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Second Edition

ELLEN BRAATEN



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Purchasers of this book can download and print the forms in Chapter 40 at www.guilford.com/braaten2-forms for personal use or use with clients (see copyright page for details).

Introduction

How *The Child Clinician's Report-Writing Handbook* Can Help You

The Child Clinician's Report-Writing Handbook provides terms, phrasings, concepts, report formats, and other practical information that clinicians working with children and adolescents use in their daily work. If you conduct evaluations or write diagnostic, personality, neuropsychological, or other testing-based reports, this book can make your life easier. It is organized to take you from the first meeting with a client to the final report and recommendations. It places particular emphasis on the reporting of test results, because testing is very often a crucial component of child and adolescent evaluations.

The Child Clinician's Report-Writing Handbook owes its inception, organizational format, and numerous borrowings (with permission) from Edward L. Zuckerman's well-loved *Clinician's Thesaurus*. Now in its eighth edition (Zuckerman, 2019), the *Clinician's Thesaurus* is an essential resource for any practitioner. The current volume, however, addresses in much greater depth the specific needs of practitioners who evaluate and report on children and adolescents.

If you are a beginning child (or adolescent) clinician, this book will help you collect the pertinent information you need from the young client and from parents/guardians, teachers, and/or other professionals. This book can then help you to organize this information into a high-quality report; to find the most precise terms to express your findings; to describe the tests used (if any); and to develop treatment plans and appropriate recommendations. If you are a seasoned clinician, you can use this book as a reference to refresh your skills, to get ideas about other tests or assessment instruments to use, to expand or be more succinct in your reports, and to develop diagnostic hypotheses about complicated cases. In other words, *The Child Clinician's Report-Writing Handbook* can help you do the following things:

- Structure your evaluations of children and adolescents, as well as interviews with their parents or guardians and professionals working with the children.
- Organize your information as you write or dictate your reports.
- Broaden your repertoire of terms and report-writing skills.
- Provide descriptions of tests used in evaluations.
- Make suggestions for treatment recommendations.

How This Book Is Organized

This book is organized in the same sequence that you would follow to conduct an evaluation and then to write the report.

2 Introduction

Part I, “Questions for Conducting a Psychological Evaluation of a Child or Adolescent,” offers a guide for interviewing parents or guardians, children, and teachers or other professionals.

- Chapter 1 provides **information on preparing for the interview**, establishing rapport, obtaining informed consent, and general questions for parents.
- Chapter 2 provides **specific questions for parents or guardians** to elicit information about particular disorders.
- Chapter 3 offers **questions that can be used to elicit information from children** of different ages, as well as information on observational assessments used with very young children.
- Chapter 4 provides general guidelines and **specific questions for eliciting information from children’s teachers, psychologists, and other professionals**.
- Chapter 5 covers the traditional aspects of a **mental status examination** as practiced with children and adolescents.
- Chapter 6 offers suggestions for **ending the interview** with a child and parents.

Part II of this book, “Standard Terms and Statements for Wording Psychological Reports,” is a guide for report writing. It begins with wordings for basic but necessary identifying information, including the referral reason and background information. It ends with recommendations and closing statements. In between, the chapters cover a wide range of possible areas and topics that might need to be addressed in a report. No single report is likely to include all these topics; rather, Part II presents a wide range of possibilities, so you can select those areas and terms most relevant to the writing task at hand.

- Chapter 7 covers **basic information** related to beginning a report, such as headings and dates, sources of information, and reliability statements.
- Chapter 8 presents wordings for possible **reasons for referral**, such as behavioral, cognitive, emotional, and family concerns.
- Chapters 9–12 cover phrases and wordings for **relevant aspects of history**, including the history of the current symptoms, medical and psychiatric background, developmental and family history, and academic history.
- Chapters 13–16 covers terms and phrases relating to the **child or adolescent in the evaluation**, such as behavioral observations; attitude toward the testing; and presentation of various affective, behavioral, and cognitive symptoms and syndromes that are first evidenced in childhood.
- Chapters 17–19 cover terms and descriptors for the **child or adolescent in the environment**, particularly home and family life, school situation, and social and recreation activities.
- Chapters 20–28 provide descriptions for the **most commonly used tests** for children and adolescents, as well as general guidelines for presenting test results in a report. Emphasis is placed on tests that are most frequently used (such as the Wechsler scales) and on tests that can be interpreted in multiple ways.
- Chapters 29–32 cover wordings for **ending the report**, including diagnostic statements, summary of findings, possible recommendations about particular disorders, and closing statements.

Part III of this book offers a chapter on the special circumstances of writing for the schools (Chapter 33), as well as chapters with a variety of useful resources. Coverage of the latter includes the following:

- Treatment-planning resources (Chapter 34).
- Formats and templates for clinical reports (Chapter 35).
- Lists of resources for professionals (Chapter 36) and for parents (Chapter 37).
- Lists of common medications (Chapter 38) and frequently used abbreviations (Chapter 39).
- Sample forms, such as a release of information form, a developmental history form, and teacher and school questionnaires (Chapter 40).

Understanding the Style and Format of the Chapters

As just described, the three parts of this book cover the questions that can be used in an evaluation (Part I); the wordings that can be used in a report (Part II); and special circumstances and resources (Part III). Each chapter is then subdivided into sections on more specific, useful topics. For example, Chapter 19, “Social and Work Relationships, Recreational Activities,” has six main sections, each relating to a specific area of functioning, from general developmental aspects to friendships to work and recreational activities. Each of these main topics has its own section number (e.g., the fourth section of Chapter 19, “Peer Groups/Dating,” is numbered 19.4). Cross-references are made throughout the book to these chapter and section numbers.

Within each numbered section, you may find the following different types of information:

- Introductory and explanatory comments.
- Cross-references to related sections of the book.
- References to standard works in the field or area.
- Descriptors, terms, and phrases for wording reports.

Figure 1 provides a quick visual guide to identifying the formats for these various types of information within a chapter. (It represents a composite of several pages, with some content omitted, so as to illustrate a wider range of information/format types.) It is from the descriptors that you may select the ones most appropriate for your report. The descriptors and phrasings in this book are standard American English usage. Because the terms are only rarely defined here, you may find a specialized psychiatric dictionary useful (e.g., Campbell, 2009; *Stedman’s Medical Dictionary*, 2006; *Stedman’s Psychiatry Words*, 2006).

Formats for Descriptors and Terms

The terms and descriptors offered in this book are printed in a font different from the regular text and headings, to set them off. They are arranged in several ways, ranging from an unordered group of related words or phrases to increasingly ordered arrangements, as follows:

1. **Unordered groups of similar but not synonymous words or phrases** in a line or paragraph.

Example:

Building is well/poorly maintained, clean/unkempt, is/is not wheelchair-accessible, is located in high-crime/unsafe/safe area, playground is well/adequately/poorly maintained, (no) outside play areas.

2. **An ordered spectrum of words or phrases**, indicated by a double-arrow graphic (\leftrightarrow), in a line or paragraph. Example:

(\leftrightarrow *by degree*) **No/avoided eye contact, stared into space, kept eyes downcast, poor, . . . looked only to one side, brief, flashes/fleeting, furtive/evasive, variable, appropriate, normal, expected, good, . . . penetrating, piercing, confrontative, challenging, stared without bodily movements or other expressions.**

3. **Groups of words or phrases sequenced by degree** (\leftrightarrow). Example:

(\leftrightarrow *by degree*) **These groups of descriptors are presented in order from strongest to weakest coping skills.**

Good:

Did not appear frustrated by inability to solve a problem, . . . required only minimal encouragement when frustrated or distracted.

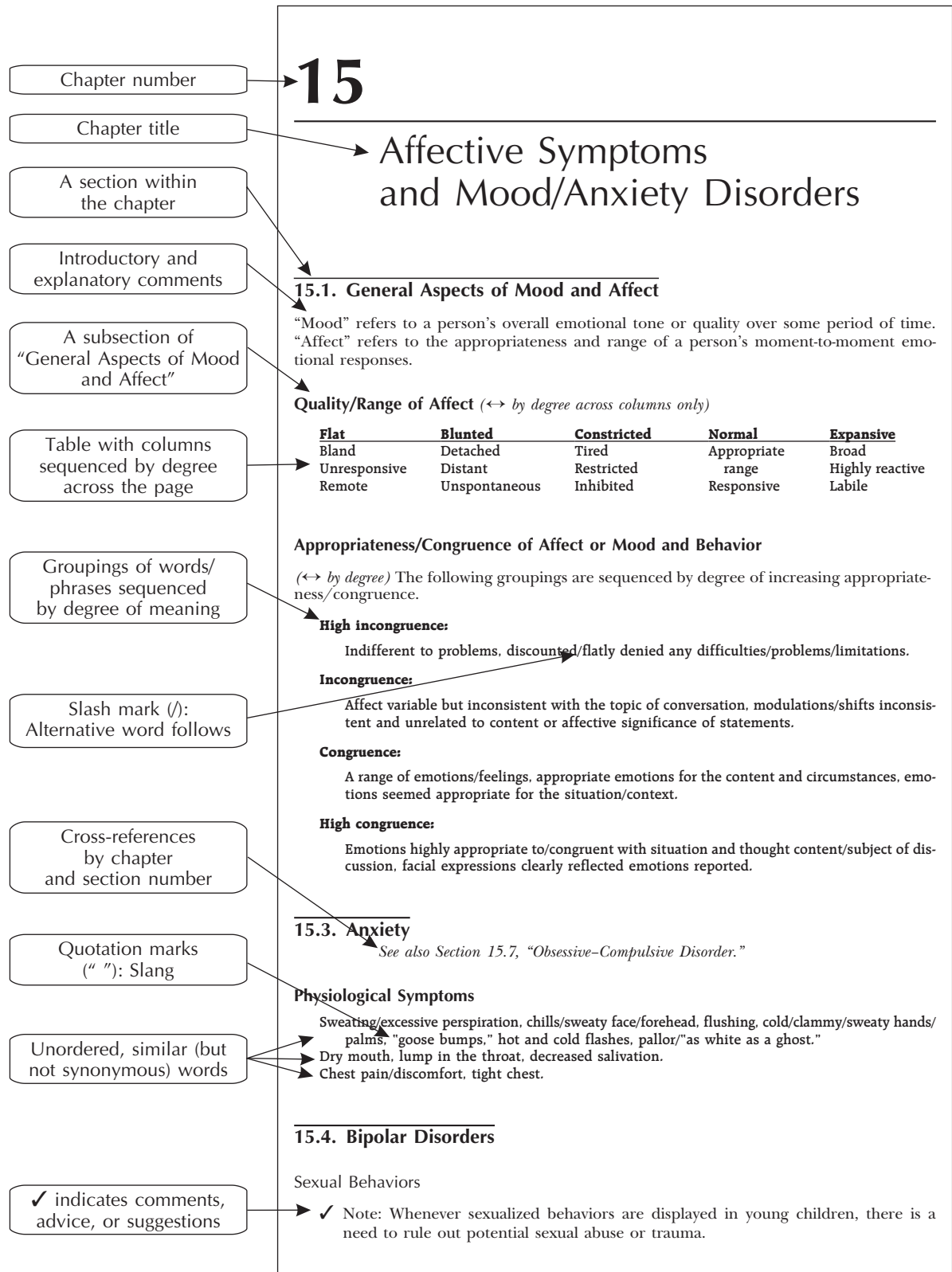


FIGURE 1. Reduced composite page illustrating various formats and typographic conventions.

Adequate:

Often became discouraged by difficult items but persevered.

Poor:

Exhibited low frustration tolerance, gave up easily, . . .

4. **Tables of words ordered by degree across columns** (\leftrightarrow). Note that in these tables, the sequencing by degree is across columns *only*; words or phrases that happen to fall in the same row in such a table do not necessarily constitute a mini-sequence. Example:

Qualities of Clothing (\leftrightarrow by degree across columns only)

Dirty	Disheveled	Neat	Stylish
Unclean	Messy	Well-groomed	Smartly dressed
Filthy	Unkempt	Neatly dressed	Chic
Grimy	Tousled	Clean	Elegant
...			

Typographic Conventions

Double arrow (\leftrightarrow): Indicates that terms or phrases are ordered along a spectrum of degree for the trait, quality, or behavior.

Slash mark (/): Indicates that an alternative word or words immediately follow. Example:

. . . presented as an attractive/handsome/pretty . . .

Quotation marks (“ ”): Indicates that a word is slang or inappropriate in a professional report. Examples:

“Tattling,” baiting, provoking others, . . . “clowns around,” “class clown.”

Check mark (✓): Indicates comments, advice, cautions, and clinical tips. Note that these are intended *only* as aids to readers and should not be borrowed for a report.

Notes on Grammar and Usage

For simplicity and convenience, nouns, verbs, adjectives, and adverbs are sometimes mixed in a listing. Just modify a word as necessary to fit the sentence you have in mind.

The pronoun forms used throughout this book are intended to lessen sexist associations and implications whose harmful effects are well known. The book uses combinations such as “he/she” and “her/him” in varying order, or (much less often) alternates in turn between “he” and “she.”

Finally, throughout the book, the term “parent” should be taken to mean biological parent, custodial parent, grandparent, foster parent, legal guardian, or any other caregiver/major attachment figure, even when alternative terms for “parent” are not provided. Also, the term “child” should be taken to mean “adolescent” whenever this is appropriate, even when the alternatives “child/adolescent” are not given.

A Functional Guide to Using This Book in Your Everyday Report Writing

The psychological report brings together not only test scores or other data, but the child’s personality, behavioral observations, case history, family and school histories, and the child’s individual strengths, weaknesses, and uniqueness. The construction of the report should actually begin long

before you sit down at a computer or with an audio recorder to write or dictate your report. *The Child Clinician's Report-Writing Handbook* can be used to organize your thoughts before you meet the child and his/her family, as well as to help you express the results of the evaluation in a coherent fashion. The following discussion illustrates how this book can be used in these ways. Table 1 summarizes a generalized format for an evaluation and notes chapters or sections of this book that are relevant to each component.

Getting Ready for the Evaluation

Preparing for an evaluation of a child usually requires more “up-front” work than is required for an adult’s evaluation. Whereas adults most often arrive for their evaluation alone, children most often arrive with loved ones. Although adult clients and the adults who accompany children are typically prepared for a face-to-face discussion, this is not necessarily the case with the children. A child’s age and developmental level significantly influence her/his approach to the evaluation. Younger children may be expecting to “play” with you, whereas adolescents would expect a more conversational approach. Thus it is essential to know the age of the child or adolescent before the first interview. In preparation, you will also want to ask yourself the following questions: “Who should attend the first session? How should I structure the interview? What toys, forms, or assessment instruments will I need? What questions do I need to ask of the parents or guardian, of the child, or of other professionals?” The following process may be helpful in preparing for the interview:

1. Consult Chapter 1 to get ideas about ways to structure the interview.
2. Chapter 40 provides forms you may want to use, such as a release of information form and a developmental history form. You will also need to have a consent form based on your state’s and/or agency’s guidelines. Make sure you have all pertinent forms at hand before you begin the interview.
3. Chapter 1 provides you with a list of general questions that can be asked of parents, while Chapter 2 provides a list of more specific questions for the parents or guardians. Based on the reason for the referral, you can tailor these lists to your specific focus. For example, if a child is coming for an appointment because he/she is said to be inattentive and hyperactive, you will want to ask the parent or guardian general questions found in Chapter 1 as well as questions found in Section 2.3, “Attention-Deficit/Hyperactivity Disorder (ADHD).” Based on the parent’s responses, you may want to delve further into other areas, such as disruptive behavior disorders (Section 2.8) or learning disabilities (Section 2.12).
4. From Chapter 3, “Observation Procedures and Questions for Children and Adolescents,” compile a list of questions appropriate for the age of the child. For example, if you are asked to assess an 11-year-old with symptoms of anxiety, you will want to pick some age-appropriate opening questions from Section 3.3; then ask age-appropriate questions about school (Section 3.4), home/family (Section 3.5), friends (Section 3.6), and interests (Section 3.7). You will also need to ask some specific questions about anxiety, obsessive behaviors, and mood (Section 3.9).
5. Either before or after the initial interview, you may need to talk with other professionals, such as the child’s teacher, pediatrician, or psychologist. Use Chapter 4 as a guide to structure your conversation with these professionals. You can also provide a teacher with the form in Section 40.3 (a questionnaire that can be used to assess a child’s classroom behavior and school functioning), or provide other professionals with the form in Section 40.4 (an assessment form with questions for such professionals).
6. If your evaluation includes formal testing, consult Chapters 21–28 for ideas on assessment instruments you may want to use, but please keep in mind that the lists of tests in these chapters are not exhaustive (and that such tests are constantly being updated).

TABLE 1. Generalized Format for an Evaluation

Components of an evaluation	Chapters/sections of this book
<u>Preparing for the evaluation</u>	
<i>Could include these:</i>	
Advance preparation	Section 1.1
Structuring the interview	Section 1.2
Establishing rapport	Section 1.3
<u>During the evaluation</u>	
<i>Could include these:</i>	
General questions for parents	
Referral question	Section 1.6
Developmental, medical, and family histories	Sections 1.8–1.10
Relationships, interests, and school history	Sections 1.11–1.13
Additional questions for parents of adolescents	Section 1.14
Questions for parents related to the referral question	Chapter 2
General questions for the child or adolescent (questions in Chapter 3 are organized by age and subject)	Chapter 3
Specific questions for the child or adolescent related to the referral question	Section 3.9
<u>Writing the report</u>	
Identifying information and other preliminary information	Chapter 7
Reason for referral	Chapter 8
History	
As it relates to the referral question	Chapter 9
Medical and psychiatric history	Chapter 10
Developmental and family history	Chapter 11
Academic history	Chapter 12
Behavioral observations	
Presentation	Chapter 13
Attitude toward the evaluation	Chapter 14
Clinical impressions	
Affective symptoms and mood/anxiety disorders	Chapter 15
Childhood behavioral and cognitive disorders	Chapter 16
Effects on presenting symptoms of:	
Home and family	Chapter 17
School	Chapter 18
Social relationships, etc.	Chapter 19
Test results	
Intellectual functioning	Chapter 21
Achievement	Chapter 22
Language functioning	Chapter 23
Memory	Chapter 24
Visual-spatial and motor skills	Chapter 25
Executive and neuropsychological functioning	Chapter 26
Emotional and personality functioning	Chapter 27
Behavioral and adaptive functioning	Chapter 28
Diagnostic statements (including original DSM-5 and/or ICD-10 codes)	Chapter 29
Summary of findings	Chapter 30
Recommendations	Chapter 31
Closing statement	Chapter 32
<u>After the interview or assessment</u>	
<i>You may want to:</i>	
Interview the child's teacher or another professional working with the child	Chapter 4
Provide the teacher or other professional with forms to complete	Chapter 40
Provide the parents with additional resources	Chapter 37

Writing the Report: A Suggested Outline

Once you have completed the assessment process and are ready to write the report, you can use the following outline to structure your results. The headings lettered A through D correspond to the subdivisions of Part II of this book.

A. *Introducing the Report*

IDENTIFYING INFORMATION

The first section of the report typically presents pertinent information about the child, including the child's name, identifying information (gender, date of birth, age, handedness), grade in school, and so forth. It also frequently includes statements about confidentiality, reliability, and self-sufficiency. The source or sources of the information are important to include as well. For example, did you interview one or both parents? Did the teacher provide information? How reliable were the informants, and were they willing participants in the assessment process? Chapter 7 provides you with information on how to present these findings within the report.

REASON FOR REFERRAL

Why did the child present for an evaluation? Who referred him/her, and what prompted the referral at this time? It is often helpful to restate the reason for the referral in a child's or parent's own language. However, it is frequently the case that the child or parent cannot succinctly state the reason for the referral, and Chapter 8 provides you with ways of describing this reason more succinctly.

B. *History and Background*

Chapter 9 covers the child's history as it relates to the referral question. This is often presented from a parent's (not the child's) viewpoint. For example, what is the parent's perception of the chief problem? When did it start? How has it progressed? Have the symptoms increased rapidly or gradually over time? Has anything been done to treat this problem? If so, how did it work? How much of an effect do these symptoms have on the child's functioning?

Other aspects of a child's background also need to be addressed. For example, what is the child's medical history? Has she/he developed appropriately? What is the family members' situation, and what are their living arrangements? Is the child doing well in school? If not, where are the difficulties? Does the child have more difficulties in one setting than in another (e.g., home vs. school)? How do these particular aspects of the child's history and background relate to the referral question? See Chapters 10, 11, and 12 for more information about these topics.

C. *The Child or Adolescent in the Evaluation*

Within the next section of the report, it is important to answer the following lists of questions.

OBSERVATIONS ABOUT BEHAVIOR AND ATTITUDE

- How did the child present during the evaluation? What is clinically relevant in her/his presentation? (Chapter 13)
- What was the child's attitude toward the evaluation? Was he/she a willing participant? Was rapport easily established? How was the child's effort and motivation? (Chapter 14)

CLINICAL IMPRESSIONS

- How was the child's mood? Did the mood change over the course of the evaluation? Were symptoms of anxiety, depression, or anger present? If so, did the child meet criteria for a formal mood or anxiety disorder? (Chapter 15)

- Did the child meet criteria for a formal childhood behavioral or cognitive disorder, such as attention-deficit/hyperactivity disorder (ADHD), a learning disability, or intellectual disability? How would you describe this child's unique presentation? How severe are these disabilities? (Chapter 16)

D. The Child or Adolescent in the Environment

What are the effects of the child's home and family (Chapter 17), school (Chapter 18), or social relationships (Chapter 19) on the presenting symptoms?

E. Test Results

Test results can be organized on a test-by-test, domain, or integrated basis. The way you choose to present the test results may depend on your referral source or on the audience who will be reading and using the report. What follows is a domain-based organizational strategy for presenting test findings.

Intellectual functioning (Chapter 21)

Achievement (Chapter 22)

Language functioning (Chapter 23)

Memory (Chapter 24)

Visual-spatial and motor skills (Chapter 25)

Executive and neuropsychological functioning (Chapter 26)

Emotional and personality functioning (Chapter 27)

Behavioral and adaptive functioning (Chapter 28)

F. Ending the Report

DIAGNOSTIC STATEMENTS/IMPRESSIONS

The diagnostic statement (Chapter 29) includes any relevant DSM-5 diagnoses, as well as any rule-outs.

SUMMARY OF FINDINGS AND CONCLUSIONS

In addition to a diagnostic statement, you will need to summarize the findings of the evaluation, integrating the results of the history, observations, interview, and test findings (Chapter 30). If formal testing has been completed, you should include a restatement of the reliability or validity of the findings (Chapter 20). A summary should always answer the referral question.

RECOMMENDATIONS

List the treatments or compensatory strategies that are most effective for the child's problems. Include whether follow-up evaluations will need to be pursued, such as a referral to an occupational therapist, neurologist, or psychiatrist (Chapter 31).

CLOSING STATEMENT

Thank the referrer, indicate your availability, provide a summary statement, and sign your report (Chapter 32).

Further Guidelines on Report Writing

If you are writing with the intent of obtaining school services for the child (see Chapter 33), document whether—and why—the child *qualifies* for services. Don't simply say, "The child needs special education services."

Write the report as soon as possible after the evaluation, so that you will be more likely to remember important details. If you are waiting for other results (e.g., teacher reports), write the history and behavioral observations as soon as possible, and add the other data to the report once they have been collected.

Be succinct in your writing. If information does not contribute to an understanding of the referral question or to the observed difficulties, the information is irrelevant and does not need to be included. Keep in mind the referral question and the resulting recommendations, and build a case for your findings. Information that does not contribute to this goal does not need to be included.

Write reports that are understandable and useful to the persons or agencies that requested the report. Reports that are filled with jargon, are unrelated to referral concerns, or fail to address treatment are of little value to the referral source and to the child.

Although you will want to report on the absence of symptoms (e.g., the child is not depressed/anxious/impulsive/etc.), the focus should be on the presence of a behavior.

In excluding irrelevant information, be particularly careful to omit any such information that can be harmful to the child or to the family, particularly if the report will be read by school personnel. Such information may include a parent's (or adolescent's) sexual history or substance use, family living arrangements (e.g., separation), parental stress, parents' medical history, and so forth. In the course of the evaluation, you will probably learn much more about the child and the family than needs to be reported. It is your job as an evaluator to sift through this information and present *only* the information that will lead to appropriate diagnosis and treatment.

The summary is arguably the most read section of the report. Make sure it is carefully written to emphasize those aspects of the evaluation that are most important to convey to your audience. At a minimum, it should include a restatement of the referral question, the major findings of the evaluation, their relation to the referral question, a possible diagnosis, and your conclusions.

Knoff (1986) has indicated that the characteristics of a good report include the following: (1) The report clearly identifies the referral's concerns and answers these concerns directly in the report; (2) the report describes the most reliable behaviors that have been observed, and the information is described behaviorally, with all abstract information defined; (3) raw data are presented in context, so that readers are not asked to draw their own conclusions; (4) the child should be presented in a positive light, to the extent that this is possible; (5) the report should be concise, not omitting essential information or including irrelevant information; and (6) recommendations are described in a way in which they can be implemented.

Proofread your report and use a spell-checker. This might seem obvious, but we've all read reports that were evidently not spell-checked. In addition, don't be afraid to get feedback on your reports from colleagues, and offer to review their reports as well. Reading and critiquing reports by other professionals will often have the effect of improving your own.

A Cautionary Note and Disclaimer

This book simply presents sample questions and lists of terms and descriptions that have been used in the field. Their presence here does not imply any endorsement by the author or the publisher. These wordings are offered without any warranty, implied or explicit, that they constitute the only or the best way to practice as a professional or a clinician.

When individuals use any of the words, phrases, descriptors, sentences, or procedures described in this book, they must assume full responsibility for all the consequences—clinical, legal, ethical, and financial. The author and the publisher cannot, do not, and will not assume any responsibility for

the use or implementation of the book's contents in practice or with any person, patient, client, or student. The author and publisher presume (1) that the users of this book are qualified by education and/or training to employ it ethically and legally, and (2) that users will not exceed the limits of documentable competence in their disciplines as indicated by their codes of ethical practice. If more than the material presented here is needed to manage a case in any regard, readers are directed to engage the services of a competent professional consultant.

Part I

Questions for Conducting a Psychological Evaluation of a Child or Adolescent

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1

Beginning the Interview

1.1. Advance Preparation

Preparing the Parent(s) and Child for the Interview

See Chapter 2 regarding initial questions for parents.

Usually the initial contact with parents (or other caregivers) and children occurs on the phone. If so, the building of rapport begins even before a family arrives in the clinician's office. Use the phone call to determine whether the parents are anxious, hostile, eager, or ambivalent about being interviewed, and use this assessment as a way to approach the family in the actual interview.

- Discuss with the parent who has called you which family members should attend the first session (one or both parents, the child, etc.).
- Introduce yourself to the child's parent(s), using the name you would prefer the parents to use when speaking to you.
- Briefly describe what you will be doing with the child and what type of participation you will need from the parent(s).
- Give the parents an indication of how long the evaluation/intake will last and of how much the evaluation will cost.

Parents will often want the clinician's help in preparing their child for the first session. It is generally best for the child to know the reason for the interview or evaluation. Clear and simple statements can be used by parents to help their child understand the purpose of the evaluation—for example, "I know you've been struggling in school lately, and we want to find out how to make things better for you," or "You've seemed really sad lately, and we want to talk to someone about how we can help you feel better." These statements won't be misunderstood by the child as implying blame or be likely to distort your evaluation.

Preparing Yourself for the Interview

Be well prepared in advance of meeting a child and his/her family. Know the child's age, gender, and reason for referral. This will help you tailor your approach to each specific child. If you are scheduled to complete a testing evaluation, have all materials ready.

There are many good books for clinicians on conducting and structuring interviews with children and families. An excellent text is *The First Session with Children and Adolescents* (House, 2002).

Materials you will need for the initial session(s) include the following:

- Information regarding confidentiality and limits of privilege.
- Releases of information, multiple copies. (*See Section 40.1 for a release form.*)
- A form giving permission to evaluate or treat (to be completed by parents and/or child, depending on the child's age and state law).
- Behavior rating scales for parents and/or teachers/other professionals to complete.

1.2. Guidelines for Structuring the Interview Process

The interview is most often begun in one of the following ways:

- Parent(s) and child are interviewed together, after which time the parent(s) or child will each be asked to respond to questions separately (with the other party out of the room).
- One or both parents are interviewed first, followed by an interview with the child, and then a joint interview.

Gathering Information from Multiple Sources

Ryan, Hammond, and Beers (1998) have suggested the following guidelines for gathering information from multiple sources.

For Inpatients

1. Observe the child's interactions with staff members.
2. Obtain information from the staff about the child's behavior and child-family interactions.
3. Evaluate whether formal assessment is appropriate.

For Outpatients

1. Obtain records from the referring professional and other relevant professionals.
2. Discuss the purpose of the evaluation with a family member (this is often done by phone).
3. Provide an opportunity for the child to speak to you, and speak plainly with the child about the limits of confidentiality and what you can and cannot do.
4. Ask parents to bring school records to the evaluation.

Structured Diagnostic Interviews

Structured interviews range from highly structured to semistructured. In clinical practice, face-to-face structured interviews are most often used when there is a research component to the treatment. The more highly structured of these interviews are typically used by lay interviewers, as experienced clinicians typically find that they do not allow for latitude in clinical decision making. Semistructured interviews are designed to be administered by more extensively trained interviewers. Some clinicians will use a combination of structured and unstructured formats, such as administering a written evaluation form that will include structured questions, as well as conducting a less structured face-to-face interview. Examples of face-to-face structured interviews include the following (all of these interviews have both a parent and a child version):

- Diagnostic Interview Schedule for Children, Version IV (DISC-IV; Shaffer, 1996; Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000)
- Schedule for Affective Disorders and Schizophrenia for School-Age Children (6–18 years; K-SADS-PL-DSM-5; Kaufman et al., 2016)
- Child Assessment Schedule (CAS; Hodges, 1993)

1.3. Establishing Rapport

The first few minutes of any interview are important. Suggestions for enhancing rapport include the following.

General Tips

- Greet the child by her/his first name and introduce yourself. Use the name you would prefer the child to call you. Some clinicians prefer to be called by their first names, while others prefer to use a title (e.g., “Dr.”). Many clinicians use their first names with very young children, but use a title when working with adolescents.
- Give younger children time to settle down. If they’ve brought something from home, use it as a way of making conversation.
- The things you say to a child and the first questions you ask should be flexible and geared to the particular child (see Chapter 3 for initial interview questions). However, these often include questions that a child can easily answer, such as “How old are you?” and “Do you have any pets?”
- Respond to the child with openness, warmth, empathy, and respect. Be attentive to the child’s needs, such as hunger, need for physical activity, or use of the toilet. In contrast, know when it is appropriate to set limits on behaviors.
- Provide age-appropriate breaks as necessary.

With the Very Young Child (Ages 2½–6 years)

- Have a working knowledge of types of toys and activities that children of this age would enjoy. Know what is currently popular for the age group. You can then ask about and comment on a child’s favorite toys and activities.
- Begin building rapport by talking about children’s clothing, toys they may have brought to the office, toys they are playing with in the waiting room, how they got to the office, what the drive was like, how long it took them to get there, or the like.
- Be aware of a child’s emotional state, and respond appropriately to how he/she feels.
- Activities that enhance rapport with a very young child include drawing pictures of her/his choosing, playing structured games (Candy Land, Connect Four, Mancala, etc.), or playing with “open-ended” toys (Legos, modeling clay, dolls, etc.).

With the School-Age Child (Ages 6–12 Years)

- Children in this age group often enjoy talking about their hobbies, teachers, school, after-school activities, friends, video games, sports, clothes, shopping, “hanging out,” and so forth.
- Have a working knowledge of activities, toys, TV programs, computer games, and the like that are of interest to this age group.
- Begin building rapport by talking about what the drive to the office was like; whether children are missing school or an activity for the appointment; any objects (e.g., Game Boy, iPod, MP3 player) or books they might have brought to the office; or similar topics.
- If an evaluation is being completed with the intention of beginning therapy, it is important to discuss the rules of therapy and of confidentiality in age-appropriate language. The “rules” of therapy vary by individual professionals or clinics, and frequently by individual cases as well. One such “rule” involves what type of information is shared by the therapist between parents and child (e.g., everything can be shared; nothing is shared, with the exception of topics the therapist is legally required to report; certain topics, such as boyfriends/girlfriends, are off limits; etc.). Other “rules” may include how frequently the parents will meet with the therapist; whether the child has a role in determining the frequency and content of

these meetings; whether the treatment is to be individual or have a family component; and so on. It is important to make these “ground rules” clear to both the child and the parents. In some cases, the establishment of these rules becomes an important part of the therapy itself, opening the discussion of limit setting for parents and their children.

- Ask the child what he/she was told would happen. Decide where and how (in the presence of the parents, with the child alone, etc.) you will address this question, as it may be differently phrased, depending upon the age of the child. If you want a frank view from the child, it is frequently best to ask the child with the parents out of the room.

With Adolescents (Ages 12–18 Years)

- It is important to acknowledge an adolescent’s feelings. Many adolescents are not happy at the prospect of an evaluation or therapy, and most will appreciate a clinician who validates their feelings.
- Adolescents also appreciate being treated as mature individuals. It is best to treat them as if they are adults, to the degree that this is reasonable. Of course, once adolescents reach the age of 18 they are legally adults, but it is the therapist’s responsibility to decide to what degree they should be treated as adults. This is a central issue of adolescence; however, each child and family is different, so you will need to develop (and model) a balance that is logical, clear, acceptable, and therapeutically appropriate to all concerned.
- Discuss confidentiality and the “rules” of therapy (see above). Adolescents are typically much more involved in establishing these types of “rules,” including who attends the sessions, what type of information will and will not be shared with the parents, how frequently sessions will be held, and so forth.

1.4. Informed Consent

Therapists are obligated to obtain informed consent before beginning assessment or treatment with any client. Although state regulations may vary somewhat, a clinician cannot treat or evaluate a minor without written consent from the minor’s legal guardian. Although some state laws may differ, you can typically evaluate or treat a child from an intact family with the permission of either parent. When a minor’s parents are divorced, it is essential to obtain the consent of the parent who has legal physical custody. If custody is shared, you will generally need to obtain permission from both parents. It is important to check your state’s legal requirements regarding consent to treating a minor.

There is no “one size fits all” informed consent form, because different informed consent procedures are likely to be needed, depending on what a parent (and sometimes a child) wants and needs to hear (Braaten & Handelsman, 1997). Handelsman (2001) encourages professionals to follow these guidelines in providing informed consent:

- Obtaining informed consent should be thought of as a process and not a one-time event. For example, issues of confidentiality involving a minor can arise throughout the course of therapy, and such issues will need to be addressed as they arise.
- The informed consent process should be incorporated into the treatment of any child. In the case of a young child (below the age of 5 or 6 years), the “client” who needs to be kept informed is typically one or both parents; for a school-age child or an adolescent, the “client” typically includes both the child and the parent(s).
- Provide information that, in your opinion, “[children] or their loved ones would want” (Handelsman, 2001, p. 457).
- Solicit assent even from those who are not competent (or of age) to consent.

- Provide information that a “reasonable person would want to know” (Handelsman, 2001, p. 454).
- Document the consent process, including the initial conversation as well as ongoing ones.
- Make your forms readable and personalized to your practice.
- Give the client (see the definitions of “client” in the second point above) a copy of the form.
- Review the initial information as needed throughout the professional relationship.

Wiger (1999) has identified several areas of confidentiality that should be addressed with the client (again, see the definitions of “client” above):

- A professional must report abuse of children and vulnerable adults.
- A professional has a duty to warn and protect when a client indicates she/he has a plan to harm self or others.
- Parents and legal guardians have the right of access to their children’s psychotherapy and testing records, unless doing so would be harmful to the children.
- The client should be informed if someone other than the therapist types the child’s reports.
- A professional is required to report admitted prenatal exposure to controlled substances.
- A therapist is required to release records in the event of a court order.
- Professional misconduct by a health care provider must be reported.
- Professionals should inform clients about their policy regarding the use of collection agencies. Clinicians have a right to use such an agency, if a client is informed that some aspects of the treatment (such as number of sessions) can be shared with a collection agency in the interest of obtaining unpaid fees.
- Information about third-party payers should be provided, such as what type of information (e.g., diagnosis, progress reports) you are required to give to a client’s insurance company in order for insurance to cover the claim.
- The client should be informed about the role of professional consultations.
- The therapist should provide clear guidelines regarding the keeping of information in child, family, and relationship counseling.
- The client should be provided with information regarding telephone calls, answering machines, and voice mail.

Here are some final points to keep in mind regarding consent with children and adolescents:

- Discuss the issues of confidentiality involved in treating minor patients with the client. The discussion should include how you intend to balance the child’s need for confidentiality against the parents’ need for essential information.
- Consider writing a formal agreement regarding this discussion. Although the agreement would not be legally binding, it is often helpful to have a clearly written understanding of this policy.
- Working with minors often entails communicating with other professionals (teachers, etc.), which can present dilemmas for clinicians. Therapists and evaluators need consent from parents in order to share information with school personnel, and a therapist or evaluator should be aware that the information thus shared may not necessarily be entirely confidential.
- *The Paper Office for the Digital Age* (Zuckerman & Kolmes, 2017) provides a wealth of data regarding informed consent to treatment and assessment, including some forms.
- Clinicians should always consult the state statutes that govern their profession.

1.5. Obtaining Identifying Information from Parents

“What is the child’s name? Address? Phone number? Date of birth? Age?”

“What is your family’s living arrangement? Who lives with your child?”

“What school does your child attend? What grade is she/he in?”

"What language is spoken in the home/the school/the neighborhood?"

"How would you describe your family's racial or ethnic identity?"

1.6. Eliciting the Chief Concern/Problem from Parents

"What is your reason for seeking this evaluation/consultation?"

"Tell me in your own words what you feel your child's main problem is."

"Tell me what has been going on with the child."

"What are your specific concerns?"

"What concerns you most?"

"What are your hopes for this evaluation/consultation/treatment?"

"What are your hopes for the child?"

Eliciting the Parents' Understanding of the Chief Concern/Problem

"Do you have any ideas about what might have caused the child's problem?"

"Do you think anything particular triggered or contributed to your child's problems?"

"What do you think are the most important aspects of the child's history in light of the chief concern?"

"Do you think that any aspects of the family's medical or psychological history may have played a role in the problem?"

Dimensionalizing the Concern/Problem

"When did you first notice the child's difficulties?" (*duration*)

"How long has this been happening?" (*duration*)

"How often does this happen?" (*frequency*)

"How intense or mild is it usually?" (*intensity*)

"How difficult is the problem for the child?" (*intensity*)

"Where are the child's difficulties most apparent? (At home? At school? In friendships?)" (*setting*)

Determining Earlier Efforts to Deal with the Concern/Problem

"How have you, as parents, dealt with the problem?"

"How has your family adjusted to the child's problem(s)? Have any types of accommodations been made in the school?"

"Has your child been previously diagnosed with a psychological or academic difficulty? (*If yes:*) What was the diagnosis? Who made the diagnosis? When was the diagnosis made?"

"Did you agree with the diagnosis? Why or why not?"

"What is the child's teacher's view of her/his problem(s)?"

1.7. Prenatal, Birth, and Neonatal History *See Chapter 10 for descriptors.*

Prenatal History

"Did you experience any difficulties during pregnancy, such as preterm labor, medical complications, or psychosocial stressors? (*If yes:*) What types of difficulties did you experience?"

"Did you receive prenatal medical care? (*If yes:*) Beginning at what month?"

"Was the child exposed to any prescription or nonprescription drugs during pregnancy? (*If yes:*) What were they, and how often were they taken?"

"Did you/the child's mother smoke during pregnancy? (*If yes:*) How much?"

"Did you/the child's mother drink alcohol during pregnancy? (*If yes:*) How much?"

Delivery

- "Was the pregnancy full-term, or was the child born prematurely? (*If prematurely:*) At how many weeks' gestation?"
- "How much did the child weigh at birth?"
- "Was the delivery normal, or were there complications?"
- "What was the child's general health at the time of the delivery?"
- "What were the child's Apgar scores?"

Infant Temperament

- "What type of baby was the child?"
- "What was the child's activity level? Level of alertness?"
- "Was it easy or difficult for you to soothe/calm the child? Could the child soothe/calm him-/herself?"
- "Would you say that the child was a generally happy baby? A generally fussy baby?"
- "How did the child respond to you as an infant?"
- "Did the child experience any feeding difficulties in infancy? Sleeping difficulties? Other problems?"

Adoption

- "At what age was the child adopted?"
- "Where did the child's adoption take place?"
- "What do you know of the child's prenatal and birth history?"
- "With whom was the child living at the time of the adoption?"
- "Describe the terms of the adoption (open adoption, international adoption, etc.)."
- "Are there any issues regarding the child's adoption that are important to consider in light of her/his current difficulties? (*If so:*) What are they?"

1.8. Developmental History

See Section 40.2 for a developmental history form that can be used to elicit information. For developmental history descriptors, as well as lists of milestones in specific developmental areas, see Chapter 11.

Ask the parent or guardian whether the child reached key developmental milestones at the appropriate ages. The following lists, adapted from one by Powell and Smith (1997), gives various milestones by average age.

List of Developmental Milestones

By 3 Months of Age

MOTOR SKILLS

- Lift head and chest when lying on his/her stomach.
- Follow a moving object or person with her/his eyes.
- Grasp rattle when given to him/her.

SENSORY AND THINKING SKILLS

- Turn head toward the sound of a human voice.
- Recognize bottle or breast.
- Respond to the shaking of a rattle or bell.

LANGUAGE AND SOCIAL SKILLS

- Make cooing, gurgling sounds.
- Communicate hunger, fear, discomfort (through crying or facial expression).
- React to “peek-a-boo” games.

By 6 Months of Age

MOTOR SKILLS

- Reach for and grasp objects.
- Play with toes.
- Explore by mouthing and banging objects.
- Move toys from one hand to another.
- Sit with only a little support.
- Roll over.

SENSORY AND THINKING SKILLS

- Imitate familiar actions a caregiver performs.

LANGUAGE AND SOCIAL SKILLS

- Babble, making almost sing-song sounds.
- Know familiar faces.
- Smile at her-/himself in a mirror.

By 12 Months of Age

MOTOR SKILLS

- Drink from a cup with help.
- Feed him-/herself finger foods (e.g., raisins or bread crumbs).
- Grasp small objects by using thumb and index finger/forefinger.
- Put small blocks into and take them out of a container.
- Sit well without support.
- Crawl on hands and knees.
- Pull her-/himself to stand or take steps while holding onto furniture.
- Stand alone momentarily.

SENSORY AND THINKING SKILLS

- Try to accomplish simple goals (e.g., seeing and then crawling to a toy).
- Look for an object he/she watched fall out of sight (such as a spoon that falls under the table).

LANGUAGE AND SOCIAL SKILLS

- Say her-/his first word.
- Respond to another’s distress by showing distress or crying.
- Show mild to severe anxiety at separation from parent.
- Show apprehension about strangers.
- Understand simple commands.

By 18 Months of Age**MOTOR SKILLS**

- Pull off hat, socks, and mittens.
- Turn pages in a book.
- Stack two blocks.
- Scribble with crayons.
- Walk without help.

SENSORY AND THINKING SKILLS

- Identify an object in a picture book.
- Look for objects that are out of sight.
- Follow simple one-step directions.

