Sensory Attachment Intervention Consultancy

www.sensoryattachmentintervention.com

Assessment and Formulation Tools Manual For Therapists

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DISCLAIMER

This course is designed to provide up-to-date information in regard to the subject matter covered. The course authors have made every effort to ensure the accuracy of the information herein.

It is the responsibility of every therapist to evaluate the appropriateness of the use of assessment and intervention techniques in the context of actual clinical situations and with due consideration to new developments.

The course authors cannot be held responsible for any malpractice committed by course participants in their clinical work.

Éadaoin Bhreathnach
2026

Introduction

SAI analyses how sensory processing, trauma and attachment relationships affect behaviour, through the use of standardised and non-standardised assessments.

This manual provides you with a step-by-step guide to the use SAI Assessment and Clinical Formulation tools, and Model of Intervention. These tools are particularly useful for complex cases where the source of presenting difficulties may be sensory, trauma, insecure attachment or any combination of all three.

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A Brief Review

The Theoretical Basis of SAI

SAI reviews, translates and implements research findings into clinical practice and seeks to evaluate the outcome of change. To enable you to do this, this course provides you with the tools to identify and track changes.

SAI is informed by:
◊ Neuroscience
◊ Sensory Integration Theory
◊ Attachment Theory

Behaviour is the end product
We need to identify the original and current sources of behaviour. This process will inform us which professionals need to be involved, what type of intervention is required and when. The source may be medical, psychological, due to sensory differences, insecure attachment or as a result of a traumatic event. Quite often it is a combination of factors so it requires the expertise of different professions. We need to work collaboratively to gain an understanding of the complexity of behaviour. If we simply look at behaviour through our single professional lens, we automatically miss some information that may be key in leading us to a different conclusion, which in turn influences the choice of intervention.

Key Points
◊ Identify the source of behaviour.
◊ Requires the expertise of different professions.
◊ Looking at behavour through a single lens means we automatically miss some information.

What is the Intention of Behaviour?
When analysing behaviour the first question we need to ask is;
◊ What is the intention or function of behaviour?
◊ Is it trauma, sensory or attachment based?

Trauma Behaviour
When the activity or interaction with others acts as a reminder of trauma, the child or adult becomes overwhelmed and survival behaviours are triggered. Sensory and attachment strategies no longer work. They can no longer regulate. What we then see is increased hypervigilance, flight, fight, or freeze, cut out and shutdown behaviours.

Sensory Seeking Behaviours
When we observe sensory seeking behaviours we need to ask the following questions:
◊ Is it a strategy to stay alert in order to maintain attention, e.g. the need to move, be active in the case of someone with low arousal, or low muscle tone?
◊ Is it to enable sensory registration when the sensory threshold is high?
◊ Is it to gain more detailed information about what is occurring on the body or in the environment?

Seeking Intense Stimulation
Intense stimulation can be a coping strategy to relieve tension or to up regulate e.g. going running, playing football, or use of down regulating activities such as climbing and hanging. It can also be used to alleviate emotional distress, as in the case of self-injurious behaviour.

Attachment Strategic Behaviours
◊ Is it to avoid unwanted or negative attention?
◊ To gain approval in the belief that positive regard from attachment figures is always conditional?
◊ Attain and maintain the attention of others?

Standardised Attachment Assessments will confirm which.

Key Point
◊ Consider whether behaviour is sensory, attachment or trauma based or a combination.

Differentiating Behaviours
The same behaviour may have different underlying reasons. Let's take climbing as an example:
◊ Is the child climbing to flee from a threatening situation?
◊ Are they sensory seeking in order to meet their regulation needs, in which case they will be happily self-absorbed in the activity.
◊ Or are they climbing in order to activate a protective response from others? You will notice they will be checking to see if their behaviour is being observed.

To help you differentiate, the context in which the behaviour happens and the narrative will help you interpret which is occurring.

Key Points
◊ Instinctive survival response, sensory seeking or attachment behaviour?
◊ Example Climbing;
(1) To flee from a threatening situation?
(2) Seeking sensation in order to meet regulation needs?
(3) To activate the protective response from others?

◊ Context and Narrative enables interpretation.

Sensory Arousal Attachment Physiological (SAAP) Profile

The SAAP profile questionnaire does not replace the need for standardised assessments or the need for observations of behaviour in different settings. It is intended for use alongside standardised assessment tools or to be used to support the need for standardised assessments or a referral to other services.

The SAAP Questionnaire helps us to identify the source of behaviour and how the child functions in their daily life. It uses a Likert Scale of 1:5 to identify the frequency of behaviours, carers are encouraged to use the comment box as it not only provides information on when, where, and with whom the behaviour occurs, but it also provides insight into how carers and professionals perceive the child and the child's behaviours. This insight is useful because it informs us whether the respondent is more cognitively or affectively biased and thus guides us to how we may relate our findings in a way that is meaningful to the respondent.

Key Points

- The SAAP helps to identify the source of behaviour.
- Carers are encouraged to complete the comment box. This provides insight to how they perceive the child and the behaviour.

Completing the Profile Questionnaire

When possible, send out the SAAP a few weeks in advance. Suggest to those completing the SAAP to first read through the Questionnaire, then quietly observe the child before filling it in. This encourages carers and professions to observe the child's behaviour more closely. Also stress that partners or key workers do not have to agree on how they perceive the child's behaviour. In the case of a couple, they separately complete the SAAP, and the same applies to key workers, as it is important to get a sense of each carer's dispositional representations of the child.

There will be sections that parents or professionals may struggle to complete as they don't have direct experience of the child's behaviour. Specify which sections or questions you would like them to answer. Tell them they are not to worry if they can't answer a question or are uncertain as to how to reply. There will be an opportunity to go through these questions again in the follow up face-to-face profile meeting, where all respondents are present to discuss and further clarify initial thoughts and findings.

Key Points

- Send the SAAP out weeks in advance.
- Carers and professionals should first read the questionnaire then quietly observe the child.
- Partners and key workers do not have to agree on how they perceive the child's behaviour.
- Couples and key workers separately complete the SAAP.
- Specify which sections to complete.
- Follow up with a face-to-face Profile Meeting, where all respondents are present to discuss and further clarify initial thoughts and findings.

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Consider the capacity of the carer to complete the questionnaire

We need to consider the capacity of the carer to complete the questionnaire.
Where carers are unable to complete the SAAP on their own, you will need to do a face-to-face interview and complete the SAAP over a few sessions
It is also important to remember the questions may be activating and act as a reminder of previous traumatic episodes. So, you need to consider how you may make conditions feel safe and regulating to help the carer to go through the process.
Remember social engagement helps to inhibit feelings of stress. The use of your voice, facial expressions, active listening, sitting around a table having tea or coffee and something regulating to eat, all helps to provide a sense of welcome and safety.

Key Points

- ◊ Face to face over several sessions.
- ◊ It is important to remember the questions may be activating and act as a reminder of previous traumatic episodes.
- ◊ Consider how you may make conditions feel safe and regulating to enable them to complete the process.
- ◊ Remember social engagement helps to inhibit feelings of stress.

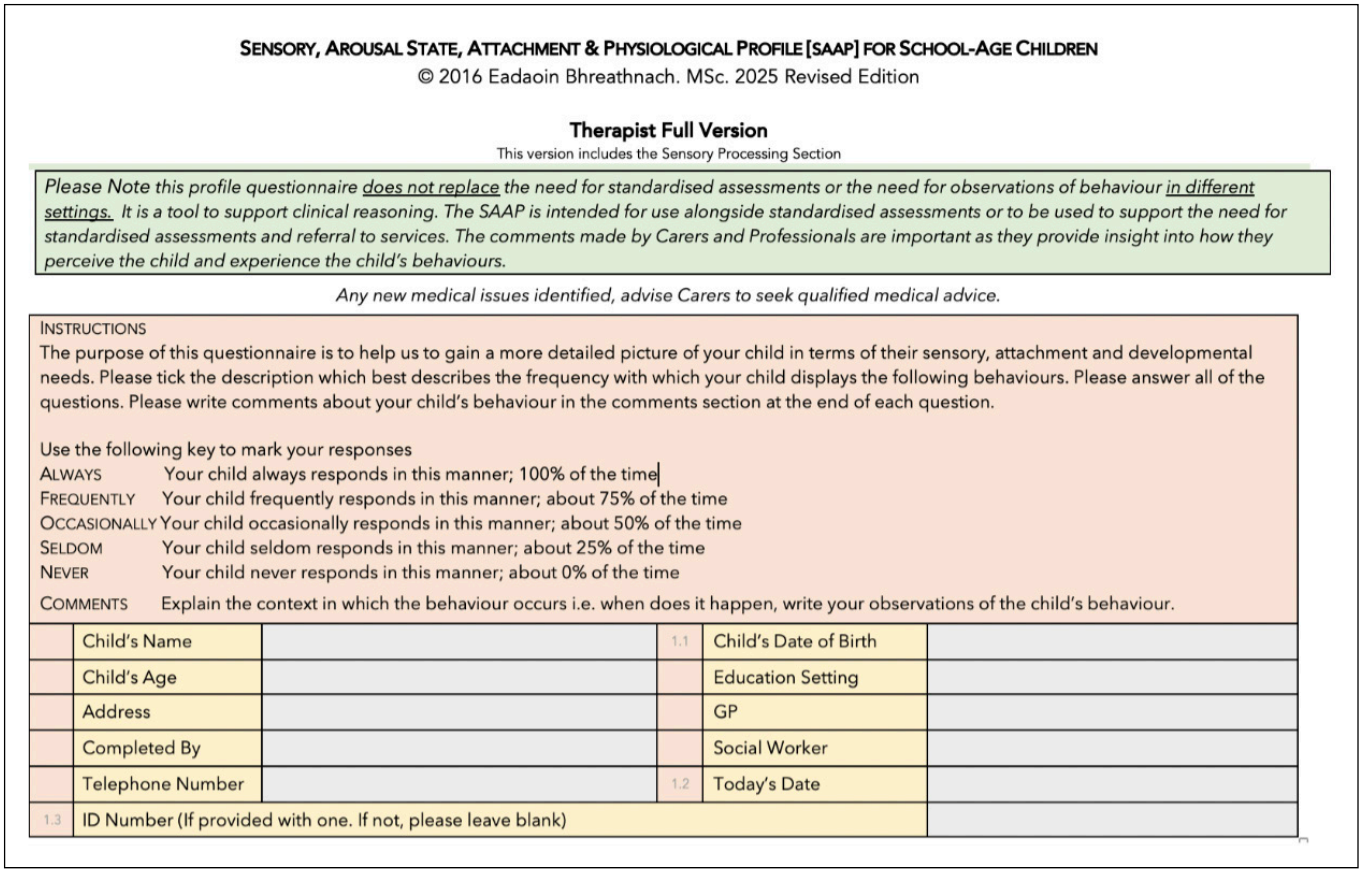
SAAP Sections

Section 1: Autonomic Regulation, ANS stress responses e.g. heart rate, sleep pattern.
Section 2: Arousal States: Survival Behaviours.
Section 3: Attachment Behaviours.
Section 4: Developmental History and Sensory Processing.

