate hearing loss, rather than a primary language disorder.
Q Which of the profiles could be the consequence of serious visual or hearing impairments?

Profile B could be the consequence of severe visual impairment though primary severe learning difficulties would be the most common reason. Profiles D and especially E could result from severe degrees of hearing impairment.

Q Which of the profiles could be the consequence of minor visual or hearing impairments?

Profile G is most likely to be the consequence of minor hearing impairment. The other profiles are unlikely to be the consequence of minor degrees of either hearing or visual impairment; however, their presence cannot be ruled out.

Q Apart from profile F which one is most likely to be that of a child with an ASD?

Profile B, as it is the only one with significant delay in both NSpSC and SoC.

There is no fixed relationship between NSC and the other domains in ASD.

Diagnosis, action planning and developmental advice

The diagnostic clues in the intellectual profile are then considered in the context of the primary history (see Chapter 2) and the test findings in the two sensory and three motor domains to arrive at a provisional diagnosis. Further exploration of the primary and secondary medical and developmental histories and some medical examination may be indicated to inform an action plan and/or developmental guidance. For example the intellectual profile of child G suggests a slight delay in language development possibly because of hearing impairment. His parents had not expressed any concerns about his development.

Q What would the assessor want to do before finalising his action plan or giving developmental advice?

Check hearing carefully and examine ears for signs of otitis media with effusion (OME), wax etc., before deciding whether and to whom to refer. Explore the history of URTIs, discharging ear, family history for hearing loss or grommets in childhood and social/cultural and language background. Suppose G has a streaming cold, the assessor could decide to review G in 2 weeks to recheck his hearing and drums before referring him on to ENT/audiology. If positive for chronic OME, the assessor might advise the parents to speak in a louder voice while referral to audiology is enacted. This would hardly be appropriate advice if G does not have any hearing loss. If G’s hearing is normal the assessor would be more inclined to give the parent advice on promoting his language development, though if social circumstances are also deprived or English is not the first language of the family, perhaps advising attendance at a nursery, with some one-to-one time with an adult dedicated to language built into his daily
Chapter 1 A developmental approach to the examination of preschool children

Adaptation of test tasks when disability is suspected or present
Insight into the developmental content of test tasks again gives assessors the confidence to adapt them to a child’s disability without degrading the main/target objective of the test. To achieve this requires more advanced developmental thinking and is discussed more fully in Chapter 13. As tasters:

• A 3-year-old severely deaf child requires a test of visual acuity. Obviously, she won’t understand spoken instructions ‘to match the assessor’s letter to one on her key card’. Pantomiming the matching task or assessor and mother demonstrating it can convey the instruction without altering the measure of acuity.

• A 3-year-old child with visual impairment requires free field audiometry. She is not able to see well enough to stack rings on a stick or put bricks in a box. Cognitively she has simple cause and effect.

Q What aspect of the test needs modification?
   The response task.

Q Will modification interfere with the test of hearing acuity?
   No.

Q Suggest a suitable modification
   Give her a soft squeaker; initially the assessor helps her squeak it each time he makes a loud pure tone. Once she starts responding reliably he commences the actual test.

• A 2½-year-old with cerebral palsy and no useful hand movement requires a test of verbal comprehension. At this age he is expected to assimilate a two-component command like ‘put dolly on the chair’.

Q How might the assessor modify the test procedure without altering the level of verbal comprehension tested?
   Space the items widely and encourage him to eye-point first to single items, e.g. ‘Look at/where is the spoon’. Once he is responding reliably raise the command to the age-appropriate level ‘Show me the doll and the chair’ and observe whether he eye-points to each in turn. The assessor has modified the response task but not the level of the verbal command; the latter still requires the child to assimilate a two-component command.

The principles for adapting tests for children with disability include the following:
• Consideration of the developmental content of the test task in each of the three categories of domain – sensory, intellectual and motor.

• Highlighting which domain is the main objective (the target of the test) and which two are subsidiary. The main one must not be altered; the two subsidiary ones can be adapted to the difficulties/impairments of the individual child.

**Allocation of skills to the most appropriate domain**

Thinking through the developmental content of skills and test tasks also ensures that in schedules they are allocated to the most appropriate domain. For example, there are a host of cognitive skills hidden in the traditional domains of eye–hand co-ordination, hearing and language and gross motor development. To delineate these and place them into the domain headed non-symbolic cognition (Chapter 6) hones the developmental thinking of professionals and gives more credence to concerns about mental delay, or its absence, during the first 18 months. Sound localisation is a good example.

Sound localisation (locating the direction, relative to self, of a sound source) is traditionally placed in the hearing and language/speech domain; however, its contribution to language development is extremely tenuous. In the author’s view the sound localisation sequence represents the development of permanence for sound-making objects/people (sound sources) and thus belongs in the NSC domain. Mary Sheridan first described the stages amongst her sequences of hearing behaviours (Sheridan 1968) but did not flag up cognition. The sense that tutors the cognitive aspects of sound localisation is vision, not hearing (Sonksen 1979, 1983).

**Key Points**

Thinking developmentally in these ways allows the professional:

• To hone the breadth and depth of her developmental thinking.

• To focus her powers of observation more effectively.

• To build and diagnostically assimilate the picture of a baby’s development throughout assessment into domains that are more clearly defined.

• To formulate a clearer diagnostic perspective on which to base both a more robust action plan and individualised developmental advice.

• To design tests and test sequences.

• To adapt tests to a child’s disability without degrading the main objective of the test.

• To allocate test tasks in the most appropriate domain(s) and thus strengthen the whole testing schedule.
• To grow professionally from novice tester to one with the knowledge base, expertise and flexibility to evaluate the neurodevelopmental status and problems of children with multiple disability.

References


Milne AA (1926) In which Eeyore has a birthday and gets two presents. In: Winnie-the-Pooh, Ch 6. London: Methuen and Co Ltd.