LANGUAGE AND SOCIAL SKILLS

- Say 8–10 words a caregiver can understand.
- Ask specifically for his/her mother and father.
- Use “hi,” “bye,” and “please,” with reminders.
- Asks for something by pointing or by using one word.
- Become anxious when separated from parent(s).
- Play alone on the floor with toys.
- Recognize her-/himself in the mirror or in pictures.

By 2 Years of Age**MOTOR SKILLS**

- Drink from a straw.
- Feed him-/herself with a spoon.
- Toss or roll a large ball.
- Open cabinets, drawers, boxes.
- Walk up steps with help.

SENSORY AND THINKING SKILLS

- Like to take things apart.
- Point to five or six parts of a doll when asked.

LANGUAGE AND SOCIAL SKILLS

- Have a vocabulary of several hundred words.
- Use two- to three-word sentences.
- Say names of toys.
- Listen to short rhymes.
- Take turns in play with other children.
- Apply pretend action to others (e.g., pretending to feed a doll).
- Refer to self by name and use “me” and “mine.”
- Verbalize desires and feeling (e.g., “I want cookie”).
- Laugh at silly labeling of objects and events (e.g., calling a nose an ear).
- Point to eyes, ears, or nose when asked.

By 3 Years of Age**MOTOR SKILLS**

- Feed her-/himself (with some spilling).
- Hold a glass in one hand.
- Hold a crayon well.
- Fold paper, if shown how.
- Throw a ball overhead.
- Dress him-/herself with help.
- Use the toilet with some help.
- Walk up steps, alternating feet.
- Kick a ball forward.
- Pedal a tricycle.

SENSORY AND THINKING SKILLS

- Remember what happened yesterday.
- Know some numbers (but not always in the right order).
- Understand “now,” “soon,” and “later.”
- Look through a book alone.
- Match circles and squares.
- Match an object to a picture of that object.
- Match objects that have similar functions (e.g., putting a cup and plate together).
- Count two to three objects.
- Follow simple one-step commands.

LANGUAGE AND SOCIAL SKILLS

- Use three- to five-word sentences.
- Use plurals (“dogs,” “cars,” “hats”).
- Name at least one color correctly.
- Ask to use the toilet almost every time.
- Demonstrate some shame when caught in a wrongdoing.
- Play spontaneously with two or three children in a group.
- Understand “I,” “you,” “he,” and “she.”
- Answer whether she/he is a boy or girl.

By 4 Years of Age**MOTOR SKILLS**

- Feed him-/herself (with little spilling).
- Hold a pencil.
- Draw a circle.
- Draw a face.
- Try to cut paper with blunt scissors.
- Brush teeth with help.
- Build a tower of seven to nine blocks.
- Put together a simple puzzle of 4–12 pieces.
- Pour from a small pitcher.
- Use the toilet alone.
- Catch a bouncing ball.
- Walk downstairs, using a handrail and alternating feet.

SENSORY AND THINKING SKILLS

- Understand “big,” “little,” “tall,” “short.”
- Sort by shape or color.
- Count up to five objects.
- Distinguish between the real world and the imaginary or “pretend” world.

LANGUAGE AND SOCIAL SKILLS

- Have a large vocabulary and use good grammar often.
- Use regular past tenses of verbs (“pulled,” “walked”).
- Ask direct questions (“May I?”, “Would you?”).
- Understand “next to.”
- Separate from a parent for a short time without crying.
- Help clean up toys at home or school when asked to.
- Like to play “dress-up.”
- Often prefer playing with other children to playing alone, unless deeply involved in a solitary task.
- Share when asked.

By Childhood Years (Ages 6–12)**SOCIAL AND EMOTIONAL DEVELOPMENT**

- Have an average of five good friends and at least one “enemy,” who often changes from day to day.
- Act nurturing and commanding with younger children, but follow and depend on older children.
- Begin to see others’ points of view more clearly.
- Define her-/himself in terms of appearance, possessions, and activities.
- Develop and practice inner control each time decisions are made.
- At around age 6–8, may still be afraid of monsters and the dark; these are replaced later by fears of school or disaster and confusion over social relationships.
- Often become attached to an adult (teacher, club leader, caregiver) other than parents, and quote the new “hero” or try to please him/her to gain attention.

PHYSICAL DEVELOPMENT

- Recognize differences between boys and girls.
- Develop muscle coordination and control (uneven and incomplete in the early stages, but almost as good as adults’ by the end of middle childhood).
- Lose baby teeth and begin acquiring permanent ones.
- Reach visual maturity (both size and function).

MENTAL DEVELOPMENT

- Begin to read and write early in middle childhood, and should be skillful in reading and writing by the end of this stage.
- At first, can rarely sit for longer than 15–20 minutes for an activity; attention span gets longer with age.
- Can talk through problems to solve them.
- Can focus attention and take time to search for needed information.
- Can develop a plan to meet a goal.
- Develop greater memory capability, because many routines (brushing teeth, tying shoes, bathing, etc.) are automatic now.

Questions about Developmental Milestones/Delays

- "How old was the child when he/she started to crawl? Walk? Talk? Use the toilet? Dress him-/herself?"
- "Was the child delayed in reaching any of these milestones?"
- (*If yes:*) "Did the child receive treatment for any of these delays/difficulties?"
- (*If yes:*) "What were the treatments, and did you feel they were successful?"
- "Were there any significant events in the child's early life that may be related to her/his current difficulties? (*If so:*) What were these events?"

1.9. Medical History *See Chapter 10 for descriptors.*

- "Tell me about the child's medical or health history."
- "Has the child experienced any difficulties with the following: Allergies? Asthma? Frequent ear infections? Epilepsy? Enuresis/bedwetting? Encopresis/soiling? Eczema? Head injury? Hypoxia/oxygen deprivation? Neonatal jaundice? Meningitis? Problems with vision or hearing?"
- "Has the child experienced any significant illnesses? (*If so:*) What were they, and when did they occur?"
- "Has the child had any surgeries? (*If so:*) What were they, and when did they occur?"
- "Has the child ever been hospitalized? (*If so:*) When and why?"
- "Has the child been exposed to toxins such as lead? Do you know whether your house has lead paint, and, if so, have you discussed this issue with your pediatrician?"
- "Does the child currently take any medications? (*If so:*) What are the medications, and do these have any significant side effects?"
- "In the past, has the child ever taken medications for an extended period of time? (*If so:*) What were the medications, and why were they prescribed?"
- "Has the child been prescribed glasses/hearing aids? (*If so:*) Does the child consistently wear them?"
- "Were there any significant medical problems in the child's life that may be related to his/her current difficulties? (*If so:*) What were these events?"

1.10. Family History *See Chapter 11 for descriptors.*

- "Tell me what your home is like."
- "Who lives in your home? What is each person's relationship to the child?"
- "Has the child moved frequently/recently? (*If so:*) What were the reasons for the moves?"
- "Has your family experienced any recent stresses that may be affecting the child's behavior?"

Information about Siblings

- "Where is the child's place in your children's birth order?"
- "Do any of the child's siblings have any significant medical problems or psychiatric problems? (*If so:*) What is the effect of these problems on the child?"

Information about Parents

- "Are you single, married, divorced, or living with a partner?"
- (*If married:*) "Is your spouse the child's natural/birth mother/father? How many years have you been married? How would you describe the quality of your relationship?"
- (*If divorced:*) "When did you separate? What was the effect of the divorce on the child's behavior? How would you describe your current relationship with the child's mother/father? Who has custody? How often does the child visit his/her noncustodial parent?"

- "How old were you when the child was born?"
- "How old was your spouse/partner when the child was born?"
- "What is your/your spouse's/partner's current occupation?"
- "What is the effect of your job/your spouse's/partner's job on the family?"
- "Does either of your families have a history of drug or alcohol abuse? Learning disabilities? Medical problems? Psychiatric difficulties?"
- (*If living with a partner:*) "How long have you been living with your current partner? How would you describe your child's relationship with your partner? How would you describe your partner's relationship with your child's father/mother?"

Adoption Issues

- "Does the child know he/she is adopted?"
- "Does the child have contact with her/his birth parents? (*If so:*) What kind of contact, and how frequently does it occur?"

1.11. Relationships

For descriptors, see Section 11.7 (relationships with parents); Section 11.8 (relationships with siblings); and Sections 19.3 and 19.4 (friendships and peer groups, respectively).

With Peers

- "Does the child have friends? (*If no:*) Why do you think the child doesn't have friends?"
- "How well does the child get along with his/her friends?"
- "Do you like the child's friends?"
- "What kinds of opportunities does the child have to make friends?"
- "How do other children treat/react to the child?"

With Siblings

- "How does the child get along with her/his brothers/sisters? What do they do that the child likes/dislikes?"

With Parents and Other Adults

- "How would you describe the quality of your relationship with your child? Is it different from the quality of the relationship with your other children?"
- "How does the child show affection for you? Anger toward you?"
- "What family member is the child most like? Why?"
- "How does the child interact with other adults? Is there anything about these relationships that concern you?"
- "How is discipline handled in your home? Is it effective? Who usually administers the discipline?"

1.12. Interests and Routines

Interests

- "What kinds of things does the child like to do in her/his free time?"
- "What does the child like to do when he/she is alone? With friends/sisters/brothers/other family members?"

"How much television does the child watch? Do you feel happy with that amount? What kinds of TV shows does she/he like to watch?"

"Does your child play video games? How much time does he/she play per day/week? What types of video games does he/she play?"

"What kinds of music does the child like to listen to?"

Routines

"Do you have any particular routines (bedtime, homework, etc.) that you typically follow? (*If so:*) Can you describe these for me?"

"What happens to your child when you're not able to follow the routines on a particular day?"

"Does the child do any chores? (*If so:*) What are they?"

1.13. Academic History *See Chapter 12 for descriptors.*

Current Placement

"What type of school does the child attend (e.g., private, public, Montessori)?"

"How long has the child attended this school?"

"What grade is the child in?"

"What type of classroom setting is this (traditional, multiple ages, etc.)? How many teachers are in the classroom? How many students?"

"How do you feel about the school? About the child's current teacher(s)?"

School Experiences

"Describe the child's school experiences, beginning with preschool."

"At which ages or grades (*if any*) did the child begin experiencing difficulties?"

"What types of difficulties were observed?"

"What type of special services (*if any*) did the child receive?"

"Has the child ever been on an individualized education plan or a Section 504 plan?"

General Academic Functioning

"How do you feel school is going for the child?"

"What does the child like/dislike about school? What are his/her best/worst subjects?"

"How satisfied is the child with his/her progress or performance in school?"

1.14. Additional Questions about Adolescents

"Does your teen date? What does she/he generally do on a date? Do you approve?"

"Do you think that your teen may be sexually active? Have you discussed appropriate sexual behavior with him/her? (*If yes:*) What have you talked about?"

"Do you have any concerns about drug/alcohol use? (*If yes:*) What kind of drugs/alcohol do you think your teen may be using? Has the teen been in trouble because of drug/alcohol use? How does she/he pay for/get drugs/alcohol? Have you ever sought treatment for her/his alcohol/drug use? (*If yes:*) What type of treatment? Was it effective?"

"Does the teen have a job? (*If yes:*) What does he/she do? Do you approve of his/her working?"

2

Questions for Parents on Signs, Symptoms, and Behavior Patterns

Chapter 1 has offered general questions for gathering background information and history, as well as for eliciting the referral reason. This chapter suggests further questions to ask parents (or other guardians), depending upon the specific referral reason or chief concern. These questions are meant only as a guide; no interviewer will ask all of these questions. The clinician should focus on those areas of concern to the particular child, as well as on the parents' or guardians' concerns and goals for the assessment.

2.1. Anger and Aggression

See also Section 2.8, "Disruptive Behavior Disorders." See Section 15.2 for descriptors.

"What does the child do when he/she gets angry?"

"When your child gets angry, what behaviors concern you most?"

"When the child gets angry, does a tantrum usually follow? And does anger usually accompany tantrums?"

"Where does this anger behavior happen most often (home, school, etc.)?"

"When does this behavior most often happen? Are there particular times?"

"Can the child get over her/his angry feelings without adult help?"

"Who are usually the targets of the child's angry behavior?"

"Are there particular things that set off the child's angry behavior? Or can anything set the child off?"

2.2. Anxiety *See Section 15.3 for descriptors.*

General Anxiety Symptoms

"Does your child worry a lot? Appear nervous or tense?"

"Does your child complain about how he/she feels? (*If so:*) Does he/she experience sweaty palms or excessive perspiration? Dry mouth? Frequent nausea or upset stomach? Shaking or dizziness? Muscle tension? Rapid heartbeat or respiration?"

"When the child was young, was she/he frequently clingy?"

"As a baby or toddler, did the child have trouble being separated from you/the parents?"

"Does your child have any nervous habits, such as nail biting, tics, or repetitive movements?"

"Has the child's anxiety/nervousness affected his/her relationships with other children? With you?"

Panic Attacks

"Do you think your child has ever had a panic attack—intense fear, rapid heartbeat, shortness of breath, sweaty palms, without an obvious trigger for the event? (*If yes:*) How did the child act? What made you most concerned? When did the panic attack happen? Has there been more than one? How frequently does your child have them?"

"Are the panic attacks linked to any specific situation, such as riding in a car or taking a test?"

"Has your child ever been treated for panic attacks? (*If yes:*) Did the treatment help?"

"Do you do anything to help your child during a panic attack? (*If yes:*) What works? What doesn't work?"

2.3. Attention-Deficit/Hyperactivity Disorder (ADHD)

See Section 16.1 for descriptors.

There are several standardized questionnaires that can be used with parents and teachers when the referral question relates to ADHD. These are the most common:

ADHD Rating Scale–5 (DuPaul, Power, Anastopoulos, & Reed, 2016)

Attention Deficit Disorder Evaluation Scale—Fourth Edition, Home Version (McCarney & Arthaud, 2013a)

Attention Deficit Disorder Evaluation Scale—Fourth Edition, School Version (McCarney & Arthaud, 2013b)

Behavior Assessment System for Children, Third Edition (BASC-3; Reynolds & Kamphaus, 2015)

Behavior Rating Inventory of Executive Function, Second Edition (BRIEF2; Gioia, Isquith, Guy, & Kenworthy, 2015)

Brown Executive Function/Attention Scales (Brown, 2018)

Comprehensive Executive Function Inventory (CEFI; Naglieri & Goldstein, 2013)

Conners 3rd Edition (Conners 3; Conners, 2008)

Inattentive Symptoms

"How well does your child pay attention to tasks? Is the child easily distracted? Does he/she frequently daydream? How well is she/he able to screen out background noise or details?"

"Is your child often forgetful? (*If yes:*) Can you give me an example?"

"Does your child have difficulty remembering to do things?"

"Does your child have problems with memory in general? (*If yes:*) Can you give me an example?"

"Does your child have any chores at home? (*If yes:*) Is he/she able to complete these chores?"

"Does your child complete her/his homework? Is the homework usually done well? Is it hard for her/him to complete assignments? How much help do you need to provide? Does your child make careless errors on assignments? (*If yes:*) What types of errors?"

Hyperactive and Impulsive Symptoms

"How active is your child? Is it hard for him/her to sit still? (*If yes:*) What is this like? Does it ever seem as if she/he is driven by a motor that you can't shut off? Does he/she have an excessive amount of energy? Does your child talk excessively? Does she/he frequently interrupt others? Does he/she have difficulty awaiting his/her turn?"

- "Does your child often act 'in the moment' without thinking of the consequences? Does she/he have trouble controlling her/his response in different situations? (*If yes:*) Can you think of an example? Would you describe him/her as a risk taker?"
- "Has your child had any serious problems at school? Expulsion? Suspensions? Poor grades? Poor attendance?"
- "Is your child easily frustrated? What types of things typically frustrate her/him?"
- "How frequent are the problems you've described?"
- "Does the child see that she/he has problems? (*If yes:*) What does he/she think of them?"
- "Has anything ever been done to treat these problems (at school or through medication)? (*If yes:*) How successful were these efforts?"
- "What are your greatest concerns about your child's behavior? Do both parents/both of you agree with each other? Does the child's other parent agree with you about these problems?"

2.4. Autism Spectrum Disorder (ASD) *See Section 16.9 for descriptors.*

- "How does the child relate to others? Does the child share interests or pleasures with others? Or does she/he prefer to play alone?"
- "How well does your child make eye contact with others? As a baby, did the child avoid looking at others? Was the child an unresponsive infant in other ways? Did he/she smile appropriately as a baby?"
- "Did you notice any problems in the child's development of language? How well does she/he understand language? Jokes?"
- "Does the child ever repeat what others say in a robotic way? Do you ever notice that the child reverses pronouns, such as referring to him-/herself as 'you,' or referring to others as 'I' or 'me'?"
- "Is the child able to carry on a conversation?"
- "Does the child repeat any actions or behavior patterns over and over again? (*If yes:*) What are they? How does the child react when someone tries to interfere with these repeated actions?"
- "Does the child talk on and on and on about a particular topic?"
- "Is the child ever fascinated with parts of objects? Is the child more interested in objects than people? Is the child obsessively fascinated with unusual things for his/her age?"
- "Describe how the child plays. What kinds of things does she/he do?"
- "Does the child have any particular patterns of body movements (spinning, hand flapping, rocking, twirling, etc.)?"
- "Does the child have any difficulties moving arms or legs? Using large muscles? Does he/she have any difficulty making small, precise movements, such as in drawing or writing?"
- "What is the child's attention like?"
- "Has the child ever been either insensitive or oversensitive to noise, touch, foods, smells, light, or pain?"

2.5. Bipolar Disorders *See Section 15.4 for descriptors.*

- "Does your child ever seem to be out of control? For instance, does she/he show extreme silliness? Extreme irritability? Impatience to the point of being highly agitated? A disregard for authority? Aggressive behaviors? (*If yes to any:*) Can you give me an example?"
- "Does your child ever have a decreased need for sleep? (*If so:*) Can you give me an example of what that is like?"
- "Does your child ever show unusual sexual behaviors? For example, does he/she engage in 'doc-

tor' play that seems abnormal for his/her age? Show inappropriate interest in sexual manners? Expose her-/himself to other children? Engage in increased masturbation?"

(*For an adolescent:*) "Does your teen show an excessive interest in sex or pornography? Make frequent and/or unwelcome sexual overtures to others? Have increased sexual activity and/or masturbation?"

✓ Note: If sexual symptoms are endorsed, the examiner should thoroughly rule out the possibility of sexual abuse.

"Is there any family history of bipolar disorders/manic–depressive illness?"

2.6. Communication Disorders *See Section 16.2 for descriptors.*

"How well does your child understand spoken language/what people say?"

"Does she/he have trouble understanding if long or complex sentences are used?"

"Do you have any concerns about the child's ability to speak or express him-/herself in words? How well does the child use language to express her/his thoughts/ideas?"

"Does the child have problems saying certain words or sounds? (*If yes:*) Can you give me an example?"

"Does your child have problems finding the right word? Do you think the child uses words like 'you know,' 'stuff,' or 'thing' when she/he can't come up with the right word? Does the child often use the wrong word for something, such as 'fork' for 'spoon'?"

2.7. Depression *See Section 15.5 for descriptors.*

"Does your child ever have periods of depressed/low mood or extreme sadness? (*If yes:*) How long do these periods last?"

"Does your child ever feel too sad to get out of bed in the morning? Does he/she smile rarely or cry frequently? Is the child uncommunicative?"

"Does your child cry easily? (*If yes:*) Tell me about the times she/he cries easily."

"Have you noticed any problems with your child's appetite—either overeating (being hungry all the time, can't stop eating) or not feeling like eating at all? (*If yes:*) Is this a change for the child?"

"Does your child complain about low energy level, feeling tired all the time, intestinal distress, stomach cramps, or just not feeling right?"

"Have these symptoms affected the child's academic performance? Social relationships and friendships? Family relationships?"

"Does the child seem harder on him-/herself these days? More self-critical than usual? Does the child have feelings of low self-esteem? Is there a preoccupation with death? Is the child overly sensitive to criticism?"

✓ Note: If depression is suspected, but typical symptoms are not endorsed, screen for symptoms of "masked" depression: anger, irritability, and/or hyperactivity.

2.8. Disruptive Behavior Disorders *See Section 16.3 for descriptors.*

There are several standardized questionnaires that can be used with parents and teachers when the referral question relates to disruptive behavior disorders. These are among the most common:

Aggression Questionnaire (AQ; Buss & Warren, 2000)

Beck Anger Inventory for Youth (BANI-Y), in Beck Youth Inventories—Second Edition (Beck, Beck, & Jolly, 2005)

- "Does your child defy or oppose you or other adults? (*If yes:*) How? Arguing? Refusing to do what you ask? Refusing to follow rules? Deliberately annoying others? Losing her/his temper?"
- "How does the child explain his/her behaviors? Does she/he blame others?"
- "Has the child ever done any of the following (*if yes, ask parent to explain*): Theft? Running away from home? Truancy from school? Setting fires? Writing graffiti? Violating curfew? Drug use? Inappropriate sexual activity? Gang membership? Frequently getting into fights?"
- "How would you describe your child's mood generally? Is he/she generally angry, resentful, irritable? Does the child have a short fuse? Feel bad about her-/himself?"

2.9. Eating Problems and Disorders *For descriptors, see Section 16.4.*

- "Has your child had any eating difficulties? Is he/she a finicky eater? Does she/he overeat? Does he/she eat unusual substances? (*If yes:*) Please describe."
- "Is your child cutting down on the amount of food she/he eats, or refusing to eat? Have you noticed any fixed patterns of behavior about eating? Does the child have a preoccupation with food or dieting?"
- "Has the child experienced any physical consequences from eating problems, such as heart difficulties? Hair loss? Low blood pressure? Reduced body temperature? (*For an adolescent girl:*) Problems with menstrual irregularity?"
- "How would you describe your child's personality? Is she/he perfectionistic, self-disciplined to a fault, or too eager to please others?"
- "How would you describe your child's normal body size? Average? Thin? Overweight? What is his/her current body weight?"
- "Does the child exercise? (*If yes:*) Describe her/his exercise routine. Do you feel this is excessive?"
- "Do you know whether your child uses laxatives, diuretics, or appetite suppressants?"
- "When it comes to food, does your child seem to have trouble thinking clearly or rationally? (*If yes:*) How? Can you give me an example?"
- "Does the child have any other emotional difficulties, such as depression, anxiety, or mood swings? Is he/she oversensitive to criticism from others? Does the child suffer from poor self-esteem?"
- "Have the child's eating problems affected her/his relationships in the family? With friends? At school? At work?"

2.10. Elimination Problems *See Section 16.5 for descriptors.*

- "Has your child had any difficulties with toileting, such as problems with toilet training, bed-wetting, or severe constipation? (*If yes:*) Can you give me an example?"
- "Does the child have any medical conditions, or is he/she currently taking any medicines, that could account for these difficulties?"

2.11. Intellectual Disability (Intellectual Developmental Disorder)

See Section 16.7 for descriptors.

- "How would you describe the child's ability to take care of his/her daily needs, such as dressing and other self-care skills?"
- "How would you describe your child's academic skills? Ability to function without adult support?"
- "Is the child able to manage money? Use the telephone? Tell time?"
- "Can your child be left alone at home or in the backyard?"

- "How does your child get along with others? Does the child have friends? (*If yes:*) Who are some of her/his friends?"
- "Does the child act aggressively? Have frequent tantrums? Harm him-/herself? Is the child verbally or physically abusive?"
- "Does the child have any physical disabilities, such as problems with walking, running, coordination, or paralysis?"
- "Does the child behave inappropriately? Does she/he seem to have fetishes? (*If yes:*) Can you give me an example?"

2.12. Learning Disabilities *See Section 16.6 for descriptors.*

General Questions

- "How would you describe your child's learning ability? Describe her/his greatest learning challenges."
- "Does your child have any of the following difficulties in the classroom: Problems with work completion? Failing to turn in homework? Problems taking notes? Difficulty taking certain kinds of exams, such as essay exams?"
- "What kinds of materials seem to make it easier for the child to learn? How many of these kinds of materials are offered in his/her current classroom?"
- "What is homework like for the child? Are certain types of homework more difficult than others?"
- "Does the child suffer from any other symptoms, such as anxiety, depression, problems with attention, or impulsivity?"
- "What are the effects of the child's learning difficulties on her/his social relationships? On family relationships?"
- ✓ Note: If learning disabilities are suspected, ask parents for copies of report cards and standardized test scores.

Reading

- "How does your child's teacher describe her/his reading ability? What kind of grades does your child receive in reading? Has your child ever received any special education support for reading? (*If so:*) What was it?"
- "Did the child have difficulty learning to read?"
- "Does/did your child have difficulty learning the alphabet, remembering the sounds that letters make, or have problems rhyming words?"
- "Does your child have difficulty with reading comprehension (understanding what he/she has read)? Does the child read slowly?"

Math

- "Does the child do well at math? Have problems with math? (*If so:*) What kind of problems?"
- "What are the child's typical grades in math?"
- "Does the child ever misread operational signs, such as plus, minus, or division signs? Does she/he have difficulty understanding basic operations, such as addition, subtraction, multiplication, or division? Problems learning basic math facts, such as multiplication tables?"
- "Does he/she transpose/switch numbers?"
- "Does the child have trouble with story/word problems?"

Written Expression

- "What does your child's teacher say about your child's writing ability?"
- "Does the child have trouble expressing her-/himself in written words?"
- "Does the child have problems with grammatical errors? Problems with spelling? Trouble thinking of ideas or things to say about an idea?"

Nonverbal Learning Disability (NLD)

- "Has your child had any problems with muscle or physical coordination?"
- "Does the child dislike being touched or touching certain textures?"
- "Does the child have problems with reading comprehension? Math reasoning? Social relationships?"

2.13. Movement and Tic Disorders *See Section 16.8 for descriptors.*

- "Does the child have any muscle twitches or verbal tics? (*If yes:*) What are they? How often do you observe these behaviors? Are there certain situations that seem to trigger these tics?"
- "Have you tried to control these behaviors? (*If yes:*) How has this worked?"

2.14. Obsessive–Compulsive Disorder (OCD)

See Section 15.7 for descriptors.

Obsessions

- "Does your child seem unusually focused on any particular situation or topic?"
- "Does your child seem particularly interested or concerned with cleanliness? Excessively worried about things that children his/her age don't frequently worry about, such as the future? World events?"
- "How concerned is the child with this topic or situation? Mildly? Moderately? Extremely?"
- "Are there other subjects or topics the child often talks on and on about?"
- "How frequently does the child get caught up in and seem stuck on a subject?"
- "Once the child seems stuck on a particular topic, how easy or difficult is it to get the child interested in something else?"

Compulsions

- "Does the child have any quirky, repetitive behaviors? For instance, does she/he seem to check on the same thing a lot? Wash hands often? Count things?"
- "Does the child need to have his/her things in a certain order? Books? Toys? Clothes? What does the child do when things are out of order?"

2.15. Phobias *See Section 15.3 for descriptors.*

- "Does the child have any extreme fears? (*If yes:*) What are they?"
- "Do these fears affect the child's behavior? Social relationships? Family relationships? (*If yes:*) In what ways?"
- "Does the child do anything to cope with these fears? (*If yes:*) Is the coping effective?"

✓ Note: Common fears include thunderstorms, the dark, enclosed spaces (such as elevators), flying, choking, needles, blood, reptiles, insects, and other animals.

2.16. Schizophrenia and Other Psychotic Disorders

See Section 16.10 for descriptors.

Cognitive Symptoms

"Does the child's thinking seem confused or disordered? Does she/he seem disoriented in time or place? Does the child have bizarre ideas or illogical thinking? (*If yes to any:*) Can you give me an example?"

Delusions and Hallucinations

"Does the child ever seem to have an exaggerated sense of his/her abilities, such as putting thoughts in other people's minds? Does she/he think anyone can read her/his mind?"

"Does the child talk to imaginary people? Complain of hearing voices in his/her head? Smell/see/hear/feel things that aren't there?"

Affective Symptoms

"Does the child seem to have problems with emotion? Have you noticed extreme mood changes? Does the child's emotion sometimes seem inappropriate to the situation? Does the child sometimes seem to have no emotion at all? Does she/he seem indifferent? Euphoric or extremely happy? Agitated or nervous? Very sad or depressed?"

"Have you noticed any changes in the child's ability to communicate or speak, such as disorganized or bizarre speech content? Mumbling? Inappropriate responses to questions? Difficulty finishing a thought? Becoming very still and unresponsive?"

"Have any of these emotions or behaviors had an effect on social relations with friends? The child's functioning at school? Family relationships?"

2.17. Suicidality *See Section 15.8 for information and descriptors.*

"Has your child ever mentioned having suicidal thoughts to you or anyone else? (*If yes:*) What did the child say? How often has the child mentioned this? How likely do you think it is that she/he would act on these thoughts?"

"Has your child seemed much more withdrawn lately? (*If yes:*) How so? Has he/she lost significant interest in recreational or social activities?"

"Has your child ever done anything intentionally to harm her-/himself? (*If so:*) What did the child do? Was there anything that could have triggered this incident?"

"Do you know whether your child uses drugs or alcohol? (*If yes:*) What kinds? How often?"

"Has your child had any stresses or crises recently? A breakup with a boyfriend/girlfriend? Rejection in school, sports, or other recreation? Stresses in the family?"

"Is there any family history of suicide attempts, completed suicides, or incidents of self-harm? (*If yes:*) What happened? How much does your child know about those incidents?"

3

Observation Procedures and Questions for Children and Adolescents

3.1. General Advice for Questioning Children

Format and Content of Questions/Comments

The format and content of an initial interview will vary considerably, depending on a child's age and presenting problem(s). The following are important points to keep in mind when you are questioning children.

- “Why” questions don't typically work well with children, because they are often beyond the children's developmental capacity. Such questions can make them feel threatened or inferior. For example, asking a question such as “Why do you have trouble staying in your seat at school?” is unlikely to yield any useful information. Instead, ask questions such as “What is it about staying in your seat at school that is hard for you?” or “What do you like best and least about sitting in your classroom at school?”
- It is important to begin with questions that are open, more general, and less threatening before proceeding to more specific questions. One rule of thumb is to start with an “essay” question, move to a “multiple-choice” question if the first approach is not productive, and finally try a “true-false” format if neither of the previous approaches is productive.
- Keep in mind that some topics may be sensitive for a child. For example, a child with a learning disability may be sensitive about topics relating to academics. It is usually best to leave these sensitive topics until rapport has been established and the child understands why you are asking about this.
- Make positive comments on a child's ongoing behavior, such as “Wow, that's a great picture,” or reflect feelings, such as “You seem really angry.”
- Use praise liberally; avoid critical statements, but set clear boundaries as to what is appropriate and inappropriate behavior.
- Use age-appropriate terms, pacing, and sentence structure.

Ascertaining the Child's Point of View

Nuttall and Ivey (1986) have provided the following suggestions for learning about a child's point of view during an initial assessment interview:

- Try to “get into the child’s shoes” by focusing on the child’s construction of the world.
- Discover the child’s perception of the problem, and be able to state what the child thinks is wrong, using his/her words.
- Note the key words that the child uses.
- Assess the child’s construction of her/his environment (e.g., socioeconomic and housing issues).
- Avoid stereotypes, and be aware of how your theoretical constructs may get in the way of your ability to conduct a successful evaluation.
- Determine the child’s goals through the use of questions such as “Imagine the perfect day. What would your life look like if everything were just the way you wanted it to be?” or “How could things be worse? What’s the worst thing you can imagine happening?”

Play-Based Interviews

In evaluations of young children, play interviews are sometimes performed (in contrast to adhering to a list of questions). In a play interview, the clinician takes the child’s lead, becoming an observing participant. Young children are often more comfortable telling a story, or sharing their inner emotional experience with toys and through fantasy. Morrison and Flegel (2016) have suggested a number of strategies that can be used to engage a child in a play interview (many of these are used outside the play context and are elaborated throughout this chapter):

Engagement—refers to building a relationship with the child, and includes techniques such as letting the child determine the pace of the interview and letting him/her choose what materials will be used.

Exploration—refers to attempts to elicit information from the child, using the play themes as a starting point.

Continuing/deepening—refers to attempts to expand a child’s exploratory themes through commenting on his/her drawings, play, and so on.

Remembering-in-play—refers to interpretations or acknowledgments of behaviors that the child may not be aware of, possibly because they occurred at a developmental stage before the onset of verbal language (Morrison & Flegel, 2016). These are typically used sparingly and almost never in an initial evaluation.

Limit setting—refers to establishing the “boundaries” of the therapeutic relationship, such as treating play materials with respect, cleaning up the office at the end of the session, and so forth.

3.2. Observing the Very Young Child (Ages Birth to 2½ Years)

For a very young child, the interview will be conducted primarily with at least one parent (or guardian/caregiver) who will provide historical information (*see Chapters 1 and 2*). However, you should attend to the following:

- Observe how the child interacts with the parent or caregiver. Note mutual gaze behavior, social responsiveness.
- How does the child react to separation from the adult? What is the reunion like when the adult returns?
- Is there a difference in the child’s behavior when accompanied by father, by mother, or by another caregiver?
- How does the child communicate with the adult? How does the adult respond?
- Does the child smile often? When the child is distressed, can she/he be consoled?
- Does the child appear secure or clingy, distant, withdrawn, or resistant?
- Observe developmental behaviors: language, motor skills, handedness, affect regulation.

3.3. Opening Statements and Questions

The Preschool-Age Child (Ages 2½–6 Years)

The evaluation of a preschool-age child is usually carried out in part with at least one parent (or other caregiver) present, and in part with the child alone. Evaluation of the preschool child is frequently elicited through play and observation of behavior. It is usually less structured than an evaluation of an older child. As in earlier stages of development, most of the information will come from the parent (*again, see Chapters 1 and 2*). When observing the child directly, you will want to attend to the following:

- How does the child relate to you, and how does it differ from the way the child relates to the parent or caregiver?
 - What is the child's approach to the appointment/evaluation? Is he/she negative, compliant, relaxed, tense, inhibited?
 - Does the child watch the adult to discover whether her/his answers or behaviors are appropriate?
 - How confident is the child's play or responses? What is the general tone of the child's play (aggressive, cooperative, etc.)?
 - How well does the child attend? Is the behavior appropriate for his/her age? Does (or how much does) the child's interest vary, depending on the task or play materials?
- ✓ Children this age respond well to initial questions that are factual and easy for them to answer, such as:

"How old are you?"

"Who came with you today?"

"Where do you live?"

"Who do you live with?"

"What kinds of things do you like to do?"

The School-Age Child (Ages 6–12 Years)

Opening Statements

You will want to begin the interview by introducing yourself and establishing rapport. With a child within this age range, if you use the title "Dr.," it is often helpful to explain what kind of "doctor" you are (e.g., you won't be giving shots or taking blood). Here are some possible opening statements:

"Hi, [name], I'm Dr. [name]. I'd like to spend some time getting to know you."

"Hi, [name], I'm Dr. [name]. Your mom/dad/grandmother/guardian told me that you're having a hard time at school, but I'd like to hear about what's going on at school from you."

"Hi, I'm Dr. [name]. You must be [name]. Come on in."

"Hi, I'm [name], it's nice to meet you. Please come in."

Opening Questions

Opening questions can include the following:

"Why do you think you're here today?"

"What did your parents tell you about me?"

"How old are you?"

The Adolescent (Ages 12–18 Years)

Opening Statements

An opening statement for an adolescent (especially when a parent is present) should be simple and casual:

"Hi, [name], I'm Dr. [name]. Thanks for coming in today."

It is important to establish the limits of confidentiality with an adolescent early in the interview and to obtain her/his assent. It is also necessary to explain what you're going to do (whether you're going to talk to the adolescent first, parents alone, etc.) and to establish "ground rules" for the evaluation process—such as how much (and what types of) information will be considered privileged, how often you will talk to the parents, whether the parents' conversations with you will be discussed with the adolescent, and so forth. The exact "ground rules" may vary considerably, based on the referral question and family dynamics (*see Chapter 1*). The important point is to have a discussion with everyone involved and to come to a clear agreement as to what would be most helpful in a particular case.

Opening Questions

When you and the adolescent are alone, opening questions can include the following:

"What did your parents tell you about this?"

"What brought you here today? Who suggested that you come here? Do you agree with their idea that you come here? Why/why not?"

"Tell me what a typical day would look like for you, from when you get up in the morning until you go to bed at night."

3.4. School-Related Questions

The Preschool-Age Child (Ages 2½–6 Years)

"What day care center/(pre)school do you go to? What do you like about it?"

"What is your teacher like?"

"Do you have friends at day care/(pre)school? (*If yes:*) What are their names?"

The School-Age Child (Ages 6–12 Years)

"What school do you go to?"

"Who is/are your teachers? Tell me about him/her/them."

"What do you like most about school this year? What kinds of things do you dislike about school this year?"

"Who helps you with your homework?"

"Are you doing poorly in any subjects? (*If yes:*) Do you have any ideas why you might be having trouble in this area/these areas?"

- ✓ Note: If a child endorses difficulty with school, consider probing further about ADHD (*see Section 3.9*).

The Adolescent (Ages 12–18 Years)

"What grade are you in?"

"What's a typical day like at your school? What time do you have to be there? How do you get to school? How do you get home?"

"What do you do after school? Are you involved in any sports/clubs/activities?"

"Do you have a lot of homework?"

"Are you having any difficulties in school? (*If so:*) What are they? Do you have any ideas about why you're having trouble?"

3.5. Home- and Family-Related Questions

The Preschool-Age Child (Ages 2½–6 Years)

"Who is in your family?"

"How do you get along with your mom/dad? With your brothers/sisters?"

Depending on a child's language and cognitive development, a clinician may want to use a few questions from the list below that is targeted for the school-age child.

The School-Age Child (Ages 6–12 Years)

A clinician will probably not ask all of the questions from the following list, but can choose some of these questions to elicit information from the child.

"Who do you live with?"

"What does your mom/dad do?"

"How many brothers or sisters do you have? What kinds of things do you do together? What kinds of things do you fight about?"

"What does your family do for fun?"

"What is dinnertime like in your house?"

"What do you like best about your mom/dad? Which parent do you get along with better?"

"If you wanted to make your mom or dad really mad, what would you do?"

"How do people in your family show each other that they appreciate them?"

"What does your house look like? Do you have your own room?"

"Pretend you were showing me around your house. What would you like to show me?"

"What would the perfect family look like to you?"

"Does your family take vacations? (*If yes:*) Where do you go?"

"Have you ever felt like running away (or have you ever run away) from home? What made you feel like that?" (*Assesses for externalizing problems.*)

(*For a child of divorced parents:*) "When you visit your dad/mom, how does that go? What types of things do you do with him/her?"

The Adolescent (Ages 12–18 Years)

See the questions above for a school-age child, as well as the following:

"Tell me about your family."

"Tell me about your brothers/sisters. Do they look up to you? Do you look up to them?"

"How do your parents get along? Have you ever heard them fight?"

"When people argue in your family, what do they usually argue about?"

"What do you usually do when people in the house are arguing?"

"Does your family get together at mealtimes?"

"When you want something from your parents, how do you usually get it?"

"Describe a typical day in your house."

"What do your parents do when they find out you've done something they don't want you to do?"

"How do your parents discipline you? Do they hit you? Did they ever hit you in the past?"

✓ Note: If abuse is suspected, probe further (*see Section 3.9*).

3.6. Questions about Friends

The Preschool-Age Child (Ages 2½–6 Years)

"Do you have friends you like to do things with? What kinds of things do you like to do?"

"Do you have a best friend? (*If yes:*) What is her/his name? What do you like to do together?"

The School-Age Child (Ages 6–12 Years)

"What do you like to do with your friends?"

"Do you have a lot of friends, or do you wish you had more?"

✓ Note: If a child is reporting few or unsatisfying friendships, consider probing further about depressive symptoms (*see Section 3.9*).

"Do you have a best friend? (*If yes:*) What is he/she like? What are your other friends like?"

"Do you go on sleepovers? (*If yes:*) What do you do at sleepovers?"

"How much time do you spend on social media (Facebook, Twitter, Instagram, etc.)?"

The Adolescent (Ages 12–18 Years)

"What are your friends like? What do you like to do together?"

"Do you date? (*If yes:*) What age did you begin dating? What do you generally do on dates?"

"Do you currently have a boyfriend/girlfriend?"

"How much time do you spend on social media?"

3.7. Interests

The Preschool-Age Child (Ages 2½–6 Years)

"What kinds of things do you like to play with?"

"What's your favorite toy?"

"What TV shows do you like?"

"Do you take any special classes or lessons, like art lessons or gymnastics?"

"Do you have any pets?"

"What did you do on your last birthday?"

The School-Age Child (Ages 6–12 Years)

"What types of activities do you like to do? Do you play any sports, like soccer?"

"Do you like to watch TV?"

"Do you have any collections (e.g., dolls, sports, or Pokemon cards)?"

"What kinds of toys do you like to play with?"

"Do you have a bedtime routine? (*If yes:*) What it is it? What other types of family routines do you have?"

"Do you get an allowance? (*If yes:*) What do you like to spend your money on?"

The Adolescent (Ages 12–18 Years)

"What do you like to do in your free time?"

"Are you involved in any extracurricular activities? (*If yes:*) What kinds?"

3.8. Adolescent-Specific Questions

Areas that are not included in interviews with young children, but are typically covered in adolescent assessments, are as follows:

- Substance use (tobacco, alcohol, drugs)
- Gang involvement or conduct problems
- Sexual experiences; birth control; knowledge of sexually transmitted diseases and AIDS
- Developmental tasks of adolescence: adjustment to changing body and sexuality; separation from family; goals for the future

Substance Use

"Do you smoke cigarettes? (*If yes:*) How often? When? Does it cause you any problems?"

"Have you ever tried alcohol? (*If yes:*) How frequently do you use alcohol? Does it cause you any problems?"

"Have you ever tried marijuana? PCP? Cocaine? Heroin? LSD? Mushrooms? Speed? Steroids? Others? (*If yes:*) How frequent is your drug use? What kinds of problems does it cause you?"

Conduct Problems

"Have you ever gotten in a physical fight with someone? Been beaten up?"

"Have you ever been in trouble with the law? Been truant from school? Run away from home? Stolen property?"

Development

"At what age did you begin developing (*ask about voice change for boys, first menses for girls, etc.*)?"

"What would you like to do after high school? What kinds of careers interest you?"

"Are you dating? Do you have a boyfriend/girlfriend? (*If no:*) Do you wish you did, or are you happier without one? (*If yes:*) What is your relationship like?"

3.9. Specific Questions Related to Psychiatric Symptoms

The following are questions to be selected on the basis of the referral question and the parents' and child's answers to the preceding questions. When you suspect specific problems or psychiatric disorders, you can choose questions from this list to probe further.

Mood Symptoms

"How do you feel right now? How do you usually feel when you're at school? At home?"

"What kinds of things make you mad? Sad? Happy? Scared? Bad? Glad? Really happy?"

"What kinds of things are easy for you to do? What kinds of things are hard?"

"Would you like to change anything about yourself?"

Depressive Symptoms

Physiological Symptoms

"What has your appetite been like lately?"

"Do you ever have stomachaches? Other aches and pains? Have you been feeling sort of sick?"

"Do you ever find you don't have much energy? Have you been feeling really tired lately?"

Behavioral Symptoms

"Do you ever have trouble getting out of bed in the morning?"

"Do you cry a lot? (*If yes:*) What do you cry about?"

"Have you had difficulty concentrating?"

"Have you had trouble completing work at school?"

Social Effects

- "How have you been getting along with your friends? Do you feel supported by them?"
- "Do you feel lonely? Do you have people who will listen to you when you need to talk to them?"