SAAP Interpretation Guide

The SAAP Interpretation Guide is not a diagnostic tool but rather a tool for exploration and reflection. It is important to note that the same behaviour may have different meanings. In follow up discussion at the profile meeting you need to consider;

- ◊ Is behaviour contingent on who is present (attachment)?
- ◊ Is behaviour contingent on the sensory environment (sensory processing)?
- ◊ Is behaviour contingent on other factors e.g., being ill or tired?



Sensory, Arousal State, Attachment & Physiological Profile [SAAP] for School-Age Children

Therapist Full Version

This version includes the Sensory Processing Section

Please Note this profile questionnaire does not replace the need for standardised assessments or the need for observations of behaviour in different settings. It is a tool to support clinical reasoning. The SAAP is intended for use alongside standardised assessments or to be used to support the need for standardised assessments and referral to services. The comments made by Carers and Professionals are important as they provide insight into how they perceive the child and experience the child's behaviours.

Any new medical issues identified, advise Carers to seek qualified medical advice.

INSTRUCTIONS

The purpose of this questionnaire is to help us to gain a more detailed picture of your child in terms of their sensory, attachment and developmental needs. Please tick the description which best describes the frequency with which your child displays the following behaviours. Please answer all of the questions. Please write comments about your child's behaviour in the comments section at the end of each question.

Use the following key to mark your responses

ALWAYS	Your child always responds in this manner; 100% of the time
FREQUENTLY	Your child frequently responds in this manner; about 75% of the time
OCCASIONALLY	Your child occasionally responds in this manner; about 50% of the time
SELDOM	Your child seldom responds in this manner; about 25% of the time
NEVER	Your child never responds in this manner; about 0% of the time
COMMENTS	Explain the context in which the behaviour occurs i.e. when does it happen, write your observations of the child's behaviour.

	Child's Name		1.1	Child's Date of Birth	
	Child's Age			Education Setting	
	Address			GP	
	Completed By			Social Worker	
	Telephone Number		1.2	Today's Date	
1.3	ID Number (If provided with one. If not, please leave blank)				

Instructions

This section provides: instructions on how to complete the questionnaire, demographic information about the child, who has completed the questionnaire and their telephone number in case you need to contact them.

If there is no social worker simply reply DNA for 'does not apply'.

The ID number (1.3) is when the questionnaire is being used for research or for a survey to maintain anonymity.

BACKGROUND

1.4	What is your relationship to the child?	Birth Parent	
		Adoptive Parent	
		Foster Parent	
		Residential Care Worker	
		Other (please specify)	
1.5	Summarise your main concerns regarding your child		
1.6	If appropriate, reasons for Fostering/ Adoption		
1.7	If appropriate, what age was the child when s/he first came to live with you?		
1.8	If appropriate, summarise the behaviour when the child first came to live with you		
1.9	Summarise the current behaviour of the child		
1.10	Are there any significant events which may have contributed to your child's behaviour? Give details.		
1.11	Summarise your child's main strengths		
1.12	What are your key goals for your child?		
1.13	Has your child received any previous therapy or is s/he currently receiving therapy? Please give details		
1.14	Please indicate which of the following applies	This is the first time completing this form	
		I am completing this form for the second time after my child has had SAI Intervention	
		I am completing this form for the third time after my child has had SAI Intervention	
		I am completing this form for the second time, but my child has not received SAI Intervention	
	Please specify if appropriate		

Background

Background information is very helpful. It quickly informs you about: the respondents main concerns, their key goals, any changes in the child's behaviour and the child's strengths. The question on significant events (1.10) provides insight into what the respondent perceives as significant. Also, have they considered the source of the child's behaviour? The question on therapy is important as it provides information on the child's capacity to participate and respond to intervention.

SAAP Sections

In each section I am only going to focus in on behaviours that may have an alternative explanation.

Section 1: Autonomic Regulation

		Almost Always	Frequent	Occasionally	Seldom	Almost Never	Comments/ Context in which this occurs
		95%	75%	50%	25%	<1%	
2.1	Tends to get infections/ ill						
2.3	Perspires/ sweats						
2.5	Feels hot						
2.7	Feels cold						
2.9	Suffers from allergies						
2.11	Finds it difficult to get to sleep						
2.13	Is a light sleeper						
2.15	Wakes up early						
2.17	Is a heavy sleeper						
2.19	Struggles to get up in the morning						
2.21	Suffers from constipation						
2.23	Suffers from diarrhoea						
2.25	Suffers from both constipation and diarrhoea						
2.27	Runs to the toilet when anxious						
2.29	Suffers from headaches						
2.31	Doesn't feel like eating when stressed						
2.33	Eats more when stressed						
2.35	When stressed goes for sweet foods						Name foods:

Q 2.11 Finds it difficult to go to sleep

It could be due to the following:

Level 1: Attachment History

◊ The child finds it difficult to settle because of the associated trauma with bedtime. For example, violence may have occurred at night between parents, the child experienced sexual abuse at that time. Thus, bedtime has become coupled with a real sense of danger.

Level 2: Sensory Modulation

◊ The child might be sensitive or defensive to certian sensory experiences which prevents the child from being able to relax and go ot sleep. For example, lighting, background noise, the feel of the bedclothes, or the room temperature.

◊ Explore with the child what bothers them and make changes accordingly.

Level 4: Attachment

◊ The child may experience separation anxiety thus resorts to attachment behaviour that keeps the Carer present in the room.

Q 2.19 Struggles to get up in the morning.

◊ If waking up is the issue it is **Level 1**.

◊ If the child is reluctant to get out of bed this could be **Level 4**. Explore is this due to separation anxiety or anxiety about going into school because the child struggles academically or is being bullied in school.

Q 2.27 Runs to the toilet when anxious.

◊ This is this **Level 2** if the child is fleeing to get away rather than needing to go to the toilet which is **Level 1**.

		Almost Always	Frequent	Occasionally	Seldom	Almost Never	Comments/ Context in which this Occurs
		95%	75%	50%	25%	<1%	
2.37	When stressed, goes for salty foods, e.g. crisps, salted nuts						Name foods:
2.39	When stressed, goes for citrus foods, e.g. oranges						Name foods:
2.41	When stressed goes for hot spicy foods, e.g. curry, chilli						Name foods:
2.43	When stressed, seeks to suck drinks from bottle of stream e.g. sports water bottle, carton with straw						Name foods:
2.45	When stressed, goes for crunchy foods, e.g. raw vegetables, biscuits, cereal						Name foods:
2.47	When stressed, goes for foods such as bread, pizza, pasta						Name foods:
2.49	When stressed, goes for chewy foods, e.g. chewing gum, toffee, steak						Name foods:
2.51	Registers pain						
2.53	Under-reacts to pain; i.e. doesn't appear to register being hurt						
2.55	Plays on regardless of feeling the pain, e.g, doesn't stop to seek comfort						
2.57	Over-reacts to pain						

Q 2.53 Under-reacts to pain, doesn't appear to register being hurt is Level 1.

◊ If the child is being emotionally avoidant and being dismissive of being in pain this is **Level 4.**

Q 2.55 Plays on regardless of pain. e.g., doesn't stop to seek comfort.

◊ If the child isn't registering pain this is **Level 1**.

◊ If the child briefly shows pain then masks it, it is **Level 4**. Emotionally avoidant behaviour.

Q 2.57 Over reacts to pain.

◊ The child may have a low threshold for pain which is **Level 1.**

◊ **Level 4** is where the child exaggerates or pretends to feel pain. This is feigned helplessness, a strategic attachment behaviour to elicit comfort.

◊ Feigned Helplessness may be misdiagnosed in the case of the child who appears to under-react to injuries but is highly sensitive to skin abrasions. In this case it is not Level 4, it is **Level 1**.

Section 2: States of Arousal

		Almost Always	Frequent	Occasionally	Seldom	Almost Never	Comments/ Context in which this Occurs
		95%	75%	50%	25%	<1%	
3.1	Finds it easy to relax						
3.3	Can ignore background sights and sounds when doing homework						
3.5	Can ignore background sights and sounds in the classroom						
3.7	Can ignore sights and sounds in public places						
3.9	Overly aware of background sounds						
3.11	Easily startled						
3.13	Tense or constantly vigilant when in the company of others						
3.15	On the look-out, checking what is happening in his/ her surroundings						
3.17	Dislikes being alone						
3.19	Clingy; reluctant to separate						
3.21	Tends to be noisier in group situations, when not getting 1:1 attention						
3.23	Constantly on the go						
3.25	Finds it difficult to sit still and not fidget						
3.27	Is quick to emotionally react						Context and with whom
3.29	Gets angry with others						Context and with whom
3.31	Gets angry/ frustrated with self						
3.33	Attacks peers						Describe Behaviour. e.g. kicking, biting, hitting etc.
3.35	Attacks adults						Describe Behaviour. e.g. kicking, biting, hitting etc.

