Preschool children and toddlers often display emotional and behavioral problems. Without early intervention, these difficulties can lead to serious problems in later years. This research from Belgium explores how Life Space Crisis Intervention and Developmental Therapy-Developmental Teaching can inform work with these young children.

Emotional, social, and behavioral difficulties in preschool children can be crucial risk factors for later academic problems, antisocial behavior, and delinquency (Snyder, 2001; Tremblay, Mass, Pagani, & Vitaro, 1996; Eron, 1990). However, there are fewer methods available for toddlers who show emotional and behavioral difficulties than are available for school-aged children.

Life Space Crisis Intervention (LSCI) is a therapeutic, verbal strategy for redirecting the lives of children and youth during moments of crisis (Long, Wood, & Fescer, 2001). LSCI was introduced in Belgium in 2002 and is becoming increasingly more popular. LSCI can be used effectively when children have acquired basic communication and learning skills. In typical development, this means that children are ready for LSCI at the age of six or seven. This article explores whether these principles are applicable with toddlers.

The OOBC Nieuwe Vaart is a special education school and day treatment center in Ghent, Belgium, serving children with emotional and behavioral disorders (EBD). The program has been using LSCI with children from primary school, but not with toddlers.
In 2008, we began to examine Developmental Therapy-Developmental Teaching (DT-DT) to find our answers (Wood, Davis, Swindle, & Quirk, 1996). Mary Margaret Wood developed this model and collaborated with Nicholas Long in two books on Life Space Crisis Intervention. Dr. Wood granted permission for her assessment instrument, Developmental Teaching Objectives Report Form (DTORF-R), to be translated into Dutch for use in this research (Wood, 1992).

The DTORF-R is the assessment instrument that determines the developmental stage of a child (Wood, Quirk, & Swindle, 2007). These stages are summarized below:

Stage 1: Responding to the Environment with Pleasure (responding and trusting)

Stage 2: Responding to the Environment with Success (learning individual skills)

Stage 3: Successful Group Participation (applying individual skills to group interactions)

Stage 4: Investing in Group Processes (valuing one’s group)

Stage 5: Applying Individual and Group Skills in New Situations (generalizing and valuing)

The full assessment instrument contains 171 observable items within four subscales; behavior, communication, socialization, and academics. This provides insight into what supports a child’s needs in order to transition to the next developmental stage.

The current study used the DTORF-R to screen seven toddlers with EBD who are transitioning from kindergarten to primary school. In order to benefit from LSCI interventions, children should have abilities in these areas:

- Basic attention span and memory
- Produce spontaneous language
- Comprehension of adult’s words
- Trust in adults

We worked with Mary Wood to select specific items within the DTORF-R which applied to the four abilities needed for effective use of LSCI.

**Before age five, complex skills such as working together, self-control, and language are learned with the support of helping adults.**

Typically, by age six, children have mastered stage two and are developing stage three goals. Six toddlers in our study were still developing within developmental stage two, with one toddler (Child 2) transitioning to stage three. Table 1 summarizes the developmental stages by subscales of DTORF-R.

<table>
<thead>
<tr>
<th>Child 1</th>
<th>Behavior</th>
<th>Communication</th>
<th>Socialization</th>
<th>Cognition</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Child 2</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Child 3</td>
<td>3</td>
<td>2-3</td>
<td>3</td>
<td>2</td>
<td>2-3</td>
</tr>
<tr>
<td>Child 4</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Child 5</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Child 6</td>
<td>2-3</td>
<td>2</td>
<td>2</td>
<td>2-3</td>
<td>2</td>
</tr>
<tr>
<td>Child 7</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
Table 2: Percentage scores for mastery of developmental stage two

<table>
<thead>
<tr>
<th>Child</th>
<th>Behavior</th>
<th>Communication</th>
<th>Socialization</th>
<th>Cognition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child 1</td>
<td>67%</td>
<td>67%</td>
<td>50%</td>
<td>65%</td>
</tr>
<tr>
<td>Child 2</td>
<td>83%</td>
<td>0%</td>
<td>83%</td>
<td>65%</td>
</tr>
<tr>
<td>Child 3</td>
<td>100%</td>
<td>83%</td>
<td>100%</td>
<td>82%</td>
</tr>
<tr>
<td>Child 4</td>
<td>83%</td>
<td>67%</td>
<td>67%</td>
<td>76%</td>
</tr>
<tr>
<td>Child 5</td>
<td>67%</td>
<td>67%</td>
<td>67%</td>
<td>82%</td>
</tr>
<tr>
<td>Child 6</td>
<td>83%</td>
<td>33%</td>
<td>67%</td>
<td>94%</td>
</tr>
<tr>
<td>Child 7</td>
<td>33%</td>
<td>33%</td>
<td>33%</td>
<td>65%</td>
</tr>
<tr>
<td>Average</td>
<td>74%</td>
<td>50%</td>
<td>67%</td>
<td>76%</td>
</tr>
</tbody>
</table>

As seen, all showed a mild developmental delay. This becomes clearer when we analyze percentage scores for individual skills of Stage Two as shown in Table 2.