Cognitions

- "When you look into the future, what do you see?"
- "Do you ever feel guilty about things?"
- "Is it hard for you to make up your mind about things?"
- "Do you think about death? (If yes:) What kinds of things do you think about?"
- "Do you ever feel helpless?"

Violence, Suicidality, Homicidality

- "Have you ever wished you were dead?"
- "Have you ever tried to hurt yourself or kill yourself?"
- "Have you ever tried to hurt someone else?"

✓ If history is positive for suicidal thoughts, ask the following questions:

- "What did you consider doing?"
- "What stopped you (or is stopping you) from following through with these ideas?"
- "When did you last have these thoughts?"
- "How often do these thoughts come? Is it hard to control them?"

Worries/Anxiety

- "Do you ever feel really scared or anxious?"
- "Are there certain things that make you worried? (If yes:) What are they like?"
- "Do you ever feel so nervous that you're sick to your stomach? Do you ever feel shaky, dizzy, or tense? Does your heart ever pound really hard? Do you sweat?"

Obsessive–Compulsive Behaviors

- "Do you ever have to do things over and over again?"
- "Do you ever have things that you need to check on all the time?"
- "Are you very neat? Do you need to have things arranged in a certain way? (If yes:) Like what?"
- "Do you ever get really upset when things in your room are moved?"
- "Are there things you feel you have to do before you can get to sleep at night?"
- "Do you ever feel you have to touch certain things whenever you see them?"
- "Do you ever feel you have thoughts or actions that you can't control?"

(If yes to the questions above:)

- "How do you feel when you do these behaviors?"
- "How does doing these things affect you in school? At home? With your friends?"

Disruptive Behavior Disorders

ADHD, Inattentive Symptoms

- "Do you have trouble paying attention at school?"
- "When someone asks you to do something, do you have trouble remembering what he/she asked you to do?"
- "Do you have trouble doing your homework? (If yes:) What's hard about it?"
- "Do you have a tendency to lose things?"

ADHD, Impulsive Symptoms

"Do you sometimes have trouble controlling your behavior?"

"Do you often get in trouble for interrupting others? Not waiting your turn? Being disruptive?"

ADHD, Hyperactive Symptoms

"Do you ever feel like you're driven by a motor or are on the go all the time?"

"Is it hard for you to sit still?"

"Do you have trouble falling asleep at night?"

Other Disruptive Behaviors

"Do you have problems with other kids at school? Do you ever get into trouble at school?"

"Have you ever run away from home? Been truant from school? Violated curfew? Stayed out all night? Driven a car without a license?"

"Do you lose your temper a lot? (*If yes:*) What causes you to lose it?"

"Do you get into a lot of fights? (*If yes:*) Who do you usually fight with? What kinds of things do you fight about?"

"Do you find that you're always in trouble? (*If yes:*) What kinds of things do you get in trouble for? What happens to you when you get in trouble?"

"Have you ever set fires? Used spray paint/made graffiti? Shoplifted? Forged checks? Broken into someone's home/store/car? Committed an armed robbery?"

"What kinds of drugs/alcohol have you tried or do you use? How frequently do you use drugs/alcohol?"

"Are you a member of a gang?"

"Do you engage in unsafe sexual practices?"

"Have you harassed someone on social media?"

Thought Disorders

"Do you ever hear voices that other people don't hear? See things that other people don't see?"

"Do you ever have times when you're feeling way too good—so terrific it's almost scary? During these times, do you find you need to sleep less?"

Eating Disorders***Behavioral Symptoms***

"What do you eat?"

"How frequently do you exercise?"

"Do you ever eat in secret? Binge-eat? Make yourself vomit? Use laxatives inappropriately?"

Cognitive Symptoms

"Are you happy with the way you look?"

"How much do you think about food? What kinds of things do you think about food?"

"Do you have any fears of getting fat? Are there certain foods you fear or avoid?"

Abuse

"Has anyone ever hit you too hard or hard enough to leave a bruise or a mark? (*If yes:*) Tell me about it. Who did this, and when did it happen?"

"Has anyone ever touched you in a way that made you really uncomfortable? (*If yes:*) Tell me more about this."

"Are you afraid of anyone? (*If yes:*) What did this person do to make you afraid of her/him?"

3.10. Questions Used in Projective Assessments

Often the interview with a child or adolescent is used to gain information about the youngster's hopes, dreams, and wishes. The following is a collection of questions or activities that can be used for this purpose.

Wishes/Fantasies

"If you had three wishes, what would they be?"

"Are there some things about you that your mom/dad don't know about? (*If yes:*) Would they be surprised if they knew this about you?"

"What is the best age to be?"

"When you dream at night, what kinds of things do you dream about?"

"If you could change something about yourself, what would it be?"

"What do you want to do when you grow up?"

"What is something you remember that happened a long time ago?"

"If you could change three things about you (your life, your family, etc.), what would they be?"

"If you were forced to live for a year on an abandoned island and could only take three people with you, who would they be? Why?"

Draw-A-Person

When a child is completing the Draw-A-Person task, it is useful to ask the child questions about the person, such as these:

"Is this person anyone in particular? (*If yes:*) Who?"

"What types of things makes this person happy? Sad? Angry? Scared?"

"What kinds of friends does the person have?"

3.11. Closing Questions

"Is there anything important we didn't talk about?"

"How do you feel about the time we've spent talking?"

"Where should we go from here? What would be helpful for you?"

4

Questions for Teachers or Other Professionals

This chapter suggests questions for eliciting the basic information you may want from a child's teacher or other professional who works with the child. See Chapter 40 for a sample teacher questionnaire (*Section 40.3*) and a sample assessment form for other professionals (*Section 40.4*).

4.1. General Guidelines

Obtaining information from a child's teacher is frequently done over the course of an assessment or treatment. It not only provides supplemental information about how the child copes and performs in school, but also provides the opportunity to establish rapport and a collaborative relationship with the teacher. Less frequently, the clinician may desire to obtain information from other professionals who know the child well. For example, a sports coach may know more about an adolescent's depressive symptoms than any classroom teacher does. When there is a medical issue involved in treatment, it is often important to discuss these issues with the child's physician, as well as to obtain a release for the child's medical records.

When interviewing a child's teacher or other professionals (such as psychiatrists, pediatricians, coaches, clergy, or guidance counselors), you will ask many of the same questions that you ask the parents. (*See the questions for parents about specific disorders in Chapter 2.*) However, you will also want to get their unique perspectives about the child's problems, such as how the child performs in the school or other settings. In many cases, these types of interviews are conducted over the phone and are often brief. Thus, it is often helpful to focus on the specific areas of concern.

4.2. Areas to Cover in Interviewing Teachers and Other School Personnel

Teachers and other school system personnel are key people in a child's life, and their input is often essential to evaluating or treating a child. In addition, they are in the unique position of helping you develop remediation strategies. A collaborative approach is often most successful, and the following strategies can be used to enhance collaboration:

- Solicit the teacher's input by making a phone call, paying a classroom visit, and/or asking him/her to fill out brief questionnaires or rating forms (*see the end of this chapter*).

- Give the teacher a description of the assessment procedure or treatment plan.
- If recommendations include classroom interventions, discuss with the teacher the necessary accommodations or other changes, and help her/him to develop procedures for implementation.
- Offer to remain available for future consultation.

What follow are suggested general areas to cover when you are talking to a teacher, followed by specific questions to elicit information in each area. Remember that you must obtain written permission from the parents before contacting a child's teachers or other professionals. As noted above, Section 40.3 provides a questionnaire that can be used to assess a teacher's perceptions of a child's classroom behavior and school functioning. It can be used by the clinician to record a phone interview with a teacher, or it can be sent to the teacher to complete as a self-report. If it is sent to the teacher, compliance will be enhanced by inclusion of a self-addressed stamped envelope for return of the form. Note that electronic communication is not considered a private form of communication under HIPAA guidelines. When communicating with a teacher electronically, use a secure file transmission that incorporates strong encryption.

Child's Major Problem

- "What do you see as the child's major problem?"
- "Tell me about his/her problems in the classroom."
- "How often are these problems a concern to you?"
- "How long has this been going on?"
- "When it happens, how long does it last?"
- "How serious do you think the child's problem is?"
- "Are there any specific situations that trigger the problem behavior?"
- "How do other kids react when she/he behaves in this way?"

Cause of the Problem

- "Do you have any ideas about why the child has this particular problem?"
- "What do you think might be causing this difficulty?"

Teacher's Reaction to Child's Problem

- "How have you reacted to the child's problem?"
- "How have you tried to help the child's problem? Was it successful? Why or why not?"
- "How do you feel about the child in general?"

Peer Relations

- "How well does the child get along with peers?"
- "How does the child get along with his/her classmates?"
- "In school, how many friends does the child have? Many? A few? None?"
- "Is she/he liked by other children? (If no:) What causes other children to dislike her/him?"
- "What do other children do when the child engages in the problem behavior?"
- "What does the child do during recess or free-play times?"
- "Are there any other children in the class with similar problems?"

Academic Performance

- "How would you characterize the child's academic performance?"
- "What was the child's highest grade on the last report card?"

- "What was the child's lowest grade?"
- "What kinds of academic problems does the child have in the classroom?"
- "Does the child have any difficulties in reading? Math? Spelling? Language? (*If yes in any area:*)
What types of difficulties?"
- "Does the child perform differently with different teachers/adults?"
- "Does the child have any learning disabilities? (*If so:*) What are they?"
- "Does the child receive special tutoring or support? (*If so:*) What?"
- "Does the child have an individualized education program (IEP)?"
- "Has the child ever had special testing in school? (*If so:*) Please explain."

Strengths and Weaknesses

- "What do you see as the child's emotional and social strengths and weaknesses?"
- "What are the child's academic strengths and weaknesses?"
- "In what situations is the child most likely to display his/her strengths and weaknesses?"
- "Do you think it is possible to build on the child's strengths to help treat her/his difficulties?
(*If so:*) How?"

Teacher's Perception of Child's Family

- "How would you describe the child's family?"
- "How often do you see the child's family?"
- "What is your perception of the child's family?"
- (*If the child has difficulties:*) "How does the family cope with the child's difficulties?"
- (*If the family has difficulties:*) "How is the family coping with its difficulties?"

General Classroom/School Behavior

- "Does the child appear motivated for school?"
- "How does the child generally behave in the classroom?"
- "Is the child in school regularly?"
- "Is the child usually in class on time?" (*If not:*) How frequently is he/she late? What is the excuse given for being late?"
- "Does the child usually complete her/his homework? (*If so:*) How well is it usually done?"
- "What are the child's attention and concentration skills like?"
- "Do you see any difficulties with memory? Problems with motor activity? Behavioral issues?"
- "Does the child participate in extracurricular activities? (*If so:*) Which one(s)?"

Teacher's Expectations/Hopes for Child

- "What expectations do you have for this child?"
- "What hopes do you have for this child?"
- "What about the child would you like to see change as a result of this evaluation/treatment?"

Thoughts on What Might Help

- "Do you have any ideas about what might be most helpful for the child?"
- "Is there anything in particular you'd like to see happen as a result of this evaluation/treatment?"
- "Is there anything else about the child that would be helpful to know?"

4.3. Areas to Cover in Interviewing Health or Mental Health Professionals

When you are interviewing a health or mental health professional, such as the child's psychologist, neurologist, or pediatrician, it is often best to focus closely on the areas of concern. Contacts with such professionals are often brief. The key areas to cover include the following.

Child's Problem

"What do you see as the child's major problem?"

(If this is the referring professional:) "Why did you make the referral at this time?"

"Do you have any ideas why this problem has emerged?"

Professional's Perception of Child's Family

"What is your perception of the child's family?"

"How do you view the family's role in the child's difficulties?"

"How has the family reacted to this problem?"

Medical Issues (for Medical Professionals)

"Are there any neurological or other medical conditions that might affect this child's behavior?"

"Is this child on any medications that might affect his/her behavioral or emotional functioning?"

Professional's Expectations

"What would you like to see happen in the course of this evaluation/treatment?"

As noted earlier, a questionnaire that can be used to interview these professionals is provided in Section 40.4. It can be either used to guide phone interviews or sent to them to complete and return; in the latter case, enclosing a copy of a signed release and a self-addressed stamped envelope for return will expedite a response. Again, remember that health and mental health professionals must have the parents' written permission to speak with you. Note that electronic communication is not considered a private form of communication under HIPAA guidelines. When communicating with a professional electronically, use a secure file transmission that incorporates strong encryption or a secure portal.

4.4. Teacher Report Measures of Functioning in Children and Adolescents

Direct interviewing of teachers is often supplemented by the use of teacher-completed questionnaires. You may want to ask a teacher to complete such a questionnaire before you meet or talk to her/him, as it may give you ideas about areas that deserve further inquiry. These questionnaires can provide quantifiable information about the severity of a child's symptoms (as compared to peer norms), the situations in which the behaviors occur, and the extent to which these behaviors interfere with school functioning. These measures can also elicit information about the quality of peer relationships, social skill strengths and weaknesses, and academic strengths and weaknesses. However, these measures should be used sparingly and thoughtfully, as teachers and other school personnel have many responsibilities, and overloading them with unnecessary paperwork is obviously not recommended.

Academic Competency Evaluation Scale (DiPerna & Elliott, 2000)

Academic Performance Rating Scale (DuPaul, Rapport, & Perriello, 1991)

ADHD Rating Scale-5 (DuPaul, Power, Anastopoulos, & Reid, 2016)
Behavior Assessment System for Children, Third Edition—Teacher Rating Scales (BASC-3 TRS; Reynolds & Kamphaus, 2015)
Brown Executive Function/Attention Scales (Brown, 2018)
Conners 3 Teacher Rating Scale (Conners 3 TRS; Conners, 2008)
Devereux Scales of Mental Disorders (DSMD; Naglieri, LeBuffe, & Pfeiffer, 1994)
Revised Behavior Problem Checklist (RBPC; Quay & Peterson, 1996)
School Situations Questionnaire (SSQ; Barkley & Murphy, 2006)
Social Skills Rating System (SSRS; Gresham & Elliott, 1990)
Student Behavior Survey (SBS; Lachar, Wingenfeld, Kline, & Gruber, 2000)
Teacher's Report Form (TRF; Achenbach & Rescorla, 2001) from the Achenbach System of Empirically Based Assessment (ASEBA)
Walker-McConnell Scale of Social Competence and School Adjustment (Walker & McConnell, 1988)

5

The Formal Mental Status Exam with Children and Adolescents

5.1. Differences between Adult and Juvenile Mental Status Exams

The formal mental status exam is used to help determine the precise nature and degree of a child's or adolescent's abnormal functioning through the observation of demeanor, thought processes, speech, memory, affect, and mood. It is used less often with children than with adults, but is often helpful in cases of traumatic brain injury, substance use disorders, or confusion in general psychological functioning (e.g., psychotic disorders).

Morrison and Flegel (2016) have described the following differences between an adult's and a child's mental status exam:

- Because child and adolescent development encompasses a wide spectrum of behavior, the examiner must have a firm knowledge of normal behavior at all ages.
- The evaluation of a young child is usually completed with the parent(s) in the room.
- Depending on the child's age, appropriate toys or projective material should be available to elicit behaviors and facilitate communication.

5.2. Contents of a Juvenile Mental Status Exam

A mental status exam with a child or adolescent often includes the following areas:

1. Appearance and behavior
 - a. Apparent age as compared to chronological age and physical characteristics (e.g., height, weight, cleanliness, nutrition); any physical abnormalities
 - b. Dress, hairstyle, body ornamentation (jewelry, piercings, tattoos)
 - c. Eye contact
 - d. Level of activity and motor movements; gait; posture; stereotyped behaviors
 - e. Appropriateness of behavior for child's age, education, and socioeconomic status
2. Alertness/cognition
 - a. Orientation with regard to time and place (appropriate for age/level of development)
 - b. Awareness of what is going on (e.g., reason why child is at clinic; what is occurring in her/his family)
 - c. Alertness; ability to concentrate
 - d. Congruence of vocabulary and fund of information with child's educational and socioeconomic background

3. Demeanor/attitude
 - a. Level of cooperation
 - b. Rapport with examiner
 - c. Facial expressions (sample descriptors: **happy, tense, tearful, relaxed, smiling**) and appropriateness of facial expressions to affect, conversational topics, and content of the interview
4. Thought processes
 - a. General descriptors: **normal, concrete, confused, psychotic**
 - b. Content of information discussed (particularly information spontaneously given by child)
 - c. Recurrent themes
 - d. Evidence for delusions, hallucinations, fantasies, fears, worries, phobias, obsessions, compulsions
5. Speech
 - a. General descriptors: **normal, pressured, fast/slow, apraxia, appropriate/inappropriate for age**
 - b. Expressive language: **normal, delayed/advanced for age, echolalia, anomia, perseverations, mutism**
 - c. Verbal fluency: **normal, problems with word finding, aphasia**
 - d. Receptive language: **appropriate/delayed/advanced for age**
 - e. Articulation
 - f. Relationship between verbal and nonverbal communication
6. Sensory–motor functioning
 - a. Intactness/unaided functioning of senses (hearing, sight, touch, smell, taste)
 - b. Fine and gross motor functioning: **normal, uncoordinated, slow performance speed, tics, tremors**
 - c. Performance on copying tasks (draw a person, clock, house; write name)
7. Mood (description of child’s pervasive, sustained emotional states)
 - a. Sample descriptors for mood: **normal, depressed, "miserable," unhappy, "down," glum, anxious, euphoric, angry**
 - b. Comments on what the child says about his/her mood and feelings
 - c. Fluctuations of mood
8. Affect (observed expressions of emotion)
 - a. Sample descriptors for affect: **flat, inappropriate, labile, congruent/incongruent with mood, broad, blunted, restricted**
 - b. Match of affect with speech content
 - c. Fluctuations in affect
9. Vegetative signs
 - a. Weight gain/loss
 - b. Energy level/sleep habits
10. Insight/judgment
 - a. Level of insight
 - b. Ability to articulate problems
 - c. Child’s belief about why he/she has come for interview
 - d. Self-awareness of her/his problem
 - e. Judgment in carrying out everyday activities
11. Memory
 - a. General descriptors: **normal, fair, poor, impaired**
 - b. Impairments in immediate, recent, or remote memory
 - c. Common ways of assessing memory: Ask about the child’s recent and early history, including details such as names, dates, events; digits forward and backward; serial subtraction; recall of words (immediate and delayed)
12. Suicidal ideation
13. Homicidal ideation

6

Ending the Interview

6.1. General Guidelines

It is important to have a clear idea of when and how to conclude the interview. Make sure you leave enough time to have adequate opportunity to summarize the important points and end the session without feeling rushed. Be sure to conclude the interview with both the child and the parents, whether they are seen separately or together. If anyone is visibly upset, you want to make sure that the individual has time to regain his/her composure. When you are conducting a play-based interview with a young child, leave time for the child to help you clean up the room, as this can facilitate the transition out of the interview.

- Give parents and child some indication of the approaching end by mentioning the length of time left:
 - "We only have 5 minutes left."
 - "Our time is almost up."
- Leave time at the end so that the child or adult has time to add information that was not previously covered, or to ask questions:
 - "Is there anything else that you'd like me to know/understand?"
 - "Are there any questions that you'd like to ask me?"
- Summarize the main points regarding the referral questions, and/or recap the problem that occasioned the referral.
- State whether you can confirm the existence of the problem, or whether you suggest further evaluation.
- Offer details about what you have learned about the child as a result of the evaluation.
- Give the child/parents an idea of the next step in the process.

6.2. Ending Statements for the Child

General

"Our time is almost up, but I can see you still have a lot to talk about. Let's make another appointment for next week/month, so that I can hear more of what you have to say."

"Thank you for taking the time to come here and talk to me."

"I know that it took a lot of courage to come here today and talk about your concerns, and I want you to know that I really appreciate it."

"Thanks for coming here today. I'm going to try to do all I can to help you, and the information you've given me will be very helpful."

"Is there anything else you want to add/tell me?"

Next Step

"Do you have any ideas about what you'd like to do next?"

"I think our next step should be _____."

Summary

"I really appreciate your cooperation today. It sounds like you're having problems in _____, and it's my job to figure out how best to help you. When we're finished with the evaluation, I'll have a better idea of how to do that."

6.3. Ending Statements for the Parent

"You will need to make an appointment with _____ for _____."

"You brought Bobby to me because you are worried that he may be depressed. Now that I've talked to you and Bobby, it does appear to me that he is feeling very sad and hopeless. His behavior is similar to that of a depressed child, in that he is having difficulty sleeping and eating. His mood and behaviors are also consistent with a depressive episode. I'd like you to make another appointment with me/make an appointment for a psychopharmacological evaluation/[*other*], so that we can help him."

"Do you have any questions about what we have done today/about this evaluation/about the report I will be writing?"

"You have some significant concerns about Cindy's performance in school and are worried that a learning disability may underlie the problems she's having. I suggest performing some testing to determine the extent of her difficulties. After we complete this, I'll have a better idea about the specific nature of her difficulties."

Part II

Standard Terms and Statements for Wording Psychological Reports

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A. Introducing the Report

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7

Beginning the Report

This chapter covers the basic information with which you would begin any report. Reasons for referral are covered in Chapter 8, while report formats are covered in Chapter 35.

7.1. Heading and Dates for the Report

Use stationery that includes your full name; degree(s); title(s); addresses (office and mailing, if different); phone number(s); and, when appropriate, affiliations, supervisor, license number, and agency.

Title or head the report to fit its contents. Most report titles are combinations of two words, one describing the discipline or activity, and one describing the kind of document:

Discipline/Activity

Neuropsychological, Psychological, Psychosocial, Psychoeducational, Educational, Intellectual, Personality, Behavioral, Multidisciplinary, Social Work, Psychiatric.
Intake, Forensic, Diagnostic, Home Observation, Classroom Observation, Custody, Clinical Interview, Testing, Treatment, Progress, Rehabilitation, Mental Status, Discharge, Closing, Termination.

Document Type

Evaluation, Assessment, Report, Summary, Plan, Note, Formulation, Consultation, Update.

Date the report itself. Also include all dates and locations for interviews, testing and evaluations; if relevant, include total testing and/or duration of each testing session. For example, near the top of the report, state:

Child was seen on 1/9/19.

Then, under “Other Sources of Information,” state:

Teacher was interviewed on 2/4/19.

In terms of insurance/reporting issues, the “date of the report” should be the date the child or adolescent was evaluated/seen, with other dates given in the body of the report itself.

7.2. Identifying Information about the Client

The headings below represent possible types of identifying information. You are not likely to use all of these areas in describing a child or adolescent.

Name

Always give the child's given name and surname. A nickname or preferred name may also be included as follows:

Prefers to be called _____.

Other Identifying Information

Give the family's address and phone number; the child's case number and medical record number; and the referral source.

Date of Birth and Chronological Age

Give the month, day, and year of the child's birth, as well as the child's chronological age on the day when the evaluation was completed. Use a year-and-month format (e.g., 10 years, 5 months—not 10.5). For a child below the age of 3 years, include an adjusted chronological age if the child was premature by more than 3 weeks and showed delays.

Gender

Do not use the term "sex"; use "gender," and specify "male" or "female." For a younger child, the term "girl" or "boy" is acceptable. Gender includes a complex relationship between biological gender identity and gender expression. Terms that are frequently used to describe gender issues include the following:

Agender: Term for persons whose gender identity does not align with male or female. Sometimes referred to as "gender neutral."

Bigender: Someone whose gender encompasses both male and female.

Cisgender: An individual whose sexual orientation matches the biological sex assigned at birth.

Gender fluid: A person who is able to manifest and adapt to various genders. Sometimes referred to as "gender queer."

Gender identity: A person's concept of self as male, female, both, or neither; that is, how individuals perceive themselves and what they call themselves.

Gender nonconforming: A person whose gender expression is different from conventional expectations of masculine or feminine.

Transgender: An umbrella term for a person whose gender identity differs from the sex assigned at birth. "Trans" is often used as a short-hand term.

School

Include the name of the school, as well as the child's grade in school. If the child does not yet attend school full-time, indicate school/preschool/day care schedules, as in these examples:

Brittany attends the Peter Pan Preschool 2 days a week for 3 hours each day.

Justin is cared for by his maternal grandmother at her home from 8 A.M. to 4 P.M. weekdays while his mother works.

If the child is in a special class, indicate:

Mary is enrolled in a second-grade self-contained classroom at the Milton Elementary School.

Note whether the child has changed schools in the last 18 months or has had frequent school changes.

Handedness

Include handedness (right, left, ambidextrous) when appropriate, and eye and foot preferences if relevant.

Previous Diagnoses

If the child has a well-documented learning disability or psychiatric disorder, identify and describe it briefly.

Nationality, Language Spoken in Home, and Immigrant/Refugee Status

When this information is relevant to the case, report the child's nationality and the language(s) spoken at home. If English is the child's second language, indicate his/her degree of proficiency in English, as in this example:

Maria was adopted from Mexico. She speaks both Spanish and English, although Spanish is her first language, and she is not yet as fluent in English as in Spanish.

If the child is not a U.S. citizen and that fact is relevant, indicate the country of citizenship:

Ahmed is a Saudi citizen currently in school at Garfield Academy.

If the child and family are immigrants/refugees from another country, indicate which country and the circumstances of their arrival:

Alisa was born in Syria, where she lived with her parents and sister until she was 3 years old, at which time the family fled the country because of persecution and moved to the United States.

Race/Ethnicity

Be consistent in reporting race/ethnicity across reports; do not report it only for members of minority groups. If you are in doubt, it is best to ask older children and adolescents (or parents) which term they prefer in describing their race/ethnicity. Race is not simply skin color. The following is a list of commonly used terms.

African American, Caucasian/Euro-American/European American/"white"/"Anglo," Asian American/Asian, Pacific Islander, Hispanic/Latino/Latina/Latinx, Middle Eastern, Native American, Inuit, biracial/multiracial/of mixed races.

Child's Familiarity with Examiner

When relevant, indicate if the child has a previous history with the examiner, as in this example:

Dan was familiar with the testing evaluator from a therapeutic relationship.

Living Arrangements

Indicate others with whom the child lives, and the parents' marital status if this is pertinent:

Child lives with his biological parents and a younger sister, age 7.

Child's parents are separated, and child lives with her mother.

If the child lives with a parent's lover or partner, indicate this as well; if pertinent to the referral question, indicate the duration of this relationship and the degree of stability within the home:

Child lives with his older sister, his mother, and the mother's boyfriend of 5 years, whom he refers to as his stepfather. The boyfriend plays a positive parental role with both children, and the home appears stable.

If the parents are separated or divorced, indicate the visitation schedule and, when germane, the type of visitation:

Child lives with her mother and sees her father during supervised visitation one night per week.

If the child lives at a location other than either parent's home, describe the living arrangements/location.

Referral Reason *See Chapter 8, "Reasons for Referral."*

7.3. Arriving for the Evaluation

Child arrived for the appointment with mother/father and readily/reluctantly separated from her/him at beginning of evaluation.

Child arrived for the appointment ____ minutes late, with parent(s).

Child arrived for the initial interview on time and in the company of his/her father/mother/guardian.

Child initially had difficulty/no difficulty separating from his parent/relative/caregiver/classroom and accompanying evaluator to the assessment room.

If the child is brought to the evaluation by someone other than a parent or legal guardian, indicate the reasons, as in this example:

Jason was brought to the appointment by his maternal aunt, Ms. Z., who is taking care of him while his mother (his legal guardian) is hospitalized for cancer treatment.

7.4. Other Sources of Information for the Report

Begin to describe the information sources consulted for the report with one or more statements such as the following:

In preparation for/In advance of the interview/evaluation, I received and reviewed the following records . . .

Sources of information may include the following:

Interview with parent/teacher/child/day care provider/foster parent/caseworker, other (specify). Indicate whether a structured interview format was used, and indicate dates if these are different from the date of the report, as described above.

Review of previous test results/school records/individualized education program (IEP)/medical records/other (specify).

Standardized tests/rating scales: List each test/scale, along with its acronym/abbreviation. (*See Chapters 21–28 for test/scale names and common abbreviations.*) Include total testing time and/or duration of each testing session, as in these examples:

Met with child for two testing sessions of 3 hours each.

Met for one 30-minute interview with parent and one 2-hour testing session with child.

Group behavior rating scales by who completed each scale:

Mrs. Brown, John's mother, completed the following behavior checklists . . .

Ms. Bagwell, John's teacher, completed the following behavior checklists . . .

Home observation: Indicate date and duration of observation, and names of family members observed.

School observation: Include date and duration of observation, and subject(s) or other activities observed.

Observation of the child during a clinical interview.

Observation of the child by other professionals.

Consultation with teacher(s) and/or other professional(s).

Results from team meeting/school conference/IEP meeting: Indicate who was present for meeting (parents, teachers, therapists, principal, etc.).

7.5. Consent and Confidentiality Statements

Please consult your agency and state guidelines for information regarding the type of information that needs to be conveyed, as well as the age at which the information needs to be explained to the child or adolescent. (*See Section 1.4 for more information on this topic.*)

The limits of confidentiality were explained to the child and/or parents. Child/parents was/were informed that information regarding danger to the child or to others would be shared with outside agencies.

We discussed the evaluation/treatment procedures; what was expected from the child, the parents, and the evaluator/therapist; who else would be involved or affected; the treatment's risks and benefits; and alternative methods' sources, costs, and benefits.

The child and/or parent(s) understand the procedures that he/she is/they are being asked to consent to and their likely consequences/effects, as well as alternative procedures and their consequences.

I have advised the parents that I am not their child's treating psychologist and that we will not have a continuing professional relationship.

The parents know that the results of this evaluation will be sent to _____ and used for _____.

The child understands and willingly agrees to participate fully in the evaluation process.

7.6. Reliability and Validity Statements

Basis of Data

The data/history are/is felt to be completely/quite/reasonably/rather/minimally/questionably reliable.

I consider the child/parent to be an adequately/inadequately reliable informant.

I have relied on the parents' report of their child's history and assumed that it was accurate (except as noted); thus, I cannot assume any responsibility for any errors of fact in this report.

The opinions offered in this report have not been influenced by the referrer/referring agency.

The diagnoses and opinions in this report are offered with a reasonable degree of psychological certainty.

Accuracy

The parents' description of their child was credible, forthright, and informed. Although somewhat dramatized, the core information appears to be accurate and valid for diagnostic/evaluative purposes.
The child's parents are/are not astute observers of their child's behavior.

Consistency

His/her appraisals tended to be supported/corroborated by my observations/others' records. The child's parents were poor/adequate/good/excellent historians.

Representativeness

Results are believed to be a valid sample of/accurate representation of this child's current level of functioning/typical behavioral patterns/behaviors outside the examination setting. Because this child refused no test items/questions, worked persistently/was most cooperative and helpful, and had no interfering emotions such as anxiety or depression, test findings/results of this evaluation are felt to be representative of her/his minimal/usual/optimal level of functioning.

Trustworthiness/Honesty/Malingering

The parents/child appeared to be honest in their/his/her descriptions of the child's strengths and weaknesses.
The parents made no special efforts to convince me of the gravity or authenticity of their child's problems.
The history offered should be taken with a grain of salt/was fabricated/grandiose.
The mother's/father's descriptions of the child's complaints were vague, self-contradictory, and not completely consistent with any recognized clinical pattern.
The mother/father offered an exaggerated/minimized description of the child's behaviors.
The mother/father was a willfully poor historian.

Validity

Given this child's high level of motivation and cooperation, results of this evaluation are felt to be a valid indicator of her/his abilities.
Given the child's strong motivation, concentration, and cooperation, it is likely that the present results provide an accurate estimate of his/her current cognitive and psychological functioning.
In spite of the child's difficulties with impulsivity, her/his attention and effort were quite adequate on all tasks. Consequently, the results are considered valid.
In general, the following results are judged to provide a valid estimate of the child's current cognitive functioning as assessed under structured conditions.
This assessment is thought to accurately reflect his/her current level of academic/cognitive/psychological functioning.
Child was able to focus when presented with firm limits, and thus results appear to be valid.
Overall, the child was cooperative, and the results appear to be a valid representation of her/his current functioning.
Child put forth very good effort on all tasks. Although he/she was candid about disliking some

tasks, he/she performed all of them attentively and often enthusiastically. Thus this evaluation appears to be a valid assessment of the child's abilities.

Questionable Validity

The following results are considered valid but may slightly underestimate the child's abilities, given his/her limited attention span.

Overall, the child was uncooperative for the evaluation. Although the results appear to be a valid representation of her/his current performance, they probably do not reflect her/his true abilities.

Child was extremely uncooperative for this evaluation, and thus the evaluation is rendered of questionable validity.

Child's limited attention had a severe impact on his/her ability to perform, and thus the evaluation is deemed invalid.

8

Reasons for Referral

This chapter covers referral reasons only. Everything else that should be included in the introduction to the report is covered in Chapter 7.

8.1. Statement of Referral Reason

In general, the statement of the referral reason should include the most pertinent identifying information, the type of evaluation, and the referral source, as well as the referral reason itself. The following are some commonly used expressions.

Patient/client is a ____-year-old _____ grader, seen for _____ evaluation (*indicate type of evaluation or service*) on referral of _____ (*indicate referral source/person*) to _____ (*indicate purpose of referral*).

Client/patient, a _____-handed, ____-year-old male/female from _____, was referred for a _____ evaluation by his/her psychologist/neurologist/psychiatrist, _____, given concerns about _____ and _____ (*specify nature of concerns*).

Patient/client is referred by _____ (*indicate referral person*) of _____ (*indicate person's affiliation/place of work*) for _____ (*indicate type of evaluation*) to obtain further information regarding _____.

The child/family was referred by _____ (*referral source/person and agency*) on _____ (*date of referral*), for _____ (*type of evaluation or other service*), to _____ (*rationale/purpose*) in regard to _____ (*referral reason*).

Types of Evaluations/Reports

- Classroom observation/consultation.
- Clinical interview.
- Cognitive evaluation.
- Custody evaluation.
- Diagnostic determination.
- Discharge summary.
- Educational placement.
- Forensic evaluation.
- Mental status evaluation.
- Neuropsychological.
- Psychological.
- Psychological testing report.
- Psychosocial evaluation.

Reevaluation.
Termination report or treatment termination report.
Treatment summary.

Common Referral Sources

Neurologist/pediatric neurologist.
Nurse/clinical nurse specialist/pediatric nurse practitioner.
Occupational therapist.
Parent/mother/father/guardian.
Pediatrician.
Physical therapist.
Psychologist/psychiatrist/psychotherapist.
School counselor/school psychologist.
Social worker.
Speech therapist.
Teacher/special education teacher.

Purposes of Evaluations

Assess academic/cognitive performance now that child has discontinued/begun _____ medication.
Assess bilingual/second-language issues.
Assess current psychological functioning and eligibility for permanent placement versus independent living.
Assess for presence of learning disorder/disability.
Assess readiness for kindergarten/first grade/etc.
Assess social skills.
Assess treatment progress.
Better understand the child's learning strengths and weaknesses.
Better understand the origin of the child's difficulties.
Clarify diagnostic impression.
Clarify discrepancies in previous test results.
Clarify nature of the child's reading/writing/math difficulties, as well as educational needs.
Collect a baseline of psychoeducational data to measure the child's progress in the next _____ months.
Determine eligibility for special education services.
Determine whether behavior problems are due to a psychiatric disorder (*if a specific disorder is suspected, name it*).
Determine whether there is a specific cause for the child's difficulties.
Formulate an accurate diagnosis and translate it into a corresponding educational classification.
Help with school placement decisions.
Identify factors underlying problem behaviors.
Inform future educational plans.
Provide updated information as to the child's performance.
Suggest the most appropriate educational setting and supportive services for the child at this time, as well as any remedial and therapeutic options needed outside of school.

In the remainder of this chapter, common referral reasons are categorized by referral category.

8.2. Behavioral and Conduct Concerns

Aggressive behavior: Pushes others, grabs toys, hits/kicks/bites parents/siblings/teacher/others, throws food or objects, overturns furniture, screams/yells, violent behavior/outbursts,

homicidal tendencies, threats of hurting others, expressed hatred of/desire to kill sibling/teacher/friend, talks a lot about killing and fighting, physical aggression, participates in physical fights, destructive of own/school/family's/others' property.

Alcohol/drug abuse: Drinking/underage drinking, drug use, drug selling, smoking.

Attention-seeking behaviors: "Tattling," baiting, provoking others, overly demanding of attention from siblings/peers/adults, craves _____'s attention, manipulates, commits pranks, "clowns around," "class clown."

Attention span/concentration difficulties: Inadequate attention span, concerns about attention span, difficulty paying attention, difficulty following directions, difficulty staying/concentrating on task, distractible/easily distracted, difficulty focusing/lack of attentional focus, inattentiveness/inattention, inconsistent attention/behavior, insufficient attention, problems focusing/listening/concentrating, relies heavily on structured support from teachers and parents in order to remain on task and complete work, poor listening skills, often needs information repeated.

Dawdles/lingers/starts late in dressing/eating/bedtime/homework, procrastinates, wastes time.

Devaluing behavior toward others, "put-downs," insults others.

Difficulty with transitions, dislikes changes, inflexible/rigid.

Disruptive behaviors at home/school, agitates/disrupts/disturbs other children, provokes others.

Expresses emotions forcefully, intense in expression of anger/sadness, difficulty modulating emotions.

Firesetting.

Frustration: Easily frustrated, low frustration tolerance, difficulty handling new situations, becomes easily frustrated if she/he is not successful from the beginning of the task presented.

Hyperactivity/overactive/restless/fidgety, problems sitting still, problems maintaining focus in groups, excessive or inappropriate talking.

Impulsivity: Difficulty regulating impulse toward activity, impulse control problems, runs out of classroom/school, reckless behavior/activities, interrupts others, unpredictable behavior/outbursts at home/school.

Legal difficulties: Truancy, loitering, panhandling, underage drinking, vandalism, drug use, fire setting, drug sales, "joy riding," auto theft, extortion, stealing, shoplifting, burglary.

Lying: Lying about homework assignments/school grades/school performance, "covers up" misdeeds.

Noncompliant/oppositional/insolent behavior toward teachers/caregivers, disregard for authority/rules, willfulness, stubbornness, headstrong.

Obsessions/hyperfocusing on certain topics, compulsions/rituals.

Regressive behavior, thumb sucking, rocking, stereotyped movements.

Self-destructive/self-injurious acts/behaviors/wishes: Cutting of wrists/arms, expressed desires/urges to harm self (e.g., jump out of moving car), etc.

Sexual behaviors: Sexual acting out/preoccupation, public/frequent masturbation, increased interest in sexual matters, initiates sexual conversations inappropriate for children his/her age, molests/molestation/molested, touched/fondled, actual intercourse/entry (oral/vaginal/anal/femoral), repeated/single-episode/recurrent, assault/rape, force used/damage/threats.

Slow-moving/lethargic.

Swearing, abusive speech, "backtalk."

Temper tantrums: Difficulty managing her/his temper, trouble calming her-/himself, "melts down" frequently, explosive behavior, prone to tantrums/severe tantrums, head banging, holds breath to point of fainting.

- ✓ For each behavior indicated, note duration and how it has been handled by parents/caregivers/teachers.

8.3. Cognitive Concerns

Developmental delays/developmentally delayed, seems behind other children his/her age with regard to cognitive skills.
 Difficulty understanding new concepts, difficulty distinguishing movies/cartoons from reality.
 Disordered thinking.
 Forgets/forgetful.
 Inability to connect cause and effect.
 Memory problems.
 Overwhelmed by large quantities of information.
 Poor judgment.
 Possible cognitive impairment underlying the child's difficulties.
 Problems learning letter names/colors/numbers.
 Processing speed difficulties.

- ✓ When any cognitive concerns are present, assess for/rule out intellectual disability.

8.4. Emotional Concerns

Abuse (physical/sexual), consequences: Fear/anxiety, depression, dissociation, etc.

- ✓ Whenever abuse is suspected/reported, note source of allegations, relationship of child to alleged perpetrator, duration, etc. If allegations are not yet being investigated, notify appropriate authorities.

Anger: Angry feelings, impulsive expression of angry feelings, expresses particular anger toward mother/father/sister/brother/other, severe rage.

Anxiety: Anxiety that affects ability to perform in school/take tests, "freezing up"/experiencing a mental block, fears, phobias, nervous habits, becomes terrified for no apparent reason, panic symptoms (sweating, rapid heartbeat, etc.).

Autistic withdrawal: Lack of responsiveness to people, resistance to change in the environment.

Depression: Suicidality/suicidal ideation, sadness, anhedonia, lethargy/dysphoric mood/loss of interest in pleasurable activities, insomnia or other physical symptoms, self-harm (cutting/razor cuts, etc.), unhappy, problems with self-esteem/low self-esteem, wishes to die, feels unloved, perceives lack of friends, hates him-/herself; cries easily/chronically, cries over everything/any little thing.

Feels inadequate.

Frustrates easily, low frustration tolerance.

Guilty feelings.

Immature emotional self-regulation, seems less emotionally mature than peers.

Imaginary playmates/fantasy.

Inadequate emotional reactions.

Irritability: Irritable in a demanding/bossy way, irritable in a sad/discouraged way.

Lack of remorse for aggressive behavior.

Lethargy.

Mood: Labile/volatile mood, mood swings, moodiness, bipolar mood cycles.

Obsessive–compulsive symptoms.

Perfectionism.

Perseverative thinking.

Poor coping skills.

Posttraumatic stress disorder (PTSD) symptoms.

Psychotic symptoms.

Restricted/limited range of emotions, emotional constriction.

Shyness.

8.5. Family Concerns

Abuse (physical/sexual) by family members. (*See Section 8.4, above.*)
 Argumentative with family members.
 Death of mother/father/sister/brother/other family member.
 Difficulty coping with recent/impending parental divorce.
 Distress regarding biological father's/mother's unreliable visits.
 Lies to parents.
 Neglected, berated, belittled, humiliated.
 Noncompliant, disobedient.
 Oppositional home behaviors, talks back to parents, defies parents' authority, refuses to do chores/jobs at home, will seldom do what is asked, refuses to comply with house rules.

8.6. Learning and Academic Concerns

Academic performance below grade level, academic problems in reading/math/writing.
 Attendance: Misses excessive days, absenteeism, tardiness, cuts classes, truancy.
 Careless/sloppy work, problems with neatness.
 Cheats, copies from peers, does not do own work.
 Concerns about child's rate of progress in school, despite special education services.
 Concerns relating to change in schools/move to new school district.
 Deteriorating school performance.
 Difficulty completing assignments, cannot work independently, does not finish things once started, difficulty organizing work.
 Dropped out of school.
 Effort: Insufficient effort, careless work, does not spend enough time on work.
 Experiences anxiety and frustration regarding school.
 Failing to seek help when appropriate.
 Failure in subjects (*specify*).
 Fatigued, too tired during the school day to put forth best effort.
 Homework: Does not complete homework/in-class assignments, fails to turn in homework, turns in assignments late.
 Inconsistent performance, learns something one day and forgets it the next.
 Learning: Difficulty learning even simple information, trouble comprehending schoolwork.
 Math: Problems learning math facts/concepts, problems retaining math concepts/rules/facts.
 Motivation: Decreased motivation regarding school tasks, lack of motivation in school, does not try, makes little effort.
 Organization difficulties/disorganized.
 Poor attitude toward school, hates school, does not persevere, needs much encouragement, gives up easily.
 Possible underlying learning disorder.
 Processing problems/slow processing speed.
 Procrastinates.
 Reading: Concerns about dyslexia/reading disability, failure to make progress in reading, problems with reading comprehension/decoding, difficulties acquiring reading skills, avoids reading, confuses similar words/letters, loses place while reading, forgets previously known words, trouble following written directions.
 Refuses to do schoolwork.
 School phobia/avoidance.
 Spelling difficulties: Cannot spell, can spell out loud but not as well in writing, unable to spell name.