		Almost Always	Frequent	Occasionally	Seldom	Almost Never	Comments/ Context in which this Occurs
		95%	75%	50%	25%	<1%	
3.37	Becomes aggressive when over-excited						
3.39	Self-Harms; e.g. head banging, biting, cutting self, etc						Describe Behaviour.
3.41	Reacts angrily when asked to do something s/he finds difficult						
3.43	Is slow to emotionally react						
3.45	Overly compliant; obedient						Context and with whom
3.47	Avoids disagreeing with others						
3.49	Is well-behaved in school but is explosive when returns home						
3.51	Is well- behaved in school but is hyperactive/ impulsive when returns home						
3.53	Zones out when stressed						
3.55	Becomes clumsy when stressed						
3.57	Feels lethargic						
3.59	Falls asleep in school						
3.61	Falls asleep on way home from school, therapy, contact, or family visits						

Section2

Q 3.19 Clingy, reluctant to separate

- ◊ When the child is clingy, reluctant to separate, it is important to explore why. There may be something or someone in the environment they deem threatening.
- ◊ It is important to differentiate instinctive survival responses from attachment behaviours which are learned.
- ◊ For example, being noisy, i.e., shouting out to be rescued as opposed to being noisy in order to gain and maintain constant attention of others.
- ◊ Also differentiate instinctive survival behaviour from sensory seeking behaviour as previously discussed.

Q 3.37 Becomes aggressive when over-excited.

◊ Check does the child become aggressive when running, hitting, and kicking a ball?

◊ Is the child constantly getting into trouble for being too rough during play?

◊ The SNS may be sensitised, so once activated it immediately goes into the flight and fight response.

Q 3.39 Self harms.

◊ Note if the child openly displays this behaviour, ensures others are around, or do they try to hide self-harming which is **Level 4.**

Section 3: Attachment Behaviours

		Almost Always	Frequent	Occasionally	Seldom	Almost Never	Comments/ Context in which this Occurs
		95%	75%	50%	25%	<1%	
4.1	Hides feelings; doesn't say when feels unhappy						
4.3	Always says "I'm fine" even when not						
4.5	Is excessively attentive to pleasing friends						
4.7	Quiet, withdrawn						
4.9	Pretends to agree with others to avoid disagreement						
4.11	Strives hard to achieve in order to please adults, e.g. teachers, parents						
4.13	Takes on a caring role towards parents or brothers and sisters						
4.15	Is too independent (i.e. does not want help from others)						
4.17	Is the "too good" child						
4.19	Is obedient with adults but bullies other children						
4.21	Displays inexplicable outbursts then returns to being compliant						
4.23	Always wants to be the centre of attention						
4.25	Can be highly charming in order to hold people's attention						
4.27	Is jealous of others						
4.29	Can quickly change response from being charming to being threatening to becoming very upset when s/he doesn't get own way or isn't getting attention						
4.31	Dislikes change in routine. Becomes very upset						
4.33	Is unable to accept responsibility for own actions						

Section 3

Q 4.15 Is too independent (does not want help from others).

◊ If the child is sensory defensive, and is being sensory triggered by the type of help being offered, the likelihood is they are being sensory avoidant which is **Level 2** rather than being emotionally avoidant which is **Level 4**.

Q 4.21 Displays inexplicable outbursts then returns to being compliant.

◊ This child pattern is compulsive compliant which is **Level 4**.

◊ However, when they become overwhelmed, they are unable to continue to inhibit negative affect and regress to **Level 2** flight and fight behaviours.

◊ Their behaviour is often misunderstood and not recognised.

◊ Children describe this pattern as being like a volcano that periodically erupts when they can no longer cope.

4.35	Blames others.						
4.37	Sets others up to get into trouble						
4.39	Looks for help a lot, even when it's not required. e.g. seeks help with dressing even though can manage independently						
4.41	Pretends to be ill or exaggerates symptoms of being ill in order to gain sympathy and more one-to-one attention						
4.43	Openly engages in risk-taking behaviours (e.g. climbs onto roof)						Give Details:
4.45	Overly obedient with certain adults						Specify which adults:
4.47	Aggressive with certain adults						Specify which adults:
4.49	Stays close but does not want to be physically held						
4.51	Behaviour is different at home; school; respite; contact visits						Specify which:

Q 4.43 openly engages in risk taking behaviour (e.g. climbing onto roof).

◊ The child is obviously placing themselves in danger. The goal of risk taking behaviour is to activate the protective response from attachment figures. This is in contrast to sensory seeking behaviour which is to meet regulating needs.

◊ To differentiate these two behaviours, the child who wishes to activate adults will be watching to see if they are being noticed whereas the child who is sensory seeking is absorbed in the activity.

Q 4.49 Stays close but does not want to be physically held.

◊ The child may fear separation, **Level 4**, but is tactile defensive, **Level 2**, so can't tolerate being held or touched.

◊ If it is sensory, it is important to point out this isn't emotional rejection; it is rejection of the sensation because the child has sensory differences which affects their capacity to tolerate physical contact.

4.35	Blames others.						
4.37	Sets others up to get into trouble						
4.39	Looks for help a lot, even when it's not required. e.g. seeks help with dressing even though can manage independently						
4.41	Pretends to be ill or exaggerates symptoms of being ill in order to gain sympathy and more one-to-one attention						
4.43	Openly engages in risk-taking behaviours (e.g. climbs onto roof)						Give Details:
4.45	Overly obedient with certain adults						Specify which adults:
4.47	Aggressive with certain adults						Specify which adults:
4.49	Stays close but does not want to be physically held						
4.51	Behaviour is different at home; school; respite; contact visits						Specify which:

Q 4.51 Behaviour is different at home; respite; and contact visits.

◊ It is important to observe the child in different settings to learn what may be contributing to the child's behaviour.

Section 4: Developmental History and Sensory Processing

	Developmental Information	Yes This Applies	No Does not Apply	Don't Know	Comments/ Context in which this Occurs
5.1	Did you/ birth mother suffer from stress or medical problems during pregnancy?				
5.3	Where there any complications at birth?				
5.5	Was s/he born early or late (more than two weeks)?				
5.7	Did s/he have any difficulty feeding in the first year of life?				
5.9	Did s/he suffer much from colic?				
5.11	Was s/he extremely demanding as an infant?				
5.13	Was s/he extremely passive as an infant?				
5.15	Did s/he feel tense when being held?				
5.17	Did s/he feel floppy when being held?				
5.19	In the first three years of life did s/he suffer from any illnesses involving extremely high temperature, delirium, or convulsions?				
5.21	Did s/he have a history of frequent ear, nose, throat or chest infections in the first three years of his/her life?				
5.23	Did s/he suffer from allergies?				
5.25	Was, or is, there a problem with wetting the bed after the age of 5 years?				
5.27	Date and Result of Last Eye Test				
5.29	Date and Result of Last Hearing Test				

Section 4
Developmental History and Sensory Processing

The developmental information can be triggering for birth parents, so it is important to allow time for them to talk and to be listened too. This may be the first and only time a professional has asked these questions and sat and listened to their lived experience.

The sensory processing questions are fully discussed on the Trauma Informed Assessment and Intervention Course. This course will focus on the questions where there is alternative explanation other than sensory.

Proprioceptive- Vestibular Processing		This Applies	Does not Apply	Know	Alternative or additional Hypothesis
5.31	During Infancy did your child dislike being placed on his/her stomach to play?	L2 sensory - vestibular postural control			L2 Sensory - tactile defensiveness, trauma
5.33	Had s/he difficulty learning to raise head and push up on extended arms in that position [on stomach]	L2 sensory - vestibular postural control			
5.35	Had s/he difficulty learning to come up from lying into sitting position?	L2 sensory - vestibular postural control			L3 Sensory Body Scheme L4 Praxis
5.37	Missed out on stages of crawling	L2 sensory - postural control			L3 Sensory Body Scheme L4 Praxis
5.39	Learned to walk at what age?				Additional question: what age did siblings walk?
5.41	Had difficulty learning to use pedals on a trike				If yes, it is because; S/he lacked the strength to push? → L2 Sensory – vestibular Postural Control S/he did not know how to organise their feet to push? → L4 Praxis Other/ Comments:
5.43	Had difficulty learning to ride a bike without stabilisers, due to poor balance	L2 Sensory – vestibular postural ocular control			Observe if issues relate to coordination difficulties rather than balance or both
5.45	Is inclined to trip and fall, bump into things	L2 sensory – postural ocular control			L2 Emotional- Flight L2 Emotional – Dissociation, shutdown L3 Sensory Proprioception L3 Sensory - visual perception

Proprioceptive-Vestibular Processing
The following questions refer to postural control: that is the capacity to come up against gravity and maintain balance.

Body Scheme: Internal working model of physical self that enables the child to guide their own movements through space.

Praxis: the capacity to plan and organise body movements; this includes co-ordination and sequencing of movement and forward planning.

Q 5.31 During infancy did your child dislike being placed on their stomach?
The child may dislike being in prone due to poor postural control as they will feel helpless. If they are tactile defensive or have experienced trauma, they will be will be resistant to going into prone as they will want to have a clear view of where people are in their space.

Q 5.45. Is inclined to trip and fall, bump into things.
This maybe symptomatic of postural-ocular control, poor proprioceptive awareness, and difficulties with depth perception. Check is this a constant pattern or does it only occur when the child is in flight and is visually checking where an individual is, or does it occur when the child is spaced out, dissociating, and going into shutdown.

Note if the behaviour only occurs after therapy or contact visits, this would suggest the child is being overwhelmed and is shutting down. This will need further exploration of what is triggering this response.