We noticed that the lowest subscale score was on communication at 50%, while mastery was 74% on the behavior dimension. It appears that behavior is more advanced than communications. Notice how this delay impacts interventions with two examples of a small child in crisis.

**Tom** suddenly starts to scream and attacks Lily. The teacher was helping another child and did not see what happened. Tom is really angry, his face turns red, and he breathes rapidly. The teacher pulls Tom away from Lily and Tom starts to throw toys on the ground. The teacher holds him tightly and, after 15 minutes, Tom stops struggling and starts crying. Another child, Dylan, saw what happened and explained to the teacher that Lily said mean things to Tom. The teacher asked Tom why he did not come to tell her what Lily had said. Tom does not manage to formulate an answer to this question, but acts out his anger by saying: “I’m gonna kill Lily.”

**Timmy** comes into class and is immediately acting out: refusing to sit on his chair, pulling another girl’s hair, screaming to the teacher. During morning break, the family worker informs the teacher that there has been a crisis at Timmy’s home this morning. His dad was drunk and abused Timmy’s mother.

It is stunning the way we rely on verbal methods, even when the child’s communication scores are so low. This finding makes us think about what we ask from children (e.g., “Tell me what’s wrong” or “If you have a problem, talk to the teacher!”). Do we frustrate our kids even more by expecting more than they can handle with their current developmental abilities? How can we reach these children? How can we teach them to communicate, to use words?

Melanie Cross (2004) stated that communication problems can limit the skills necessary for effective social interactions, self-regulation of behavior, and the ability to learn and to think. Language development and emotional development occur together and are affected by experience, in particular the relationship between the child and a helping adult. Before age five, complex skills such as working together, self-control, and language are learned with the support of helping adults.

**Do we frustrate our kids even more by expecting more than they can handle with their current developmental abilities?**

The toddlers in our study had not mastered the LSCI related DTORF-R items, so we can conclude that they are not ready for typical LSCI interventions. However, adults can stimulate development of the skills to help children overcome developmental lags.

DT-DT suggests an abbreviated form of LSCI: the “talk, fix it, smile” procedure. This simple approach stimulates children to describe problem events, resolve conflicts, and restore a positive
emotional state. This may be the most effective preparation for toddlers to achieve the needed skills for a full LSCI.

We conclude that the DTORF-R is a valuable instrument in screening and determining developmental stages. The results give parents and professionals information to adapt interventions and methods to the developmental needs of the child. Accurately assessing developmental levels within areas of behavior, communication, socialization, and academics is valuable in working with hurt and troubled children.

**Communication problems can limit the skills necessary for effective social interactions, self-regulation of behavior, and the ability to learn and to think.**

Current preschool education in Belgium and elsewhere focuses more and more on the cognitive domain. The results of this study suggest that preventive methods with preschool children should focus more on communication and socialization, and particularly on language stimulation within a trusting relationship with an adult. Children who are learning to respond to the environment with success (Developmental level 2) need opportunities to focus on reflective tasks (describing one's own characteristics and characteristics of others), on ways to communicate (sharing information with adults and peers), and on successful interactions with adults and peers (participate in interactive play, initiate social movement).

This study was limited to one class with seven toddlers in a school setting, thus results should be carefully interpreted. Nevertheless, this first exploration of DT-DT, which resulted in a Dutch translation of DTORF-R, yielded some noteworthy results which raise critical questions of how we work with troubled young children. Further research with more subjects in different contexts is indicated.

**Katrien Goorix, MA**, is orthopedagoge at the Home St. Elisabeth, Ronse, Belgium. She can be reached by email at kgoorix@gmail.com

**Franky D'Oosterlinck, PhD**, is a Master Trainer in LSCI, and pedagogical director of the OOBC Nieuwe Vaart, Ghent, Belgium. He can be contacted by email at frankyd@oobc-nieuwevaart.be

**Eline Spriet, MA**, is clinical psychologist and scientific co-worker at the OOBC Nieuwe Vaart, Ghent, Belgium. Email: elines@oobc-nieuwevaart.be

**Mark Freado, MA**, is President, Reclaiming Youth International, and Trainer/Consultant, Cal Farley’s. He can be reached by email at freado@reclaiming.com

**Eric Broekaert, PhD**, is Professor in Orthopedagogics and President of the Department of Orthopedagogics in the University of Ghent. Contact him by email at eric.broekaert@ughent.be

Special thanks to Mary M. Wood for her advice and cooperation in this research.

**References**


For further reading:


For subscription information or to order back issues, go to www.reclaimingjournal.com or call us toll free in the USA and Canada: 1-800-285-7910

Makes a great gift!