Underachievement in school, academic underachievement.
 Visual processing problems, difficulty with visual tracking.
 Writing: Dysgraphia, difficulties with written output, slow writing, difficulty organizing written output, trouble copying from the board, difficulty expressing him-/herself in writing, problems with note taking.

8.7. Motor and Physical Concerns

Ambidextrous, alternates right–left, nonestablished hand dominance.
 Delays in acquisition of fine motor/gross motor skills.
 Eating: Poor feeding habits, poor manners, refuses food, appetite changes, odd combinations, pica.
 Enuresis/bedwetting.
 Fine motor difficulties: Problems with drawing/coloring/copying/cutting/staying on the line when writing, problems reversing letters and numbers.
 Gross motor problems: Problems with crawling/walking/running, difficulties with skipping/climbing, unable to learn to ride a tricycle/bicycle, etc.
 Hearing problems.
 Hypotonia/hypertonia.
 Motor coordination delays, motor control difficulties.
 Motor tics.
 Physically overactive.
 Repetitive motor activities.
 Sensory integration difficulties: Extremely sensitive to odors/clothing/textures/loud noises/particular noises/bright light/tastes, extreme sensitivity to environmental stimuli, tactile defensiveness.
 Sleep: Poor sleep habits, refuses to go to bed, nightmares/night terrors, sleepwalking, excessive daytime drowsiness, parasomnias, refuses to get out of bed.
 Slow processing speed/slow processor.
 Toileting problems, unable to be toilet-trained at appropriate age.
 Visual–motor integration difficulties.
 Vocal tics.

8.8. Social Concerns

Attachment/bonding problems, inability to form an attachment or close relationship with others.
 Clique membership/exclusion of other children.
 Conversational inappropriateness: Makes rude comments, makes sexualized or grandiose statements, makes comments that have no relevance to current situation.
 Difficult relationship with parents/siblings, noncompliant, fights.
 Difficulty cooperating with others, trouble tolerating group situations, does not participate in group activities.
 Difficulty discriminating known from unknown people.
 Difficulty engaging in reciprocal conversation, problems interpreting social cues.
 Difficulty interacting with peers, fights/argues frequently with playmates/peers, bossy, bullies others, deficits in interpersonal skills.
 Difficulty making friends, has no friends, does not fit into peer group, is not accepted by peers, difficulty sustaining friendships, becomes obsessed with certain friends, continuing difficulties with social interactions.

Does not respect the rights and/or property of others.

Eye contact: minimal eye contact, lack of eye contact.

Immature social skills, social immaturity.

Is easily influenced/led, suggestible.

Lack of responsiveness to others.

Loner, isolates self, doesn't belong/fit in, socially isolated from peers, withdrawn, tendency to withdrawal.

Passive or uncomfortable in multiple-peer interactions.

Selective responses to people.

Sexual inappropriateness.

Teased or picked on in school/neighborhood by peers.

- ✓ For various problems in the development of social skills, assess for/rule out autism spectrum disorder (ASD)/nonverbal learning disability (NLD); determine whether child demonstrates characteristics consistent with those found in people with ASD/autistic withdrawal.

8.9. Speech and Language Concerns

Auditory discrimination weakness.

Concerns about communication skills.

Difficulty in the areas of pragmatics and verbal problem solving.

Expressive language difficulties, problems with verbal output, concerns about spoken language ability.

Failure to acquire normal speech.

Impaired language, language delays.

Mutism (elective/selective).

Poor articulation, specific speech misarticulations.

Problems comprehending and retaining information.

Problems understanding spoken language.

Word retrieval problems.

B. Background and History

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9

History of Current Symptoms

The “Background Information” section of a report generally includes information provided by parents, caregivers, teacher(s), and the child, as well as information from previous evaluations and records. There are two reasons to mention particular areas of a child’s background and history. The first is to describe historical events that are or may be connected with the child’s current problems. The second is to state that particular areas or topics were checked and reported as normal.

This chapter covers the child’s history as it relates specifically to the referral question. Reasons for referral are covered in Chapter 8. Other aspects of history, such as medical/psychiatric background, developmental/family history, and academic history, are covered in Chapters 10–12. More information about psychiatric disorders can be found in Chapters 15 and 16.

- ✓ In child reports, the history is usually presented from the viewpoint of one or both parents. Teacher or caregiver input is important in many cases as well, and, depending on the age of the child, it is helpful to provide the child’s view of problem areas.

9.1. Onset of Symptoms

A formal statement of the parents’/teachers’/other authority’s perception of the chief concern/problem usually starts with age of onset and perceived precipitating factors.

Age of Onset

State the child’s age or grade at the time when problems were first noted. If they were only retroactively noted, indicate your conclusions about the actual onset. Different symptoms or changes in severity may have different onset dates and different precipitants.

Precipitating Factors

Indicate whether/if onset of symptoms was preceded by a particular incident or stressful event. In children, common precipitating factors include the following:

- Abuse (physical/sexual).
- Beginning or changing schools.
- Death of parent/grandparent/sibling.
- Divorce or separation of parents.
- Illness, either in child or in another family member.
- Move to a new home or location.
- Parent’s marriage/remarriage.

Separation from parents.

Birth of sibling.

State the reason for seeking treatment/evaluation at the current time, and the goal(s) of treatment/evaluation.

Summary Statements

_____ (*child's name*) is a ____-year, ____-month-old boy/girl/male/female referred for a _____ evaluation (*specify type of evaluation*) by _____ (*specify referral source*) to address concerns regarding _____ difficulties (*indicate nature of difficulties*).

The current testing was requested to help characterize _____'s strengths and weaknesses in order to aid in academic planning.

This child is referred for _____ (*specify type of evaluation*) to obtain updated information about his/her skill levels and learning/emotional/behavioral profile. The evaluation will be used to plan educational/treatment interventions.

_____ (*child's name*) was described as a happy/outgoing/normal/quiet/etc. child until _____ (*date*), when she/he began exhibiting _____ (*specify symptoms/behavior changes*).

This is the first psychiatric hospitalization for _____ (*child's name*), who was admitted on _____ (*date*) due to _____ (*indicate problem*).

This child began exhibiting behavior/academic/attention/etc. problems at age ____.

9.2. Course

Structuring the History of the Current Problem in the Report

Provide a chronological account of the reason(s) the child has been brought for evaluation or treatment, beginning with when symptoms were first seen. This may have been at birth (e.g., in cases involving prematurity or a genetic defect); in early childhood; or in elementary, middle, or high school.

As Morrison and Flegel (2016) note, children's histories often contain multiple threads, such as behavior problems, learning disabilities, and mood dysregulation. It is helpful to disentangle these strands within the report, with one paragraph devoted to each strand. Information highlighted in this area should help build a case for the diagnosis that comes later; it should particularly include aspects of the history that confirm the diagnosis, as well as aspects that refute, or perhaps weaken, the diagnosis.

Describe premorbid functioning: personality, behavioral, emotional, academic, and social.

Describe development/chronology of signs/symptoms/behavior changes. Include duration, progression, and severity of symptoms. Note if symptoms occurred suddenly or had a slower onset. If so, note time period that symptoms developed.

Single episode or multiple episodes? If the latter, describe as:

Recurrences, relapses, exacerbations, worsenings, flare-ups, fluctuating course.

Any remissions? If so, describe these as partial or full/complete. Also, indicate duration and possible reasons.

Any previous diagnoses of current problem? If so, indicate age at diagnosis, type/name of diagnosis, and validity of diagnosis; also, explain any changes of diagnosis.

Impact of Previous Treatments on Any Past Symptoms

See Section 10.7, "Psychiatric History."

Effects of Current Symptoms on Functioning

Behavioral: Indicate whether symptoms have caused increased behavior problems in other areas (e.g., whether symptoms of depression have caused aggressive behaviors toward family members).

Family: Describe effects of symptoms on family functioning and dynamics (*see Chapter 17 for descriptors*).

School: Describe impact of symptoms on school performance, grades, ability to complete homework, interest in school, and/or achievement motivation (*see Chapter 18 for descriptors*).

Social: Describe impact of symptoms on child's friendships and ability to interact with others (*see Chapter 19 for descriptors*).

10

Medical and Psychiatric Background Information

This chapter first covers a child's prenatal, birth, and early infancy histories, as well as topics relevant to adopted children. It then covers the child's medical history, use of medications, and history of previous psychiatric symptoms and treatment. Keep in mind the two reasons to mention any of these particular areas in a report, as noted at the start of Chapter 9. The first is to describe historical events that are or may be connected with the current problems; the second is to state that particular areas or topics were checked and reported as normal.

10.1. Prenatal and Maternal Health

Alcohol and Tobacco Exposure

Describe any reported alcohol or tobacco use during pregnancy, along with any possible effects of prenatal exposure, such as a child born with fetal alcohol syndrome (FAS).

Mother denied a history of tobacco and alcohol use during pregnancy.

Mother denied smoking during pregnancy/smoked tobacco for ____ months during pregnancy/throughout pregnancy.

Mother denied using alcohol during pregnancy/admitted having approximately ____ drinks a day for ____ months during pregnancy/throughout pregnancy.

Father/child protective services worker/other (*specify*) reported maternal alcohol use during pregnancy.

Child's medical record reports signs/symptoms of FAS.

Illegal Drug Exposure

Describe any reported illicit drug use; indicate the specific drug if known (e.g., cocaine, crack, heroin, marijuana); and note any possible effects of prenatal exposure, such as drug addiction at birth.

Mother denied using illegal drugs during pregnancy/admitted using _____ (*specify amount*) of _____ (*specify illegal drug/drugs*) for ____ months during pregnancy/throughout pregnancy.

Father/child protective services worker/other (*specify*) reported maternal illicit drug use during pregnancy.

The child's medical record reports that he/she was born positive for/addicted to _____ (*specify illegal drug/drugs*).

Use of Prescription Drugs and Vitamins

Describe any drugs prescribed, reason for use, and timing of use during pregnancy. In addition, note use of prenatal vitamins.

The child's mother was prescribed and took _____ (*specify prescription drug/drugs*) during _____ trimester(s) of pregnancy/throughout pregnancy for _____ (*indicate condition*).

The child's mother used prenatal vitamins during ____ months of pregnancy.

Pregnancy Course

Report the mother's previous pregnancies and miscarriages (and any complications), hospitalizations, prescribed bedrest, abnormal fetal activity, lack of medical care, preterm labor, and associated medications.

The pregnancy was normal/uneventful/uncomplicated/complicated.

The pregnancy was planned/unplanned.

The child is the product of the mother's first/second/third/etc. pregnancy.

Mother had ____ previous miscarriage(s).

Mother required bedrest for ____ months of pregnancy.

Mother was placed on partial/complete bedrest beginning at ____ weeks'/months' gestation.

The pregnancy was complicated by _____ (*see the list of common complications below*).

Fetal activity was very high/low throughout pregnancy.

Mother was hospitalized for _____ (*see the list of common complications*).

Mother received no/little/regular medical care during pregnancy.

Preterm labor was reported at ____ weeks' gestation.

Preterm labor was treated with _____ (*see the list of medications below*).

Common Medical Complications during Pregnancy

Anemia.

Hypertension/elevated blood pressure.

Infections: Staph, sinus. (*Indicate whether infections needed to be treated with antibiotics, and when during the pregnancy the infections occurred.*)

Intrauterine tumors.

Morning sickness: Mild/severe; treated with _____ (*specify drug, if any*).

Preeclampsia.

Radiation/X-ray exposure.

Rh incompatibility.

Spotting/bleeding/threatened miscarriage.

Toxemia.

Weight gain: Abnormally low/high.

Common Medications Used to Treat Preterm Labor

Terbutaline, ritodrine, magnesium; indomethacin, nifedipine (*less frequently*).

Psychosocial Stressors during Pregnancy and Birth

The child's mother and father separated when the mother was ____ months pregnant.

The mother experienced mild/moderate/severe emotional stress before/during/after pregnancy.

The family was under severe stress due to parental unemployment/illness/death in family/move/divorce/separation.

10.2. Birth History

General Statements

Pregnancy and birth histories were insignificant/unremarkable/essentially normal.
 Prenatal and delivery histories were reported to be free of complications.
 The child was the product of a full-term, uncomplicated gestation and delivery.
 Prenatal and delivery histories were significant for _____ (*specify*).

Labor and Delivery

Time in labor was brief/lengthy.
 Birth was preceded by _____ hours in labor.
 Labor was intense/difficult/induced/spontaneous.
 Birth was attended by doctor/midwife.

Describe the delivery in any of the following terms that apply. In particular, report any unusual or complicating aspects of the labor and delivery that might be related to the child's current difficulties.

Normal/uncomplicated/vaginal, normal vaginal, vaginal breech, vaginal presentation under/
 without spinal/general anesthesia, natural delivery.
 Emergency cesarean section/C-section due to fetal distress/fetal aspiration of meconium/failure
 to progress/maternal distress.
 Scheduled C-section due to breech position/narrow maternal pelvis/other (*specify*).
 Forceps birth/forceps were used during birth.
 Meconium staining.
 Vertex presentation.

Birth Weight and Gestation

The child was born full-term/born on time/at term, weighing _____ lbs. _____ oz./_____ kg.
 The child was born at _____ weeks' gestation.
 The child was born _____ days late.
 The child was born prematurely at _____ weeks.

Apgar Rating

The Apgar scale (Apgar, 1953) is used to evaluate the vital signs of newborns in the delivery room. The scale is administered within the first 60 seconds after birth and again at 5 minutes after birth to check a baby's appearance (color), pulse (heart rate), grimace (reflex irritability), activity (muscle tone), and respiration (breathing); note that the first letters of these five words spell the name "Apgar." Each vital sign is scored 0, 1, or 2, based on criteria described in the table below. Most infants score in the 7-10 range. Scores between 5 and 7 indicate that a baby is in need of careful observation, while scores below 4 indicate significant risk.

Apgar scores were _____ at 1 minute and _____ at 5 minutes.
 Apgar scores were reportedly low/normal/good.
 Child's initial Apgar score was 1, but he/she recovered quickly, and 10-minute Apgar was 10.

<i>Vital sign</i>	<i>0</i>	<i>1</i>	<i>2</i>
Appearance	Blue, pale	Body pink, extremities blue	Completely pink
Pulse	Absent	Slow (below 100)	Over 100
Grimace	No response	Grimace	Vigorous cry

<i>Vital sign</i>	<i>0</i>	<i>1</i>	<i>2</i>
Activity	Limp	Some flexion of extremities	Active motion
Respiration	Absent	Slow, irregular	Good strong cry

10.3. Neonatal Health and Behavior

General Statements

Neonatal course was unremarkable.

Child was discharged home with her/his mother at the appropriate time.

Infant was hospitalized for ____ days after birth for _____ (*specify*).

Child had jaundice as an infant.

Infant required oxygen for ____ hours/days.

Infant had breathing difficulties due to hyaline membrane disease.

As an infant, child spent ____ hours/days/months in an incubator.

As an infant, child spent ____ days in the neonatal intensive care unit.

Reflexes

Snow (1998) describes the reflexes present in newborns as follows:

Rooting and sucking (rooting reflex should disappear by 3 months).

Grasp (replaced by voluntary grasp by 3 or 4 months).

Moro (begins to disappear by 3 months).

Babinski (disappears between 12 and 16 months of age).

Tonic neck (disappears by 4 to 6 months).

Stepping (disappears by 5 months).

General Temperament and Behaviors

Describe activity level, crying behavior, social interest, and general disposition.

The following descriptors for sensitive temperament are sequenced by degree of difficulty:

(↔ *by degree*) Sensitive, highly reactive to external stimuli such as clothes/sounds/touch/light/noise, pulled away from affection, unresponsive.

Moods are generally positive, is somewhat negative, tends to react negatively and cry a lot.

Adapts quickly to new experiences, is reluctant to adapt, has significant difficulties accepting new experiences.

Eating Behavior

Nursed/ate well, good eater/normal eating patterns, breast-fed well, feeding patterns were unremarkable.

Breast-fed/bottle-fed until ____ months/years of age, weaned at age ____.

Difficulty learning to suck.

Lactose-intolerant.

Reflux/problems with gastroesophageal reflux; spit up frequently.

Sleeping Behaviors

Slept well, good sleeper, normal/unremarkable sleeping patterns.

Difficulty falling asleep/had trouble falling asleep, poor/light sleeper, awoke frequently during the night.

Slept through the night at ____ weeks/months.

10.4. Adopted Children

Report the child's age at adoption, and describe what is known about the home prior to adoption (or, if appropriate, indicate the country from which he/she was adopted).

The child was adopted at birth/ ____ months/years of age.

The child was fostered by the _____ center/foster mother/foster parents for ____ days/weeks/months.

Records indicate that the child lived with her/his biological mother until age ____.

The child was adopted from an orphanage in _____ (*specify nation*).

- ✓ Often little is known about an adopted child's prenatal and birth histories. In these cases, report what is known, as in these examples:

Little is known about the child's birth parents, except that his/her mother was a young teenager and the father was employed as a _____.

Little is known about the child's prenatal or birth history.

The child was adopted from _____ (*specify nation*), and there is no information regarding prenatal history.

10.5. Medical History

As relevant, note the following:

Current/recent illnesses.

Symptoms.

Surgeries and other treatment.

Injuries and accidents—especially traumatic brain injury, closed head injury, and all other traumatic incidents resulting in loss of consciousness.

Drug treatment, use, and abuse. Note especially use of illegal/illicit drugs, as well as of nonprescription drugs, over-the-counter medicines, vitamins, herbal remedies, supplements, etc.

Exposure to toxins: Duration, amount, type, source, and treatments.

Medical Problems Frequently Observed in Children

Allergies. Descriptors:

The child is allergic to _____/has seasonal allergies/hay fever.

Asthma. Descriptors:

The child has asthma treated with _____ (*specify medication*).

Asthma is allergenic/seasonal/exercise-induced.

Asthma resulted in ____ (*specify number*) hospitalizations/emergency room visits.

Bowel disorders: Colitis, Crohn disease, irritable bowel syndrome, frequent diarrhea.

Brain tumors: Meningiomas, primary neoplasms, gliomas, secondary neoplasms.

Cerebral palsy. Hallahan and Kauffman (1994) describe two approaches to classifying cerebral palsy. The first classification is according to the parts of the body involved:

Hemiplegia (condition where one side of body—right or left—is paralyzed).

Diplegia (condition where legs are paralyzed to a greater extent than arms).

Quadriplegia (condition where all four limbs are paralyzed).

Paraplegia (condition where both legs are paralyzed).

The second classification is according to type of brain damage and consequent motor disability:

Pyramidal (spastic). Brain damage is to the pyramidal cells in the cerebral cortex, resulting in spasticity.

Extrapyramidal (choreoathetoid, rigid, and atonic). Damage to brain is outside of pyramidal tracts and results in involuntary movements, stiffness, or floppiness.

Mixed.

Childhood illnesses: Anemia, chicken pox, diphtheria, encephalitis, German measles, measles, meningitis, mumps, rheumatic fever, scarlet fever, sustained high fever, tuberculosis, whooping cough.

Congenital infections: Human immunodeficiency virus (HIV), herpes virus, syphilis, toxoplasmosis.

Cystic fibrosis (a fatal disease affecting the lungs and intestinal tract).

Ear infections/otitis media: Indicate frequency of the infections, timing of ear infections (e.g., first year of life), severity, and impact on development, if any; indicate also whether child received tympanostomy tubes to treat condition, and, if so, age at operation. General statement about ear infections:

The child's medical history is remarkable for frequent otitis media during critical language periods.

Eczema/other skin problems.

Ehlers–Danlos syndrome: Include what effect disorder has had on psychological/physical functioning, and whether surgery (e.g., skin grafts) was needed.

Epilepsy/seizure disorder. Indicate type of seizure disorder, age at diagnosis, frequency and length of seizures, and medication used to control seizures. Lezak, Howieson, Bigler, and Tranel (2012) provide the following clinical classification of epilepsy:

Partial seizures: Can be simple, complex, or partial evolving to generalized seizures.

Generalized seizures: Can be nonconvulsive/absence/petit mal, or convulsive.

Unclassified: Includes seizures that are poorly documented or don't fit into previous categories.

Enuresis/bladder incontinence, encopresis/bowel incontinence: Indicate whether it occurs during daytime/nighttime/both day and night; also indicate age of onset and whether condition is secondary to a medical condition.

Febrile seizures: Indicate number of seizures, age(s) at occurrence, and cause(s).

Fibromyalgia: More commonly diagnosed in adolescence than in childhood. Symptoms that commonly occur with fibromyalgia include unrestful sleep, fatigue, morning stiffness; less common symptoms include headache, Raynaud syndrome, irritable bowel syndrome, and depression.

Head injury/concussion: Indicate age at injury; whether loss of consciousness was observed; circumstances (car accident, fall, etc.); whether stitches were needed; whether skull was fractured; and impact on child's functioning, both immediately following injury and later.

Hearing loss/impairment: Indicate severity and whether problem is bilateral/unilateral.

Heart murmur: Indicate whether problem was resolved without/with intervention (and age at surgery, if applicable) or remains unresolved.

Hemophilia.

Hernia: Report age at operation.

Hydrocephalus: Report whether hydrocephalus was congenital or developed later (if later, age of onset); whether ventriculoperitoneal shunt was placed and at what age; and sequelae (e.g., seizure activity).

Juvenile rheumatoid arthritis or osteoarthritis.

- Musculoskeletal conditions:** Clubfoot, scoliosis, Legg–Calvé–Perthes syndrome, osteomyelitis.
- Respiratory problems:** Pneumonia, bronchitis, croup, asthma (see above), other pulmonary problems, seasonal wheezing; indicate frequent hospitalizations or emergency room visits.
- Sinusitis:** Report age of onset, and note whether it affects ability to concentrate or results in frequent headaches.
- Spina bifida** (deficit resulting from failure of bony spinal column to close during prenatal period).
- Stomach disorders:** Acid reflux, gastroesophageal reflux, esophageal strictures (indicate whether and when surgery was performed to treat condition), lactose intolerance.
- Tonsillitis:** Report whether tonsillectomy was performed (at what age) and whether adenoids were removed.
- Undescended testes:** Indicate whether child received surgery for this and age at surgery.
- Vision loss/impairment:** Indicate severity, whether corrective glasses are effective in treating condition, and whether problem is bilateral/unilateral. Also report color blindness, if present.

Summary Statements

Unremarkable Medical History

- The child's health history is essentially benign.
 Her/his medical history is unremarkable, and immunizations are up-to-date/complete.
 Child's medical history has included no significant medical illness, head trauma, loss of consciousness, or seizure disorder.
 Medical history is noncontributory.

Remarkable Medical History

- Medical history is remarkable for _____. (Include information about current/past illnesses, past/current surgeries, injuries, exposures to toxins, etc.)

10.6. Medication History *See Chapter 38, "Medications."*

Indicate any medications that the child is currently taking or has ever taken for longer than 6 months; in each case, include the type of medication, the reason for taking it, and the duration for which it has been or was taken.

Summary Statements

- _____ (*child's name*) is not currently taking medications.
 The child has not received any medication, either currently or in the past, for his/her symptoms.
 _____ (*child's name*) currently takes _____ (*name of medication*) for _____ (*name of disorder/symptoms*). In the past, she/he has taken _____ (*name of medication*) during _____ (*grades/years*) to help with _____ (*name of disorder/symptoms*).
 The child takes _____ (*name of medication*) to help him/her manage problems with _____ and _____ (*names of disorders/symptoms*).

10.7. Psychiatric History

See Chapter 9, "History of Current Symptoms," for guidance in describing the history of the present concern.

Describe psychological difficulties in the past, as well as any treatment(s) and professional help sought.

Hospitalization: Report number of previous psychiatric admissions; reason for psychiatric admissions; length of hospital stays; therapies instituted during hospitalization, and responses to these treatments; condition on discharge from inpatient treatment; involvement with other agencies/treaters.

Previous diagnoses: Indicate whether child was ever previously diagnosed with a psychiatric disorder:

Child was diagnosed with _____ (*name of disorder*) in _____ (*date*) by Dr. _____ (*name*).

Past psychiatric medications: Report all medications previously prescribed, as well as their effects, the child's response, and the side effects.

Previous outpatient therapies: State the history of previous interventions; for each intervention, note the type of therapy, reason for therapy, dates of therapy, name of therapist, and outcome. Types of outpatient therapy may include the following:

Psychiatry, psychotherapy, occupational therapy, physical therapy, speech/language therapy, special education services.

Previous testing: Report any previous evaluations by type:

Neuropsychological, psychological, intellectual, emotional, projective, speech/language, occupational, physical, neurological, vocational.

Postdischarge history: Report any follow-up treatments or referrals and compliance with these, or report as lost to follow-up.

Summary Statements

The child has never been treated for any psychiatric disorder.

The child previously received _____ (*indicate type of therapy*) to treat _____ (*name of disorder/symptoms*) from _____ to _____ (*dates*).

No significant mental health problems were reported, except for _____ at age ____.

Separation	No problems with separation. At age ____, child exhibited difficulty tolerating separations from parents.
Sleep	Took time to settle into a sleep routine. Began sleeping more at age ____. History of increased sleeping/delayed sleep onset since age ____.
Toilet training	Was toilet-trained at age ____. Was bladder-trained at age ____ and bowel-trained at age ____.

Adaptive Skills Milestones

Average ages at which important adaptive skills milestones appear are as follows (Santrock, 2019; Snow, 1998):

30–36 months	Dresses self with supervision.
48 months	Uses toilet alone.
5 years	Ties shoes.
7 years	Can brush and comb hair in an acceptable manner. Can use a knife for cutting meat.
8 years	Can help with routine household tasks, such as dusting and sweeping.
10 years	Can wash and dry own hair without difficulty.

11.3. Language Development

General Statements

Articulation difficulties (mild/severe, specific/multiple) noted at age ____.
 Began speaking at age ____, began using single words at age ____, began combining words at age ____.
 Experienced difficulties with speech.
 Expressive language was delayed/average/above average.
 Did not use words until age of ____.
 Has history of expressive/receptive language difficulties.
 Idiosyncratic speech patterns developed at age ____.
 Receptive language was delayed/average/above average.
 Slow to speak/talk.
 Speech therapy was prescribed/used to treat problems with _____ at age(s) ____.
 Spoke in sentences at ____ months.
 Stuttering began at age ____ /was noted briefly at the age of ____.

Language Milestones

Average ages at which important language milestones appear are as follows (Bee & Boyd, 2010; Sattler, 2002):

1 month	Responds to voice.
2 months	Coos.
4 months	Turns head to sound.

5–6 months	Babbles.
8 months	Vocalizes three different vowel sounds.
12 months	Jabbers expressively.
13 months	First words.
18 months	First two-word combinations.
22 months	Combines words and gestures.
2 years	Mean sentence length of two words.
34 months	Poses questions.
3 years	Mean sentence length of three words.
42 months	Understands two prepositions.
4 years	Mean sentence length of four words. Follows three commands.

11.4. Motor Development

General Statements

Gross/fine motor skills are described as being within the normal range.
Mild/moderate/severe difficulties with fine/gross motor skills.
Motor skills were age-appropriate/well developed/good/fair/delayed.

Statements about Fine Motor Skills

Avoided fine motor tasks.

Child had difficulty in/was adept in buttoning pants/coat, tying shoes, drawing/coloring/writing/copying/staying on line when writing, cutting with scissors, fastening clothes, putting puzzles together, snapping/zippering garments (pants, jacket, etc.).

Statements about Gross Motor Skills

Activity level	Preferred being active/inactive. Did not like sitting in a stroller.
Balance	Shows good/normal/poor balance. Described by parents as "clumsy"/"accident-prone."
Bike riding	Rode a bike at age ____. Had difficulty/became easily frustrated learning to ride a bike.
Catching/throwing	Catching/throwing a ball was difficult.
Climbing	Was a fearless/fearful climber.
Crawling	Crawled at age ____. Never crawled.
Running	Ran at age ____. Has an awkward run. Was a "floppy" runner.

Stair use	Walked up/down stairs at age ____. Had difficulty learning to walk up/down stairs.
Walking	Walked at ____ months. Took first steps at ____ months and began to walk shortly thereafter. Walked within normal limits.

Motor Milestones

Average ages at which important motor milestones appear are as follows (Bayley, 2005; Bee & Boyd, 2010; Santrock, 2019):

1 month	Thrusts arms or legs in play. Makes fists.
2 months	Holds rattle briefly. Rolls from side to back.
3 months	Attempts to bring hand to mouth.
4½ months	Rolls from back to side.
5 months	Uses eye-hand coordination in reaching. Picks up cube.
7 months	Sits alone. Transfers objects from hand to hand. Makes early stepping movements when standing.
7-10 months	Crawls. Pulls self to standing position.
11 months	Stands alone. Pincer grasp. Walks sideways while holding onto furniture. Sits from standing position.
12 months	Walks alone.
12-18 months	Scribbles with crayon on paper. Builds four-block tower with 2-inch cubes. Throws ball while standing.
18-24 months	Unscrews a lid put loosely on a jar. Zips and unzips large-sized zipper.
23 months	Jumps in place.
25 months	Runs with coordination.
31 months	Builds tower of eight cubes. Swings leg to kick ball.
37-48 months	Catches large ball. Cuts paper with scissors. Draws circle and plus sign. Hops three hops with both feet. Walks up stairs, alternating feet. Throws ball overhand.

49–60 months	Bounces and catches ball. Copies figure X. Cuts following line. Kicks 10-inch ball toward target. Hops on one foot. Prints first name. Skips.
61–72 months	Draws rectangle, circle, square, and triangle. Skips. Reproduces letters. Rides bicycle with training wheels. Jumps rope.
7 years	Can balance on one foot without looking.
7–8 years	Rides bicycle without training wheels.

11.5. Social Development

General Statements

Extremely social baby/toddler/child.
 Social skills were age-appropriate at all stages of development.
 Social skills were reportedly delayed.
 History of difficulty in social situations with peers.
 Difficulties in social interactions beginning at age ____.
 Social situations more/less difficult than academic pursuits.

Statements about Specific Skills/Problems

Affection	Always/never showed affection to others. Constantly pulled away from others. Affectionate at an early age.
Being bullied	Was bullied at age ____ by _____.
Eye contact	Avoided eye contact as an infant. Did not engage in eye contact until age ____.
Fears	Became fearful of _____ at age ____.
Friends	Had few friends in preschool/elementary/middle/high school. Isolated him-/herself in preschool/kindergarten/etc.
Play	Play skills were excellent/awkward. Engaged in imaginary play until age ____. Had trouble playing with other children from an early age because she/he was bossy/withdrawn/rigid/insensitive/argumentative/etc. Preferred individual activities to playing with other children in the neighborhood/at school. Preferred playing with younger children at an early age. Preferred playing with boys/girls.
Shyness	Was shy/uncomfortable meeting new people at age ____. Was very quiet in ____ grade/at ____ age. Socially introverted when younger.

Social Milestones

Average ages at which important social milestones appear are as follows (Berk, 1994; Santrock, 2019; Snow, 1998):

1–2 months	Social smile emerges. Adjusts in anticipation of being held.
3–4 months	Laughter appears.
5–8 months	Plays peek-a-boo.
6 months	Smiles at mirror image.
7–12 months	Attachment to caregiver as a secure base emerges.
10 months	Cooperates in game.
2–3 years	Parallel play appears.
3–5 years	Friendships are concretely viewed in terms of play and exchange of material goods. Limited ability to take perspective of others.
6–10 years	Friendship emphasizes mutual trust and assistance.

11.6. Living Arrangements/Home Environment

Report the child and family's cultural/ethnic background as appropriate, country of birth, and language(s) spoken in the home. If doing so is pertinent to the history and referral reason, chronicle the child's home locations and relocations, and note with whom the child was living at each location (parents, foster homes, grandparents, extended family, etc.). For foster home/group home placements, report age of child at time of each placement, circumstances regarding the placement, and length of time in the placement. Be aware of issues in same-sex parenting. Lesbian, gay, bisexual, and transgender (LGBT) adults can become parents through various means, including adoption, donor insemination, previous relationships, foster care, and surrogacy, and some of this information may not be appropriate or necessary to share in a report. It is important to identify each parent in the way that she/he is typically identified by the child.

General Statements about Living Arrangements

The child lives with his/her parent(s)/mother/father/mother's boyfriend/father's girlfriend and with ____ older/younger sister(s)/brother(s).

The child lives with his/her legal guardian, _____ (name). (Indicate when guardianship was awarded, to whom it was awarded, relationship of guardian to child, and reasons for transfer of guardianship.)

The child lives with his/her grandmother/grandfather/aunt/uncle/etc., who is her/his legal guardian.

The family resides in _____, _____ (city, state), a metropolitan/urban/suburban/rural/military location.

The child lives at home with her/his mother, father, and ____ siblings ages _____, _____, and _____.

The child is one of ____ (number) children born to _____ (names of parents). The family is intact and lives in _____.

Family is originally from _____ and has been residing in _____ for the past ____ years/months.

For a Young Adult/Adolescent Living Independently

If a young adult/adolescent client is living independently of the family of origin, report the following:

Living circumstances:

Client is living alone/with relatives/friends/boyfriend/girlfriend.

Reasons for move from family of origin.

If client is married: Age at marriage, date of marriage.

If client has child(ren): Age at birth(s) of child(ren), circumstances surrounding birth(s), effects of birth(s) on client, client's relationship with child(ren)'s other parent.

Aspects of the Home Environment

Type of home:

Apartment/flat, house/single-family home, public housing, motel/shelter, homeless.

Language(s) spoken:

Language(s) spoken in home is/are _____ (*English, Spanish, etc.*).

(For a bilingual home:) Child's primary language is _____, while parent's primary language is _____.

Socioeconomic status:

Lower/middle/upper income level, impoverished/destitute, "working poor," modest means, prosperous/well-to-do.

Quality of home environment:

Enriched environment/environment was lacking in enrichment/unstimulating.

Home is overly structured/rigid/unstructured, stable/unstable.

Parents describe immediate family members as very close to/distant from one another.

Family atmosphere was described as positive/close/distant/isolated/volatile/violent.

✓ If violence in the home is reported, note type of violence (physical, emotional); target of violence (e.g., mother, child); and whether and how frequently the child has witnessed violence.

Extended family relationships:

Grandparents live with/near parents.

Child has positive/negative relationship with grandparents/uncles/aunts/other extended family members (*specify*).

Family does not do things with extended family members or with other families.

Family is estranged/cut off from extended family.

11.7. Parents**General Information about Parents**

Age(s)/year(s) of birth; age(s) at birth of child.

If applicable, date of a parent's death; cause of death; child's age and reaction to death and its consequences.

General physical and mental health; present health; chronic or severe illnesses, disabilities.

Years of education/degrees.

Ethnicity/nationality.

Discipline style:

Authoritarian/authoritative/controlling, lenient/laissez-faire/hands-off/permissive, strict/firm/harsh/stern.

Parents' Work History

Report the parents' occupations; indicate whether neither parent, one parent, or both parents work; and indicate place(s) of employment (outside or inside home, and location[s] if outside home).

Mother/father/both parents worked outside of home when child was age ____/until child was age ____.

Parent's job hours are flexible/inflexible.

Parent's job requires much travel.

Parent's job requires him/her to work away from home indefinitely/for extended periods of time.

Parents' Legal History

Report the parents' legal history *only* if it is relevant to the child's diagnosis or treatment.

Arrests: Number, reason(s), whether child was a witness to arrest(s).

Incarcerations: Number, reason(s), age of child at incarceration(s), effect on child.

Other legal history: Indictments, prosecutions, convictions, probations, parole, bankruptcy.

Parents' Medical and Psychiatric History

Family medical/psychiatric history is significant for _____. *(Try to avoid identifying the particular family member by name in the report, unless absolutely necessary. This is particularly true for psychiatric disorders.)*

Alcohol and drug use histories: Note any history of alcohol/drug use/abuse/addiction, as well as any treatment history for alcohol or drug use.

Learning disabilities: Note name of disability/disabilities; if not formally diagnosed but suspected, list symptoms reported by parent.

Medical history: Note good health; for any health problems, record name(s) of disorder(s), age(s) at which disorder(s) was/were diagnosed, and impact of medical problems on child's development.

Psychiatric history: Note whether any psychiatric disorders were reported; for any psychiatric problems, record name(s) of disorder(s), age at which disorder(s) was/were diagnosed, hospitalization of parent during child's lifetime, and impact of disorder(s) on child.

Absence/Death of a Parent

Absence:

Child's father/mother is not involved in her/his care.

Child sees his/her father/mother very infrequently; his/her last contact was ____ months/years ago.

Death: Indicate ages of parent and child at time of parent's death and circumstances surrounding death.

Child's father/mother died of _____ when child was ____ years old.

Parent died unexpectedly/after a long illness/violently.

Child witnessed death/found parent.

Parents' Marital/Couple Relationship

If married: Note year of marriage.

If separated: Note status of separation (legal vs. informal), time of separation, age of child at separation, and effect of separation on child's behavior.

If divorced: Note year of divorce, age of child at divorce, and effect of divorce on child's behavior.

Quality of parental relationship (\leftrightarrow by degree):

Close/secure/warm/cordial, functional, unsettled/"up and down," distant, dysfunctional, tempestuous/violent/stormy/abusive.

Summary statement:

_____ (*child's name*) is the oldest/youngest/etc. child in an intact family.

The child's parents separated/divorced when she/he was ____ years old, and the child lives with her/his mother/father.

The child's parents divorced when he/she was ____ years old, and his/her father/mother is remarried.

Parents' Relationship(s) with Other Partners

Dating:

Parent has a boyfriend/girlfriend who has a poor/good relationship with child.

Parent's boyfriend/girlfriend lives with parent and child.

Remarriage(s): Note age of child at remarriage(s) and child's relationship with stepparent(s).

Visitation and Contact with Noncustodial Parent

Visitation: Note frequency, schedule (including holidays), length of visits, and supervision status, as well as the effects of visitation on the child's functioning.

The child sees her/his father/mother weekly/monthly/etc.

Child saw his/her father/mother for 1/2/etc. days every/every other/etc. week from ages ____ to ____.

Child spends holidays with mother/father every/every other/etc. year.

Visitation takes place for ____ hours per week/____ weekends per month.

Visitation is unsupervised/supervised.

Other contact with noncustodial parent: phone calls (indicate frequency of phone contact); letters to/from parent/child (indicate frequency).

11.8. Siblings

_____ (*child's name*) is an only child.

Child reportedly gets along well/poorly with his/her brother(s)/sister(s)/sibling(s).

Child has normal relationship with siblings.

Quality of Sibling Relationships

Close/protective, good, average/fair, poor, "love-hate," volatile/explosive.

Sibling Rivalry

Sibling rivalry is nonexistent/typical/intense.

Rivalry increased with onset of birth of sibling/divorce of parents/other event (*specify*).

The child had difficulty adjusting to birth of sister/brother, but now has good relationship with her/him.

The child responded positively to birth of new brother/sister.

Information about Siblings

Age of siblings (if parents are expecting another child, note the due date). Birth order of siblings, and patient's location in birth order.

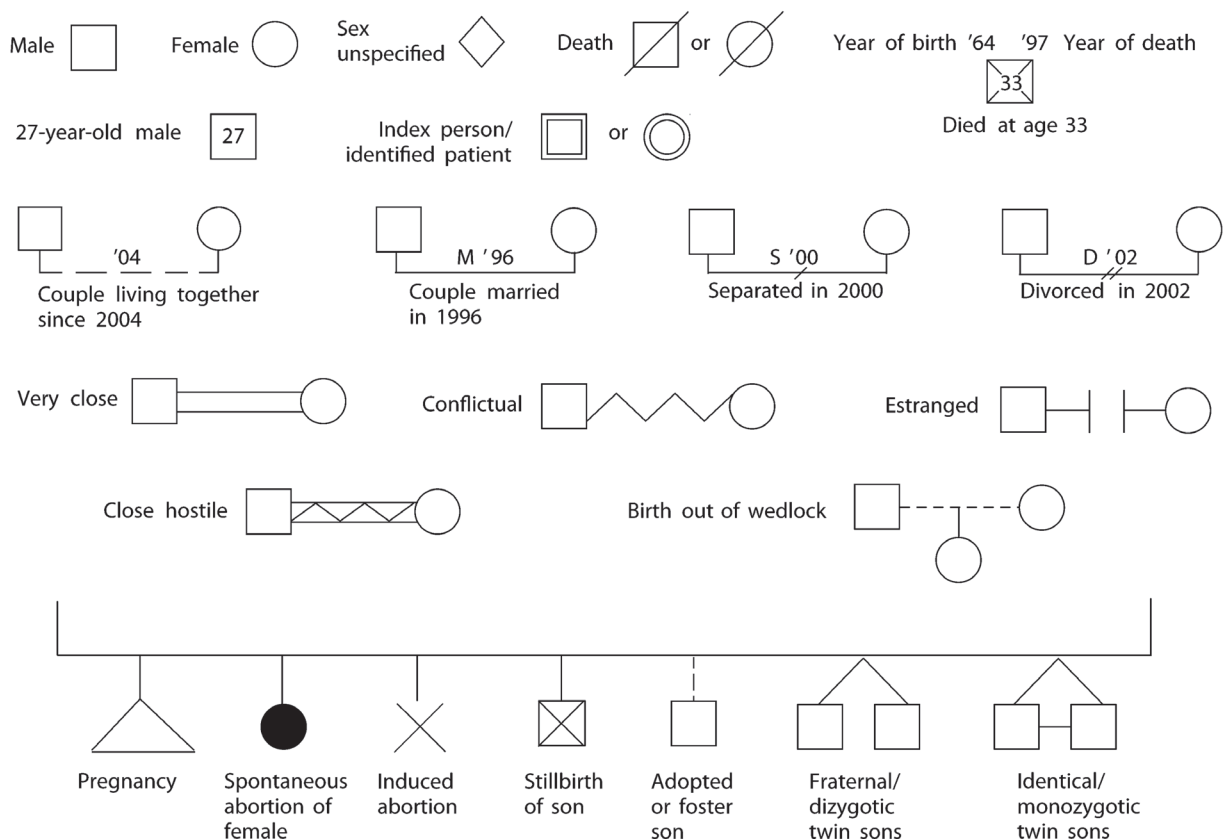
Living arrangement of siblings: Note whether living at family home or not; if not, note year sibling left home, reasons for living outside of family situation.

Medical history of siblings: Note important medical diagnoses, years of diagnoses, effect on child's development.

Psychiatric history of siblings: Note psychiatric diagnoses, psychiatric care (including hospitalizations), effect on child's development.

11.9. Family Genogram

A "genogram" is a diagram that maps family patterns and relationships across generations. It is more comprehensive than a family tree, because it provides information about the quality of the relationships, communication, and other behaviors. The figure below offers a key to the conventions of constructing genograms. It is reprinted with permission from Zuckerman (2019). For more information, consult Bowen (1980), Kramer (1985), or McGoldrick, Gerson, and Shellenberger (1999).



12

Academic and School History

This chapter describes general issues related to school and academics. For more information about intellectual functioning and academic achievement, see Chapters 21 and 22. For more information about current school functioning, see Chapter 18.

What follow are some of the more common issues that are encountered at different points in a child's school history. Although these issues are categorized, there is much overlap between categories.