5.47	Struggles to correctly position body on play equipment; e.g. doesn't centre self, is half on half off, gets on back to front etc		L3 Sensory – Proprioception [body scheme]	
5.49	Constantly seeks out movement; e.g. run, jump, spin, tilt self-upside down		L2 Sensory – Prop/ Vestibular [SS]	Consider function of sensory seeking L2 Sensory - Meeting Sensory Threshold L2 Emotional- Flight, L4 Emotional - to activate others
5.51	Becomes hyperactive/ over-excited/ aggressive during play		L2 Sensory – Sensitised response to movement	where and when?
5.53	Seeks out rough and tumble play, the rougher the better		L2 Sensory – Prop/ Vestibular/Tactile [SS]	
5.55	Actively avoids rough and tumble play		L2 Sensory – Proprioception, Vestibular, Tactile [Defensive]	L1 Emotional - History of domestic violence Identify the sensory source of activation
5.57	Prefers a swing that gives support [e.g. a bucket seat, garden swing seat] to a single strap swing that gives no added support		L2 Sensory – Postural insecurity	
5.59	Fearful of slides		L2 Sensory – Postural insecurity	Visual Perception
5.61	Gets stuck at the top of the slide, needs help down		L2 Sensory – Postural insecurity	L3 Sensory - body scheme L4 Emotional - to elicit caregiving [C]
5.63	Can hang from bars and maintain balance on a climbing frame		L2 Sensory – Postural control	
5.65	Likes being spun slowly on a roundabout		L2 Sensory – Vestibular	Developmental stage
5.67	Likes being spun fast on a roundabout		L2 Sensory – Vestibular [SS] to meet threshold	L2 Emotional - Dissociation
5.69	Can kick a ball when;	s/he is still, and the ball is still	L4 Sensory - Projected action sequencing	
		s/he is running, and the ball is still		
		s/he is still, and the ball is moving towards him/her		
		s/he is moving, and the ball is moving		
5.71	Tires easily, tends to slump in a chair		L2 Sensory – Vestibular Low tone.	L2 Emotional - Shutdown
5.73	Constantly shifts about when sitting in a chair		L2 Sensory – Vestibular [SS] to stay alert and attend	L2 Emotional - Flight, wants to get away

Q 5.47 Constantly seeks out movement, e.g. run, jump, spin, tilts self upside down.
Consider the function of the behaviour. Differentiate sensory seeking **(Level 2)**, Flight behaviour **(Level 2)** and seeking to activate others **(Level 4)**.

Q 5.59 Fearful of Slides.
This may be due to postural insecurity. Difficulties with depth perception may also contribute to avoidance.

Q 5.61 Gets stuck at the top of the slide, needs help down.
If the child has good postural control the behaviour may be strategic, feigning helplessness in order to elicit a caregiving response.

Q 5.73. Constantly shifts about when sitting in a chair.
Is the child fidgety, agitated? It may be because the child wants to get away but feels they can't get up and leave.

5.75	Has a tendency to use too much force when playing with an object or using a pencil	L3 Sensory – Tactile – Proprioception.	L2 Emotional – Fight L2 Sensory - Registration
5.77	Can gently handle objects if needs to	L3 Sensory – Tactile - Proprioception	
5.79	Has a weak grasp	L2 Sensory – Vestibular [low muscle tone]	L3 poor tactile and proprioceptive discrimination. Check Manual form perception and look for lack of in hand manipulation
5.81	Is your child right or left-handed or does s/he continue to use either hand	L3 Sensory - Hand dominance	
5.83	Confuses right from left	L3 Sensory – Spatial orientation	
5.85	Struggles with managing zips, buttons, laces	L4 Sensory – BIS	L3 poor tactile-proprioceptive discrimination

Q 5.75 Has a tendency to use too much force when playing with an object or using a pencil.
Consider is the child using too much force because they are angry and in fight mode.

Tactile processing		Yes This Applies	No Does not Apply	Don't Know	Alternative or additional Hypothesis
6.1	Dislikes being touched unexpectedly	L2 Sensory – Tactile Sensitive Defensive.			**Note**: Sensitive = Dislikes the sensation but doesn't avoid Defensive avoids the stimulus A . avoids, moves away (flight response) B. become aggressive (fight response) State Which Consider trauma history in interpretation Consider compulsive compliance where the child dislikes the stimulus but obeys adult request May be explosive afterward
6.3	Easily irritated or angry when touched by others	L2 Sensory – Tactile Defensive.			
6.5	Touch has to be on his/her terms only	L2 Sensory – Tactile Defensive			
6.7	Easily irritated if someone accidentally pushes into him/her	L2 Sensory – Tactile Defensive			
6.9	Tends to rub or scratch the spot that has been touched	L2 Sensory – Tactile [sensitive, defensive			
6.11	Has a tentative approach to touching objects	L2 Sensory – Tactile sensitive, defensive			
6.13	Dislikes having hands dirty	L2 Sensory – Tactile Defensive			
6.15	Avoids walking barefoot	L2 Sensory – Tactile Defensive			
6.17	Dislikes the feel of tight-fitting clothing	L2 Sensory – Tactile Defensive			
6.19	Dislikes the feel of labels on clothing	L2 Sensory – Tactile Defensive			
6.21	Dislikes having a shower or bath	L2 Sensory – Tactile Defensive.			

Tactile Processing
These questions are primarily **Level 2 Sensory Modulation.** It is important to note the history of the child, and the context in which the behaviour occurs.

Consider compulsive compliance if the child stiffens when touched but obeys an adult's request to touch them.

Note: if they present with an over bright smile, it is another marker for compulsive compliance.

6.23	Dislikes having hair washed	CONSIDER TRAUMA HISTORY IN INTERPRETATION	Hates water on face	L2 SENSORY – TACTILE DEFENSIVE
			Hates head being tilted/ manipulated	L2 SENSORY - VESTIBULAR DEFENSIVE GRAVITATIONAL INSECURITY
			Hates water in eyes	L2 SENSORY – TACTILE DEFENSIVE
			Other/ Comments:	
6.25	Dislikes having hair cut	CONSIDER TRAUMA HISTORY IN INTERPRETATION	Hates head being tilted/ manipulated	L2 SENSORY - VESTIBULAR GRAVITATIONAL INSECURITY OR DEFENSIVE TO BEING TOUCHED/. MANIPULATED
			Hates feel of hair on skin	L2 SENSORY – TACTILE DEFENSIVE
			Other reason	
			Does not apply	
			Other/ Comments:	
6.27	Dislikes having nails cut	L2 SENSORY – TACTILE DEFENSIVE	CONSIDER TRAUMA HISTORY IN INTERPRETATION CONSIDER MEDICAL TRAUMA	
6.29	Constantly trying to touch people and objects; can't keep hands to self	L2 SENSORY – TACTILE [SS]	L3 SENSORY- DISCRIMINATION, L4 EMOTIONAL - TO GAIN ATTENTION [C]	

Q 6.23 and **Q 6.25** avoidance of the head being manipulated or tilted may be due to gravitational insecurity. This needs to be assessed and confirmed when carrying out your trauma informed clinical observations.

6.31	Appears to be unaware if touched by others or comes into contact with others. Carries on as if nothing has happened	L2 SENSORY – TACTILE [LOW REGISTRATION]	L2 EMOTIONAL - DISSOCIATION /SHUTDOWN
6.33	Poor awareness of objects in hands, fumbles when handling objects	L3 SENSORY – TACTILE DISCRIMINATIO	L2 DROP IN MUSCLE TONE. EMOTIONAL - DISSOCIATION /SHUTDOWN
6.35	Can't match/ name hidden objects or shapes through touch	L3 SENSORY – TACTILE DISCRIMINATION	L2 EMOTIONAL - NOTE IF CHILD IS FEARFUL OF THIS ACTIVITY, RELATED TO TRAUMA HISTORY

Q 6.31 and **Q 6.33** ask if the behaviour is typical or does it only occur in certain situations. If the behaviour is constant it usually means it is sensory. If it is context specific, this may indicate dissociation and shutdown.

Observe during parent-child engagement, is the carer avoidant of nurturing touch? Does the carer distally regulate their child? This maybe the reason why the child seeks to self soothe.

7.19	Dislikes the feel of toothbrush in mouth	L2 SENSORY – TACTILE DEFENSIVE OR POOR ORAL AWARENESS REFER TO 7.21]	L1 EMOTIONAL - INTRUSIVE CAREGIVING, ORAL SEXUAL ABUSE
7.21	Only tolerates battery operated toothbrush; won't use manual	L2 SENSORY– PROP [SS]. NEEDS INCREASED INTENSITY OF STIMULATION TO ENHANCE SENSORY AWARENESS	
7.23	Poor diction / pronunciation of words	L3 AUDITORY DISCRIMINATION	L2 SENSORY REGISTRATION L 4 SENSORY MOTOR CONTROL

Oral Motor

Q 7.19 Dislikes the feel of the toothbrush in the mouth.

Additional questions to ask are:

- ◊ Does the child only object to having their teeth brushed with certain people? Is the child like this irrespective of who is helping them?
- ◊ Follow up observations in the home or clinic will help identify whether the issue is sensory or attachment.

VISUAL FORM, SPACE PERCEPTION AND VISUAL CONSTRUCTION		YES THIS APPLIES	NO DOES NOT APPLY	DON'T KNOW	ALTERNATIVE OR ADDITIONAL HYPOTHESIS	
8.1	Difficulties with matching and sorting shapes	L3 SENSORY - FORM AND SPACE				
8.3	Struggled learning to draw shapes such as a circle, square, triangle, X, etc	L4 SENSORY – CONSTRUCTION				
8.5	Struggles with Jigsaw Puzzles	L3 SENSORY - FORM AND SPACE, L4 SENSORY - CONSTRUCTION, FINE MOTOR SKILLS.			Doesn't visually recognise pieces Has difficulty physically placing pieces Other/ Comments	 EXPLORE FURTHER
8.7	Struggles to follow Lego step-by-step picture instructions and successfully construct object	L3 SENSORY - VISUAL PERCEPTION L4 SENSORY - VISUAL CONSTRUCTION				
8.9	Struggles with dot-to-dot drawings	L3 SENSORY –VISUAL. RECOGNITION OF NUMBERS, LETTERS AND MEMORY OF SEQUENTIAL (TEMPORAL) ORDER			MOTOR CONTROL. E.G. L2 POSTURAL CONTROL OR L4 FINE MOTOR CONTROL?	
8.11	Struggles with "spot the difference" games	L3 SENSORY -VISUAL DISCRIMINATION				

Visual Form, Space Perception and Visual Construction

Ask the teacher to complete this section and provide an example of school work.

8.13	Has Handwriting difficulties	L3 SENSORY –VISUAL PERCEPTION L4 MOTOR SKILL, PRAXIS	NOTE WHETHER DIFFICULTY IS: PENCIL GRASP, FORMING LETTERS; SPATIAL ORIENTATION, ALIGNMENT OF LETTERS
8.15	Has difficulty copying down from the whiteboard	L3 SENSORY – VISUAL DISCRIMINATION, VISUAL MEMORY REMEMBERING INSTRUCTIONS -	CONSIDER DX OF SPECIFIC LEARNING DIFFICULTY E.G. DYSLEXIA HANDWRITING DIFFICULTIES L2 VESTIBULAR – POSTURAL OCULAR CONTROL. VISUAL TRACKING RETENTION OF PRIMITIVE REFLEXES. EG. STNR L2 EMOTIONAL: HYPERVIGILANCE
8.17	Has reading difficulties	L3 SENSORY – VISUAL PERCEPTION	POSTURAL OCULAR MOTOR CONTROL COMPREHENSION
8.19	Struggles to find objects / toys in a cupboard	L3 SENSORY – FIGURE GROUND	
8.21	Puts on jumpers back to front/ inside out	L3 SENSORY – SPATIAL ORIENTATION	L4 EMOTIONAL - ELICIT CAREGIVING RESPONSE [C]

Q 8.13 Has Handwriting difficulties.
Ask the teacher or carer to provide an example of the child's handwriting.

Q 8.21 Puts on jumpers back to front/inside out.
Check is this a constant problem or only occurs with certain adults, in which case it is feigned helplessness in order to elicit a caregiving response.

	Auditory Processing	Yes This Applies	No Does not Apply	Don't Know	Alternative or additional Hypothesis
9.1	Has problems remembering sequences of instructions	L3 sensory – auditory sequential memory			L2 Emotional - hypervigilance, inability to focus attention
9.3	Finds it difficult to carry out tasks on verbal instructions only	L3 sensory – auditory receptive language			L2 Emotional – hypervigilance L4 Emotional - elicit caregiving [C]
9.5	Needs to be shown what to do before carrying out a task	L4 -auditory receptive language			L4 Sensory -praxis L4 Emotional - elicit caregiving [C]
9.7	Has difficulty paying attention where there are other sounds nearby	L2 sensory – auditory sensitive			L2 Emotional - hyper-vigilance
9.9	Is fearful of mechanical sounds, e.g. Hoover, Hairdryer, Lorry	L2 sensory – Auditory Defensive			L2 - postural insecurity
9.11	Certain sounds are associated with bad / traumatic memories	L2 sensory – Auditory [TB]			L1 Emotional – trauma event
9.13	Describe the behavioural responses to these sounds				
9.15	Makes noises when working or playing, e.g. hums, sings, whistles	L2 sensory – Auditory [SS] to regulate and provide sensory feedback.			may indicate contentment L2 Cut out peripheral sounds. L4 trauma- activate caregiver's attention

Auditory Processing
It is recommended where possible to get an SLT assessment to evaluate the child's receptive and expressive language. This evaluation needs to be taken into consideration when assessing praxis and carrying out story stem or other attachment assessments.

Play		Yes This Applies	No Does not Apply	Don't Know	Comments/ Context in which this Occurs
10.1	Has If left to his/her own devices, what sort of activities will s/he engage in?				
10.3	What sort of activities does s/he enjoy?				
10..5	Will s/he amuse her/himself for long periods?				
10.7	Does s/he enjoy imaginary play?				Describe Play
10.9	What are the play themes?				
10.11	Is the play rigid and repetitive?				
10.13	Are others invited to join in?				
10.15	Enjoys constructing an imaginary world out of cardboard or other materials				
10.17	Has a chaotic, disorganised approach to play Lots of ideas but then can't follow through and make them happen				
10.19	Relies on someone else to come up with play ideas				
10.21	Tends to watch how others play before joining in				

Play

Observations of the child's play at home, clinic and school will help to identify whether the issues are sensory, attachment or a means of processing their trauma. When the child starts to play symbolically and remains regulated, they may be ready to attend and benefit from play therapy.

Levels of Self-Regulation (LOSR) Document

Child's Name		Child's DOB	
Child's Age		Education Setting	
Address		GP	
		Social Worker	
Telephone Number		Today's Date	
SAAP Completed by	1. Mary Williams 2. Catherine Smith 3. Annie Jones 4. Self	Relationship to the Child	1. Teacher 2. SW 3. Foster Carer 4. Key Professional carrying out SAI assessment.

Levels of Self-Regulation Document

On completion of the SAAP Questionnaire transfer the information across onto the Levels of Self-Regulation Document.

Note the replies are colour coded so it is easy to identify the different respondents who complete the questionnaire.

Summarise main reported concerns regarding the child	List the main concerns of each person (colour code) who has completed the SAAP.
If appropriate, reasons for Fostering/ Adoption	
If appropriate, what age was the child when s/he first moved into the home/ placement	
If appropriate, summarise the behaviour when the child moved into the home/ placement	
Reported current behaviour of the child	
Reported significant events which may have contributed to the child's behaviour?	This informs you how insightful or knowledgeable the respondent is to the origins of behaviour.
Reported Summary of the child's main strengths	
Reported key goals for the child	Note if the bias is towards achievement and performance or affective states or both.
Has the child received any previous therapy or is s/he currently receiving therapy? Please give details	

Cut and paste the statements, don't summarise what has been said; you want the actual discourse of the respondent to inform you of their Dispositional Representations of the child and the context in which the behaviour occurs. If you are interviewing write down exactly what the respondent says.

As you review this document you will see that the comments are in purple to guide you where the SAAP information goes.

LEVEL 1 AUTONOMIC NERVOUS SYSTEM FUNCTIONING	LEVEL 1 IMPACT OF OTHERS ON CHILD'S ANS REGULATION
CHILD: **Medical History:** Birth history, medical diagnosis etc. **Immune System:** **Temperature:** **Allergies:** **Sleep:** **Constipation:** **Diarrhea:** **Eating Pattern:** **Response to Pain:** **ANS STRESS RESPONSE:** **Overall ANS Bias;** **SNS;** physiological symptoms only, e.g., increased heart rate, muscle tension, sweating, rapid breathing, sleep issues, anxiety, **not** flight fight **PNS;** physiological symptoms only, e.g., decrease heart rate, feeling cold, numbness, low muscle tone and **not** freeze, dissociation, shutdown. **Fluctuates;**	HOW DO/DID THE FOLLOWING INDIVIDUALS AFFECT THE CHILD'S CAPACITY TO REGULATE? INCLUDE ATTACHMENT HISTORY WHERE RELEVANT. **MOTHER:** **FATHER:** **FOSTER CARERS:** **ADOPTIVE PARENTS:** **SIBLINGS:** **SCHOOL: staff and peers:** **OTHER:**

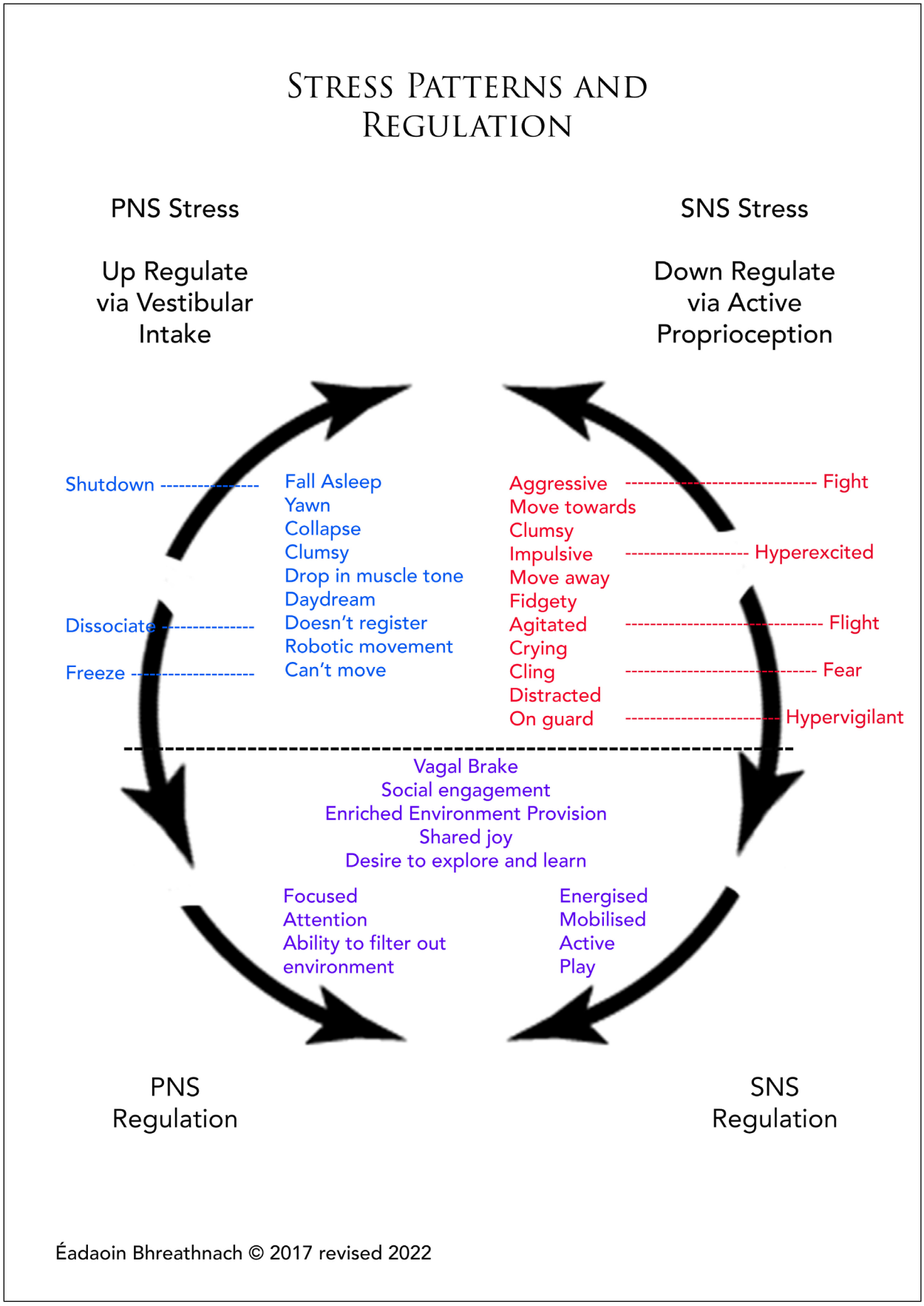
Note
A common error is to place the instinctive survival behaviours into this column. Record the physiological symptoms only.