- ✓ It is often helpful to construct an outline, using each academic year or time period as a guideline. For each year or time period (e.g., preschool, elementary, middle school), record significant school experiences: any change in school or grade retention; problems in specific academic areas (e.g., reading, spelling, math); grades received; special education services; evaluations; frequent absences; school behavior problems; and concerns about particular teachers.

12.1. Educational Situation

Highest grade completed:

Preschool/kindergarten/first/second/etc., elementary school, middle/junior high school, high school, technical school, college, dropped out of school in grade ____.

Nature of enrollment:

Day, full-time, part-time, boarding, summer school.

Special education: *See Section 12.16, "Special Education."*

Types of classrooms:

Traditional/regular, language-based, mixed-age/open classroom, structured/unstructured/rigid/loose, lacked a sense of control/seemed overcontrolled.

Age at school entry:

Began preschool/nursery school/kindergarten/elementary school at age ____.

Types of schools:

Preschools:

Montessori, play-based, parent cooperative, integrated/inclusion program, special-needs program, early intervention program, Head Start.

Kindergartens:

Traditional, Montessori/Waldorf, full-day/half-day, public/private/parochial, integrated/inclusion program, special-needs program.

Elementary and high schools:

Public/private/preparatory/parochial/vocational/religious/sectarian, residential boarding school, traditional/regular/special, Montessori/Waldorf, bilingual, charter school, magnet school, proprietary, International Baccalaureate, military academy, home school/cyberschool.

Location(s) of school(s):

Rural, suburban, metropolitan/urban/inner-city.

Name(s) of teacher(s), relationship(s) with teacher(s), teacher report/description of problems.

Class assignment/level (specify), age–grade discrepancy (if any).

Educational program:

Academic, technical/vocational, college preparatory, etc.

Extracurricular activities:

Athletics, social service, music, scholarly, religious, political, special interests (*specify*), other (*specify*).

Other aspects: Favorite subjects, peer and teacher relationships, position in peer group, aspirations.

12.2. General School Issues

Overall level/quality of academic achievement/performance/grades, grade point average, standing in class.

Grades:

Consistently good/poor/mediocre, should be higher.

Received mostly A's/B's/C's/etc. in grade(s) _____.

Typical grades in elementary school/middle school/high school were described as A's/B's/C's/etc.

Uneven/variable grades.

Grades got worse/better in middle school/high school.

Summer school:

Attended summer school in _____ (*indicate years*) to help with _____ (*specify difficulties*).

Child–teacher interactions:

Child enjoyed his/her _____th-grade teacher.

Child had a strong bond with teacher.

Child was not comfortable with her/his classroom teacher.

In grade _____, there was a bad match between child and teacher.

Teacher behaviors:

Warm/caring, strict/rigid, became easily angered with child.

Standardized testing:

The child earned scores on the Iowa Tests of Basic Skills/Stanford Achievement Tests/etc. of _____ in grade(s) ____.

Scores on the ACT/SAT were _____ and were felt to reflect/not to reflect student's ability.

Summary Statements

The child has always been a good/poor/average student.

The child was always a good student until grade/age ____.

12.3. Early Care/School Experiences

Day Care

Age at entry:

Began day care at age ____.

Types of day care and day care providers:

Family day care, in-home care (*includes nannies, au pairs*), center-based day care.

Time spent in day care:

____ days a week for ____ hours a day beginning at age ____, for ____ months/years.

An average of ____ hours a week in outside-the-home day care.

Day care provider behaviors:

Caring/loving, mean, unkind, aggressive/abusive.

Positive child behaviors:

No significant difficulties were noted.

Was attached to day care provider.

Child behavior difficulties (*see also Section 12.8, "Behavior Difficulties"*):

Aggression/was extremely aggressive, bit/hit/pushed other children.

Preschool/Nursery School/Kindergarten

Preschool/nursery school experience:

Attended preschool/nursery school at age ____/from ages ____ to ____ and reportedly did well/poorly.

Experienced difficulties in _____ (*specify*).

Kindergarten readiness:

No problems/difficulties were seen in kindergarten readiness screening.

Was below/at/above age level on tests of academic skills/perceptual development/social-emotional development/cognitive functioning in kindergarten screening.

Failed kindergarten screening.

Transition to kindergarten:

Uneventful/difficult/very traumatic.

Reasons for repeating kindergarten:

"Young" for age/grade, more interested in playing than working, socially immature, lacked appropriate academic skills, lacked attention skills necessary for kindergarten environment.

12.4. Academic Difficulties

Preschool/Nursery School

Had no interest in prereading activities/demonstrated difficulties with prereading skills, problems with fine motor tasks (cutting/holding crayon/etc.), problems learning letter names/colors/shapes, was reluctant to engage in language/fine motor/gross motor activities, had trouble writing, was slow to learn the alphabet.

Kindergarten

Was identified as a child at risk, had difficulty finishing work and organizing her-/himself, problems with fine motor/gross motor tasks, had difficulty acquiring prereading/premath/writing skills, did not perform at a level expected for a typical kindergarten student, had difficulty attending.

Elementary School

Trouble with task completion/difficulty completing assignments/took longer than other children to complete assignments, difficulty with handwriting/math/reading, needed help expressing ideas clearly, visual-spatial difficulties, did not meet grade expectations for reading/math/etc., could not keep up with class, had difficulty acquiring core academic skills, had a dependent learning style, had poor penmanship, had difficulty putting ideas in writing.

Middle School

Problems changing classes/dealing with more than one teacher, long-standing difficulties with reading/math/written expression/etc. continued in middle school, problems completing homework, problems organizing written work, could not complete grade-level work without considerable tutorial support.

High School

Often got lost getting from one class to another, had difficulty with increased course load and amount of homework, failed to do homework conscientiously, did not know how to study.

Summary Statement

The child had difficulty in the acquisition of age-appropriate academic skills.

Academics have always come easily for the child.

No problems with academic skills have been noted in this child's history.

12.5. Academic Progress

Elementary School

Good/much progress, performed well academically with exception of math/reading/spelling/writing, good progress in _____ (*specify*), satisfactory marks were noted in all/some

subjects, was above grade level in all/some subjects, was noted by teachers to be working hard to develop math/reading/etc. skills, made good progress in all academic areas, was an early reader, had a knack for numbers.

Middle School/High School

Has made much/little academic progress during middle and high school years, was able to keep up with classmates in all academic areas except for _____ (*specify*).

12.6. Anxiety and Separation Difficulties

Separation anxiety/difficulties, had initial separation difficulties that resolved quickly, had difficulty tolerating separations from parents, was shy.

12.7. Attention Difficulties

Had attention problems/was inattentive, was easily distracted, problems following directions/processing information, had a short attention span, was frequently unresponsive when teachers called his/her name; seemed to "fade out," often "spaced out."

Had great difficulty attending/paying attention/focusing, appeared not focused enough to complete all tasks in class, difficulty with listening tasks/listening comprehension, problems staying on task, had difficulty retaining information.

12.8. Behavior Difficulties

Preschool/Nursery School

Aggression/aggressive behavior, bit other children, expelled from preschool due to biting/hitting/lack of toilet training, impulsivity, refused to participate in structured activities, was always "on the go," had a difficult time sitting still, was easily overstimulated, had severe temper tantrums, bossy/uncooperative.

Kindergarten

Engaged in significant acting-out behavior that interfered with classroom functioning, was defiant/oppositional, demonstrated lack of response to reward systems, problems with mood regulation, violent outbursts, was disruptive, walked out of class on ____ occasions, had a propensity to fidget and move about, had difficulty remaining in his/her seat, was very impulsive.

Elementary School

Got into fights with other students, had trouble delaying gratification, demonstrated increased behavior problems in grade(s) _____, stole from classmates, was argumentative, did not complete work on time/did not use time wisely, could not work without disturbing others, poor self-control, difficulty with classroom compliance/problems following directions, fighting in the schoolyard, demonstrated disobedience toward teacher(s)/substitute teacher(s), hyperactive, unable to stay in seat.

Middle School/High School

Truant from school on a number of occasions, disruptive, unmotivated, brought gun/knife/drugs to school.

Was defiant, showed problems with mood regulation, fought with teachers/other students, stole items from other students/teachers/school property.

12.9. Language Difficulties

Preschool/Nursery School/Kindergarten

Problems with expressive/receptive language observed by teacher, had difficulties engaging appropriately in conversation, problems with auditory comprehension/processing, poor articulation, problems with self-expression.

Elementary School

Had difficulty with pronunciation of vowels/consonants/etc. in first/second/third/etc. grades, problems with verbal comprehension/articulation/word retrieval/written language/spoken language.

Middle School/High School

Had difficulty with pragmatics/discourse/megalinguistic awareness.

12.10. Math Difficulties

Difficulty learning basic math facts, had trouble learning multiplication tables, difficulty comprehending high-level problem solving.

12.11. Medication

The following statements relate specifically to the impact of medication on a child's educational progress and history. Medication history is covered in detail in Chapter 10.

Medication has helped with _____'s behavior and her/his academic performance in school.

He/she has been medicated with _____ since _____, and his/her teachers have indicated that this is very helpful.

Although medication was effective in school, in the evenings the medication wore off, and _____ the child had a great deal of difficulty focusing on homework and coping.

Medication had significant/little/no impact on school performance.

Parents tried medication for ____ weeks/months, but school personnel did not see a difference.

12.12. Positive Behaviors

Preschool/Nursery School

Did well, no academic difficulties, parents described preschool as a positive experience, _____ was a great student, was actively interested in classroom materials.

Kindergarten

Solid academic skill development, maturity, contributed a great deal to class discussions, kindergarten year was successful, _____ was an early reader.

Elementary School

Was able to follow directions/listened well, cooperated with others, accepted responsibility, was courteous and well mannered, displayed self-control, had a positive attitude, demonstrated strong effort, demonstrated good behavior and academic performance at school.

Middle School/High School

Did not have to study to get good grades, was a quick student who rarely needed to study, enjoyed sports/other extracurricular activities, demonstrated positive behavior/leadership.

12.13. Reading Difficulties

Kindergarten

Was not interested in reading activities, had trouble blending sounds, difficulties learning to read, problems learning letter names, difficulty rhyming words, problems learning sound-symbol associations, trouble learning the alphabet.

Elementary School

Difficulty learning to read, problems learning letter names/sounds, difficulty comprehending what she/he read.

Middle School/High School

Did not read for pleasure, problems with reading comprehension, difficulty reading textbooks in particular subject(s) (*specify*), continued to struggle with reading difficulties in middle school/high school.

12.14. Social Difficulties

Preschool/Nursery School/Kindergarten

Poor peer interactions, often isolated him-/herself, had difficulty connecting with others/did not connect with children in her/his class, did not engage in cooperative play, didn't participate in circle time, was socially immature, did not initiate peer interactions, had high levels of solitary or parallel play, appeared emotionally vulnerable.

Elementary School

Problems with peers/peer relationships, often teased by others, was a "loner"/avoidant/withdrawn, would react to teasing with verbal or physical aggression, often dominated classroom discussions, had difficulty picking up on verbal cues, had difficulty keeping friends, often angry at peers, had difficulty letting an argument go.

12.15. Social Skills

Elementary School

Was able to make friends at school, demonstrated extremely good social skills, made friends easily, was good-humoredly teased by peers, had many friends, child's sense of humor and likeability kept him/her out of trouble.

Middle School

Began to make friends, in contrast to elementary school history.

High School

Had many friends/several close friends, was very involved in extracurricular activities, played sports such as _____, was involved in drama/band/chorus/music/etc.

12.16. Special Education

Special education services are services designed to meet the needs of a child whose needs cannot be met within the general educational program (i.e., the regular classroom). Special education services can include special materials, teaching techniques, or equipment; special transportation; physical, occupational, or speech/language therapy; consultation services; and counseling. The brief listings below of possible services are by no means exhaustive.

- ✓ It is important to document a child's history of special education services at each grade level. For each type of service provided, note the frequency and duration of delivery.

Math Services

Had remedial math help, received specialized math tutoring focusing on _____ (*specify*).

Peer Relationships and Special Education

Was teased by peers about going to the learning center, is frequently ridiculed by classmates for being "dumb."

Reading Services

Participated in small-group reading instruction, received Chapter 1 reading resource assistance, took part in Reading Recovery/Project Read/Orton–Gillingham program/Wilson program/Lindamood–Bell program/other (*specify*).

Writing Services

Writing workshop, help with organizing written work, occupational therapy.

Specialized Services

Occupational therapy, physical therapy, speech/language therapy, sensory integration therapy, music therapy, counseling, other (*specify*).

Other Special Education or Support Services

Mild/moderate/significant support from learning disability specialists, special help from teacher out of class, private tutoring, Lunch Bunch/other lunchtime activities, other (*specify*).

Types of Classroom Settings

Regular classroom setting with support, classroom for emotional and learning difficulties, inclusion language arts classroom, integrated classroom with remedial services, mainstreamed classroom, resource room/learning center.

Individualized Education Programs (IEPs) *See Section 35.9 for a sample IEP.*

It is useful to review the child's history of services as outlined in current and past IEPs. An IEP, by law, must include the following information: statement of present educational performance; instructional goals; educational services to be provided; and criteria and procedures for determining that the instructional objectives are being met.

Summary Statements about Special Education Services

The child has not received special education services and has done well academically.

The child never received special services during elementary or middle school.

The child has never needed special services or accommodations.

The child has received special education services throughout his/her school history.

The child receives resource room support/speech and language therapy/occupational therapy/counseling/etc. for ____ minutes/hours a day/week.

C. The Child or Adolescent in the Evaluation

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13

Behavioral Observations

This chapter covers the following areas: physical appearance, clothing, activity level, speech and language skills, and motor skills. How the child responded to the evaluation and presented him-/herself in the evaluation is covered in Chapter 14.

13.1. Physical Appearance

- ✓ Use behavioral observations of the child's appearance to consider or rule out certain syndromes. For example, head shape and facial appearance are important in diagnosing disorders such as fetal alcohol syndrome (FAS), Sotos syndrome, and fragile X syndrome, while eye and hair colors are important in diagnosing Waardenburg syndrome.

Overall Physical Appearance

Child/adolescent presented as an attractive/handsome/pretty, well-groomed girl/boy/young woman/young man who appeared her/his stated age.

Child appeared to be well cared for/neglected.

The child seems to be well kept, well nourished, and in no apparent distress.

Hygiene is managed independently, effectively, and appropriately.

Clean, well groomed, and well dressed.

The child and/or his/her parents took good care of his/her appearance in regard to dress, hygiene, and grooming.

Child's appearance was appropriate for age.

At the time of this assessment, hygiene, grooming, and attire were appropriate for sex, age, and social norms.

_____ 's appearance is not unusual.

No unusual visible features/deformities/dysmorphic features.

Nothing unusual/remarkable/noticeable about her/his posture, bearing, manner, or hygiene.

Child arrived for appointment poorly groomed.

This child showed some signs of neglect, specifically _____ (*indicate*).

Haggard, weak, pale and wan, frail, sickly, sleepy/tired. (*Note time of day; ask about sleep.*)

Height and Weight

It is best to describe height and weight by using the actual numbers. It is also helpful to note at which percentiles height and weight fall for the child's age. Current stature-for-age and weight-for-age percentiles can be found at a U.S. government website (www.cdc.gov/growthcharts).

Build

As explained in the Introduction to this book, the following table and similar tables in this and later chapters are \leftrightarrow by degree across columns only (i.e., individual entries that happen to fall within the same row in a table do not necessarily represent points on a mini-continuum).

Gaunt	Small for age	Average for age	Large for age
Emaciated	Thin	Well-nourished	Obese
Frail	Petite	Healthy	Tall
Malnourished	Underweight	Trim	Large frame
Skinny	Slender	Robust	Plump
Lean	Little	Well-developed/ well-built	Fat
Bony	Short	Weight proportionate	Lanky
Scrawny	Diminutive	to height	Long-limbed
Too thin	Slim	Within usual range	Leggy
Underfed	Willowy		Tall and thin
"Skin and bones"	Tiny		Rotund
Undernourished	Undersized		Stout
Skeletal	Short-statured		Overweight
Gaunt	Bony		Heavy
Cachectic	Wiry		Corpulent
	Lanky		Chubby
	Skinny		Big for age
	Small-boned		Heavy-set
			Stocky
			Pudgy

Summary Statements for Build

Appeared smaller/larger than her/his stated age.

Appeared his/her given/stated age of ____ years.

Stature in relation to age is short/normal/tall.

Child is quite tall/large/small for her/his age and looks older/younger than her/his ____ years would indicate.

Child is at the ____, ____, and ____ percentiles (respectively) of the standard tables for height, weight, and head circumference for children.

Height and weight are average/below average/above average for age, at the ____ and ____ percentiles for height/weight.

Child is not obese, but appears to be tall and heavy-set.

Child is at ____ Tanner stage of sexual development (*Tanner, 1978*).

Eyes

Appearance/size/shape:

Large, small, squinty, sunken, hollow, deep-set, bulging, close-set, wide-set, cross-eyed, bloodshot, wide-eyed, hooded, almond-shaped, reddened, bleary-eyed.

Brows:

Light/heavy, raised, pulled together, pulled down, shaven, plucked.

Color:

Blue, gray, green, brown, hazel.

Eye contact:

(↔ *by degree*) No/avoided eye contact, stared into space, kept eyes downcast, poor, broken off as soon as made/passing/intermittent, wary, looked only to one side, brief, flashes/fleeting, furtive/evasive, variable, appropriate, normal, expected, good, had a frank gaze, lingering, staring, steady, glared, penetrating, piercing, confrontative, challenging, stared without bodily movements or other expressions.

Expression:

Sleepy, tired, heavy-lidded, had dark circles under his/her eyes, eyes looked red/pink, often rubbed her/his eyes, staring, unblinking, penetrating, squinting, nervous/frequent eye blinking/fluttering, vacant, glassy-eyed.

Glasses:

Wears/does not wear glasses for distance/reading, wears contact lenses, wears regular corrective lenses, wears sunglasses, glasses needed but not worn, glasses broken/poorly repaired.

Facial Complexion

Rosy, flushed, ruddy, tanned, glowing, healthy-looking, sallow, sickly, pale, jaundiced, wan, washed-out, ashen, pallid, pallorous, pasty, scarred, blemished, pocked, pimply, warty, mottled, shows negligence, birthmarks/port-wine stains, scars.

Facial Expressions

See also Chapter 15, "Affective Symptoms and Mood/Anxiety Disorders."

Smiling, happy, cheery/cheerful, positive, joyful, silly, delighted, elated.

Attentive, alert, vigilant, observant, interested, focused.

Calm, tranquil, peaceful, composed, serene, relaxed, dreamy, head bobbed as if nodding off.

Grimace, frown, scowl, sad, unhappy, glare, puckered brow, tense.

Crying, weeping/weepy, sobbing, sniffing, tearful/in tears, eyes watered/teared up.

Frightened, scared, terrified, startled, anxious, upset, worried, panicky, withdrawn, agitated, alarmed.

Annoyed, angry, irritated, cross, enraged, defiant, sneering, tight-lipped, disgusted.

Indifferent, uninterested, listless, droopy, lethargic, apathetic, meek, withdrawn, reserved, vacuous, blank, mask-like, flat, lifeless, unresponsive, tended to stare with little affective/emotional variability, lifeless, rigid.

Teeth

Unremarkable, crooked, wore braces, had many missing teeth (*indicate if inappropriate for age*), poor dental hygiene was apparent, bad breath/breath odor/halitosis.

Hair

Color:

Dark/light, brown, brunette, chestnut, black, red/red-haired/coppery/auburn, golden-brown, platinum, blond, strawberry-blond, fair-haired, streaked, albino, bleached, colored/dyed, frosted, streaks of color, different-colored roots.

Neatness:

Clean, dirty, unkempt, messy, tousled, greasy, oily, matted, tangled, knotted, disheveled, uncombed.

Hairstyle:

Fashionable length and style, long, short, "edgy," braided, cornrows, "relaxed," crew/brush cut, tousled, uncombed, frizzy, curly, wavy, straight, dreadlocks, natural/Afro, ponytail, "pigtails," finger curls, "Goth/Gothic," "Mohawk," shaved head, stylish, currently popular haircut, unusual cut/style/treatment, moussed, permed, unremarkable.

Facial hair:

Clean-shaven, beginning to get "peach fuzz," full beard, goatee, moustache, light facial hair.

13.2. Clothing

What is most relevant about a child's clothing is what it says about the parents' ability to care for the child and the parents' judgment of appropriateness. Fashion, cost, or newness of a child's clothing is usually not important in itself. For an adolescent, dress is evaluated as to how appropriate it is when compared to that of the typical adolescent, as well as whether the clothing is being used to make a statement (as in the case of extreme hairstyles, dress, piercings, etc.).

Appropriateness

Dressed suitably/presentably, dressed appropriately for weather/climate, dressed in a style popular in his/her age group, school uniform.

Casually dressed, care of clothing was only fair, dressed carelessly.

Not suitably dressed for age/clothing suitable for a much younger/older child.

Inadequately dressed for the weather, lacked shoes/coat/boots.

Clothing was out of date/old-fashioned/unfashionable, unconventional, eccentric/odd/peculiar.

Garish/bizarre clothing, dressed to offend, attention-seeking/drawing, outlandish.

Qualities of Clothing (\leftrightarrow by degree across columns only)

Dirty	Disheveled	Neat	Stylish
Unclean	Messy	Well-groomed	Smartly dressed
Filthy	Unkempt	Neatly dressed	Chic
Grimy	Tousled	Clean	Elegant
Soiled	Ill-fitting	Trim	Fashionable
Grubby	Too tight	Well-dressed	Trendy
Muddy	Sloppy	Spotless	Classy
Encrusted with food/ etc.	Tattered	Dirt-free	Current
Caked with mud/etc.	Shabby	Unsoiled	The latest thing
Smelly	Frayed	Tasteful	Cool
Dusty	Threadbare	Well put together	Meticulous
Musty	Worn	Clothes-conscious	Immaculate
	Unzippered	Careful dresser	Overdressed
	Unbuttoned	In good taste	Seductive
	Rumpled		Revealing
	Disheveled		Flashy
	Clean but worn		
	Torn		
	Baggy		

13.3. Demeanor/Presence/Style (\leftrightarrow by degree across columns only)

Withdrawn	Anxious	Shy	Friendly/ confident	Immature or eccentric
Reserved	Threatened	Guarded	Outgoing	Silly
Neutral	Tense	Quiet	Energetic	Atypical
Unreadable	Overwhelmed	Inhibited	Polite	Bizarre
Expressionless	Apprehensive	Introverted	Engaging	Dramatic
Distant	Distrustful	Timid	Likeable	Infantile
Asocial	Nervous	Retiring	Warm	Odd
Detached	Worried	Bashful	Delightful	Peculiar
Isolated	Concerned	Reticent	Personable	Strange
Uninvolved	Uneasy	Apprehensive	Appealing	Unconventional
Uninterested	Apprehensive	Tentative	Sociable	Unusual
Impassive	Fearful	Demure	Playful	Out of the ordinary
Estranged	Frightened	Passive	Gracious	Affected
Solitary	Hesitant	Reserved	Calm	Histrionic
Aloof	Suspicious	Humble	Relaxed	Abnormal
Dejected	Wary	Subdued	Open	Idiosyncratic
	Edgy	Restrained	Pleasant	
	Jumpy	Composed	Affable	
	Panicky	Placid	Civil	
	Distraught	Mild-mannered	Well-mannered	
	Weak	Unassuming	Courteous	
	Vulnerable	Plaintive	Respectful	
	Fragile		Attractive	
	Low-resilience		Charming	
	Threat-sensitive		Agreeable	
			Amiable	
			Jolly	
			Warm	
			Extroverted	
			Chipper	

13.4. Movement/Activity Level

High Activity Level

See also Section 16.1, "Attention-Deficit/Hyperactivity Disorder (ADHD)."

Child had difficulty staying in seat/chair, difficult for child to sit for short periods of time, was nearly impossible for child to sit in a chair, high activity level, motorically active.

Child was very active and in constant motion, many out-of-seats, restlessness and distractible, difficult to redirect.

Child exhibited continual body movements while completing tasks.

Child often asked to get a drink/take a break/go to the bathroom/check to see whether parents were in waiting room.

Exhibited increasing motor restlessness as the day went on.

Was excited and tried to go too fast for accuracy.

Investigated all the contents of the room/desk/testing materials, intrusive, a "darter."

Child was fidgety/exhibited moderate to pronounced fidgeting, level of fidgeting increased as tasks increased in difficulty/became less challenging, child was "antsy"/wiggly.
Mild/moderate/severe impulsivity was noted in response style, child did not wait for feedback or directions and would impulsively respond, child began responding before the examiner finished explaining the task at hand.

Variable Activity Level

Movement was transient, activity level was changeable, still and pensive moments were followed by abrupt change to hyperactivity.
Although child was quite hyperactive, she/he was also easily fatigued and wanted to give up easily. Child's level of arousal fluctuated during testing, child was sometimes highly distractible and at other times demonstrated good attention to the tasks.

Low Activity Level

Appeared tired, frequently stated that he/she was tired or did not get enough sleep, was initially tired but brightened considerably as evaluation/interview progressed.
Child frequently put her/his head on the table and complained that she/he was often tired.
Behavior was significant for slow performance speed.
Signs of fatigue were noted after a ____-minute work period.

Mannerisms/Odd Physical Behaviors

Twirling, rocking, self-stimulating, hand flapping, aimless/repetitious/unproductive/counter-productive movements, head bobbing, wriggling, hand or finger movements, bounced leg, posturing.
Played with lips, clicked tongue, stuck out tongue, bit lips, tongue chewing, lip smacking, whistling, made odd/animal/grunting sounds, belching, pulled lips into mouth.
Played with hair, picked at eyelashes/eyebrows.
Sniffled repeatedly/loudly, used/needed but did not use tissues/handkerchief, freely and frequently picked nose, repetitively "cleaned" ears with fingers.
Tapped fingers on table, tapped teeth with fingers.
Yawned frequently/excessively/regularly/elaborately, rubbed eyes.
Was often red in the face, as if straining his/her bowels.
Made audible breath sounds.
Chewed fingernails, nails were chewed down to a marked extent, bit nails down past the quick of all/some fingers.
Deliberately dropped items so she/he could retrieve them.
Sat on feet or knees, laid body on table, made faces, shook head back and forth, tried to look at examiner's test book, crawled under the table, did headstand on the chair, preferred to stand for most of the evaluation, tipped chair back and forth, twirled hair, moved arms in and out of shirt.
Kept thumb in mouth for ____ minutes of the ____-hour session, sucked fingers.
Covered face with hands and peeked out.
Walked on toes/heels/ankles.

13.5. Motor Skills

Fine Motor Skills

General Statements

Basic hand development was good.
No difficulties were noted in his/her fine motor abilities.

Fine motor skills were appropriate/delayed for age.
Difficulties with dexterity and fine motor control were evident in her/his manipulation of test materials.

Handedness

Right-handed/left-handed, demonstrated clear right-/left-hand preference, has a well-established dominance of right/left hand, ambidextrous, no hand preference observed, appears undecided about hand preference.

Pencil Grip

Demonstrated appropriate/poor pencil grip, grasped crayon/pencil with pronated grip, whole-hand pencil grasp with no evident web space between thumb and index finger, awkward grasp, palmar grasp, tense grip, mature pencil grip.

Scissors Use

Unable to grasp scissors appropriately or snip without maximum assistance, snipped paper with scissors when maximal assistance was given for hand placement and holding the paper, able to cut a 2-inch line, demonstrates no difficulty with cutting skills.

Writing

Writing was graceful/neat/precise/poor/sloppy/small/large/difficult to read/illegible, child was able to scribble spontaneously, able to imitate crayon strokes, able to copy circle/square/triangle, able to write name, demonstrated poor letter formation, handwriting was labored and obviously difficult for him/her, could not cross midline in writing, wrote with good/poor speed for each task, stabilized paper with her/his right/left hand, placed excessive pressure on pencil.

Other Observed Skills

Child was able to build block designs for ____-cube tower, build bridge of cubes, fold paper with crease, unscrew cap from a bottle, complete puzzles, string small/large beads, button/zip/snap, draw a person.

Tests of Fine Motor and Visual–Motor Skills

See Chapter 25 for citations and more information on some of these tests.

Beery–Buktenica Developmental Test of Visual–Motor Integration, Sixth Edition (Beery VMI)
Bender Visual–Motor Gestalt Test, Second Edition (Bender–Gestalt II)
Bruininks–Oseretsky Test of Motor Proficiency, Second Edition (BOT-2)
Developmental Test of Visual Perception–Third Edition (DTVP-3)
Developmental Test of Visual Perception–Adolescent and Adult (DTVP-A)
Finger Tapping or Finger Oscillation Test
Grooved Pegboard
Rey–Osterrieth Complex Figure Test (ROCF)
Wide Range Assessment of Visual Motor Abilities (WRAVMA)

Gross Motor Skills

General Statements

Child has excellent/good/poor gross motor skills.
Gross motor planning is poor/good/age-appropriate/excellent.

Gross motor skills are notable for difficulties with balance/coordination/motor planning and output/neuromaturational delay.

Balance

Balance was good, excellent/good/poor balance reactions, balance is steady/normal/firm/solid, child could stand on one leg for ____ seconds, is able to maintain control on a playground swing without back support, complained of dizziness/lightheadedness, balance is wobbly/shaky/unstable/uneven/unsteady.

Gait

(↔ *by degree*) Astasia/abasia, ataxic, steppage, waddling, awry, shuffles, desultory, effortful, dilatory, stiff/rigid/taut, limps, drags/favors one leg, awkward, unusual, odd, abnormal, atypical, collided frequently with other children/people/furniture, walks with slight posturing, lumbering, leans, rolling, lurching, collides with objects/persons, broad-based, knock-kneed, bow-legged, normal, ambled, no visible problem/no abnormality of gait or station, fully mobile (including stairs), springy, graceful, relaxed, glides, brisk/energetic, limber.

Runs/walks in a manner mature/immature for age.

When running, child had poor to fair coordination and balance with overflow movement of his/her arms and hands (indicating neuromaturational delay).

Contact with floor is a mature heel-toe pattern/a flat-footed pattern.

Muscle Tone/Strength

Muscle tone and strength are normal/within a typical range, upper/lower extremities were found to be within functional limits, strength appeared appropriate for child's age and size, exhibited low/high muscle tone in trunk/shoulder girdle/legs/etc., presented with poor/weak strength in upper abdominal/lower leg/etc.

Posture

Postural reactions are good, posture is erect/upright/straight/rigid/stiff/"military," sat on edge of chair, posture is slouched/slumped/droopy/stooping, hunched over/curved spine, "hunched down," round-shouldered, limp, hangs head, peculiar posturing/atypical/inappropriate (sat sideways in the chair, reversed chair to sit down), relaxed.

Proprioception

Child consistently sought out activities that provided vestibular input and proprioception through climbing/jumping/falling/swinging/etc., visual attention/sensory modulation/etc. improved when child was provided with proprioceptive input.

Other Observed Skills

Able to walk forward/backward on balance beam with/without heels and toes touching, walks up/down (ascends/descends) stairs with/without handrail, can catch and throw small tennis ball, able to kick a stationary/moving ball, able to perform long jump, can hop on one leg.

Tests of Gross Motor Abilities *Chapter 25 provides more information about the BOT-2.*

Bruininks-Oseretsky Test of Motor Proficiency, Second Edition (BOT-2)

Peabody Developmental Motor Scales—Second Edition

Test of Gross Motor Development—Third Edition (TGMD-3)

Summary Statements about Motor Skills

Child's motor planning and fine motor skills appeared age-appropriate at this time.
 Motor ability appeared unremarkable.
 Child demonstrated poor fine motor/handwriting skills.
 Visual-motor control (eye-hand coordination) was age-appropriate/delayed.
 Overall, the child's fine/gross motor skills are delayed, but many of the skills are emerging.
 Graphomotor skills were awkward and laborious, and there were difficulties with motor output skills.

Glossary of Terms Frequently Used in Motor Skill Evaluations

In more specialized evaluations of motor skills, the following terms are often used; the simple definitions provided below can be used in report writing.

Bilateral coordination: Ability to use both sides of the body in a smooth and coordinated fashion.

Eye-hand coordination: Ability to use the eyes and hands together in a coordinated fashion for tasks such as writing, throwing, cutting, etc. (*see also visual-motor integration, below*).

Kinesthesia: Ability to perceive the movement of individual body parts.

Motor planning skills: Ability to formulate an idea for a motor task (hitting a ball with a bat, tying shoes, etc.), as well as to organize and sequence a plan for the task.

Ocular motor control: Ability to smoothly locate and follow a moving object with one's eyes.

Postural stability: Sufficient muscle strength and control to participate in daily activities without excessive fatigue or clumsiness.

Proprioception: Ability to process and integrate information from muscles and joints to determine where, how, and with what force they are moving.

Range of motion: Amount of movement in extremities or joints.

Sensory processing: Ability to take in information from the environment and organize it into motor and social responses.

Tactile discrimination: Ability to determine, without vision, where one is being touched and with what.

Tone: Tension in a muscle at rest and/or reaction to passive stretch.

Vestibular processing: Ability to monitor the position of the head as one moves through space.

Visual-motor control: Use of visual skills in conjunction with motor skills, such as writing, drawing, and painting.

Visual-motor integration: Ability to translate with the hands what is perceived visually; this is especially important for writing.

Visual perception: Visual skills that do not necessarily involve a motor response; they are important for learning left versus right, doing matrix puzzles, etc.

13.6. Speech and Language Skills

Articulation

If articulation is unclear, indicate whether the lack of clarity is within normal limits for age.

Good/moderate/variable/fair intelligibility, unclear/unintelligible, intelligibility was excellent/poor/within normal limits, was difficult to understand due to poor articulation, child's articulation was so poor that his/her mother/father needed to interpret his/her responses, stumbles over words, mumbles, whispers to self/mutters under breath, lisps, slurred/garbled, clear/precise/clipped, choppy and mechanical, poor diction/enunciation.

Child's vocabulary outpaced her/his pronunciation ability.

Child stammered/had noticeable speech impediment.

- ✓ When a child has a regional or foreign accent, note this fact only if the accent is strong enough to interfere with clarity. If the child's first language is not English, consult (if possible) with a native speaker of the child's first language to determine whether the child has articulation difficulties in that language.

Voice Qualities

Voice quality was unremarkable/appropriate for age.

Soft/quiet/weak voice, speaks so softly it is difficult to hear him/her, soft-spoken, voice is frail/feeble/thin/"small"/barely audible, whispered/aphonic, tremulous/quivery.

Used baby talk (including higher-pitched tone), spoke in a very high-pitched voice, sing-song, strident/whiny, shrill/squeaky.

Hypernasality/nasal tones.

Low tone of voice, flat voice tone, gravelly/hoarse/throaty/croaky/raspy, bellowed, monotonous pitch/tone, sad/low tone of voice.

Spoke in a loud voice, screamed/squealed/shrieked/yelled/shouted, noisy, brash, harsh.

Comprehension

Demonstrated understanding of prepositions, size differences, body parts, number concepts, etc.

Frequently asked for repetition of information.

Problems with auditory comprehension were noted.

Has difficulty processing simple "wh-" questions (what, where, when, etc.).

Responses to Questions

Responded appropriately to questions posed by the examiner, eagerly answered examiner's questions.

Despite child's good understanding of question forms, she/he was not always responsive to questions when they were asked.

Brief responses, did not initiate conversation/did not volunteer information, tended to offer the minimal answers to questions.

Child echoed the last word of what he/she heard (in)consistently, often repeated part of the verbal question before responding.

When asked direct questions, would frequently ask for repetition or only acknowledge half of the question.

Tended to mumble when asked a question, verbal responses were vague and imprecise.

When child was unsure of a verbal answer, she/he frequently provided a tangential response.

His/her answers indicated considerable failure to understand the intent of the question.

Answered questions impulsively, responses were disorganized and did not appear well thought out.

Responses to Directions

Quickly understood directions.

Followed one-step/two-step/etc. related/unrelated commands.

Often took instructions/directions too literally.

Often had trouble understanding directions, seemed to mishear or misunderstand administered questions, often needed to have test instructions repeated and clarified.

Had difficulty consistently following oral directions, followed one- and two-step commands but frequently needed visual cues for full compliance, was able to follow commands but

did better when a task was demonstrated and he/she was verbally instructed to attend to the demonstration.

Speech Amount/Rate/Rhythm/Productivity (↔ by degree across columns only)

Slow	Normal	Pressured	Verbose
Stammered	Talkative	Fast	Hyperv verbal
Reticent	Articulate	Rambling	Dramatic
Mute	Fluent	Garrulous	Effusive
Unspontaneous	Communicative	Loquacious	Long-winded
Taciturn	Spontaneous	Impulsive	Wordy
Slow response time	Natural	Forced	Long and drawn out
Uncommunicative	Chatty	Expansive	Excessively detailed
Sluggish	Smooth	Rapid	Bombastic
Unhurried	Clear	Unrestrained	Overproductive
Measured	Coherent	Excessively wordy	Nonstop
Deliberate	Lucid	Hurried	Vociferous
Unforthcoming	Expressive	Rushed	Overabundant
Restrained	Initiates	Animated	Copious
Silent	Concise	Voluble	Overresponsive
Terse	Grammatical	Blurts out	Voluminous
Brusque	Intelligible	Run-together	Flight of ideas
Curt	Well-spoken	Raucous	
Clipped	Productive		
Halting	Animated		
Incoherent			
Paucity			
Impoverished			
Laconic			
Economical			
Single-word answers			

Vocabulary and Expressive Language

Child appeared to have good verbal skills, was highly verbal, engaged in pleasant conversation using interesting vocabulary.

Child was remarkably verbal for his/her age.

Child uses words well with good sentence structure.

_____ (*child's name*) is a highly articulate child, whose vocabulary and expressed ideas were well beyond what would be expected for her/his chronological age.

Child spoke in complete sentences.

Often used colloquial language such as "That was wicked good," "This sucks."

Often used profanity.

Verbal responses were severely limited/limited to one or two words, expressive language included mostly labeling.

Expressive language was mildly/moderately/severely delayed.

Often said "uh" before speaking as if trying to find the right word. Used words such as "thingy" or "that thing" because she/he had difficulty coming up with the correct word.

Hesitated before speaking.

Child was unable to formulate spontaneous sentences to express his/her thoughts.

Child's sentences were out of context or inappropriate to what the examiner presented to her/him.

Conversational Style

Child used appropriate turn-taking skills in conversation.

He/she is a reciprocal conversationalist/engaged spontaneously in dialogue/is able to carry on a conversation.

Child readily engaged in conversation/initiated and maintained dialogue appropriately.

Thoughts were connected and flowed logically, child did/did not skip randomly from one topic to another.

She/he appeared quite comfortable conversing with an adult/child.

He/she was able to maintain a conversation and enjoyed asking questions to obtain information.

Child follows the conventions/social rules of communication (including appropriate phrasing and turn taking) and understands the suppositions and expectations of native speakers of American English.

Child offered no spontaneous comments during the evaluation but answered questions easily.

Child spoke in single words and short phrases (most of which were difficult to understand).

Child demonstrated marked impairment in the ability to sustain conversation/was unable to carry on a conversation.

Speech was slow/deliberate/sometimes evasive.

Child was verbal but not articulate.

Child was excessively verbal, examiner had to interrupt her/him to redirect attention to task at hand, child ran on verbally, has difficulty limiting the amount of talking she/he does.

Conversational speech was noted for a quick rate of speech and a tendency to respond tangentially to verbal questions.

When conversing with peers, tends to talk excessively on the same topic without taking other people's point of view into account.

Where one word would suffice/answer the question asked, he/she produced a paragraph.

The child's speech needed more braking than prompting.

The child attempted to be helpful by trying to tell a great deal and so created pressured speech.

Problematic Communication Behaviors

Anomia (child could describe objects but was unable to name them).

Child often asked questions at inappropriate times.

Child frequently complained.

Child subvocalized (softly whispered) as she/he worked, was observed to hum/sing/laugh/giggle throughout session.

Child exhibited significant frustration over his/her inability to express thoughts spontaneously.

Echolalia was present in some/many/most responses, echolalia was noted throughout the sessions.

Malapropisms (e.g., "reef" for "wreath," "elephant" for "elegant").

Syntactical errors. (*Indicate whether errors are appropriate for developmental age.*)

Commonly Used Tests of Speech and Language Ability

See Chapter 23 for citations and more information regarding most of these tests.

Expressive One-Word Picture Vocabulary Test, Fourth Edition (EOWPVT-4)

Expressive Vocabulary Test, Third Edition (EVT-3)

Illinois Test of Psycholinguistic Abilities—Third Edition (ITPA-3)

Peabody Picture Vocabulary Test, Fifth Edition (PPVT-5)

Receptive One-Word Picture Vocabulary Test, Fourth Edition (ROWPVT-4)

Test of Early Language Development—Fourth Edition (TELD-4)

Test of Language Development—Intermediate: Fourth Edition (TOLD-I:4)

Test of Language Development—Primary: Fourth Edition (TOLD-P:4)

13.7. Other Behavioral Observations

Sensory Input

Demonstrated sensory processing regulation deficits.
Displayed an oversensitivity/hypersensitivity to light touch/lights/noise/messy substances.
Threshold level for sensory input was very low.
Is irritated by certain textures and will not touch some things (lotion, shaving cream, etc.).
Certain auditory/visual/tactile input was aversive to the child.
Demonstrated a mild/moderate/severe level of tactile defensiveness, perceived light touch as threatening and noxious.
Lacked ability to regulate her/his sensory system without additional sensory input.

Attention to Detail

Lost sight of the "bigger picture" and tended to become overly focused on irrelevant details.
Excessive attention to detail slowed the child's performance considerably.

Personal Space

Examiner did/did not note difficulties with personal space.
Child would get too close to examiner (about ____ inches from face).
Child needed to be reminded that he/she was in the examiner's personal space.
Child seemed unaware of physical boundaries.

Tics

Motor tics:

Blinking, facial grimacing, twitching/jerking of specific body parts (e.g., head, shoulder, extremities), abdominal tensing.

Vocal tics:

Coughs, sneezes, grunts, snorts/sniffs, throat clearing, mutters phrases or single syllables, barks.

Miscellaneous Observations

Child often sucked her/his thumb between responses to questions.
Frequently asked for a snack or drink throughout the evaluation.
Child often placed head in his/her hands and rested it on the table as a strategy to visualize the auditory information.
There appeared to be little appreciation of danger (e.g., ran out of office onto street), safety awareness was poor.
Brought items to the examination (possessions, presents, refreshments/candy/food/gum, stuffed animals, iPod, etc.).

14

Attitude toward Testing

14.1. Response to Examination Process

Child's Interaction with Testing and Examiner

(↔ *by degree*) The following groups of descriptions are presented in order from most to least cooperative.

Very cooperative:

Seemed highly interested in the testing, exhibited an optimistic attitude, was an eager participant, appeared to be comfortable with the evaluation process, was eager to participate in all tasks presented, demonstrated test-appropriate behavior, was cooperative and willing to comply with all directives, had a good understanding of why she/he was undergoing evaluation, appeared relaxed and comfortable in the testing/therapy environment, insight appeared to be good for age, approached the testing with enthusiasm.

Dependent:

Consistently required visual/verbal modeling before attempting a task unfamiliar to him/her, did not initiate spontaneous interactions but would imitate play after visual cues were given, responded positively to organizational cues provided by therapist, would only attempt testing items after much cajoling and creative play with examiner, often asked the examiner for assistance, was able to engage in testing but was distracted by new playroom, therefore difficult to engage her/him for very long in directed activities.