LEVEL 2 RESPONSE TO EXTERNAL SENSORY STIMULATION Differentiate sensory and attachment issues	LEVEL 2 AROUSAL RESPONSE TO SENSATION AND ENGAGEMENT WITH OTHERS i.e. survival behaviours
Clinical Observations & Profile Information on: **Sensory Modulation/Thresholds.** **Behavioural Response to Sensation.** Seek or recommend an SAI OT evaluation or Sensory Integration Assessment if outside your professional training or remit. Where there isn't access to an evaluation, use Winnie Dunn *Living Sensationally* Profile and report findings, stating limitations of this i.e., standardised assessments are required to confirm findings. **Sensory System:** Name findings for each sensory system. **Clinical Observations & Standardised Tests of Postural Control:** Prone extension; Head lag in supine flexion; ATNR/STNR; Slow movement (repeat 3 times); Protective extension; Equilibrium responses; Standing and walking balance; Balance on one leg; Visual pursuits; Oral Motor Control.	Refer to Circle Chart and SAAP behaviours. **Hypervigilance:** e.g. can't ignore etc., overly aware, on the look out. **Fear:** e.g., cry cling, tends to be noisier in groups. **Flight:** e.g., fidgety, agitated. **Fight:** e.g., gets angry with self, others, self harms. **Freeze:** e.g., robotic, overyly quiet, withdrawn. **Dissociate** e.g., day dreams, doesn't react. **Shutdown**: e.g., clumsy, lethargic, falls asleep.

Level 2 Response to External Sensory Stimulation
This section requires the therapist to have completed the SAI Trauma Informed Assessment and Intervention Training or training in the use of standardised assessments of sensory processing. The clinical observations items for Level 2 are listed. State your clinical findings.

Level 2 Arousal Response to Sensation and Engagement with others
Refer to the Stress Patterns and Regulation Chart and SAAP behaviours to complete this section.

Note: You are not stating what the child is afraid of, simply stating their instinctive survival behaviours.


Stress Patterns and Regulation
PNS Stress
Up Regulate via Vestibular Intake
SNS Stress
Down Regulate via Active Proprioception
Shutdown
Fall Asleep
Yawn
Collapse
Clumsy
Drop in muscle tone
Daydream
Dissociate
Doesn't register
Robotic movement
Freeze
Can't move
Aggressive
Move towards
Clumsy
Impulsive
Move away
Fidgety
Agitated
Crying
Cling
Distracted
On guard
Fight
Hyperexcited
Flight
Fear
Hypervigilant
Vagal Brake
Social engagement
Enriched Environment Provision
Shared joy
Desire to explore and learn
Focused
Attention
Ability to filter out environment
Energised
Mobilised
Active
Play
PNS Regulation
SNS Regulation
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LEVEL 3 INTERPRETATION OF SPATIAL TEMPORAL QUALITIES OF SENSATION. NOTICING SIMILARITIES & DIFFERENCE.	LEVEL 3 EMOTIONAL INTERPRETATION Interpretation/representation/perception of relationships is based on previous and ongoing experiences of relationships at home and in school
Clinical Obsrvations: TICO: Finger to Nose; Finger Thumb Opposition; Diadochokinesia; Slow Movements (discriminative awareness of movement and positioning of limbs); Tactile Discrimination: **Standardised Sensory Processing Assessments:** **Psychological Tests:** **Educational Tests:** **Other:**	This refers to: the child's expectations of adults, the child's relationship with adults and **not** the adult's behaviour towards the child. **Attachment Assessment:** Name Test. **Coding;** Results. Simply name the individual the child and the location/environment **SECURE: PREDICTABLY ATTUNED CAREGIVING RESPONSES.** **Expectations that needs will be attended to with empathy and affection.** State Where and with Whom; E.g., Foster Mother at home, SNA in school. **TYPE C: UNPREDICTABLE AND UNATTUNED CAREGIVING RESPONSES.** **Can't rely on the availability of attachment figures. Rely on affect, activate arousal states of others to gain and maintain attention.** State Where and with Whom; **Type A: PREDICTABLE AND UNATTUNED CAREGIVING RESPONSES.** **Fear of being close to others, expressing true emotions, e.g. desire for comfort or expression of negative affect is dangerous. It can lead to a punitive response and rejection.** State Where and with Whom.

Level 3 Interpretation of Spatial Temporal Qualities of Sensation, Noticing Similarities and Differences in Sensation

This column is simply to record test findings.

Level 3 Emotional Interpretation
This section refers to the child's expectations of adults; it is the child's relationship with adults and not the adult's behaviour towards the child.
There are no specific questions in the SAAP pertaining to the child's mental representations of significant adults.

Attachment Assessments such as the CAPA (Child Attachment and Play Assessment) provide this information. However, one can hypothesise the child perceives carers as unpredictably available, and that they are more likely to respond to the display of intense affect if the child's pattern of behaviour is to become highly aroused, or activate arousal in others, in order to gain and maintain the attention of adults.

If the child is afraid to express true emotions, is compulsively compliant, it is reasonable to assume they have a fear of rejection or fear of a punitive response if they don't comply.
If you are not qualified to carry out an attachment assessment, recommend this is done by a professional who has been trained in the administration of the test. Attachment assessments are blind coded so a separate request needs to be made for a qualified coder to code the assessment. State the findings of the attachment assessment i.e. the pattern of the child and how they strategically function.

LEVEL 4 SENSORY ORGANISATION	LEVEL 4 EMOTIONAL/COGNITVE ORGANISATION
Praxis: OT/SI evaluation. Ideation: Feedback Dependent: Projected Action Sequences: **Describe organisational skills in the following areas:** **ADL:** e.g. bathing, feeding, dressing. **Play/Leisure Pursuits:** Includes questions on capacity to come up with own play ideas (ideation), constructing an imaginary world. Information on the child's motor skill and motor planning. **School Observations:** Classroom: Playground: Other:	**Attachment Behaviours:** **1. Balanced/Integrated Behaviours;** Expresses true affect with the expectation that needs will be responded to. **2. Avoidant Behaviours;** From SAAP.Attachment Section. **3. Ambivalent & Coercive Behaviours;** From SAAP Attachment Section. Include your observations of parent child engagement and place accordingly under the headings of balanced, avoidant, or ambivalent. Report observations of attachment behaviour during attachment assessments. **Drive Motivation:** What motivates them to engage. **Attention:** Capacity to attend, how long for? Include your observations. **Symbolic Play:** Expression of thoughts and feelings through play. SAAP information on play themes. Include your observations of the child exploring their thoughts and feelings through play. Report observations of symbolic play during the CAPA and other attachment assessments.

Sensory Organisation

Praxis
Describe the child's capacity to self organise and perform in the areas listed.
It is recommended that the child is observed in the school and playground, compare school to the home environment.

Emotional Cognitive Organisation
List the attachment behaviours from the SAAP. Include your observations of parent-child engagement and place accordingly under the headings of balanced, avoidant or ambivalent.
Report observations of significant attachment behaviours during attachment assessments.

Drive Motivation
This is a really important question as it provides information on how to get the child to engage.

Attention
Include your observations of the child's capacity to attend.

Symbolic Play
In this section we are looking at the child's capacity to express their thoughts, and feelings through play.
Place the SAAP information on play themes here e.g. safety, rescue, desire for comfort, separation and loss, anger.
Report observations of symbolic play during the CAPA and other attachment assessments.

What's the Difference
Let's review again where to place information when completing the Levels of Self Regulation Document.

Food
Food covers Level 1 and 2.

Level 1 is Appetite
We have biological drivers for food preferences to meet our physiological needs; foods that contain the six essential nutrients that the body cannot produce on its own.
Proteins, carbohydrates, fats, vitamins, minerals and water. These foods do not provide an immediate effect on our arousal state. A well balanced diet provides a sense of wellbeing over a period of time.

Stress: impacts digestion. It affects appetite, and in turn mental and physical wellbeing.

Two patterns:
◊ Loss of appetite and weight loss.
◊ Increased appetite and weight gain.

Level 1. Taste and Appetite.
Stress not only affects our desire to eat. It also affects our desire for certain tastes. Hormonal changes, such as the release of cortisol, occur during stress which promote fat storage and an increased appetite for foods that are high in saturated fat, salt, and sugar as they provide immediate relief. This, unfortunately has long term negative consequences for health e.g., heart disease, type 2 diabetes, cancer, osteoarthritis.

Level 2. Sensory Regulating Properties of Food which provide an immediate, or short-term effect on arousal states.
In SAI we use snack and chat, which is part of the social engagement system to regulate arousal states and enable difficult conversations.

In Level 1 we looked at appetite for certain tastes. However, taste (Level 1) isn't enough on its own. Sensory motor actions are also required to meet regulation needs.

Sucking is soothing, munch crunch is alerting, biting, is down regulating and chewing also helps to down regulate.

Remember the regulating principle, the level of effort required equates with the level of arousal.

Example: some people like eating a Mars Bar directly from the freezer, others when it is soft, warm and gooey. The food content is the same i.e., it contains saturated fat, sugar, and salt. The frozen Mars Bar helps to lower arousal, it down regulates, because of the level of effort or proprioceptive intake required to eat it, whereas the soft warm gooey Mars Bar requires no oral motor effort, it fills the mouth and provides immediate comfort.

Survival Behaviours vs. Strategic Attachment Behaviours
When carrying out your formulation it is important to differentiate whether the child is operating in survival mode, that is reflexively responding to threat, or being strategic. For example, does the child reflexively lash out if feeling physically threatened or do they use aggression to coercively control others. The latter is a learned organized response to mental models of relationships.

Level 2. Survival Behaviours
Innate, reflexive responses to protect the body and stay alive.

Level 4. Strategic (Attachment) Behaviours
Learned, organised **(Level 4)** responses to mental models of relationships **(Level 3).**

Interpretation vs Organisation
Level 3 and **Level 4** are commonly confused.

Level 3 refers to our thoughts, perception, mental representation of attachment figures. This includes the capacity for reflective functioning or mentalization.
Our perception of our physical self and the environment is referred to as Sensory Discrimination.

Level 4 is Action, what we do, how we behave around others and how we perform in daily life. e.g., Academically, participating in social events, leisure pursuits.
.
Key Aspect of SAI
A Key Aspect of SAI is having an understanding of Dispositional Representations
The disposition to respond or behave is based on one's perception of relationships or events. Change the representation and you change the disposition to behave.

SAI enables a new, more nuanced perception of self, others and the environment. It changes dispositional representation through providing different enriching and regulating experiences, opportunities for reflection and provides education regarding sensory processing, arousal states and attachment relationships.

Clinical Formulation
"In formulation the underlying task is to share and pool information, test assumptions, explore apparent contradictions, try to fill in gaps and develop a management plan which is based on as comprehensive information as can be gathered."
(Baird et al 2017)

It can't be a solo exercise!
There are gaps in every model and in how we are trained. We need to be aware and keep in mind that we are looking at behaviour in a limited way and through a particular lens.

To avoid omission of key information it has to be a collaborative process.
The outcome of taking a collaborative approach is likely to lead to successful intervention.
If we think back to the Foundation Course which looked at Wampold's (2014) findings on factors that influence therapeutic efficacy, the key factors were goal consensus collaboration, empathy, and congruency.

Clinical Formulation involves active listening and gaining an empathetic understanding of the lived experiences of all parties, i.e. parents, carers, child, and professionals. They are much more likely to come on board if they feel their experience of the situation is being acknowledged and taken into consideration.

Clinical Formulation
- ◊ Identify the origins of behaviour
- ◊ Identify the intention and function of behaviour
- ◊ Identify the impact on functioning and relationships
- ◊ Identify needs, strengths of the child
- ◊ Identify resources available

Levels of Self Regulation Document
The Levels of Self Regulation document is a working document where you collate and sort out what information goes where. Place the SAAP replies onto the LSR document and any relevant follow up discussion.
Use a colour key for the different respondents. Include key information from Professional Reports, Assessment Observations and Standardised Tests Findings.

Levels of Self Regulation, Clinical Formulation Tool

	Level 1 ANS Regulation	Level 2 Modulation	Level 3 Interpretation	Level 4 Organisation
Emotional Processing	Attachment History – Developmental history of attachment behaviours. History during pregnancy, early childhood, ACEs and impact on child development. Identify the stress patterns of parents, as this predisposes the infant to PNS bias or SNS bias. Influences how they function when they are stressed and when their child is stressed.	UL, Utr, Failed Strategy - Regression to instinctive survival behaviours. Hypervigilance. Fear. Flight. Fight. Dissociation. Shutdown. Capacity to remain regulated when in heightened states i.e. fear, excitement and physical exertion.	Representation of Attachment Perception of Self, Other, and the Physical Environment. Predictable, Attuned, Available to meet needs. Dismissing, Rejecting, Punitive. Unpredictable, variably attuned. Sense of psychological self	Parent's and Child's Dispositions and Functional Capacity. Balanced – cognitively and affectively organised behaviour. Type A Strategies Inhibited, Distancing. Avoids expressing negtive or true affect. Type C Strategies Threatening/Disarming. Organises around intensity of arousal of self and/or other.
ANS & Sensory Processing	Physiological Implicit Interoception. Unconscious, automatic regulation for homeostasis. The body's internal drive to reach an optimal state for a given task. Explicit interoception. Conscious Awareness of visceral feelings. Awareness of pain, temperature, breathing, sleep, hunger, thirst, fullness, discomfort, need to urinate, need to defecate, heart rate, muscle tension, for regulation purposes. States of Arousal SNS Stress Response PNS Stress Response	**Sensory Modulation:** Threshold and Responsiveness to sensation. Impact on modulation of arousal states. Specify if responsiveness is trauma based. Tactile. Proprioception. Vestibular. Visual. Auditory. Olfactory. Gustatory. Development of postural control against gravity, integration of pro-gravity reflexes. Impact on affect regulation.	**Sensory Discrimination.** Identification and interpretation of spatial and temporal qualities of sensation. Capacity to notice similarities and differences. Provides the foundation for: Perception of body self, body scheme, and environmental scheme.	**Motor Skills & Praxis** Co-ordination & sequencing of movements (spatial and temporal order), motor engrams. Praxis. Anticipatory Actions/Forward Planning. Capacity to re-organise response – adaptive behaviour i.e. successfully makes adjustments to environmental demands. Independence in Living Skills Ability to engage in: Leisure Pursuits Academic Learning Work Parenting Skills – care of child and home.

Levels of Self Regulation, Clinical Formulation Tool

This tool is used to help explain the SAI Clinical Formulation Process. This formulation chart can be used with all age groups. The chart helps to illustrate the four levels of self-regulation.

Autonomic Nervous System or Physiological Regulation is Level 1
The pink box documents the attachment history, ACE's, the impact on Child Development, for example Foetal Alcohol Spectrum Disorder, or other medical diagnoses linked to Developmental Trauma. It also documents the stress patterns of the parents, as this provides valuable information on how the parent is likely to function when stressed and when their child is stressed.

The lower blue box looks at the child's physiological regulation patterns which are influenced by the parent. SAI focuses on: interoceptive awareness and on physiological stress patterns.

Level 2 Modulation
Pink Box is regulation of Arousal States. It documents the innate reflexive survival responses of hypervigilance, fear, flight fight, freeze, dissociation, shutdown and the capacity to remain regulated even when in a heightened state. The letters UL refers to unresolved loss, Utr is unresolved trauma, Failed Strategy is when either the sensory or attachment strategy to regulate fails, the individual is so overwhelmed they regress to instinctive survival behaviour.

The lower blue box looks at Sensory Modulation i.e., sensory thresholds and responsiveness to sensation, how this impacts arousal states.
Consideration needs to be given as to whether the behaviour is due to a traumatic event, sensory differences or attachment relationships (Level 4) as this helps to identify the function of behaviour.

Trauma Based Responses includes;

- ◊ A sensitised response to stimulus. This occurs when a particular sensation is coupled with a traumatic event. Once exposed to the stimulus the child becomes immediately activated.

- ◊ A sensitised response to movement i.e., the flight fight response is activated when the child carries out the same sensory motor actions during play such as running, hitting, or kicking a ball.

Level 2 also includes;
Postural control against gravity, the integration of pro-gravity reflexes and the impact of postural control on affect regulation. This is part of the SAI Therapist assessment.

Level 3 Interpretation
The top pink box documents the child's perception of Attachment Figures. It outlines whether the relationship is Secure, Dismissing or Unpredictable, Variably Attuned.

The lower blue box Sensory Discrimination is the capacity to interpret the spatial, temporal qualities of sensation, notice similarities and differences. This provides the foundation for

perception of (physical) body self, body scheme(internal working model of physical self) and environmental scheme.

Level 4 Organisation
How the child organizes their behaviour around others and in the physical environment.

The top pink box documents the learned behaviours, use of strategies.
Balanced is the term given for the capacity to affectively and cognitively organise behaviour.

The lower blue box looks at the ability to perform in terms of motor skills and motor planning (praxis) and Independence in living skills. The ability to engage in leisure pursuits, academic learning work and parenting skills which involves care of child and home.

Sensory Attachment Intervention Personal Impact Chart

Devised by Éadaoin Bhreathnach. (c) Revised Edition 2025

Levels of Self -Regulation	Level One Attachment History Its Impact on ANS Regulation	Level Two Modulation of Arousal States in Response to Others and the Environment	Level Three Interpretation Perception of Relationships and of the Environment	Level Four Organised Responses Attachment Behaviours and Functional Abilities
	Medical History: Medical Reports Attachment History: Social Work Report. Court Reports Trauma History: ANS Regulation: Sleep: Allergies: Appetite: Elimination: Pain: Temperature: Arousal State: Low: Regulated: Heightened: Fluctuates:	Instinctive Survival Responses Hypervigilant: Fear: Flight: Fight: Freeze/Dissociation/Collapse: Capacity to remain regulated when in a heightened state due to fear, excitement and or physical exertion. Sensory Modulation. Impact on capacity to regulate arousal (OT Assessment Findings) Muted or Delayed Response Sensory Seeking Sensory Craving Intense Response to Stimulus Sensitised Response to Movement. Fluctuating Response Trauma Based Responses Postural Control -SAI Trauma informed Clinical observations. L2 items	Attachment Relationships (Attachment assessments e.g. MoTC, CAPA, Blind coded by a certified coder) Predictable, Attuned, Available to meet needs. Dismissing, Rejecting, Punitive. Unpredictable, Variably Attuned. Sensory Discrimination (OT Assessment Findings) Trauma Informed Clinical Observations L3 items & Standardised Tests. Receptive Language (SLT, Findings) Cognitive Evaluation (Psychology Findings)	Attachment Behaviours Blind Coded Attachment Assessments. Observations & Reported Behaviours Expresses positive and negative emotions. Capacity to form and repair relationships. Avoids expressing true affect. Compulsive strategies to attain approval and engagement of attachment figures. Organises around intensity of arousal of self or/and others to attain and maintain the attention of attachment figures Functional Abilities. ADL: IADL: Play/Leisure Pursuits: Academic: Educational Reports, Classroom & Playground Observations of behaviour.

MutDelR: Muted or Delayed Response to Stimulus · **SS:** Sensory Seeking · **SC:** Sensory Craving · **IR:** Intense Response to Stimulus · **SRM:** Sensitised Response to Movement · **FR:** Fluctuating Response to Stimulus · **TB:** Trauma-Based Response ·

Completing the SAI Personal Impact Chart

Simply delete the headings/behaviours that don't apply so the information on the chart only applies to the individual. For example, if there are no flight and fight behaviours delete these. To fully complete the chart you will require information from other professionals. Fill in the areas that you are professionally qualified to complete that is professionally trained to carry out formal assessments. Where appropriate, indicate the need for other professional involvement in the assessment process for example requesting a sensory integration assessment of the child's sensory differences, blind coding of attachment assessments, a SLT evaluation of expressive language or a psychological assessment of cognitive functioning.