Variable:

Could be quite cooperative when tasks were interesting to him/her but quite uncooperative when they weren't, cooperation and behavior depended on child's mood, was able to perform on task yet clearly did not enjoy the demands of the testing process, appeared somewhat uncomfortable with the examiner and the testing environment.

Difficulty cooperating during the evaluation:

Indicated by words/actions that she/he did not like the testing process, resisted formal attempts to administer tests, refused several test items, often complained "When will this be over?" or "I want to go home," wanted to give up easily, did not respond to limit setting.

Difficulty understanding the purposes of or completing the evaluation:

Appeared to be untestable, did not understand the significance of the evaluation, denied knowing reason for the evaluation, did not meet minimum requirements for appropriate social interaction.

Parent's Interaction with Examiner

Parent related to the examiner in an appropriate, trusting, warm/friendly/gracious, open/unguarded, sociable/pleasant/affable way.

Parent's manner of relating to examiner was arrogant/threatening, suspicious/distrustful, impatient, uncooperative, controlling/manipulative, seductive, needy/dependent, grudging/condescending, aloof/detached/cold, etc.

Parent's attitude did/did not change during the interview.

Parent took _____ role and assigned _____ role to examiner during interview (*specify*).

Child's Behavior with Parent

Child actively explored environment with parent/guardian present, was quite affectionate and loving toward his/her parents, appeared to have a very good relationship with parents, actively participated in the interview, elaborated on her/his mother's/father's comments and added her/his own opinions about what the problems were.

Child was seen initiating hand holding with his/her father/mother upon leaving the clinic, showed great exuberance when reunited with parents at the close of the session.

Child played easily/unwillingly/not at all in the waiting room, did/did not put away the toys used.

Child exhibited _____ level of play, used playthings appropriately/inappropriately for his/her age.

Child did not display a warm reaction to mother/father when parent entered the examination room.

Parent's relationship to child was unsupportive/unilaterally controlling/harsh/etc.

Child was noted to be curt/bossy/noncompliant/etc. to her/his mother.

Parent used control in _____ ways (*specify degree, kind/methods/means, timing*) over issues of _____ (*specify*).

Parents showed agreement/disagreement/conflict over discipline, rewards, language, attention given, etc.

Child's Separation from Parent

Child had no difficulty separating from her/his mother/father/parents.

Child came willingly to the testing/entered the testing environment willingly.

Separated with minimal/appropriate anxiety from his/her father/mother and quickly became engaged with the examiner.

Child was aware that her/his parents were meeting in the adjoining room, but she/he was not distracted by their presence.

Child displayed some initial separation anxiety, but quickly became comfortable with the therapist/examiner.

Child initially requested that his/her mother/father accompany him/her for testing, but accepted without difficulty that she/he needed to remain in the waiting room.

Child showed initial hesitation to engage in testing.

Preferred to play with toys in the waiting room and was reluctant to begin examination.
 Child was shy at first and needed some time to warm up to the examiner.
 During stressful times during the evaluation, child requested to see his/her parents in the waiting room, apparently to verify that they were still there.
 Upon separation, child showed excessive/expected/limited/no anxiety, expressed as _____ (*specify*).
 Child used appropriate/a few/no coping mechanisms upon separation (*if any, specify*).
 Child separated easily/poorly/reluctantly from the parent/examiner.
 Child's reaction upon rejoining parent was _____ (*specify*).
 Child showed anger and distress when separated from her/his father/mother at the beginning of testing.
 Child refused to be separated from parent, and thus evaluation was completed with parent in the room at all times.

Observations of Child's Play

Isolates him-/herself from other children and prefers solitary play.
 Play was mostly self-directed parallel play.
 When invited to play, child had some difficulty initiating play.
 Child initially rejected toys presented to him/her, but became increasingly cooperative.
 Preferred self-directed play to examiner-directed play.
 Child was able to enter into cooperative play.
 Child enjoyed imaginative play.
 Play was interactive.
 Child was overly aggressive when playing with other children.
 Child tended to want to control play activities.
 Child exhibited appropriate/inappropriate play with toys.
 Child played eagerly/willingly/unenthusiastically/not at all with same-age/younger/older peers.
 Child showed eager/expected/limited/no approach to and interest in toys/materials.
 Toys/materials actually used were _____ (*specify*).
 Manner of play was constructive/disorganized/mutual/parallel/distractible/disruptive/other (*specify*).
 Child was tractable/intractable to discipline, such as _____ (*specify*).

Child's Response to Transitions

Transitions between activities were challenging for the child.
 When child was asked to change activities, she/he refused/became aggressive/began to cry/showed visible signs of anxiety/threw the materials across the room/ran from the room/became oppositional.
 Child consistently became disorganized when transitioning demands were placed on him/her.
 She/he made transitions from task to task well.
 Child was sensitive to changing task parameters.

Child's Separation from Teacher/Classroom

Child separated comfortably from his/her teacher to accompany the examiner to the testing room.
 Child separated from class with ease.
 Child did not want to separate from class environment and very reluctantly joined the examiner.
 Child refused to accompany the examiner.

14.2. Rapport with Examiner

Cooperative Behaviors (\leftrightarrow by degree across columns only)

Friendly	Cooperative	Dependent	Indifferent
Enthusiastic	Responsive	Shy	Unresponsive
Vivacious	Attentive	Obsequious	Uninterested
Enjoyed one-to-one contacts	Compliant	Deferential	Apathetic
Engaging	Diligent	Ingratiating	Passive
Solicited interaction	Hard-working	Tried too hard to please	Careless
Imaginative	Curious	Needy	Noncommittal
Playful	Flexible	Overly reliant on examiner's input	Blasé
Sweet-natured	Considerate	Sycophantic	Aloof
Entertaining	Polite	Fawning	Remote
Amiable	Tactful	Submissive	Lazy
Upbeat	Agreeable	Docile	Bored
Chummy	Cordial	Meek	Curt
Enjoyable	Kind	Overly obedient	Submissive
Amusing	Civil	Help-seeking	Nonchalant
Sociable	Forthright	Eager to please	Neutral
Good-natured	Obliging	Accommodating	Minimal cooperation
Affable	Accommodating	Effusive	Submissive
Likeable	Courteous	Pleading	Passive
Good-humored	Well-mannered	Oversolicitous	
Cheerful	Respectful	Compliant	
Optimistic	Thoughtful	Overapologetic	
Bubbly	Direct		
Cheery	Frank		
Familiar	Candid		
Tactful	Open		
Cordial			
Sollicitous			

Negative Behaviors (\leftrightarrow by degree across columns only)

Guarded	Brusque	Defensive	Challenging	Antagonistic	Aggressive
Unreadable	Curt	Reticent	Sarcastic	Belligerent	Physically abusive
Unresponsive	Surly	Inflexible	Negative	Oppositional	Verbally abusive
Downbeat	"Crabby"	Interpersonally distant	Disagreeable	Defiant	Swore
Evasive	Sulky	Suspicious	Uncooperative	Angry	Hostile
Sneaky	Gruff	Self-protective	Disobedient	Rude	Rageful
Wary	Abrupt	Resentful	Rebellious	Rebellious	Belligerent
Hesitant	Grumpy	Noncompliant	Mocking	Disrespectful	Intimidating
Restrained	Bad-tempered	Refused to participate	Sardonic	Quarrelsome	Obstreperous
Expressionless	Short-tempered	Unforthcoming	Cynical	Loud-mouthed	Malicious
Unemotional	Testy	Inflexible	Derisive	Confrontational	Violent
Cagey	Irritable	Obstinate	Nasty	Spoiling for a fight	Destructive
Hard to pin down	Cranky	Obstinate	Obstinate	Stubborn	Hateful
Reserved	"In a bad mood"		Contrary	Manipulative	
			Stubborn	Cantankerous	
			Manipulative		

Reticent	Cross	Uncompro-	Demanding	Irate	Spiteful
Recalcitrant	Petulant	mising	Imposing	Cross	Malevolent
Resistive	Resentful	Rigid	Insistent	Livid	Mean
Reluctant	Sullen	Intransigent	Indignant	Enraged	Nasty
Inaccessible	Broody	Detached	Confronta-	Bad-mannered	Cruel
Distant	"Out of sorts"	Subtle	tional	Foul-mouthed	Sadistic
Remote	"In a funk"	Hostile	Presumptuous	Vulgar	Vicious
Withdrawn	Snippy	Uncooperative	Frustrated	language	Disparaging
Withholding	Balky	"Sick and	Complaining		
Avoidant	Pouty	tired"	Domineering		
	Peevish	Noncompliant	Rude		
	Snappish		Nagging		
	Grouchy				

Response to Examiner's Behaviors

Normal/positive:

Child responded quickly to cuing from the examiner.
 When psychologist provided structure to play, child became more oriented and responsive.
 Child clearly benefited from redirection, praise, and positive reinforcement for his/her responses.
 Was able to calm down and refocus with praise from the examiner.
 Responded to firm limit setting.
 Child responded well to positive reinforcement.
 Child responded nicely to structure and redirection.
 Demonstrated improved attention and concentration when motivational techniques (e.g., sticker chart, token reinforcement) were employed.

Overly affectionate:

Client formed an immediate superficial attachment to evaluator/therapist.
 Upon meeting therapist, child immediately hugged him/her.
 Child initiated hug from therapist at end of each session.

Concerned/controlling:

Child tried to negotiate with examiner how much she/he had to complete each time a new item was introduced.
 At times child became defiant and argumentative in response to praise, often denying he/she was really doing a good job.
 Child was vigilant about evaluator's behavior, frequently asking what she/he was writing on her/his clipboard.
 Child seemed to need to have some control over how examiner understood his/her answers.

Summary Statements about Rapport

Child could engage with the examiner rather well/easily established rapport with the examiner.
 Child appeared to be at ease and happily engaged in the interview process.
 Rapport was quickly and easily/intermittently/never established and maintained.
 From the beginning, the child appeared to be comfortable with the examiner(s) and quickly engaged in conversation.
 She/he was fully cooperative during the evaluation and seemed to establish rapport fairly well.
 Rapport developed over the first few sessions.

The child appeared relaxed and comfortable with the interview process/shared thoughts without hesitation/gave responses that appeared genuine and thoughtful.
 He/she seemed to enjoy the attention received.
 Response to authority was cooperative/respectful/appropriate/productive/indifferent/hostile/challenging/undermining/unproductive/noncompliant/contemptuous.
 Child preferred to socialize with the examiner rather than focus on the tasks at hand.
 Child displayed ambivalence toward therapist/examiner.
 Child was quiet and did not try to engage with the examiner.
 In relating to the examiner, she/he made sporadic eye contact and seemed unaware of physical boundaries.

14.3. Attention/Concentration

See also Section 16.1, "Attention-Deficit/Hyperactivity Disorder (ADHD)."
 (↔ by degree across columns only)

Passive	Inattentive	Normal	Hyperactive
Quiet	Distractible	Attentive	Very active
Subdued	Intermittent attention	Hard-working	Wiggly
Lethargic	Lost concentration	Observant	Impulsive
Inactive	Could not stick with task	Curious	Fidgeting
Unreceptive	Daydreaming	Self-directed	Problems remaining seated
Sluggish	Distracted	Thoughtful	Constant activity
Restrained	Careless	Concentrated	Constantly interrupted
Unresponsive	Unmindful	Adequate	Squirring
Slow-moving	Forgetful	Motivated	Restless
Listless	Absent-minded	Engaging	Easily overstimulated
Apathetic	Scatterbrained	Inquisitive	"Hyper"
Dull	Unfocused	Interested	"Wired"
Uninvolved	Dreamy	"All ears"	Agitated
Uninvested	Inconsistent	Focused	Restless
Sluggish	Varied with tasks	Listening carefully	Overly energetic
Worked slowly	Low attending skills	Alert	Overexcited
"In slow motion"	Had great difficulty following directions	Paying attention	Twitchy
Slow reactions		"On the ball"	
Slowed		Cooperative	
Nonpersistent		Spontaneous	
		Responsive	
		Adequate	
		Good effort	

Summary Statements about Attention

(↔ by degree) These groups of statements are presented in order from highest to lowest quality of attention.

Excellent:

Child was focused and engaged.
 Child exhibited appropriate effort, focus, and attention throughout the testing/interview.
 Child never appeared clearly inattentive or distracted.
 Child seemed to have a good attention span, as seen in his/her ability to sit for long periods of time without a break.

There were no behavior management issues evident.
She/he was able to stay in his/her seat and work as directed.

Good:

Child's attention to task was good, but not excellent.
Pattern of performance on tests did not indicate a consistent problem of attending to tasks.
Child was able to focus on task when reminded to do so.
Child's listening skills and ability to follow directions were inconsistent.
Child's attention was better when the task was challenging.

Some difficulties:

Child's ability to attend on tasks was variable.
At times he/she was noted to become distracted by things in the environment (e.g., noises, pencils).
Child often closed her/his eyes during verbal tasks as if to listen better or concentrate on the task.
Child had poorer attention when tasks were verbal/more challenging/paper-and-pencil/auditory in nature/nonverbal in nature.
Levels of attention and concentration were below age expectations in this one-to-one assessment situation.

Poor:

Child could attend for no more than 5–15 minutes.
Child was continually/easily distracted by objects on the table/environmental noises/his/her own thoughts.
Child readily became distracted by internal/external stimuli.
When asked to concentrate, she/he became oppositional.

14.4. Attitude toward Performance

Positive attitude:

Handled failure well, demonstrated good insight about his/her performance (particularly on items he/she found difficult), made use of corrective feedback when it was provided, was willing to make guesses when material was difficult, has a good sense of the limits of her/his knowledge, will not attempt tasks judged to be beyond his/her solid knowledge.

Indifference/lack of awareness:

Took no pride in her/his work, gave up easily when confronted with a challenging task, was not bothered by incorrect answers, often seemed unaware when he/she gave an incorrect answer or response.

Anxiety:

Demonstrated anxiety on particular tests (e.g., timed tests, unstructured tests, projective tests), constantly asked whether answers were "right" or "okay," tried hard to determine whether answers were correct from subtle verbal and body language cues exhibited by the examiner, frequently tried to look at the score sheet, frequently made disclaimers about performance/predictions of poor performance before beginning tests for which she/he lacked confidence or ability, seemed unsure of him-/herself and seemed not to want to give a response unless he/she was absolutely sure of it.

Perfectionism/high self-criticism:

Seemed to hold her-/himself to high standards, had difficulty making decisions/answering questions because he/she was afraid of getting something wrong, would often report an answer and then declare "Oh, no, that's not right" and rework the problem, sometimes arriving at the same answer later; appeared troubled/frustrated/embarrassed when she/he did not know the correct answer to a question, frequently asked whether tests were timed and how they were scored, meticulously checked and rechecked his/her answers, took significantly longer to finish a problem than the average examinee, tended to be rather perfectionistic about responses, spent more time than needed on many questions.

14.5. Coping Skills

(↔ *by degree*) These groups of descriptors are presented in order from strongest to weakest coping skills.

Good:

Did not appear frustrated by inability to solve a problem or by repeated tasks and exercises, required only minimal encouragement when frustrated or distracted, child coped well when presented with difficult problems.

Adequate:

Often became discouraged by difficult items but persevered.
Showed some frustration during difficult tasks, but was able to cope given sufficient time.

Poor:

Exhibited low frustration tolerance, gave up easily, would begin to express self-denigrating remarks/exhibit inappropriate laughter when faced with challenging tasks, had trouble bearing the frustration of not succeeding, was aware of areas of weakness and became somewhat avoidant on these tasks, often asked to stop or end soon, was on the verge of tears when asked to complete certain test items (*specify*).

14.6. Effort

Summary Statements

Child appeared to put forth his/her best effort on all the tests administered.
Generally she/he showed strong effort, although at times needed encouragement from the examiner to continue working.
Child craves attention and will work very hard for adult attention and reinforcement.
Child's effort varied considerably depending on the nature of the task.
Although _____ wanted to do well and put forth full effort, he/she was easily overwhelmed when presented with detail and complexity.
Child did not want to put forth effort that could prove unproductive, and thus she/he gave up when an item was perceived as beyond her/his mastery level.
Child exhibited little effort and did not care whether his/her answers were correct.
Task persistence was diminished.
There was low tolerance for frustration.

14.7. Motivation and Persistence

(↔ *by degree*) The following groupings of statements are presented in order from highest to lowest motivation or persistence.

High motivation or persistence:

- _____ was persistent in the face of difficulty.
- Child persevered on difficult tasks and would try his/her best until the time limit.
- Child demonstrated good attention to tasks overall, impressive perseverance, and consistently high motivation.
- During testing she/he was persistent and highly motivated to give her/his best effort and do well.
- Child was highly motivated and cooperative for the evaluation.
- Child particularly enjoyed tasks that were challenging for him/her, often requesting to complete additional items just to see whether he/she could "get it right."
- _____ was hard-working and task-oriented, proceeding like a soldier through the tests presented.
- Child maintained a high level of effort, even on tasks she/he reportedly found difficult or boring.
- Child was offered breaks several times during the testing, but refused them/was eager to continue.
- _____ concentrated on one task for a long time/finished every task.
- Child was distracted only by extreme circumstances.
- Child exhibited sustained/diligent/systematic/conscientious effort.

Average motivation or persistence:

- Child attempted all tasks presented to him/her.
- At no time did child become frustrated or ask when she/he would be done.
- Child complained a little about the length of the evaluation but still persevered.
- Child was candid about tests he/she did not like, but performed all tasks attentively and often enthusiastically.
- Task persistence was variable, but overall well maintained.
- Although she/he was cooperative, it was obvious that she/he did not enjoy certain aspects of the exam (*specify*).
- Child was only rarely discouraged or inattentive.
- On the whole, child was work-oriented/cooperative and put forth satisfactory effort on each evaluation task administered.
- Child participated fully in the evaluation process, became involved in tasks, and changed tasks appropriately.

Low motivation or persistence:

- Child was easily frustrated.
- _____ constantly wanted to leave the testing situation/examination/therapy session.
- When child was unsure of an answer, he/she asked to turn the page or go on to another item/changed the subject/became silly/spoke more softly/spoke less clearly/attempted to control the area of conversation.
- Child worked without enthusiasm.
- _____ tended to be persistent when challenged by tasks, but was quick to give up trying if she/he could not solve the task quickly.
- Child did just the minimum to get by.

Child displayed a strong "I don't care" attitude.

Whenever a new test was introduced, child would question whether he/she had to complete it.

Child had difficulty making decisions.

Child had a tendency to give up easily.

Child needed constant prompting and persuading to keep working.

She/he would often develop a defeatist attitude when challenged.

Sustained effort only for _____ (*specify time period*).

Child preferred only easy tasks/showed no motivation to succeed with difficult tasks or perform well for examiner.

_____ offered only perfunctory cooperation.

Refusal:

Child refused some test items that were perceived as too difficult.

Even with words of encouragement, he/she preferred not to guess at a possible answer.

Child was quick to respond "I don't know" when asked verbal questions.

Child often became unsure of her-/himself and then shut down/withdrew.

Child showed irritation/became angry/complained.

15

Affective Symptoms and Mood/Anxiety Disorders

This chapter describes terms for symptomatology involving mood or affect, as well as for various mood and anxiety disorders. For more information regarding the assessment of mood and anxiety disorders and symptoms, see Chapters 2 and 3.

15.1. General Aspects of Mood and Affect

“Mood” refers to a person’s overall emotional tone or quality over some period of time. “Affect” refers to the appropriateness and range of a person’s moment-to-moment emotional responses.

In reports, comment on the following:

- Child’s general mood.
- Fluctuation of mood/affect during interview, evaluation, or treatment.
- Appropriateness of affect for the speech and content of child’s communication.
- Child’s self-report of mood and affective state(s).
- Congruence of child’s self-report and examiner’s observations of child’s mood/affect.
- Congruence of child’s self-report and parent’s (or other adult’s) reporting and observation of child’s mood/affect.

Quality/Range of Affect (\leftrightarrow by degree across columns only)

Flat	Blunted	Constricted	Normal	Expansive
Bland	Detached	Tired	Appropriate range	Broad
Unresponsive	Distant	Restricted	Responsive	Highly reactive
Remote	Unspontaneous	Inhibited	Fine	Labile
Unvarying	Unattached	Shallow	Adequate levels of	Disinhibited
Impassive	Apathetic	Low-key	emotional energy	Euthymic
Aloof	Uninterested	Contained	Integrated	Deep
Withdrawn	Listless	Limited range		Intense
Passive-appearing	Lacking energy	Repressed		Pervasive
Affectless	Stoic	Subdued		Generalized
Vacant stare	Inexpressive	Controlled		
Absent	Dispassionate	Low-intensity		
Expressionless	Uninvolved	Muted		
		Uninflected		

General Statements Regarding Affect

- Affect and compoirtment were normal.
- Affect was sweet and agreeable.
- Affect and mood were appropriate at all times.
- Child displayed an appropriate range of affect, though she/he tended toward a depressive/anxious/etc. presentation.
- Child displayed the full gamut of emotions during the sessions/demonstrated full range of appropriate affect.
- Testing reflects an affective style that matches/does not match the child's clinical presentation.
- Child presented a very restricted range of affect.
- Child's affect was inappropriate for content/task.

Quality/Range of Moods (↔ by degree across columns only)

The table below presents very general descriptions of mood states—that is, the prevailing emotional tone—ranging from depressed to angry. See later sections of this chapter for more information regarding moods as they relate to specific disorders.

Depressed	Anxious	Normal	Expansive	Angry
Agitated	Nervous	Bright	Animated	Defiant
Sad	Irritable	Happy	Overly dramatic	Aggressive
Tearful	Hypervigilant	"Fine"	Wide-ranging	Suspicious
Indifferent	Skittish	"Okay"	Overly cheerful	Annoyed
Miserable	Tense	Cheery	Exuberant	Irate
Unhappy	Perplexed	Cheerful	Extroverted	Mad
"Down in the dumps"	Restless	Lively	Elevated	Fuming
Dejected	Fretful	Optimistic	"High-spirited to a fault"	Irritated
Low	Fearful	Positive		Livid
Sad	Frightened	Upbeat		Cross
"Down"	Worried	Jolly		Furious
Despondent	Concerned	Buoyant		Incensed
Weepy	Uneasy	Hopeful		Enraged
Melancholy	Wary	Confident		Outraged
Mournful	Jumpy			Infuriated
Sorrowful	Edgy			"Hopping mad"
Upset	Stressed			
	"Uptight"			
	On edge			
	Apprehensive			

General Statements Regarding Mood

- Mood was generally pleasant.
- Mood was even throughout testing/evaluation session(s).
- Child had difficulty modulating her/his responses to incoming stimuli.
- Shifts in mood were noted when _____ (e.g., child faced any type of frustration, was presented with affectively charged information, etc.).
- Child prefers to avoid emotional stimulation.
- _____ seems to restrict his/her expression and utilization of emotion, especially when making decisions or solving problems.

Appropriateness/Congruence of Affect or Mood and Behavior

(↔ *by degree*) The following groupings are sequenced by degree of increasing appropriateness/congruence.

High incongruence:

Indifferent to problems, discounted/flatly denied any difficulties/problems/limitations.

Incongruence:

Affect variable but inconsistent with the topic of conversation, modulations/shifts inconsistent and unrelated to content or affective significance of statements.

Congruence:

A range of emotions/feelings, appropriate emotions for the content and circumstances, emotions seemed appropriate for the situation/context.

High congruence:

Emotions highly appropriate to/congruent with situation and thought content/subject of discussion, facial expressions clearly reflected emotions reported.

15.2. Anger

Anger in children is sometimes a sign of underlying depression, conduct problems, or a juvenile-onset bipolar disorder. (*See Sections 15.5, 16.3, and 15.4, respectively, for more information regarding these disorders.*)

General Aspects

In reporting anger in children, note the following:

Aggression as a result of angry affect:

Verbal abuse (screaming, lying, swearing, etc.), physical (hitting, fighting, property destruction), etc.

Resolution of anger:

The child can/cannot self-soothe, can/cannot resolve angry feelings with/without adult assistance.

Targets of angry behaviors:

Parents, teacher, siblings, peers, etc.

Any factors that appear to have precipitated or triggered the anger and aggression.

Tantrums

Angry feelings never/sometimes/often/always result in/accompany tantrums.

Aggressive Behaviors in Children

Look for and/or comment on the following:

Location/place:

Home, school, other (*specify*).

Timing:

- Frequently throughout the day.
- During particular times of the day (*specify*).
- When other children "crowd" his/her space.
- When child is not getting any attention.
- During structured activities.
- During unstructured activities (playground, free choice, etc.).
- During transition times.
- During unsupervised times.
- On the weekends.
- At custodial/noncustodial parent's house.
- Other (*specify*).

Precipitating factors:

- Child has had limits placed on her/him.
- Child is in close proximity to other children.
- Child is pushed or threatened physically.
- Child is provoked by another child or adult.
- Child is frustrated with inability to complete/begin/etc. a task.
- Child does not want to do what he/she has been asked to do.
- There is no apparent trigger to the aggressive actions.

Targets:

- Parents/family members/a particular family member.
- Peers at school/a particular peer.
- Anyone who places limits on child.
- Only timid/shy/younger/smaller children.
- Only assertive/older/bigger children.
- Other (*specify*).

Aggressive actions:

- Hitting, kicking, scratching, biting, slapping, punching, pinching, pulling hair, pushes/pokes/knocks down others, jumps on others, wrestles.
- Verbal abuse, name calling, swearing/cursing, insulting, threatening, shouting.
- Illegal behaviors (stealing, drug use, etc.).

Descriptors of Angry Behaviors/Moods (↔ by degree across columns only)

Annoyed	Unpredictable	Irate	Hostile
Irritated	Temperamental	Explosive	Provocative
Aggravated	High-strung	Infuriated	Antagonistic
Upset	Moody	Maddened	Aggressive
Bothered	Volatile	Riled	Intimidating
Exasperated	Excitable	Incensed	Argumentative
"Snippy"	Erratic	Very angry	Seething
Complaining	Ill-tempered	Mad	Threatening
Cranky	"Whiny"	Livid	Belligerent
Resentful	Short-tempered	Outraged	Bullying
Grouchy	Fickle	Enraged	Menacing
Grumpy	Capricious	"Beside him-/herself"	Harassing
Disagreeable	Unstable	Piqued	Imical

Ill-humored
 "Prickly"
 Bristled
 Restive
 "Bothered"
 Sarcastic
 Disgruntled
 Miffed
Displeased

"Burned up"
 Chronically angry
 Infuriated
 Furious

Unreceptive
 Unfriendly

15.3. Anxiety

See also Section 15.7, "Obsessive-Compulsive Disorder (OCD)." Of note, while OCD and PTSD (and a few disorders related to each) were grouped in earlier editions of DSM with the anxiety disorders and are still often conceptualized as anxiety disorders, in DSM-5 they are classified under obsessive-compulsive and related disorders and under trauma- and stressor-related disorders (respectively).

Relevant Original DSM-5 and ICD-10 Codes

See Sections 29.1 and 29.2 for explanations of the original DSM-5 codes (e.g., 300.02 for generalized anxiety disorder) versus the ICD-10 codes (e.g., F40.10 for generalized anxiety disorder).

In this and similar lists in this chapter and Chapter 16, the original DSM-5 code numbers appear first, followed by the ICD-10 code numbers (in parentheses). For ease of reading and consultation in these two chapters, the subtypes of some disorders (e.g., specific phobia) are given in full rather than as "*Specify if,*" and some specifiers may be omitted.

300.23	(F40.10)	Social anxiety disorder (social phobia)
300.29	(F40.218)	Specific phobia of animals
300.29	(F40.230)	Specific phobia of blood
300.29	(F40.231)	Specific phobia of injections and transfusions
300.29	(F40.233)	Specific phobia of injury
300.29	(F40.232)	Specific phobia of other medical care
300.29	(F40.228)	Specific phobia of natural environment
300.29	(F40.298)	Other specific phobia
300.29	(F40.248)	Situational specific phobia
300.02	(F41.1)	Generalized anxiety disorder
300.3	(F42.2)	Obsessive-compulsive disorder
294.8	(F06.8)	Obsessive-compulsive and related disorder due to another medical condition
309.81	(F43.10)	Posttraumatic stress disorder
308.3	(F43.0)	Acute stress disorder
293.84	(F06.4)	Anxiety disorder due to another medical condition
300.09	(F41.8)	Other specified anxiety disorder
300	(F41.9)	Unspecified anxiety disorder
309.24	(F43.22)	Adjustment disorder with anxiety
300.01	(F41.0)	Panic disorder
300.22	(F41.00)	Agoraphobia
309.21	(F93.0)	Separation anxiety disorder

General Aspects

Common childhood phobias or fears include fear of spiders; thunderstorms/lightning; loud noises; animals (e.g., dogs, cats, horses, zoo animals); being alone; blood/injection/shots; clowns/people in costumes; crowds; darkness; ghosts/monsters; insects (e.g., bees, wasps); water; snakes; height; closed spaces; airplane travel; and dentists.

Agoraphobia symptoms in children can include fear of public places, shopping, crowds, travel, bridges, elevators, or the like. Agoraphobia is often associated with school refusal or school avoidance.

Social anxiety disorder (social phobia) symptoms in children can include fear of speaking (e.g., answering questions in class, reading out loud); performance anxiety (e.g., playing at piano recitals, participating in sports, writing on the chalkboard, appearing in a play); fear of eating in public or using public restrooms; fear of asking someone on a date; or fear of negative evaluation.

For panic disorder in children, include information about length of attacks (seconds, minutes, etc.); whether attacks are linked to specific activities or symptoms (e.g., driving in a car, school situations); and frequency of attacks (e.g., four attacks in 2 weeks).

General Statements about Anxiety

The child reports high levels of anxiety.

The child experiences fatigue as a result of high perceived stress.

Because of high levels of anxiety and tension, she/he may not be able to meet even minimal role expectations without feeling overwhelmed.

The child's/adolescent's anxiety is so significant that his/her ability to concentrate and attend are significantly compromised.

Relatively mild stressors will not feel mild to the child because of his/her high levels of general anxiety.

Subjective Symptoms of Anxiety

Discomfort	Fear	Dread	Panic
Uneasy	Trepidation	Scared	Horrified
"Uptight"	Distressed	Frightened	Petrified
Embarrassed	Stressed	Distraught	Paralyzed
Nervous	"Keyed up"	"Unnerved"	"Out of control"
Worried	Foreboding	Alarmed	"Go to pieces"
Irritable	Tense	Frazzled	Terrified
Restless	Apprehensive	Flustered	Hysterical
Disquieted	Agitated	Harried	Frenzied
Jittery	"The creeps"		Panic-stricken
Flighty	On edge/edgy		Frantic
			"Everything goes black"
			"The world is not real"

Physiological Symptoms

Sweating/excessive perspiration, chills/sweaty face/forehead, flushing, cold/clammy/sweaty hands/palms, "goose bumps," hot and cold flashes, pallor/"as white as a ghost."

Dry mouth, lump in the throat, decreased salivation.

Chest pain/discomfort, tight chest.

Headaches/temples pounding.

Nausea/sickness/queasiness, unsettled/upset/churning stomach, frequent stomachaches/abdominal discomfort, stomach "butterflies," diarrhea, "dry heaves," frequent urination, loss of bladder/anal sphincter control.

Dizziness/giddiness/faintness/lightheadedness/"wooziness"/vertigo, shaking unsteadiness/trembling/"wobbly"/tremulous/quivering/"fluttery," ears ringing, room spinning, faintness/syncope, overall weakness.

Sleep disturbances, trouble falling or staying asleep, insomnia.

Tense muscles (especially neck and shoulder), diffuse limb/muscle aches, eyelid or other twitching, numbness/tingling in hands or feet, no control over limbs/legs felt leaden, incapable of moving.

Pupils dilated.

Rapid/racing heartbeat/pulse rate, pounding heart, palpitations, tachycardia.

Respiratory difficulties, shortness of breath/fast and shallow respiration, difficulty breathing/could not catch breath, choking/smothering sensations, "air hunger," hyperventilation.

"Everything looks funny/blurry/shimmering/far away."

Behavioral Symptoms

Avoidance behaviors, school refusal.

Breathing disturbances, took deep breaths between sentences, had trouble catching his/her breath, periodically exhaled audibly, sighing.

Swallowing frequently between words, frequently gulping before speaking, repeated requests for water.

Crying, clinging, bedwetting/enuresis, encopresis, regressive behaviors (e.g., thumb sucking, baby talk, immature speech).

Fainted, passed out, fell unconscious, collapsed, "blacked out."

Fatigue, tiredness, overall weakness.

Fidgeting, couldn't sit still; tapped pencil/foot/fingers, frequently changed position in seat, jittery, restless, paced.

Frequent trips to the school nurse.

"Freezing," unable to move or respond.

Nervousness/nervous habits, easily distracted, agitated, impatient, wide-eyed, nail biting, chewed on pencil/pen, picked at skin, wringing hands, coughing, cleared throat, played with clothes/hair, chewed on shirt/hair, repetitive movements (*specify*).

Voice cracked, stuttered, stammered, tremulous/shaky voice.

Cognitive Symptoms

Depersonalization/derealization/sense of unreality, preoccupation with bodily sensations.

Trouble concentrating/lessened concentration, increased confusion.

"I'm going to die/go crazy/lose control/collapse/have cancer," etc.

"Worry wart," constant worrier, apprehensive about all possible disasters, ruminates.

Fears of losing parents/dying/being attacked/being rejected by peers/illness/disability, worries about schoolwork/integrity of family (e.g., possibility of parental divorce), upset by fantasies, obsessive thoughts.

"My mind goes blank."

Feels the need to escape.

Misinterprets symptoms and events in a negative way that exacerbates feelings of anxiety.

Catastrophic misinterpretations of normal bodily changes.

Consequences of Anxiety

Problems in interpersonal relationships, few friends, reluctant to attend playdates/sleepovers/summer camp/parties.

Clingy, insecure, self-doubting/lacking confidence, timid, unsure of him-/herself.

Ill at ease, socially anxious.

Inflexibility, rigidity, upset by little things, cannot cope unless everything is "just right."

Oversensitivity/excessively sensitive.

Self-induced pressures, perfectionism.

Assessment Instruments for Anxiety

The tests listed below specifically measure anxiety in children and youth (*see Chapter 28 for more details about one of these, the RCMAS-2*). General behavior rating scales and projective measures are also commonly used (*see Chapters 28 and 27, respectively, for more information regarding these latter types of assessment instruments*).

Depression and Anxiety in Youth Scale (DAYS)

Revised Children's Manifest Anxiety Scale, Second Edition (RCMAS-2)

Internalizing Symptoms Scale for Children (ISSC)

Multidimensional Anxiety Scale for Children—Second Edition (MACS-2)

Screen for Childhood Anxiety-Related Emotional Disorders—Revised (SCARED-R)

State-Trait Anxiety Inventory for Children (STAIC)

15.4. Bipolar Disorders

Relevant Original DSM-5 and ICD-10 Codes

296.5x	(F31.xx)	Bipolar I disorder, current or most recent episode depressed
296.4x	(F31.xx)	Bipolar I disorder, current or most recent episode hypomanic
296.4x	(F31.xx)	Bipolar I disorder, current or most recent episode manic
296.7	(F31.9)	Bipolar I disorder, current or most recent episode unspecified
296.89	(F31.81)	Bipolar II disorder
293.83	(F06.33)	Bipolar and related disorder due to another medical condition with manic features
293.83	(F06.33)	Bipolar and related disorder due to another medical condition with manic- or hypomanic- like episodes
293.83	(F06.34)	Bipolar and related disorder due to another medical condition with mixed features
301.13	(F34.0)	Cyclothymic disorder
296.89	(F31.89)	Other specified bipolar and related disorder
296.80	(F31.9)	Unspecified bipolar and related disorder

General Aspects of Childhood-Onset Bipolar Disorders

The next three subsections provide more specific descriptors for the manic, depressive, and sexual symptoms of childhood-onset bipolar disorders, but the following is a general summary:

- Abnormal mood states (mania and depression).
- Distractibility.
- Increase in activity.

- Grandiosity (often in the form of defiance, reckless activities).
- Decreased need for sleep.
- Increased interest in sex.
- Poor judgment (e.g., attempting to exit a moving vehicle, jumping out of a window or off a high ledge).

House (2002) notes that initial symptoms may include depression, anxiety, irritability, mood swings, problems with concentration, alcohol and/or drug abuse, legal problems, relationship difficulties, problems with impulse control, and insomnia.

Common Symptoms of Childhood-Onset Mania

Periods of extreme silliness.

Immature states where child exhibits "baby talk" or acts like a baby.

Extreme irritability, which may include being demanding or bossy.

Impatience to the point of being highly agitated.

Often interrupting others.

Disregard for authority of parents/school personnel/other adults.

Quick temper/proneness to intense emotional displays.

Aggressive behaviors (e.g., hitting/pushing/kicking people, throwing things, attempting or expressing desire to kill someone, verbal abuse/swearing).

Fits/explosive behaviors/tantrums, child is unable to calm him-/herself.

Narcissistic features (self-focusing).

(In some adolescents:) Manic symptoms accompanied by psychosis.

Common Symptoms of Depression in Children with Bipolar Disorders

See Section 15.5 for general information about depression in children.

Depression in children with bipolar disorders is often severely impairing and may have an angry quality that includes self-destructive acts. Commonly seen behaviors include the following:

Severely impairing depressive states.

Acts of self-harm while feeling depressed (e.g., biting/scratching/cutting self, suicide attempts).

Attempts to harm others, obsessive thoughts about harming others.

Sexual Behaviors

- ✓ Note: Whenever sexualized behaviors are displayed in young children, there is a need to rule out potential sexual abuse or trauma.

In Preschool and School-Age Children

Increased masturbation, particularly in public.

"Doctor" play that is abnormal for age.

Increased interest in sexual matters, initiating sexual conversations inappropriate for age.

Exposing self to other children.

In Adolescents

Obsessive interest in pornography.

Increased sexual activity and/or masturbation.

Frequent and unwelcome sexual overtures to others, sometimes in public places.

Differences between Adult-Onset and Childhood-Onset Bipolar Disorders

- Irritability, often with prolonged and aggressive temper outbursts, is a more common mood change in children. Between outbursts, the children are often described as persistently irritable or angry.
- Very rapid cycling is more common, particularly in children under 8 years of age. Regular cycling (as would be seen in adults with bipolar disorders) is very uncommon before adolescence.
- Abnormal mood in children with mania is seldom characterized by euphoria.

Comorbidity of Bipolar Disorders and ADHD

Almost by definition, a child with a bipolar disorder will meet criteria for ADHD, and distinguishing between the two in children and adolescents is difficult. House (2002) has noted some important distinctions:

- A bipolar disorder diagnosis should include symptoms of elation or grandiosity, whereas a diagnosis of ADHD does not.
- A bipolar disorder diagnosis is more likely when a case of apparent ADHD appears to worsen and remit, independently of interventions.
- A bipolar disorder is more common in children with a family history of mood disorders.
- Poor response to treatments that have been found to be effective in ADHD (e.g., stimulant medication, behavior treatments) may be more indicative of a bipolar disorder.

Cyclothymia

Symptoms of cyclothymia are similar to those seen in the more severe bipolar disorders (DSM's bipolar I and bipolar II disorders), but the symptoms are less intense and, by definition, longer-lasting. The symptoms include periods of depression/lethargy alternating with periods of energy/irritability/agitation.

Summary Statement about a Childhood-Onset Bipolar Disorder

Evaluation revealed findings consistent with a bipolar disorder, including intense mood lability, grandiosity, narcissistic features, significant irritability, etc.

15.5. Depression

Relevant Original DSM-5 and ICD-10 Codes

296.3x	(F33.x)	Major depressive disorder, recurrent episode
296.2x	(F32.x)	Major depressive disorder, single episode
300.4	(F34.1)	Persistent depressive disorder (dysthymia)
311	(F32.89)	Other specified depressive disorder
311	(F32.9)	Unspecified depressive disorder
309	(F43.21)	Adjustment disorder with depressed mood
296.99	(F34.81)	Disruptive mood dysregulation disorder

General Information on Depression in Children

Depression in childhood is often mixed with a broader range of behaviors than in adulthood. Behaviors that are associated with depression in children include aggression, school failure, prob-

lems with peer relationships oppositional/antisocial behaviors, poor peer relationships, substance use, lack of motivation, decreased physical well-being, encopresis, enuresis, extreme fear of school or refusal to go to school, and talk of suicide.

According to DSM-5, somatic complaints, irritability, and social withdrawal are more common symptoms in children than in adults, while psychomotor retardation, hypersomnia, and delusions are less common in prepubescent children than in adolescents and adults (American Psychiatric Association, 2013).

Approximately 4–6% of children suffer from symptoms of depression, with fairly equal prevalence in boys and girls until adolescence, when twice as many girls as boys report experiencing depression (Merrell, 1999).

Although there is a general lack of consistency between self-reports and parental reports of depression in children, the reporting of a child's depressive symptomatology by parents is associated with more severe symptoms and poorer outcome (Braaten et al., 2001).

Affective Symptoms (\leftrightarrow by degree across columns only)

Sad	Very sad/irritable	Despairing	Suicidal
"Down in the dumps"	Unhappy	Despondent	Anguished
Bored	Self-derogatory	Demoralized	Desperate
Brooding	Anhedonic	Dejected	Self-destructive
Glum	Temperamental	Bitter	In the depths of despair
"Blue"	Changeable	Grave	"Nothing to live for"
Down-hearted	Melancholic	Beaten down	Tormented
"Low"/low-spirited	Volatile	Explosive	Unbalanced
Troubled	Angst-ridden	Disconsolate	Giving up hope
Somber	Distressed	Profoundly unhappy	"No light at the end of the tunnel"
"Down"	Gloomy	"On the edge"	Hopeless
Tearful	"Fed-up"	Inconsolable	In grave pain
Cheerless	Desolate	Miserable	Funereal
Dour	Distraught	Sorrowful	Morbid
Dispirited	Unstable	Suffering	
Dismayed	Forlorn	Morose	
Downcast	Bitter	Woeful	
	Unpredictable		
	Highly strung		
	"Wiped out"		
	"Up and down"		

Physiological Symptoms

Appetite absent/poor, cannot stop eating/is hungry all the time, appetite/hunger increase/decrease, fasting, binges.

Bowel/bladder/stomach symptoms, encopresis/enuresis, diarrhea/constipation/stomachaches, increased frequency of urination, overconcern with elimination, chronic use or abuse of laxatives, sensations of abdominal distention or incomplete evacuation of bowels.

Lethargy/physical weakness.

Low/depleted energy, lacks energy to get things done, loses stamina easily, listless, needs to be constantly pushed to do schoolwork/chores, tired, deenergized, weary.

(*In adolescents:*) Loss of libido, no interest in sex/opposite sex.

Poor general health, often complains about not feeling well.

Psychomotor retardation, absence of/lessened spontaneous verbal/motor/emotional expressiveness, long reaction time to questions (*indicate number of seconds*), slowed pace of thinking/acting/speaking.

Vegetative symptoms: Fatigue, anergia, sleep disorders/terrors, appetite changes, weeping, abdominal pains, alopecia areata, tics, eczema, allergies.

Behavioral Symptoms

Agitation, hypersensitivity, temper tantrums.

Appearance indicative of poor self-care, looks "worn."

Cannot get out of bed, has to force him-/herself to get out of bed.

Crying spells, never smiles/smiles infrequently, teary/tearful, cries openly and often inappropriately.

Concentration problems/difficulties, unable to concentrate.

Downward gaze, dejected look.

Grooming problems, difficulty grooming self, lacks good grooming habits.

Helplessness.