Please Note that Sensory Modulation and Sensory Discrimination require an Occupational Therapy Assessment, preferably by an SAI trained Occupational Therapist who will differentiate whether the presenting behaviours are sensory, trauma and/or attachment based or refer the child to an Occupational Therapist who is trained in Ayres Sensory Integration to identify if the child has sensory differences.

The chart below illustrates where each professional assessment is placed.
A common error when completing this chart is in **Level 2** to state what the child is afraid of which is **Level 3** perception of fear. Simply fill in the SAAP fear behaviours from the states of arousal section. The SAAP interpretation and the Circle Chart (Stress Patterns and Regulation Chart) informs you which behaviours indicate hypervigilance, fear, flight fight, freeze, dissociation and shutdown.

SAI Model of Development Carer's Chart

	Level 1 ANS Regulation	Level 2 Modulation	Level3 Interpretation	Level 4 Organisation
Carer	**Attachment History:** Childhood experiences of nurture, comfort and routine care. **Carers & Adults:** Capacity to self care = Capacity to care and regulate child.	Carer provides the just right challenge to facilitate child's physical development and emotional regulation. Provides play experiences: Scary fun play, Rough & Tumble, Physically challenging. Provides comfort and reassurance when child is distressed to enable re-engagement.	Understands child's developmental needs. Reflective of how their own arousal state can affect child's. Considers how the child may be experiencing events to inform their response.	Provides predictable routine and nurturing care, a sense of boundaries regarding safety and social engagement. Carer encourages expression of thoughts and feelings.
Child	Calm, socially engaged. Responds to comfort. Capacity to recover from stress.	Capacity to respond in a regulated manner to sensory experiences, everyday care activities and interactions with the environment.	Child has a sense of how the Carer is likely to respond, when, where, in what order and outcomes. Inner drive is activated towards curiosity and exploration of the physical environment.	Confident to express true emotion. Ability to socially engage. Appropriately handles conflict and repairs relationships in accordance with their developmental stage. Acquires independence in ADL. Engages in academic tasks and leisure pursuits.

(Bhreathnach, 2015 © Revised 2025)

SAI Model of Development Carer's Chart

The top pink boxes refer to the carer and the bottom blue boxes refer to the child.

Level 1
Crittenden uses the term raising parents. We start learning how to parent when we are infants. The early experiences of our parent's availability to provide nuture, comfort, and routine care lays down the pattern for self-care and how we relate to and care for others in later life.

A regulated sensitively attuned carer enables the child to be: calm and socially engaged. The child is responsive to comfort and has the capacity to recover from stress and to regulate.

Level 2
The carer provides the just right challenge to facilitate the child's physical development and the capacity for emotional regulation. This is enabled by providing play experiences such as scary fun play. R & T play and play that is physically challenging. The carer also provides comfort and reassurance when the child becomes distressed to enable re-engagement. The child in turn develops the capacity to respond in a regulated manner to sensory experiences, everyday care activities and interactions with the environment.

Level 3
This looks at the carer's ability to understand the child's developmental needs.
The carer is reflective of how their own arousal state may affect the child's state. They also consider how the child may be experiencing events to inform their response to the child. The child develops their own internal working models of how their carer is likely to respond, through their experience of being cared for. The child's inner drive, if safe and regulated, is for curiosity and a strong desire to explore the physical environment.

Level 4
The carer provides a predictable routine and nurturing care, and a sense of boundaries regarding safety and social engagement. This includes saying no, preventing the child from taking actions that are unsafe.

The carer encourages expression of thoughts and feelings, particularly when things go wrong. This in turn gives the child the confidence to express true emotion.

The ability to socially engage, to appropriately handle conflict and repair relationships, in accordance with their developmental age. The child acquires independence in ADL, is able to engage in academic tasks and leisure pursuits.

SAI Model of Intervention

Level 1 ANS Regulation	Level 2 Modulation	Level 3 Interpretation	Level 4 Organisation
Passive Assimilation Enriched Environment Provision No demands Provide Routine Care to meet physiological needs Nutrition, Choice of foods to regulate Sleep Routine Personal Care JRS Spa Activities	**Enabling Regulation through Active Participation** Create a Predicatable Sensory Regulating Environment Up Regulate e.g movement activities + Down Regulate Activities that involve physical effort and muscle resistance + Shared Joy and Pleasure = Development of the Vagal Brake & Co-Regulation	**Curiosity and Exploration** Exploration of Function of Behaviours - Be Curious What is the upside of the behaviour? What is the downside of the behaviour? What might meet the need and replace the behaviour? Empathetic Understanding Awareness of Time & Spaces for Regulation Notices details, similarities, differences Being present in the moment Notice positive things to counteract the pattern of looking for danger	**Action for Change** Explore: Dispositional Representations of current relationships Education on Function of Behaviours Goal Orientated Plans: Self Care: ADL IADL Creating an Enriched Environment.

SAI Model of Intervention

This model applies to all ages so it needs to made bespoke to the individual you are treating.

Level 1
Passive Assimilation
You start intervention here if the individual isn't capable of being an active participant in the intervention process. The environment regulates, no demands are made. Everything is provided, for example, a hand spa. Regulating foods are prepared and served. The goal is for you to provide nurture, comfort to facilitate regulation or enable the carer to provide this type of nurturing care.

Passive Assimilation also applies to creating an environment where the individual feels welcomed and safe. So, think about the environment you are inviting people into. What does it immediately convey? How can you make the environment more regulating e.g. choice of lighting, seating, the range of objects and equipment available to engage with.

Level 2
Active Participation
Up and down regulating activities are done in the presence of significant others. Provide opportunities to experience shared joy and pleasure. Through co-regulation the individual develops the capacity to remain regulated even when in a heightened state. They neither become over anxious or aggressive when aroused.

Level 3: Interpretation is about Encouraging curiosity and exploration
Attachment
Gently explore the function of behaviour.
Start with exploring the upside of behaviour. Use statements such as I am curious to know … Ask What does it feel like when you are behaving in this way. What are you thinking in the moment?

Identify through discussion what the true function of their behaviour is. Is it a desire for comfort, for protection, to be noticed and listened to? Then progress to asking about the downside. If the behaviour has its downsides explore what could be done differently to satisfy the true need. The Scared Gang Are Asked to Tell Resource Pack is a useful tool on how to approach children who are scared and reluctant to talk.

Sensory
Provide opportunities for exploration and discovery of new sensory experiences. Activities such as a treasure hunt and foraging are examples of this. Encourage the individual to be present in the moment and notice the different sensory systems involved in the process, details, sensory similarities and differences. Encourage the individual to notice what is positive in their immediate environment. All of this helps to counteract the pattern of looking for danger and missing opportunities for safety.

Level 4
Action, Self Organising.
Explore how the individual is disposed to behave because of their perception of relationships. What do they do, how do they behave?
Provide education on the function of behaviours, for young children this is done through the Scared Gang Book Set.

Making Goal Oriented Plans regarding changes to behaviour:
Children who do the Just Right State Programme, write their own Scared Gang Book about their behaviours and what they can do to help them regulate.
The Just Right State Adolescent and Adult Programme also enables self-organisation and change.

Self Care
Refers to Activities of Daily Living i.e. basic living skills for example feeding and dressing and Instrumental Activities of Daily Living which are the more complex skills necessary for independent living, such as managing finances, shopping, preparing meals. It also includes the ability to enrich one's own environment e.g., using the JRS Enriched Environment Chart.

Sensory Attachment Intervention
SAI refers to a specific approach to assessment and intervention.
It has its own Fidelity Measure to ensure adherence to the principles of the model and support evidence-based practice.

SAI Model of Interventions provides a template to plan the temporal order of interventions in accordance with the current regulating capacity of the individual. This should be reviewed frequently and changed to reflect the changing needs of the individual.

Sensory Attachment Model of Interventions Chart:
Devised by Éadaoin Bhreathnach. M.Sc. © Revised Edition 2021
Example.

Name

Levels of Self-Regulation	Level 1 Passive Assimilation	Level 2 Enabling Regulation through Active Participation	Level 3 Interpretation: Curiosity and Exploration	Level 4 Organisation. Action for Change
	Not able to be an active participant in intervention. Or intervention provides background regulation e.g., medication, enriched environment provision. SAI Medicine Nursing Care Spa Activities	The individual actively participates. Self-regulation and co-regulation is achieved through active participation in activities. SAI Ayres Sensory Integration Gym Sessions Outdoor pursuits Physiotherapy	Must be able to remain regulated and engaged even when in a heightened state. Sensory regulation (L2) maybe used to assist regulation during a therapy session. However, if the individual continues to be highly activated by the process stop! Return to level 2 interventions until such time they are ready to safely re-engage again. SAI Ayres Sensory Integration Play Therapy Psychotherapy Cognitive Behavioural Therapy Drama Therapy	. Self-Organises, takes action to change how they take of take care of self, how they engage with others and in everyday tasks. There needs to be evidence of change, On the basis of what they do and not on what they say in session (L3). SAI Ayres Sensory Integration Professions that enable ADL IADL Academic, Social and Work Skills.

SAI Model of Intervention Chart

Here is an example of where to place interventions or stages of intervention on the model. This chart provides a helpful guide as to when a particular intervention is likely to be most effective.

Level 1
The Individual isn't able to be an active participant. Regulating input is provided.

Level 2
The individual actively participates. Self-regulation and co-regulation are achieved through active participation in activities.

Level 3
Must be able to remain regulated and engaged even when in a heightened state.
Sensory regulation (Level 2) maybe used to assist regulation during a therapy session.
However, if the individual continues to be highly activated by the process stop! Return to Level 2 interventions until such time they are ready to safely re-engage again.

Level 4
Self-Organises, takes action to change how they take of take care of self, how they engage with others and in everyday tasks.

There needs to be evidence of change,
On the basis of what they do and not on what they say in session (Level 3).

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Tuning In to Your Vagal Brake to discover its Calming and Energising Dimensions https://www.youtube.com/watch?v=OQJbmclwkfc