Lack of interest in playing/favorite activities/sports, boredom.

School problems, learning difficulties, school refusal/"phobia," fails to perform up to her/his normal academic standards, school failure.

Substance use/abuse (*particularly in adolescents*).

Shuffling gait, wrings hands, rubs forehead.

Uncommunicative, flat/expressionless/monotonous voice.

Unmotivated.

Other: Irrational fears (e.g., parent's dying, terrorist attacks, etc.), clingy, aggression.

Social Effects

Alienation from friends.

Belief that there is little or no social support system.

Gradual or sudden decline in interaction with friends.

Isolation from others/social isolation, withdrawal from social relationships.

Loneliness.

Plays alone, does not join in games.

Spends free time alone.

Depressive Cognitions

Arbitrary inference: Drawing a negative conclusion not supported by the evidence (e.g., thinks other children often make fun of him/her).

Automatic thoughts that reflect a sense of inefficacy and hopelessness.

Catastrophizing: Automatically assuming that the worst-case scenario will occur.

Discouraged about the future.

Dissatisfied with life.

Emotional reasoning (e.g., "Because I feel afraid, there must be danger").

Exaggerated concerns with bodily functions.

Guilt, blames self for setbacks.

Indecisiveness.

Lack of optimism about future, sees any prospects for future successes as dependent on actions of others, has considerable uncertainty and indecision about her/his plans and goals for the future.

Low self-esteem, loss of self-esteem, negative attitudes that result in low self-esteem, poor self-concept.

Mind reading: Assuming knowledge of another's thoughts (usually negative).

Negative self-worth when compared to others (often associated with imagined rather than real experiences), tends to judge him-/herself unfavorably.

Overgeneralizing: Basing a general conclusion on too few data or one incident, jumping to conclusions.

Personalization: Relating negative events to self without an empirical or rational basis.

Pervasive pessimism, self-pity.

Preoccupation with death (*more often seen in older than in younger children*), concern with separation.

Ruminations.

Selective abstractions: Attending to only the negative aspects of a situation and ignoring the other (positive) ones, mental filter, selective attention, disqualifying the positive.

Self-critical, dwells on past failures and lost opportunities, engages in self-inspection to a fault, ruminates on personal features that she/he perceives to be undesirable.

Sensitivity to criticism, thinks others do not like him/her.

Sense of helplessness/hopelessness.

Sense of worthlessness.

Common Triggers of Depression in Children

Chaotic and/or punitive home environment.

Death of a loved one.

Rejection by peers.

School failure.

Separation from parents.

Developmental Factors

In infants and toddlers, common symptoms of depression include withdrawal; slow growth or weight loss; general health problems such as frequent infections; dazed, immobile facial expressions and/or flat affect; problems with social interactions; decline in previously mastered developmental tasks; self-stimulation; and decreased play.

Preschool-age children with depression are often more tearful, clingy, and physically slowed down; are less talkative; and exhibit weight loss. Because most children in this age group cannot verbalize feelings of depression, it is important to examine physical and external symptoms (e.g., flat voice, sad facial expressions, low energy level/tiredness, unwillingness to engage in play, slow speech, and irritability).

✓ Although relatively rare, suicidal ideation does occur in the preschool-age population.

In school-age children with depression, somatic complaints (e.g., headaches, stomachaches), failure to make appropriate weight gains, low activity level, excessive sleeping, complaints of feeling bored or stupid, and decreases in school or sports performance are often common.

✓ Children this age are more able to verbalize depressive symptoms and cognitions.

Adolescents have even better capacity to describe their symptoms, which often include guilt, hopelessness, problems with schoolwork and friendships, conduct problems (e.g., promiscuity/sexual acting out, drug use, criminal activities), rageful behaviors, and decreased self-esteem. Sleep problems (either oversleeping or insomnia) are more common in this age group.

Disruptive Mood Dysregulation Disorder

Disruptive mood dysregulation disorder (DMDD) is a diagnosis that is new to the DSM-5 depressive disorders and is meant to better characterize children and adolescents who suffer from frequent and severe outbursts but otherwise do not meet criteria for a bipolar disorder.

Key characteristics of DMDD include severe temper outbursts and irritable to angry mood. The outbursts must occur at least three times a week for at least a 12-month period.

A key distinguisher of bipolar disorders from DMDD is the persistence of relatively stable irritability even in the presence of explosive outbursts.

Summary Statements about Depressive Symptoms

Child's/adolescent's responses indicated that she/he is not suffering from a clinical depression at this time and that she/he has no thoughts of suicide.

Although he/she did not report experiencing significant depression, he/she does appear to have some depressive symptomatology, including _____ (*specify*).

The child/adolescent appears to be severely depressed, discouraged, and withdrawn.

The child's/adolescent's symptoms meet criteria for a major depressive episode.

The adolescent's/child's thinking tends to be pessimistic, and she/he approaches life with a sense of doubt and discouragement.

The child's/adolescent's responses suggest that he/she is experiencing a chronic and serious depression.

Child has a negative sense of her/his own self-worth compared to others.

Child has a sense of dissatisfaction with him-/herself and views him-/herself with a marked sense of damage or inadequacy.

Child does not perceive her-/himself as being frequently happy.

Child tends to approach life with a sense of pessimism, doubt, and discouragement and is likely to anticipate gloomy outcomes.

His/her self-concept involves much negative self-evaluation and harsh self-criticism.

She/he is plagued by thoughts of worthlessness, hopelessness, and personal failure.

_____ admits openly to feelings of sadness, a loss of interest in normal activities, and a loss of sense of pleasure in things that were previously enjoyed.

He/she is showing significant difficulties with sleep patterns and a general decrease in his/her level of energy.

Results indicate that the child/adolescent has been experiencing a chronically depressed mood for a long period of time.

Assessment Instruments for Depression

The tests listed below specifically measure depression in children and youth (see Chapter 28 for more details about one of these, the CDI 2). General behavior rating scales and projective measures are also commonly used (*see Chapters 28 and 27, respectively, for more information regarding these latter types of instruments*).

Children's Depression Inventory 2 (CDI 2)

Children's Depression Rating Scale—Revised (CDRS-R)

Hopelessness Scale for Children (HSC)

Internalizing Symptoms Scale for Children (ISSC)

Reynolds Child Depression Scale

Reynolds Adolescent Depression Scale

15.6. Grief in Children

Descriptors include the following:

- Distress, anguish, sorrow, despair, heartache, pain, woe, suffering, affliction, troubles.
- Preoccupation with loss/loved one/memories.
- Easily becomes tearful, slowed thinking and responding with long latencies of response, stares into space.
- Feels helpless/vulnerable/useless, has lowered self-esteem.

Jarratt (1994) describes the grief process in children as having three phases: early grief, acute grief, and subsiding grief. In early grief, common reactions include denial, dissociation, hyperactivity, irritability, regressive behaviors, increased sleep, and separation anxiety. Acute grief's components include "yearning and pining"; searching (either literally searching for the person who has left/died or being preoccupied with the person); dealing with emotions such as sadness, anxiety, guilt, shame, and anger; and disorganization (e.g., lack of focus, reduced ability to concentrate). Subsiding grief includes acceptance of the grief trauma and the ability to "move on."

15.7. Obsessive–Compulsive Disorder (OCD)

Relevant Original DSM-5 (ICD-10) Codes

300.3 (F42.2) Obsessive–compulsive disorder

- ✓ Compulsions are repetitive, ritualistic behaviors, whereas obsessions are recurring and persistent thoughts.

Common Obsessions in Children

- Fears of being dirty/touched/contaminated, bodily excretions, trash/dirt/contaminants, animals, resulting illness of self or other.
- Ideas about cartoon characters/superheroes.
- Concerns about the future, worries about making decisions/future plans.
- Need for orderliness.
- Religious concerns.
- Worries about sexuality.
- Somatic concerns, fears of illness or disease, ideas about body parts.
- Worries about world events (possibility of war, poverty, crime, homelessness, terrorism, environmental destruction).
- Other: Ideas/concerns/worries about colors, sounds/music, names/titles, numbers, phrases, memories, unpleasant images, impulses (to hurt, blurt, harm, steal, cause disaster), saying/not saying certain things, not losing things, remembering things, etc.

Common Compulsions in Children

- Checking door locks, important papers, details of a story or an event, items of potential danger (kitchen knives, iron, stove, gas taps, etc.).
- Completing sequences of activities correctly, restarting from the beginning if necessary (homework projects, chores, etc.).
- Frequent cleaning/handwashing/showering (*note number of times per hour/day*).
- Counting number of things seen or number of times something is completed, counting out loud, repeating a ritual behavior a certain number of times.
- Hoarding (particularly food) or collecting objects (frequently objects of little or no value).

Need for symmetry/order/balance: must have clothes/books/foods/etc. in certain order, will rearrange objects in room over and over again, demonstrates compulsive straightening.
 Touching certain items whenever child sees them.
 Verbal compulsions (repeats expressions, phrases, etc.).

Summary Statements

Child denied experiencing any obsessive thoughts or compulsive behaviors.
 Child reported experiencing recurring thoughts, such as _____ (*specify*), that he/she cannot control and that cause him/her marked distress.
 Child feels need to wash hands/count things/silently repeat words/etc.

15.8. Suicidality

Degree of Suicidal Risk

(↔ *by degree*) The following groupings are sequenced in order of increasing suicidal risk.

No risk:

Highly unlikely, improbable, never considered suicide, implausible, inconsistent with strongly held religious beliefs, no thoughts of giving up or harming self.

Ideation:

Fleeting thoughts of suicide, thoughts/ideation/wishes to end life, expressed ambivalence about living, smoldering ideation, wonders whether she/he can "make it through this," raises questions about what happens to people after they die, suicidal "flashes."

Verbalizations:

Discusses other people's suicides, talks about plans, discusses methods/means, states intent, thoughts of self-mutilation, asks others to help kill him/her, reunion wishes/fantasies.

Behavioral gestures:

Says goodbye to others, gives away possessions, writes suicide note, nonlethal/low-lethality/nondangerous method, acts of self-mutilation, symbolic/ineffective/harmless attempts, command hallucinations with suicidal intent, assembles method(s) to be used, tells others of intent.

Attempts:

Deliberateness, action planning, method/means selected/acquired, medium- or high-lethality method.

Persistent attempts:

Continuous/continual efforts, unrelenting preoccupation.

Data on Suicide in Adolescents

Suicide is the second leading cause of death among individuals ages 10 to 18 (CDC, 2017). Completed suicides are five times more common among adolescent boys than among girls. Suicide *attempts* are two to four times more common in girls than in boys, in part because girls use less "successful" methods (e.g., pills) than boys (Grunbaum et al., 2002).

European American youth have higher suicide rates than African American youth. Asians and Pacific Islanders have the lowest rates, and Native American youth have the highest suicide rates of all (Anderson, 2002). Suicide attempts are often preceded by a number of warning signs, such as those listed below. A family history of suicide or severe psychiatric disorder increases the risk for suicide. There is greater risk in rural areas.

Suicide is not always linked to depression in adolescents; rather, suicide is often preceded by personal stressors, conflicts, or crises. These may include the breakup of a love affair, loss of a parent or other loved one, recent suicide of a peer or family member (“social contagion”), an unwanted pregnancy, contraction of a sexually transmitted disease, recent changes in school, birth of a sibling, or remarriage of a parent.

Warning Signs of Suicide in Adolescents

The following warning signs are mentioned by Schaughnessy and Nystul (1985) and Merrell (2001): emotional apathy, social withdrawal, poor grooming habits, loss of interest in recreational activities, giving away cherished belongings, blatant suicide threats, suicide notes, preoccupation with death, heavy substance abuse, losses and severe stressors (as described above), and unusual changes in behavior.

Shaffer, Garland, Gould, Fisher, and Trautman (1988) suggest that these three elements are important:

1. A triggering stressful event, such as a disagreement over parental rules or discipline, or some rejection or humiliation, such as breaking up with a boyfriend/girlfriend or a real or perceived failure.
2. A mental state that has been altered by something such as extreme hopelessness (particularly in girls), rage (*see Section 15.4, “Bipolar Disorders,” for more information*), or alcohol or drug use.
3. A readily available opportunity, such as a loaded gun, medications, or other lethal means in the home.

Continuum of Suicidal Behaviors

House (2002, p. 101) sees suicidal behaviors as a continuum from ideation to completed suicide, as follows. (Note the similarity between House’s continuum and the groupings of descriptors ordered by degree of risk, above.)

1. *Ideation*, ranging from “infrequent, passive thoughts to frequent, intrusive, active planning.”
2. *Precursor behaviors*, such as “saying goodbye, giving away possessions, writing note, communicating intent, assembling elements of method to be used.”
3. *Attempts*, ranging from low-lethality with “delayed or little risk” (e.g., “overdoses of pills, superficial wounds”) to medium-lethality with “more rapid, destructive” risk (e.g., “specific drug combinations, slashing wounds”) to high-lethality with “rapid, very dangerous” risk (e.g., “hanging, firearms”).
4. *Completion*.

Suicide Contract

A suicide contract is used when a child or adolescent is not in imminent danger of self-harm, but there is still concern about the possibility. The contract should include a written statement that the client will not engage in self-harm, as well as names of persons the child or adolescent can call if she/he experiences a wish or urge to engage in self-harm, and/or a plan that she/he has agreed to follow.

Confidentiality issues need to be considered. If you feel that a child or adolescent is at reasonable risk for self-harm, inform him/her that you will need to notify the parents, and then take appropriate steps to notify them.

Summary Statements about Suicidality

She/he was not feeling suicidal at the time of the evaluation.

_____ denied suicidal ideation.

Suicidal and homicidal ideation was denied.

The child denied any current wish to hurt him-/herself.

The child specifically denies any suicidal ideation, intent, or plan.

Child denied any suicidal or homicidal ideation at the time of admission/evaluation, but acknowledged significant depression and very severe mood lability.

Child had some thoughts of suicide, but agreed to a contract for safety.

The child/adolescent is at moderate/high risk for harming her-/himself.

The child/adolescent was feeling suicidal at the time of evaluation and had a well-formulated plan.

Assessment Instruments for Suicidality

Although there are few assessment instruments that specifically measure suicidality in children and adolescents, general behavior rating scales and projective measures (*see Chapters 28 and 27, respectively*) can be used to assess a child's level of depression and stress, and subsequent risk for suicidal ideation and behavior.

16

Childhood Behavioral and Cognitive Disorders

This chapter provides ways to describe and report information about the DSM-5 disorders that are most commonly seen in childhood and adolescence. For more information regarding affective symptoms and mood/anxiety disorders, see Chapter 15. For more information about assessing these disorders, see Chapters 2–3 and Chapters 20–28. For more information regarding recommendations for treatment, see Chapter 31.

16.1. Attention-Deficit/Hyperactivity Disorder (ADHD)

Relevant Original DSM-5 and ICD-10 Codes

314.01	(F90.2)	Attention-deficit/hyperactivity disorder, combined presentation
314.0	(F90.0)	Attention-deficit/hyperactivity disorder, predominantly inattentive presentation
314.01	(F90.1)	Attention-deficit/hyperactivity disorder, predominantly hyperactive-impulsive presentation <i>Specify:</i> In partial remission <i>Specify</i> current severity: Mild, moderate, severe
314.01	(F90.8)	Other specified attention-deficit/hyperactivity disorder
314.01	(F90.9)	Unspecified attention-deficit hyperactivity disorder

Diagnostic Notes

Primary symptoms of ADHD include impulsivity, inattention, and hyperactivity. Other diagnoses can be masked by ADHD, and ADHD is frequently comorbid with oppositional defiant disorder (ODD), conduct disorder (CD), anxiety, depression, learning disorders, and cognitive processing disorders (Root & Resnick, 2003). Links with PTSD, addictive behavior, OCD, tics, sleeping problems, and the autism spectrum have also been noted (Masi & Gignac, 2015). A sudden onset of ADHD symptoms (as opposed to lifelong characteristics that are present before the age of 12 years) would rule out true ADHD. Thus, obtaining a developmental history is crucial, and other potential causes of the symptoms (e.g., trauma, depression) need to be ruled out.

Developmental Aspects of ADHD

Infants/Toddlers/Preschoolers

Because toddlers and preschoolers are naturally active, it is important to distinguish between normal activity level and ADHD.

Frequently reported ADHD behaviors include:

Cried more than other babies, was colicky/irritable/hard to console/difficult to soothe, difficulty sleeping, "once _____ learned to walk, he/she immediately started running," was incredibly active, accident-prone/clumsy, slow to establish eating and sleeping patterns, inability to control impulses, temperamental.

School-Age Children

Problems in school are frequently the most impairing.

Problems in establishing friendships begin to occur at school age, because the children's behavior is annoying to others.

The majority of children with ADHD are identified in the first three grades of elementary school (Santrock, 2019).

Boys frequently display more hyperactive-impulsive behavior, while girls display more inattentive symptoms. This is one possible reason why girls are frequently underdiagnosed.

Frequently reported behaviors in this age group include the following:

Overactivity, impulsivity, inattention, fidgeting, poor/inconsistent school achievement, low self-esteem, disorganization, failing to complete homework/schoolwork, difficulties in giving close attention to details in schoolwork, organizational problems, difficulty attending to task when extraneous stimuli are present.

Adolescents

Hyperactive symptoms tend to remit or decrease or feel more like "restlessness."

Schoolwork continues to suffer.

Risk-taking behaviors are more common than in peers (speeding, traffic accidents); rebelliousness is also more common.

These adolescents have more problems finishing high school than teens without ADHD.

Frequently reported symptoms in adolescents include the following:

Restlessness, poor concentration, "spaciness," disorganized, shows poor follow-through, difficulty working independently, impulsivity, alcohol/drug use/abuse, antisocial personality patterns, low self-esteem, emotional/behavioral problems.

Inattentive Symptoms

Avoids tasks requiring sustained effort, difficulty with the mobilization and maintenance of effortful attention, "can't get started on tasks."

Cognitive sluggishness/slowing.

Daydreams, stares out the window/into space.

Distractible/easily distracted/self-distracting, problems staying on task, attends to background noises (voices, footsteps, traffic noises, etc.), lessened ability to sustain attention/concentration on school tasks/work/play, poor attending skills.

"Doesn't listen," seems not to listen.

Doesn't complete chores or must be constantly reminded to complete chores, fails to finish tasks.

- Easily diverted from a task at hand, unable to find and attend to the relevant components of a task, tends to focus on whatever catches his/her attention rather than on the most salient parts.
- Forgetful, forgets to write down homework assignments/bring homework home/bring completed homework to school or turn it in.
- Frequently says "I don't know" and "I forget" when asked a question, needs/asks for repetitions of instructions, gets confused, misses announcements.
- Homework difficulties, can't finish homework unless someone is standing next to her/him, does not study/prepare/organize/protect own work/do problem's steps in sequence, does not complete assignments on time, starts work before receiving full instructions, unprepared for school assignments, does not make good use of study times.
- Inability to shift or move from one event to another.
- Inability to divide attention or pay attention to two or more events simultaneously.
- Inefficient use of time, underestimates the amount of time it will take to complete a task or assignment.
- "Loses everything" (e.g., backpack, homework, mittens, coat), loses things necessary for an activity (e.g., toys, pencils, keys, assignments, books, equipment).
- Makes careless errors, inattentive to details.
- Organizational difficulties, difficulty organizing him-/herself/schoolwork.
- Working memory difficulties, poor short-term memory skills (two- or three-step instructions), fails to remember sequences.

Impulsive Symptoms

- Acts "in the moment" without considering the consequences.
- Blurts out answers.
- Difficulty controlling how she/he responds to a variety of situations.
- Fails to consider possible alternatives.
- Interrupts others, answers questions before persons asking them have finished, tends to jump into a task before hearing all the instructions.
- Low frustration tolerance.
- Responds quickly but incorrectly, reacts without considering, acts before thinking, limited self-regulatory functions.
- Risk taker, engages in physically dangerous activities.
- Senseless/repetitive/eccentric behaviors, darts around aimlessly.
- Shoots rubber bands/paper airplanes/spitballs.
- Shows off own work when not called on by the teacher.
- Trouble/difficulty waiting turn.

Hyperactive Symptoms

- Clumsiness.
- Constantly/always in motion, changes seating position or posture frequently, prefers to run rather than walk, climbs on furniture, hops/skips/jumps rather than walking.
- Difficulty engaging in leisure activities quietly, does not/cannot sit through an interview or meal.
- Drums/taps fingers on table, constantly taps foot, swings/shakes legs.
- Feels "driven by a motor," "on the go all the time."
- Frequently gets up to go to bathroom/get a drink from water fountain, can't stay in seat/slides in seat, frequently "roams the classroom," moves about constantly, climbs furniture.
- Makes popping sounds with mouth, hums/clicks teeth/whistles, frequently yawns loudly, makes sounds that inadvertently disturb anyone nearby.
- Makes noise by slamming books, banging objects, tapping pencil, etc.
- Plays with/twists hair, fiddles with objects.

Sleeplessness, hard time falling asleep.

Squirms/fidgets/twists/turns/wiggles, physically active, a "whirlwind" of activity.

Restlessness.

Talks excessively/incassantly, repeatedly asks irrelevant questions, talks about things that are not related to the task at hand, engages in lengthy conversations when he/she is supposed to be working.

Difficulty sitting still.

Associated Problems

Adaptive skills deficits:

Poor self-help skills, trouble assuming personal responsibility and independence.

Aggressive behaviors:

Destroys (tears/crumples/etc.) others' work, destroys classroom materials (e.g., breaks pencils/crayons, writes in books, rips books), writes on other children's papers/on the desks/classroom walls/textbooks, hits others, grabs other children's materials, uses inappropriate/abusive language, curses, threatens/teases/criticizes/bullies others.

Cognitive deficits:

Weak working memory, visual/auditory memory.

Discipline problems (besides aggression):

Noncompliant, hostile, demonstrates signs of or has comorbid CD/ODD.

Emotional problems:

Poor self-esteem, anger, emotional lability, comorbid mood disorder, low tolerance for frustration, temper outbursts.

Family difficulties:

Argumentative with parents, disrupts shopping and family visits/family vacations, babysitters complain about her/his behavior, interrupts/intrudes butts in, fights with siblings/parents.

School problems:

Poor quality of schoolwork, difficulty sitting still to take tests, grades that are lower than expected or erratic, performs below ability level, grade retention/failure to graduate/expulsion, special education placement, comorbid learning disability, refractory to usual instructional approaches, may seem unresponsive to punishment or rewards.

Social skills deficits:

Poor peer relationships because of ADHD behaviors (e.g., impulsive aggression, excessive talking, poor listening skills), failure to comply with rules that leads to poor participation in sports or clubs, difficulty with authority figures, less socially competent, tactless/bossy/obstinate, unwilling to take turns, provokes/disrupts other children's activities, betrays friends, peers avoid/reject him/her, has great difficulty keeping friends.

Summary Statements about ADHD

No evidence of attention deficit was indicated on the parent report symptom checklists/teacher reports/etc.

The child's/adolescent's mother/father/teacher completed the _____ (*give name of measure*). Their ratings were not consistent with a diagnosis of ADHD.

The child's/adolescent's parents and teachers also completed the _____ (*specify instrument*), where their responses indicate that she/he does not have ADHD, either predominantly inattentive presentation or predominantly hyperactive/impulsive presentation.

The child's/adolescent's difficulty concentrating does not fit the profile of ADHD because _____ (*specify*).

The child's/adolescent's mother/father/teacher completed the _____ (*specify instrument*). His/her responses indicate that the child/adolescent demonstrates many of the symptoms common to ADHD, but not at a significance level that meets formal diagnostic criteria.

The child/adolescent does exhibit some subthreshold symptoms of ADHD, which do not meet diagnostic criteria at the present time but do need to be monitored.

Consistent with a diagnosis of ADHD, the child/adolescent was found to have difficulty with sustained auditory attention, visual organization, and shifting set.

The overall results of testing support the existence of a primary attentional and organizational disorder that is consistent with frontal lobe impairment. A diagnosis of ADHD is therefore appropriate.

Behavior rating scales and history indicate that the child/adolescent is exhibiting significant symptoms of inattention, impulsivity, and hyperactivity consistent with a diagnosis of ADHD.

Behavior rating scales indicate that the child/adolescent meets the criteria for ADHD, combined presentation/predominantly inattentive presentation/predominantly hyperactive-impulsive presentation. In addition, she/he demonstrates difficulties on tasks requiring sustained concentration and focus and presents with organizational difficulties and impulsive responding.

The child/adolescent exhibits symptoms consistent with a diagnosis of ADHD. His/her symptoms are quite severe and interfere with his/her functioning in all areas, including academic/social/family functioning.

The child/adolescent performed in the clinically significant range on several tasks requiring sustained attention, consistent with her/his previous diagnosis of ADHD.

Assessment of ADHD

Behavior Rating Scales *See Chapter 28 for more details about many of these scales.*

BROAD-BAND SCALES

Behavior Assessment System for Children, Third Edition (BASC-3)

Child Behavior Checklist (CBCL), Teacher's Report Form (TRF), and Youth Self-Report (YSR)—all components of the Achenbach System of Empirically Based Assessment (ASEBA)

NARROW-BAND SCALES

ADD-H Comprehensive Teacher's Rating Scale (ACTeRS), Second Edition

ADHD Rating Scale-5

Behavior Rating Inventory of Executive Function, Second Edition (BRIEF2)

Brown Executive Function/Attention Scales

Child Symptom Inventory

Conners 3rd Edition (Conners 3)

Home Situations Questionnaire

School Situations Questionnaire

SNAP-IV Teacher and Parent Rating Scale

Classroom Observation Forms

ADHD School Observation Code
Revised ADHD Behavior Coding System

Tests of Attention and Other Executive Functions

See Chapter 26 for more details about many of these scales.

Brief Test of Attention (BTA)
Conners Continuous Performance Test 3rd Edition (Conners CPT 3)
Conners Kiddie Continuous Performance Test 2nd Edition (Conners K-CPT 2)
d2 Test of Attention
Gordon Diagnostic System
Stroop Color and Word Test
Test of Variables of Attention (TOVA and TOVA-A)
Trail Making Test, Parts A and B
Visual Search and Attention Task (VSAT)
Wisconsin Card Sorting Test (WCST)

16.2. Communication Disorders

See also Section 13.6, "Speech and Language Skills."

Relevant Original DSM-5 and ICD-10 Codes

315.39	(F80.2)	Language disorder
315.39	(F80.0)	Speech sound disorder
315.35	(F80.81)	Childhood-onset fluency disorder (stuttering)
315.39	(F80.82)	Social (pragmatic) communication disorder
307.9	(F80.9)	Unspecified communication disorder

General Information

The American Speech–Language–Hearing Association (1982) groups speech and language problems according to the following subsystems of language:

Phonology (e.g., substitution/omission of speech sounds, unintelligible speech).
Morphology (e.g., problems understanding/producing word forms, use of inappropriate prefixes/suffixes).
Syntax (e.g., problems ordering elements of a sentence).
Semantics (e.g., trouble understanding word or sentence meaning).
Pragmatics (e.g., difficulty in social use of language).

Sattler (1992) describes the following as language problems often seen in preschool/early school years:

- Ages 3–5 years: Lack of speech, speech that is unintelligible or incoherent, and an inability to speak in sentences.
- Ages 5–6 years: Substitution errors, dropping of word endings, problems with sentence structure, and nonfluency/dysfluency.

Problems with Language Quality

Poor/limited vocabulary, confabulations, stereotyped phrases, poverty of amount/content of speech, tangential, telegraphic speech, word-finding errors/problems with word recall, shortened sentences, problems with grammatical structure of language, errors in tense, poor conversational skills.

Expressive Language Difficulties

Limited/small vocabulary, speaks in short/simple sentences, vocabulary errors, simplified grammar, unusual word order; slow rate of language development.

Receptive Language Difficulties

Problems understanding words/specific types of words, difficulty understanding sentences/statements, problems with auditory processing, fails to respond to speech, seems deaf.

Problems with Vocal Quality

Loud, soft, monotonous, high/low-pitched, harsh, hoarse, nasal/hypernasal/hyponasal.

Aphasia

Types of aphasia:

Congenital/developmental/acquired, expressive/receptive/auditory.

Subcategories of aphasia:

Agraphia, agnosia, apraxia, alexia, anomia.

Symptoms in children:

Reduced spontaneous speech (often beginning as mutism and followed by limited speech), hesitations, impoverished speech, difficulty understanding verbal commands (*Satz & Bullard-Bates, 1981*), problems with word order/word choice, word omissions, problems comprehending verbal commands, errors of circumlocution, semantic approximations.

Articulation Problems

Abnormal production of speech sounds, unintelligible speech, difficulty saying certain speech sounds, poor diction, lisp, dysarthria.

Word sounds omitted/substituted/distorted/added/poorly produced, substitutes certain sounds for other sounds, reverses order of sounds within words, uses incorrect sounds in the place of more difficult ones (e.g., "wabbit" for "rabbit"), omits difficult phonemes (e.g., "bu" instead of "blue").

Stuttering

Andrews et al. (1983) and the American Psychiatric Association (2013) note the following developmental aspects of stuttering:

Most stutterers are identified between ages 2 and 7 years, and stuttering occurs by age 6 years for 80–90% of affected children.

Onset can begin gradually or more suddenly, with a typical course occurring gradually.

Most children (65–85%) recover from stuttering.

Characteristics of stuttering are as follows:

Vocal behaviors:

Abnormal hesitations in speech, prolongations/prolonged sounds, repetitions, disordered/impaired rate/rhythm/fluency, interrupted speech flow, repeats/repetitions, blocking.

Physical symptoms:

Grimaces/clenches fists, gestures, bodily movements indicating struggle to speak/struggle behavior, blinking/eye blinks, tics.

Associated problems:

Fear of speaking, avoiding certain situations (public speaking, talking on phone, speaking up in class), anxiety, frustration.

Other Speech Difficulties

Dysprosody, neologisms, echolalia, "word salad," disorganized, pedantic, formal/stilted, overly familiar, slow reaction times, circumstantiality, illogicality, paraphasia, perseverations, misnamings, pressured.

Summary Statements about Language

The general array of the child's language testing indicates that she/he has an average/below-average/above-average ability to use and understand language.

The child's linguistic difficulties seem more related to construction and mechanics than to comprehension and understanding.

Overall, language is an area of strength/weakness for this child.

Performance on oral language measures was within the average/below-average/above-average range.

Articulation was generally normal, with fluent speech.

The nonverbal attributes of communication were age-appropriate, including intonation, prosody, volume, and the expression of affect in tone of voice.

The child's speech is appropriate in terms of articulation, volume, modulation, and prosody (range of intonation).

Literal paraphasic errors (mispronunciations) were heard/not observed during fluent speech.

Verbal paraphasic errors (word substitutions) were heard/not observed during fluent speech.

No significant word-finding difficulties or symptoms of dysnomia were heard during fluent speech.

Verbal and situational pragmatics (the use of language as a tool of communication) were generally appropriate/inappropriate.

Spontaneous speech was virtually absent throughout the examination.

Expressive/receptive language skills were found to be within normal limits/moderately delayed/severely delayed.

Both expressive and receptive language skills are quite underdeveloped relative to potential.

The child's performance was indicative of significant problems with word retrieval.

Assessment of Language Functioning

The following are commonly used measures of language functioning in children. (*For more information about many of these tests, see Chapter 23.*)

Comprehensive Receptive and Expressive Vocabulary Test—Third Edition
Expressive One-Word Picture Vocabulary Test, Fourth Edition (EOWPVT-4)

Expressive Vocabulary Test, Third Edition (EVT-3)
 Multilingual Aphasia Examination
 Oral and Written Language Scales, Second Edition (OWLS-II)
 Peabody Picture Vocabulary Test—Fifth Edition (PPVT-5)
 Receptive One-Word Picture Vocabulary Test, Fourth Edition (ROWPVT-4),
 Test of Early Language Development, Fourth Edition (TELD-4)
 Test of Language Development—Primary: Fourth Edition (TOLD-P:4)
 Test of Language Development—Intermediate: Fourth Edition (TOLD-I:4)
 Test of Word Finding—Third Edition (TWF-3)

16.3. Disruptive Behavior Disorders

See also Section 16.1, “Attention-Deficit/Hyperactivity Disorder (ADHD).”

Relevant Original DSM-5 and ICD-10 Codes

313.81	(F91.3)	Oppositional defiant disorder <i>Specify</i> current severity: Mild, moderate, severe
312.34	(F63.81)	Intermittent explosive disorder
312.81	(F91.1)	Conduct disorder, childhood-onset type
312.81	(F91.2)	Conduct disorder, adolescent-onset type
312.89	(F91.9)	Conduct disorder, unspecified onset <i>Specify</i> if: With limited prosocial emotions <i>Specify</i> current severity: Mild, moderate, severe
313.89	(F91.8)	Other specified disruptive, impulse-control, and conduct disorder
312.9	(F91.9)	Unspecified disruptive, impulse-control, and conduct disorder

ODD Symptoms

Argumentative, annoys others, touchy, overreacts to appropriate rule setting, swears at parents/teacher, “hell on wheels,” defiant, rude, talks back/“sasses,” insubordinate, challenges/disputes.

Blames others for mistakes or problems, denies all responsibility, persistently resists others' ways of doing things.

Temper outbursts/loses temper, is spiteful/vindictive/disobedient, volatile, stubborn/noncompliant, irritability, resentment, negativism, provokes others.

Refuses to cooperate/follow rules during group activities, frequently cheats during games or makes up own rules to games, refuses to do what others tell him/her to do.

(Associated symptoms:) Low self-esteem, low frustration tolerance, drug/alcohol/tobacco use, mood lability, school suspensions.

CD Symptoms

Aggression:

Physically aggressive to peers/parents/teachers/animals, bullies others, uses weapons, rape, gets into frequent fights with others on the playground/on the bus/in the neighborhood/anywhere, fist fighting, gang fighting, is mean to other children, “foul mouth,” uses derogatory/insulting language, violent/dangerous, assaults, threatens/intimidates/bullies, physical cruelty to animals or people.

Destruction of property:

Sets fires, writes graffiti (particularly hate graffiti), blows up mailboxes with firecrackers, vandalism, deliberate destruction of property known to belong to others.

Deceitfulness:

"Often lies to get out of trouble," places blame on others, a "pathological liar"/"born liar," will cheat/lie in order to win/be seen as the winner, makes an effort on a task or toward others only if it serves his/her interests, selfishly accepts favors without any desire to return them.

Theft:

Shoplifts, forges checks, breaks into people's homes/cars/stores, auto theft/"joy riding," mugging, extortion/blackmail, armed robbery, stealing, burglary, purse snatching.

Violations of rules:

"Always in trouble," truant from school, has run away from home ____ times, violates curfew, stays out all night, disobeys school rules, driving a car without a license, trades sex for money/goods/drugs, coerced others into sexual activities, substance use before age 13 and recurrent use after 13 years of age.

Associated emotional symptoms:

Low self-esteem, poor frustration tolerance, "short fuse," temper outbursts, irritability, superficial bravado, belief that people "pick on" her/him.

Associated academic symptoms:

Poor school achievement/drop in grades, expelled from school/school probation, special education placement, repeating a grade.

Other associated symptoms:

Substance abuse/dependence, sexually active from an early age/multiple sex partners, gang membership, history of sexual/physical abuse, insecurity, juvenile delinquency.

Assessment of ODD and CD

See also the broad-band scales listed for assessment of ADHD in Section 16.1.

Antisocial Process Screening Device (APSD)

Conduct Disorder Scale (CDS)

Jesness Behavior Checklist (JBC)

Jesness Inventory—Revised (JI-R)

16.4. Feeding and Eating Disorders

Relevant Original DSM-5 and ICD-10 Codes

307.52	(F98.3)	Pica in children
307.52	(F50.89)	Pica in adults
307.53	(F98.21)	Rumination disorder
307.59	(F50.82)	Avoidant/restrictive food intake disorder
307.1	(F50.01)	Anorexia nervosa, restricting type
307.1	(F50.02)	Anorexia nervosa, binge-eating/purging type

307.51	(F50.2)	Bulimia nervosa
307.51	(F50.81)	Binge-eating disorder
307.59	(F50.89)	Other specified feeding or eating disorder
307.50	(F50.9)	Unspecified feeding or eating disorder

General Intake/Feeding Difficulties

Snow (1998) states that problems related to infant nutrition and feeding practices can include the following:

- Iron deficiency anemia.
- Adverse/allergic reactions to food.
- Dental caries (e.g., “bottle-mouth syndrome,” “nursing-bottle syndrome,” or “baby-bottle tooth decay”).
- Obesity.
- Malnutrition (including protein energy malnutrition, kwashiorkor, and marasmus).

Snow (1998) also notes these positive signs of growth in infancy:

- Normal growth rate.
- Good appetite.
- Firm muscle tone.
- Curiosity.
- Alertness.

Problems with eating can include the following:

Problematic eating behaviors:

Finicky eater, verbally expresses dislike for many foods, shows distress/cries when certain foods are on his/her plate, tries to remove food from plate/throws food, holds food in mouth for long periods of time/doesn't swallow food, plays with food, complains that something is wrong with the food.

Problems specifically associated with overeating:

Physical health problems (e.g., cardiovascular problems, diabetes), social problems, difficulty in physically keeping up with peers (e.g., may run out of breath when she/he walks, tires easily during movement/exercises, prefers sedentary activities), poor self-esteem.

Pica

Pica is the ingesting of non-nutritive substances such as dirt, chalk, plaster, soap, glue, matches, feces, clay, charcoal, baking soda, ashes, coffee grounds, laundry starch, or hair. It usually begins between the ages of 1 and 2 years; it is also seen in pregnant women (including pregnant teens; hence the inclusion of pica in adults above). It may be associated with iron deficiency, and it can cause lead poisoning and intestinal obstruction.

Rumination Disorder

In rumination disorder (also called “merycism”), a child regurgitates and rechews food. Medical complications may include malnutrition or failure to thrive in infants (which can be fatal), and the act of ruminating may be associated with a hiatus hernia. It is more common in children with intellectual disability than in those with normal intelligence.

Anorexia Nervosa

Physical Presentation and Symptoms

Emaciated appearance:

Protruding ribs/hipbones, "skull-like" face, "broomstick" limbs, cachexia/cachectic, emaciation, weight loss of at least 15% without disease.

Physiological consequences:

Amenorrhea/menstrual irregularities/disruption/cessation, degeneration of muscle, cardiac stress/arrhythmia/bradycardia/heart failure, edema, electrolyte imbalance, hair loss, low blood pressure, reduced body temperature/hypothermia, growth of thick soft hair over the body.

Behavioral Symptoms

Excessive exercising/overexercising.

Laxative/diuretic misuse/abuse.

Reduces food intake to only a few vegetables/crackers/etc. a day, eating only low- and no-calorie foods, ritualizes food habits/eating (e.g., cutting food into very small pieces, chewing for long periods).

Refusal to eat/self-starvation/fasting.

Spends hours observing body in mirror.

Cognitive Symptoms

Distorted body image (believes she/he is always too fat, despite significant weight loss), loses ability to see body realistically, sees self as grossly overweight even if actually emaciated, dissatisfied with bodily appearance.

Fear of becoming obese, food phobia, fear of pubertal changes.

"Good child," well-behaved, conscientious, quiet, intense drive to be perfect or please others.

Morbid fear of gaining weight/becoming fat, distorted and implacable attitudes toward food, avoidance of "fattening" foods, overvalued ideas of/dread of fatness.

Obsession with thinness, preoccupied with food, excessive interest in food preparation/trying new recipes/cooking elaborate meals for others.

Perfectionistic, overly self-disciplined/controlled, pride in weight management, overly critical of self and/or others.

Sees family in overly positive light, denies any family conflict, idealized view of family, enmeshment with a parent, family does not reveal feelings/emotions.

Emotional/Social Aspects

Dependent/compliant.

Depression, anxiety, difficulty sleeping.

Difficulty expressing feelings (particularly negative ones).

Low self-esteem.

Socially inactive.

Bulimia Nervosa

Physical Presentation and Symptoms

Appearance:

Normal body size, near-normal weight (sometimes obese), great body fluctuations.

Physiological consequences:

Frequent sore throats, swollen glands, dental problems due to destruction of tooth enamel, intestinal problems/constipation, nutritional deficiencies, intense hunger, dehydration, lowered body temperature, disturbances of body chemistry/electrolyte imbalances, loss of hair, insomnia, amenorrhea.

Behavioral Symptoms

Alternates between binge eating and periods of fasting/normal eating behavior, eats food in secret, purchases large quantities of food that suddenly "disappear," other people's food "disappears."

Engages in gross overeating followed by purging (self-induced vomiting or overdoses of laxatives), consumes enormous amounts of high-calorie food, frequently eats high-calorie foods without gaining weight.

Excessive exercising.

Frequent weighing, attendance at weight control clinics.

Impulsivity, hyperactivity.

Junk food consumption.

Makes attempts to lose weight, is a lifelong dieter.

Perfectionism.

Self-induced vomiting, uses laxatives/diuretics/appetite suppressants/thyroid preparations.

Cognitive Symptoms

Abnormal concern with body size, weight central to self-evaluation, feels powerless about controlling weight.

Difficulty thinking clearly, rationalizes eating/symptoms, dichotomous thinking, overpersonalization, rationalization of eating/symptoms.

Fear of obesity/morbid fear of becoming fat.

Negative/distorted/irrational body image, overconcern with body appearance/shape/weight, dissatisfied/disgusted with bodily appearance.

Perfectionism.

Preoccupation with food.

Shame about abnormal behavior.

Emotional Aspects

Depression, anxiety, mood swings, masked anger.

Feelings of disgust/helplessness/panic/guilt over inability to control binges/purging.

Impulsivity.

Low self-esteem, oversensitive to criticism from others.

Suicidality.

Social Aspects

Difficulty with interpersonal relationships, refuses to date because of self-consciousness about looks.

Eats alone due to embarrassment over amount eaten/eating rituals, frequent trips to bathroom (for purging).

Family problems.

High achievement, academic success.

Restriction of social activities.

Work impairment.

Binge-Eating Disorder

Diagnostic Features

Binge-eating disorder, a new disorder in DSM-5, consists of recurrent episodes of eating in a discrete period of time (i.e., a single sitting) an amount of food that is much larger than what most people would eat in that period of time, along with a sense of a lack of control over the episode of eating. These behaviors typically begin in adolescence and frequently occur in people who are overweight and sedentary.

Typical Symptoms

"Once I get started, I can't stop."

Binges on donuts, ice cream, fast food, pizza, frozen pies/cakes, etc.

"Feels like someone else is doing the eating."

Always eat in front of TV, at work, at McDonald's/other favorite fast-food place, in bedroom.

Eats everything in freezer/refrigerator/cupboards.

Assessment of Eating Disorders

The Eating Disorder Inventory-3 (EDI-3) can be used for specifically assessing eating disorders. (See Chapters 27 and 28 for projective measures and general behavior rating scales, respectively.)

16.5. Elimination Disorders

For eating disorders, see Section 16.4, "Feeding and Eating Disorders."

Relevant Original DSM-5 and ICD-10 Codes

307.6	(F98.0)	Enuresis <i>Specify</i> whether: Nocturnal only, diurnal only, nocturnal and diurnal
307.7	(F98.1)	Encopresis <i>Specify</i> whether: With constipation and overflow incontinence, without constipation and overflow incontinence
788.39	(N39.498)	Other specified elimination disorder with urinary symptoms
787.60	(R15.9)	Other specified elimination disorder with fecal symptoms
788.30	(R32)	Unspecified elimination disorder with urinary symptoms
787.60	(R15.9)	Unspecified elimination disorder with fecal symptoms

Enuresis

Enuresis is wetting after the age of 5 years. "Primary" enuresis occurs when symptoms have been present throughout childhood (i.e., toilet training was never successfully accomplished). "Secondary" enuresis occurs after at least 6 months of successful toilet training.

Associated medical conditions:

Juvenile-onset diabetes, sickle cell disease, urinary tract infection, kidney infection, minor neurological impairments, structural anomalies.

Associated emotional and behavioral symptoms:

Social stigma related to bedwetting at friends' houses, reluctance to have sleepovers or go to sleep-away camp, trauma or separation from parents (often associated with secondary enuresis).

Encopresis

Encopresis is soiling after age 4 years.

Associated medical conditions:

Constipation, anal fissures, refusal to eat, weight loss, dehydration, leakage of unformed stool around impaction, Hirschsprung disease/aganglionic megacolon.

Associated emotional and behavioral symptoms:

Hiding/smearing stool or feces, high family stress/psychopathology, disorganized household, physical/sexual abuse, increased anxiety, toilet phobia, stressful events (e.g., birth of sibling, separation from parents, starting school).

16.6. Learning Disabilities

See Chapter 33, “Writing for the Schools,” for more information regarding the determination of a learning disability according to the Individuals with Disabilities Education Improvement Act of 2004 (IDEA 2004).

Assessment of Learning Disabilities

See Chapters 21 and 22 for more information about many of the tests mentioned below.

Tests of intelligence, academic skills, relative cognitive abilities, and (often) emotional skills are usually needed to make a diagnosis of a learning disability. There is no one standard battery for any of the learning disabilities described in this section, as the selection of tests should be based on the referral question, the child’s age and grade level, and the severity of the disability’s impact. Listed below are general tests of intelligence and academic achievement.

Tests of Intelligence

Differential Ability Scales—Second Edition (DAS-II)
 Kaufman Assessment Battery for Children, Second Edition (KABC-II)
 Kaufman Brief Intelligence Test, Second Edition (KBIT-2)
 Stanford–Binet Intelligence Scales, Fifth Edition (SB5)
 Wechsler Adult Intelligence Scale—Fourth Edition (WAIS-IV)
 Wechsler Intelligence Scale for Children—Fifth Edition (WISC-V)
 Wechsler Preschool and Primary Scale of Intelligence—Fourth Edition (WPPSI-IV)
 Woodcock–Johnson IV (WJ IV) Tests of Cognitive Abilities

Tests of Academic Achievement

DABERON Screening for School Readiness—Second Edition
 Diagnostic Achievement Battery—Third Edition
 Diagnostic Achievement Test for Adolescents—Second Edition
 Wechsler Individual Achievement Test—Third Edition (WIAT-III)
 Wide Range Achievement Test, Fifth Edition (WRAT5)
 Woodcock–Johnson IV (WJ IV) Tests of Achievement
 Young Children’s Achievement Test—Second Edition (YCAT-2)

Associated Emotional and Behavioral Symptoms

Anxiety, depression, comorbid ADHD.
Low motivation, perception of lack of ability, less likely to credit successes to his/her ability.

Negative attitudes shown by teachers/students/parents toward child, child is teased by other children because she/he can't read/write/do math.

Poor impulse control, juvenile delinquency, aggressive behaviors.

Poor social competence.

Summary Statements about Ability–Achievement Discrepancies

Academically, the child's overall level of educational achievement is significantly higher than his/her overall level of intellectual development, based on his/her performance on the _____ (give name of test).

The child's academic testing performance is comparable to or exceeds her/his cognitive test performance.

On each of the achievement tests, the child/adolescent scored at expected levels based on IQ (a measure of aptitude) and performed at grade level as compared to age-mates on tests of reading/spelling/mathematics.

His/her academic achievement was commensurate with expectations based on cognitive ability.

Although performance in a number of domains was not significantly discrepant from that of same-age peers, achievement in some areas (*specify*) was below what would be expected, given the child's overall intellectual abilities.

The child's performance on most measures of academic performance was at/slightly below/far below expectations, given his/her overall intellectual abilities.

A regression-based discrepancy analysis indicates a significant ____-point difference between reading/math/spelling/writing/etc. ability on achievement tests and the child's expected abilities. This difference occurs in only ____% of her/his same-age peers ($p < \underline{\quad}$).

Various dimensions of reading/writing/math/listening/speaking/etc. were evaluated, and certain aspects (*specify instrument*) were discrepant from intellectual functioning as measured by the _____ (give name of test).

Mathematics Disabilities/Dyscalculia

Relevant Original DSM-5 and ICD-10 Codes

315.1 (F81.2) Specific learning disorder with impairment in mathematics
Specify impaired subskills (number sense, memorization of arithmetic facts, accurate or fluent calculation, accurate math reasoning)
Specify current severity: Mild, moderate, severe

Assessment of Mathematics Disabilities

Comprehensive Mathematical Abilities Test

KeyMath–3 Essential Resources

KeyMath–3 Diagnostic Assessment

Test of Early Mathematics Ability—Third Edition (TEMA-3)

Test of Mathematical Abilities—Third Edition (TOMA-3)

Symptoms

Difficulty performing mathematical operations (addition/subtraction/multiplication/division), trouble counting, problems with identifying/using money, cannot tell time, unable to consistently add/subtract single-digit numbers, unable to complete any multiple-digit items.

Difficulty comprehending mathematical terms/operations, trouble understanding story prob-

blems, cannot analyze word problems and make the correspondence between manipulative and abstract numbers.

Misreads operations signs, does not acknowledge corresponding signs.

Problems learning math facts (e.g., multiplication tables).

Transposes numbers.

Associated Emotional and Behavioral Symptoms

Academic problems, comorbid dyslexia, problems with conceptual aspects of learning.

Attention deficits.

Depression.

Difficulties with social cognition, social withdrawal.

Opposition to written work.

Summary Statements

The child's performance on the current testing is consistent with a diagnosis of specific learning disorder with impairment in mathematics, as achievement scores in math were discrepant from expected performance and showed a ____-year grade delay.

(For a younger child:) Academic achievement skills fall well below current grade level for math, where the child shows an insecure grasp of basic concepts (e.g., 1:1 correspondence, number recognition, appreciation of number magnitude) and has difficulty manipulating numbers, even for very simple problems and concepts.

Reading Disabilities/Dyslexia

The terms “dyslexia,” “reading disabilities,” and “reading disorder” are often used interchangeably. The old DSM-IV diagnostic label was Reading Disorder. However, DSM-5 now uses “specific learning disorder with impairment in reading,” and much of the research literature uses “dyslexia.” The term “reading disabilities” encompasses everything.

Relevant Original DSM-5 and ICD-10 Codes

315.00 (F81.0) Specific learning disorder with impairment in reading
Specify impaired subskills (word reading accuracy, reading rate or fluency, reading comprehension)
Specify current severity: Mild, moderate, severe

Assessment of Reading Disabilities

See Chapter 22 for more details about several of these tests.

Classroom Reading Inventory—Twelfth Edition

Comprehensive Test of Phonological Processing (CTOPP-2)

Gates–MacGinitie Reading Tests, Fourth Edition (GMRT-4)

Gray Oral Reading Tests—Fifth Edition (GORT-5)

Gray Silent Reading Tests (GSRT)

Lindamood Auditory Conceptualization Test, Third Edition (LAC-3)

Nelson–Denny Reading Test

Rosner Auditory Analysis Test

Test of Early Reading Ability—Fourth Edition (TERA-4)

Test of Reading Comprehension—Fourth Edition (TORC-4)

Woodcock Reading Mastery Tests—Third Edition (WRMT-III)

Reading Skill Deficits

- Auditory discrimination problems, unable to identify beginning/ending sounds in words, cannot recognize initial consonants/consonant clusters, cannot recognize vowel sounds.
- Comprehension problems/difficulty comprehending what has just been read, relied on pictures for sentence comprehension.
- Decoding problems, inaccurate reading, difficulty in the ability to recognize sounds and their sequences in words, difficulty with tasks of nonword/nonsense word reading, unable to accurately read the simplest of stories, unable to provide correct sounds for consonants/consonant digraphs/consonant blends/short vowels/long vowels/vowels embedded in three-letter consonant–vowel–consonant words, often added letters and rearranged letters within words when reading single words.
- Fluency problems/dysfluent reading, hesitations, slow reading.
- Letter-naming problems, unable to match upper- to lower-case letters.
- Limited basic sight word vocabulary.
- Oral reading errors, omission/insertion, mispronunciation/phonemic substitution, skipped words, lost place, reversed words, repetition, visual errors/whole-word guesses, lexicalizations, errors on function words, consistent word-decoding errors at the middle to end of words, guessed at words based on the first few letters.
- Rhyming problems, unable to provide rhymes for specific words (e.g., "cat–hat").
- Spelling impaired/limited, made letter reversals, struggled with basic sound–symbol association for both vowels and consonants.

Associated Difficulties

- Academic problems in math.
- Attentional difficulties.
- Articulation problems.
- Delinquency.
- Language-processing difficulties.
- Poor short- or long-term memory, difficulty with rote auditory memory (e.g., learning math facts, such as multiplication tables).
- Self-esteem problems.
- Visual–spatial difficulties.
- Word-finding problems.

Summary Statements

FOR YOUNGER CHILDREN AND EARLY READERS

- The child's performance indicates that she/he is at risk for developmental dyslexia.
- The child demonstrated a pattern of scores typical of young children with dyslexia: Reading tests that depended on phonics were very difficult for him/her.
- Academic achievement skills fall well below current grade level for reading and spelling.
- The child's recognition of letters (visual skill) is more developed than her/his ability to associate sounds with letters (phonemic/auditory skill); the child has only the beginning of phonemic awareness at this time.

FOR SCHOOL-AGE CHILDREN

- The child's test results indicated that he/she has a specific learning disability, dyslexia. Children with dyslexia have an early deficit in phonological processing (ability to recognize sounds and their sequences in words), which affects the ease with which letter–sound correspondences are learned and automatized. This results in slowed progress in learning to

read and even more striking difficulties in learning to spell. The child's educational history and tests results clearly reflect this pattern.

In summary, the child is a ____-year-old boy/girl who qualifies for a diagnosis of specific learning disorder with impairment in reading.

School history, early developmental history, and present test results all indicate that this is a child with a specific reading disability (dyslexia).

Results are highly consistent with a specific learning disability (dyslexia), with a significant weakness in phonological processing.

Test results and prior history indicate that she/he has a specific learning disorder with impairment in reading (also known as dyslexia). Specifically, achievement in reading and spelling is significantly below grade level and discrepant from what would be expected on the basis of her/his general intellectual ability.

The child's school history and present test results indicate that he/she has a specific reading disability (dyslexia), as phonological processing skills (a core deficit in dyslexia) are weaker than would normally be expected for a child of his/her educational experience and intellectual ability.

The child performed significantly below expectations with respect to reading and spelling skills. Analysis of her/his performance indicated significant difficulties with basic phonemic decoding (reading) and encoding (spelling) skills. Reading comprehension is also significantly below expectations.

The child's overall reading ability (composite of reading comprehension and word recognition) as well as his/her basic reading skills (word recognition), differed significantly from expectations based on his/her overall intellectual abilities.

FOR OLDER CHILDREN/ADOLESCENTS

The pattern of this adolescent's scores and the types of errors she/he made are both highly characteristic of young adults with dyslexia who have compensated well/partially compensated.

The adolescent's history and pattern of scores indicate a previously undiagnosed specific learning disorder with impairment in reading.

Nonverbal Learning Disability (NLD)

NLD is not a DSM-5 diagnosis, although it can be given the ICD-10 code F81.9 (specific developmental disorders of scholastic skills).

Assessment of NLD

Assessment of NLD typically involves administering tests of intellectual ability, visual-spatial ability, achievement measures, and executive functioning. Listed below are tests that specifically measure nonverbal intelligence. (*The CTONI-2 and the TONI-4 are discussed further in Chapter 22. See other chapters in Section E, "Test Results," for more information regarding other types of measures.*)

Comprehensive Test of Nonverbal Intelligence—Second Edition (CTONI-2)

Raven's Progressive Matrices

Test of Nonverbal Intelligence—Fourth Edition (TONI-4)

Universal Nonverbal Intelligence Test 2 (UNIT2)

Symptoms

Higher Verbal Comprehension Index than Perceptual Reasoning Index on a Wechsler test (*specify test*).

Academic difficulties in math, reading comprehension.

Coordination (fine motor, gross motor, and/or psychomotor) difficulties.

Problems with visual–spatial organization.

Social relationship difficulties, trouble reading nonverbal cues (such as gestures or facial expressions).

Tactile or sensory integration problems (or history of such problems), dislike of loud noises/touch/specific foods/certain smells.

Associated Difficulties

Anxiety, obsessional thinking/tendencies.

Difficulty organizing and conceptualizing verbal material, difficulty conceptualizing abstract mathematical and scientific concepts, trouble learning grammatical structures of foreign languages.

Emotional problems, oppositional behavior.

Executive function impairment, variable attention, impulsivity, perseverative tendencies, organizational problems.

Hyperlexic.

Trouble adjusting to new situations/shifting set (e.g., changes in classroom, teachers).

Summary Statements

Results of the current testing do not indicate the presence of NLD, as the difference between the child's verbal and nonverbal abilities was not at a level consistent with this diagnosis. Although this child demonstrates better-developed verbal than nonverbal skills, test data do not indicate that she/he meets full diagnostic criteria for NLD.

In light of the ____-point discrepancy between the child's Verbal Comprehension Index and Perceptual Reasoning Index scores, the possibility of NLD was explored via further testing. Indeed, he/she was found to meet most of the primary criteria for NLD, including relatively weaker performance in calculation skills, visual–motor integration delays, motor planning and graphomotor output difficulty, problems reading social cues, etc.

Test results indicate a pattern typical of individuals with NLD. People with this type of learning disability have difficulty with the perception, analysis, integration, and storage of nonverbal information.

The child's current performance and past history indicate that she/he meets the primary criteria for NLD, including a significantly lower Perceptual Reasoning Index than Verbal Comprehension Index score; academic weaknesses in reading comprehension (due to problems making inferences) and calculation skills; visual–motor integration delays; motor planning and graphomotor output difficulties; and problems in reading nonverbal/social cues, which affect social reasoning.

Writing Disabilities/Dysgraphia

Relevant Original DSM-5 and ICD-10 Codes

315.2	(F81.81)	Specific learning disorder with impairment in written expression <i>Specify</i> impaired subskills (spelling accuracy, grammar and punctuation accuracy, clarity or organization of written expression) <i>Specify</i> current severity: Mild, moderate, severe
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Assessment of Writing Disabilities

Test of Early Written Language—Third Edition (TEWL-3)

Test of Handwriting Skills—Revised (THS-R)

Test of Written Language—Fourth Edition (TOWL-4)

Symptoms

Letter reversals, substitution of upper- for lower-case letters (and vice versa) in words.

Misspellings of common/uncommon words.

Organization of writing was poor/confusing.

Pencil grip was poor/variable, inconsistent/soft/hard pencil pressure.

Poor handwriting, difficulty copying, difficulty in the mechanics of writing, poorly formed letters, retraced letters, too much/too little space between words, does not separate words, prints letters with significant difficulty, has idiosyncratic manner of producing letters.

Poor motor speed/sequencing.

Poor spelling/punctuation/capitalization, run-on sentences, omitted apostrophes in contractions, used upper-case letters incorrectly.

Problems composing text, poor paragraph construction, grammatical errors, added and missing words in sentences, inability to formulate phrases/complete sentences from a picture, sentences are not grammatically formulated, had difficult time coming up with connected ideas that were according to a given topic.

Utilized overly short/concrete/simple sentences, no sentence coherence or story development in his/her writing, vocabulary was basic, sentences lacked variation in structure and word use, more impoverished writing content than would be expected from child's intellectual abilities and educational level.

(Difficulties seen in middle and high school:) Problems with note taking, difficulty taking essay exams (including problems organizing and expressing thoughts effectively and in a limited time period), persistent problems with handwriting, slow writing speed, failure to complete work on time.

Summary Statements

Assessment of academic achievement revealed a significant weakness in written language abilities, as the child's performance on tests assessing writing/spelling/capitalization/punctuation/word usage fell below grade and age expectations.

Within the academic domain, a significant discrepancy was seen between the child's general intellectual ability and his/her performance on academic measures of written language.

16.7. Intellectual Disability (Intellectual Developmental Disorder)

Relevant Original DSM-5 and ICD-10 Codes

319	(F70)	Mild intellectual disability (intellectual developmental disorder)
319	(F71)	Moderate intellectual disability (intellectual developmental disorder)
319	(F72)	Severe intellectual disability (intellectual developmental disorder)
319	(F73)	Profound intellectual disability (intellectual developmental disorder)
315.8	(F88)	Global developmental delay
319	(F79)	Unspecified intellectual disability (intellectual developmental disorder)

Characteristics by Diagnostic Category

Mild Intellectual Disability

Traditionally, an IQ of 50–55 to 70 (although DSM-5 no longer includes IQ ranges for the different severities of intellectual disability).

Speech is typically similar in structure to that of individuals without intellectual disability, but is often concrete in content.

Individuals can expect to achieve up to a sixth-grade level in academic skills. They can work and live independently, usually with some support from family or community. About 85% of those diagnosed with intellectual disability have the mild form.

Moderate Intellectual Disability

Traditionally, an IQ of 35–40 to 50–55 (see above). Individuals are typically able to communicate needs to others through speech, but slow to develop language skills. They can work if significant oversight is provided, but typically cannot live independently. About 10% of individuals diagnosed with intellectual disability have the moderate form.

Severe Intellectual Disability

Traditionally, an IQ of 20–25 to 35–40 (see above). Language typically consists of vocalizations, single words, or two- to three-word phrases. Individuals can often perform simple jobs with appropriate supervision, although they cannot live independently. About 5% of individuals diagnosed with intellectual disability have the severe form.

Profound Intellectual Disability

Traditionally, an IQ below 20–25 (see above). Individuals lack verbal language, but may be able to indicate needs through vocalizations/behaviors. About 1–2% of individuals diagnosed with intellectual disability have the profound form.

Categories of Adaptive Functioning

Life skills:

Can/cannot manage money/use the telephone/tell time.

Safety:

Can/cannot be left alone at home or in backyard.

Self-care:

Can/slow to learn/cannot tie shoes/brush teeth/get dressed/use a knife and fork, no problems/problems with feeding/dressing/toileting/personal hygiene.

Social skills:

Social skills adequate/deficient (e.g., difficulties interacting with peers at an age-appropriate level).

Causes of Intellectual Disability

Pregnancy and birth:

Maternal infections (e.g., cytomegalovirus [CMV], rubella, toxoplasmosis, syphilis), maternal substance abuse (e.g., fetal alcohol syndrome [FAS]), anoxia during birth process, extreme prematurity.

Environmental toxins or causes:

Severe malnutrition, severely deprived environment/understimulation, lead poisoning, meningitis, encephalitis.

Hereditary or congenital conditions:

Down syndrome, fragile X syndrome, tuberous sclerosis, Tay–Sachs disease, phenylketonuria (PKU), trisomy 18, Prader–Willi syndrome, Wilson disease, anencephaly, hydrocephaly, porencephaly, microcephaly, hydrocephalus.

Trauma:

Anoxia, infections, head injury.

Common Medical and Developmental Problems

Epilepsy.

Growth difficulties as a fetus or developing child, low birth weight.

Physical disabilities, paralysis, problems with coordination, cerebral palsy, fine and gross motor delays, abnormal muscle tone.

Sensory problems, blindness, deafness.

Associated Emotional, Behavioral, and Cognitive Problems

Mood-related symptoms, depression, low self-esteem, problems with mood regulation, vulnerability to emotional/psychiatric disorders.

Aggression, self-injurious behaviors, verbal abusiveness, tantrums, noncompliance, unpredictable behavior.

Passivity, easily led by others.

Inappropriate behaviors (e.g., stripping, vocalization, fetishes).

Low frustration tolerance.

Poor judgment.

Poor attentional skills, hyperactivity, impulsivity.

Stereotypes/stereotypic behavior.

Stubbornness.

Summary Statements

In summary, this child/adolescent is a ____-year-old male/female with Down syndrome/etc. (*specify*) and mild/moderate/severe/profound intellectual disability.

The results of today's evaluation place the child's overall level of intellectual functioning within the mild/moderate/severe/profound range of intellectual disability, with performance on tests of intelligence, language, visual–motor, and adaptive skills all converging on this level of functioning.

The child is a ____-year-old girl/boy who is currently functioning in the mildly/moderately/severely/profoundly intellectually disabled range of intelligence, with widespread cognitive and adaptive difficulties consistent with this picture.

Assessment of Intellectual Disability

Assessment of intellectual disability typically involves the administration of a standard intelligence test. (*See Chapter 21 for more information about such tests.*) Since a diagnosis of intellectual disability also must include problems in everyday functioning, the first list below covers tests of adaptive functioning (*see Chapter 28 for more details about most of these*). The second list covers assessment measures for children with severe or profound intellectual disability.

Tests of Adaptive Functioning

Adaptive Behavior Assessment System, Third Edition (ABAS-3)

Vineland Adaptive Behavior Scales, Third Edition (Vineland-3)

Assessments for Children with Severe Disabilities

A Developmental Assessment for Students with Severe Disabilities—Third Edition (DASH-3)
Assessment for Persons Profoundly or Severely Impaired—Second Edition (APPSI-2)

16.8. Motor and Tic Disorders

Relevant Original DSM-5 and ICD-10 Codes

307.23	(F95.2)	Tourette's disorder
307.22	(F95.1)	Persistent (chronic) motor or vocal tic disorder
307.21	(F95.0)	Provisional tic disorder
307.20	(F95.8)	Other specified tic disorder
307.20	(F95.9)	Unspecified tic disorder
315.4	(F82)	Developmental coordination disorder
307.3	(F98.4)	Stereotypic movement disorder

Developmental Coordination Disorder

Clumsy; has difficulty tying shoes/buttoning shirt/zipping pants or jacket/trouble assembling puzzles, playing games or sports, difficulty with writing, abilities well below others of his/her age in daily activities requiring motor coordination, has not achieved motor milestones on time.

Tourette's Disorder and Other Tic Disorders

Motor tics:

Stereotypic movements (*see below*), eye blinking, grimaces, taps hands/feet, touching, twirling when walking, retracing steps, knee bending, picking.

Verbal tics:

Makes strange noises (barks/growls/clicks/snorts/sniffs), uses inappropriate words or phrases/obscene language (coprolalia), coughs/clears throat, repeats words/phrases/sounds.

Merrell (2001) describes depressed mood, social discomfort, shame, self-consciousness, and obsessive-compulsive behaviors as associated characteristics of Tourette's disorder.

Stereotypic Movement Disorder

"Endless" body/head rocking, repetitive twirling/spinning, mouthing, wall patting, ritualistic hand movements, grimacing, "blindisms," hand waving, playing with hands/fingers.

Self-injurious behaviors (e.g., head banging, biting, pinching, hitting, face slapping, poking/rubbing the eyes, skin picking).

16.9. Autism Spectrum Disorder (ASD)

Relevant Original DSM-5 and ICD-10 Codes

See Section 29.3 for the multiple specifiers for ASD.

299.00	(F84.0)	Autism spectrum disorder
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Developmental Deficits in Infancy and Toddlerhood

- Does not enjoy close physical contact/cuddling, does not respond to voices of others.
- Has failed to develop appropriate smiling.
- Has failed to develop appropriate attachment to parents, develops "mechanical" or "inflexible" attachment to single adult.
- Lack of eye contact, unresponsive infant.
- Lacking in normal fear of strangers.

Social Interaction Deficits

- Cries in unfamiliar settings or among unfamiliar people, no affection or interest when held, goes limp/stiff when held.
- Does not need caregiver, unaware of caregiver's absence.
- Fails to develop attachment, emotionally distant.
- Lack of spontaneous sharing of interests/pleasures/achievements with others, "happiest when left alone," does not seek comforting from others or seeks it in strange ways when distressed/upset/frightened, ignores people.
- Little or no social reciprocity, prefers solitary activities, impaired awareness of others, has no concept of others' needs, absence of sharing behaviors, lacks social give and take.
- Peer relationship difficulties, little interest in other children, problems understanding the conventions of social relationships.
- Poor eye contact, gaze avoidance, looks "through" people, lack of appropriate facial expressions, little use of appropriate gestures, no social smile.
- Inability to infer mental states in self and others/theory-of-mind deficits, unawareness of the existence of feelings in others.

Communication Deficits

- Delayed/undeveloped language skills, lack of verbal spontaneity/sparse expressive speech, does not imitate speech or does it strangely/mechanically.
- Difficulty with nonverbal communication.
- Echolalia, affirmation by repetition.
- Either extreme literalness or "metaphorical language."
- Intonation/pitch/rhythm problems, monotonous voice, "woodenness" in speaking.
- Language comprehension difficulties, unable to understand humor/jokes/questions/satire, problems with higher-order language functions/inferencing/abstractions.
- Neologisms.
- Play skills delayed/impaired/nonexistent, lack of spontaneous play, unable to engage in imaginative play, struggles with initiating and sustaining play with peers.
- Pragmatic difficulties: Fails to use appropriate greetings when meeting other people, asks inappropriate questions, interrupts others, difficulty with appropriate turn taking.
- Pronoun reversals, never uses first-person pronouns, refers to self as "you," refers to others as "I" or "me."
- Repeats requests excessively (to the point of being socially inappropriate).
- Tends to talk excessively on the same topic without taking peers'/other people's point of view into account.
- Unable to sustain a conversation.
- Uses stereotyped/idiosyncratic language, repeats TV shows/commercials/movies verbatim.

Baker (1983) mentions the following typical language deficits in autism:

- Receptive language skills may be better developed than expressive skills.
- Echolalia or repetition of rote phrases often does not constitute meaningful language (e.g.,

a child who often repeats the phrase “Come here” may not actually want someone to come near her/him).

- Language skills often do not generalize from one setting to another.
- Language skills may not follow a normal developmental trajectory.

Stereotyped Behaviors

Fascination with parts of objects, more interested in objects than in people, obsessively fascinated with unusual things for age (e.g., bus schedules, numbers).

Has restricted pattern of interests that is abnormal for age.

Inflexibility, has apparent need to perform specific rituals/patterns of behavior, becomes extremely distressed over minor changes in environment, becomes defiant when others try to redirect his/her play or social behavior, preservation of sameness.

Play is rigid/lacking in imitation/imagination.

Repetitive motor mannerisms, repetitive play habits.

Stereotyped body movements (e.g., spinning, clapping, hand gestures/flapping, rocking, swaying, twirling, head banging, tiptoe walking), staring at spinning things (e.g., fans, spinning tops).

Associated Behavioral and Cognitive Symptoms

Aggressiveness toward others, self-injurious behaviors.

Demonstrates splinter skills (e.g., mathematical ability, musicality, rote memory), savantism.

Gross and fine motor difficulties, trouble moving body in space, will often inadvertently bump into people/things or fall off chairs.

Hyperactivity, impulsivity.

Inattention, short attention span.

Masturbation.

Mood dysregulation, absence of emotional reactions, inappropriate emotional reactions, depression.

Sensory integration difficulties, insensitivity/oversensitivity to pain/sounds/touch/foods/smells, perceptual deficits, does not show normal startle response, hates bright lights/loud noises/certain types of clothing.

Sleeping difficulties.

Temper tantrums.

Summary Statements

The tests of cognitive, behavioral, and neuropsychological functioning did not indicate a pattern consistent with ASD.

Although the child has some symptoms that are consistent with the autism spectrum, she/he does not appear to meet full diagnostic criteria for ASD.

Current testing is consistent with a diagnosis of ASD, as the child has generally demonstrated relative weaknesses in visual–motor integration, executive functions, higher-order language, pragmatics, and social reasoning. His/her behavioral concerns (e.g., rigidity/oppositionality, anxiety, moodiness) are also associated with ASD.

Results from this testing, and previous history, indicate that the child meets criteria for ASD.

In review, her/his social skill weaknesses (including problems in social awareness, social comprehension, and emotional insight; inflexible adherence to routines; and obsessional tendencies) are all consistent with this diagnosis. In addition, her/his poor gross motor coordination and sensory integration problems are also frequently observed in people with ASD.

Given the test data, historical information, and behavioral observations, a diagnosis of ASD appears to be warranted. The key features of ASD include persisting impairment in commu-

nication; markedly abnormal or impaired development in social interactions; and restricted, repetitive, and stereotyped patterns of behavior, interests, or activities.

The child exhibits behavior consistent with a diagnosis of ASD, in that he/she shows severe and pervasive impairment in reciprocal social interaction skills, a restricted pattern of interests and activities, and a failure to develop peer relationships appropriate to developmental level. The child's abnormal functioning in the areas of social interaction and communication is long-standing.

Results of the evaluation indicate that the child meets criteria for ASD, including impaired use of language, a lack of social interest and responsiveness, and stereotypies; she/he also exhibits an uneven cognitive profile, odd responses to sensory stimuli, and atypical body use.

Assessment of ASD

Autism Behavior Checklist

Autism Diagnostic Interview—Revised (ADI-R)

Autism Screening Instrument for Educational Planning—Third Edition (ASIEP-3)

Behavior Observation Scale (BOS) for Autism

Childhood Autism Rating Scale, Second Edition (CARS2)

Gilliam Autism Rating Scale, Third Edition (GARS-3)

16.10. Schizophrenia Spectrum and Other Psychotic Disorders

Relevant Original DSM-5 and ICD-10 Codes

295.90	(F20.90)	Schizophrenia
295.40	(F20.81)	Schizophreniform disorder
295.70	(F25.0)	Schizoaffective disorder, bipolar type
295.70	(F25.1)	Schizoaffective disorder, depressive type
297.1	(F22)	Delusional disorder
298.8	(F23)	Brief psychotic disorder
293.81	(F06.2)	Psychotic disorder due to another medical condition, with delusions
293.82	(F06.0)	Psychotic disorder due to another medical condition, with hallucinations
293.89	(F06.1)	Catatonia associated with another mental disorder (catatonia specifier)
293.89	(F06.1)	Catatonic disorder due to another medical condition
293.89	(F06.1)	Unspecified catatonia: Code first 781.99 (R29.818), followed by 293.89 (F06.1)
298.8	(F28)	Other specified schizophrenia spectrum and other psychotic disorder
298.9	(F29)	Unspecified schizophrenia spectrum and other psychotic disorder

General Information

According to Barker (1990), psychotic disorders of childhood or adolescence fall into four groups:

- Schizophrenia.
- Disintegrative psychosis, usually as a result of an organic disease of the brain (this can be progressive or nonprogressive).

- Reactive psychosis.
- Psychosis caused by an infection, a metabolic disorder, or intoxication with drugs (marijuana, LSD/acid, cocaine, opiates).

Very-early-onset schizophrenia begins before age 13 years. Early-onset schizophrenia begins in either late childhood or adolescence. Schizophrenia most often manifests itself during late adolescence or early adulthood.

Symptoms

Affective symptoms:

Extreme mood changes, inappropriate affect, flat affect, behavioral passivity, indifference, euphoria, irritability, agitation, catatonia, depressed mood.

Negative symptoms:

Unmotivated, alogia, avolitional/lack of volition, flat affect, blocking.

Behavioral symptoms:

Disorganized/bizarre/incoherent speech, loose associations, tangentiality, circumstantiality, derailment, either poverty of content or flood of ideas, mumbles considerably, inappropriate responses to questions, stops talking in the middle of a sentence and does not continue, excitability, either hyperkinesia or immobility, rigidity, muteness, sudden shifts from immobility to excitability, social or occupational dysfunction.

Cognitive symptoms:

Confusion, spatial/temporal, disorientation, disordered thinking, bizarre ideation, illogical thinking, thought disorder, loss of contact with reality/real world.

Delusions:

Paranoid delusions, feelings of being persecuted, ideas of reference/grandiosity/control, other distortions of thought content (*specify*).

Hallucinations:

Auditory/visual/olfactory/tactile disturbances, specific perceptual distortions (*specify*).

16.11. Sleep–Wake Disorders

Relevant Original DSM-5 and ICD-10 Codes

780.52	(F51.01)	Insomnia disorder
780.54	(F51.11)	Hypersomnolence disorder
347.00	(G47.419)	Narcolepsy without cataplexy but with hypocretin deficiency
347.01	(G47.411)	Narcolepsy with cataplexy but without hypocretin deficiency
347.00	(G47.419)	Autosomal dominant cerebellar ataxia, deafness, and narcolepsy
347.00	(G47.419)	Autosomal dominant narcolepsy, obesity, and type 2 diabetes
347.10	(G47.429)	Narcolepsy secondary to another medical condition
327.23	(G47.33)	Obstructive sleep apnea hypopnea
327.21	(G47.31)	Idiopathic central sleep apnea
786.04	(R06.3)	Central sleep apnea with Cheyne–Stokes breathing
780.57	(G47.37)	Central sleep apnea comorbid with opioid use
327.24	(G47.34)	Idiopathic sleep-related hypoventilation

327.25	(G47.35)	Congenital central alveolar sleep-related hypoventilation
327.26	(G47.36)	Comorbid sleep-related hypoventilation
307.45	(G47.21)	Circadian rhythm sleep-wake disorder, delayed sleep phase type
307.45	(G47.22)	Circadian rhythm sleep-wake disorder, advanced sleep phase type
307.45	(G47.23)	Circadian rhythm sleep-wake disorder, irregular sleep-wake type
307.45	(G47.24)	Circadian rhythm sleep-wake disorder, non-24-hour sleep-wake type
307.45	(G47.26)	Circadian rhythm sleep-wake disorder, shift work type
397.45	(G47.20)	Circadian rhythm sleep-wake disorder, unspecified type
307.46	(F51.3)	Non-rapid eye movement sleep arousal disorder, sleepwalking type
307.46	(F51.4)	Non-rapid eye movement sleep arousal disorder, sleep terror type
307.47	(F51.5)	Nightmare disorder
327.42	(G47.52)	Rapid eye movement sleep behavior disorder
333.94	(G25.81)	Restless legs syndrome

Nightmare Disorder

Child has long/vivid/frightening dreams, awakens repeatedly during sleep, is able to recall many details of dreams.

Sleep Terrors

During sleep child suddenly begins to have episodes including screaming/heart palpitations/sweating, child is inconsolable/does not respond to others' attempts to comfort him/her, child cannot recall dreams or episode.

Sleepwalking

Child gets up and walks about during sleep (usually during first third of sleep), child is not awake during episode and can only be awakened with difficulty.

D. The Child or Adolescent in the Environment

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17

Home and Family

See Chapter 11, “Developmental and Family History,” for more information regarding family functioning and relationships.

17.1. Living Situation

Indicate whichever of the following factors are relevant to a child’s assessment/treatment: family structure (include parents, stepparents, parental partners, adopted siblings, stepsiblings, and siblings who do not live in the home); length of time the child has spent in the current living situation; and primary caregivers (indicate the relationship of each to the child, the number of hours per day the child is in a child care setting, and the number of different people who care for the child). If the parents are separated or divorced, indicate who has custody of the child (physical and legal) and how often the child sees the other parent.

Types of Family Structure

Intact, mother–stepfather, father–stepmother, single mother/father (never married/widowed/divorced).

Lives with parents, mother, father, adoptive/biological parents, siblings, relatives, guardian, mother/father and her/his spouse/live-in partner, etc.

Types of Housing

Single-family home, apartment, trailer, duplex, “double/triple-decker,” condo, townhouse, row house, mobile home.

Home is owned/rented, family is living with relatives/living in shelter/homeless.

Family lives in unsafe neighborhood, inadequate housing, adults are concerned they may lose their home/rental support/housing support.

- ✓ If relevant, note number of bedrooms; whether child shares a room or bed, and if so, with whom; and presence/absence of books, televisions, computers, and age-appropriate toys.

Routines

Mealtimes

Family/caregiver maintains routine times for breakfast/lunch/dinner.

Family eats no/some/most meals together.

Atmosphere at mealtimes is happy/angry/quiet/noisy/filled with frequent fighting/animated conversations/arguments.

Chores

Setting table, washing dishes, taking out trash, help with grocery shopping, laundry, ironing, putting clothes away, emptying garbage, meal preparation, babysitting younger children, care of pets (e.g., walking the dog).

- ✓ Also comment on appropriateness of chores for age/developmental level, frequency of chores, punishment/reward for chores not done/done.

Sleep

Does/does not take morning/afternoon naps, naps usually last ____ hours/minutes.

Has/does not have a regular night bedtime, has a bedtime but it is inconsistently/infrequently/rarely enforced.

Child/parent denies any difficulties with sleep.

Has difficulty falling/staying asleep, wakes up ____ times per night and is/is not able to go back to sleep with/without difficulty.

Family Activities

Church/synagogue/mosque/temple attendance, meals, movies, sports/games, vacations, volunteer work, watching television together, etc.

17.2. Parents

Identify which parent (or both, if applicable) takes primary responsibility for the child regarding school, health problems, doctor visits, discipline, housework.

Employment/Financial Status

- ✓ Note the parents' employment status as it affects family/child care (e.g., dual-career family, stay-at-home mother/father); also note the effect on the child when a stay-at-home mother/father returns to work.

Flexible/inflexible hours/schedule/working situation.

Happy/unhappy with present employment.

Work stress negatively affects quality of family life.

Father/mother is laid off/unemployed.

Family finances/financial resources are adequate/inadequate.

Family receives public assistance.

Relationship between Parents

Positive, loving/warm, peaceful, affectionate, close, functional.

Critical/accusatory, frequent yelling, controlling, unstable, parents always "dwell on the negative," lack of affection between parents, parents frequently belittle each other, stormy, distant, mismatched.

Abusive (physically/verbally), frequent screaming, slamming doors, physical threats (to divorce/cause harm to someone/leave/leave and take the kids), throwing things, brutal.

17.3. Parenting

Styles

Maccoby and Martin (1983) describe four kinds of parenting styles; these styles, with appropriate descriptors, are as follows:

Authoritarian:

Rely on coercive techniques (e.g., punishment, threats) for controlling child's behavior, value utmost respect for authority, impose rules and expect obedience, often say things such as "Why? Because I said so."

Permissive:

Set few limits, make few demands on child, permits child to make his/her own decisions about many routine activities (e.g., amount of TV and video time, mealtimes, bedtimes).

Authoritative:

Expect child to behave in mature manner, use rewards more than punishment, communicate expectations clearly to child, encourage communication to and from child, explain reasons for rules, allow exceptions when making rules.

Uninvolved:

Neglectful, uninterested in events or people in child's life (e.g., school, friends), expect little and invest little, are psychologically unavailable to child.

Behaviors/Emotional Tone toward Child

Accepting, friendly/gregarious, helpful, affectionate, courteous/respectful, warm, parent frequently expresses affection toward child, shows enthusiasm toward child's activities, puts child's needs first, responds to child with empathy, is responsive to child's needs, initiates play.

Rejecting, little empathy toward child, affection rarely expressed toward child, child's needs are rarely responded to, punitive response to crying, muted/no demonstration of affection. Dysfunctional, neglectful, angry, negative, violent/abusive.

Discipline

- ✓ Note who is primarily responsible for disciplining the child, as well as the level of agreement between parents on discipline techniques. For use of a curfew, note its type, its reasonability for age, and the child/teen's reaction to the curfew.

Limits:

Overprotection/excessive restriction, overpermissiveness/indulgence, unrealistic demands.

Strictness/leniency:

Rules/no rules on mobility, feeding/eating, interruption by child(ren), table manners, neatness/cleanliness, bedtime, noise, radio/TV, chores, obedience/compliance/aggression, nudity/modesty, masturbation/sex play.

Aggression:

Inhibit/redirect aggression, encourage child to fight back/defend self, different responses to aggression toward parents/siblings/peers.

Parental differences:

High/low ratio of maternal to paternal discipline, mother/father views other parent as overly strict, parental conflicts over discipline.

Praise:

Use praise for table manners/obedience/nice play, use praise frequently/often/occasionally/rarely, make no use of praise.

Problematic discipline:

Lack of discipline, inconsistent discipline, harsh/overly severe discipline, fear/hatred of parent, decreased initiative/spontaneity, unstable/erratic values.

Consistency of discipline:

Clear and consistent enforcement of rules, inconsistent in administering punishment, unclear and inconsistent rules, lack of rules/limits.

Methods of discipline:

Ignore problem behavior, redirect child's attention, assign extra chores, time out/send child to room/make child sit on chair, scold, spank, take away toy/activity/special food/television/play dates/allowance/money/access to car, set curfew.

Problematic methods of discipline:

Verbally/physically threaten child, punitive/erratic discipline, unrealistic expectations, isolation, child is hit/kicked/bitten/beaten with/without an object (belt, shoe, paddle, etc.), child is threatened/assaulted with a weapon (knife, gun, etc.), neglect.

17.4. Social Support

Family receives wanted/unwanted support from extended family/friends.

Family has adequate/some/little/no access to practical/logistical/emotional assistance from family/friends, family lacks adequate social support, family has difficulty with acculturation/discrimination.

17.5. Sibling Relationships

Relationship with brother(s)/sister(s) is normal.

Typical sibling rivalry is noted.

Child is picked on/picks on other siblings, often teases/is teased by siblings, siblings are verbally abusive/physically violent toward one another.

Parental expression of favoritism/dislike toward certain child/children in family results in tense/anxious/stressed/strained/negative/confrontational/violent sibling relationships.

18

School

18.1. Physical Environment

School Building

Building is well/poorly maintained, clean/unkempt, is/is not wheelchair-accessible, is located in high-crime/unsafe/safe area, playground is well/adequately/poorly maintained, (no) outside play areas.

School is small/medium/large in size, with a total student population of _____.

Classroom

Note any problematic aspects of the physical classroom environment, such as temperature, lighting, noise level, or condition/cleanliness; also describe the classroom's physical arrangement.

18.2. Classroom Climate

Class Size

Note number of students, teachers, aides, and/or other adults.

Schedule

Note length of classroom day, number of days per week (for preschool/kindergarten), subjects taught (length of sessions), and amount of free time/playground time.

Classroom Resources

Adequate/inadequate number of chairs/desks/tables/chalkboards/bulletin boards.

Room arranged in rows of desks with teacher in front, desks arranged in circle, no desks/only tables in classroom, open classroom.

Classroom resources are/are not adequate/appropriate for children's academic needs.

Classroom resources include computers, tablets, TVs, radios, audiovisual equipment/CD players/DVD players (*specify number of each*), adequate/inadequate number of textbooks/library books/worksheets/instructional materials.

18.3. Classroom Group Dynamics

General Group Climate

Nature of relationships between children:

Children tend to get along with one another well/poorly, very cohesive/noncohesive class of children.

Child's position in group climate:

Leader/follower, bossy, has difficulty/no difficulty entering group situations, is frequently angry/annoying/agitated/irritating/bothersome/passive/calm/relaxed/quiet in group activities.

Reaction of group toward teacher:

Positive/negative/etc. (*specify*).

Transitions (i.e., routines for finishing/beginning work, putting away or getting out materials, and lining up for recess/lunch):

Smooth/easy, well-structured/well-ordered, uneventful/without incident, chaotic/disordered/disorganized, confusing to some/most/all students, hectic/frenzied, topsy-turvy, resulted in unruly behavior from a few/some/all students.

Child's reaction to transition times:

Has no/some/much difficulty transitioning from one activity to another, reacts to transitions by crying/refusing to participate/shutting down/having tantrums.

18.4. Child's/Parents' Attitudes

Child's Attitudes toward School

Child comes to school ready to learn, curious/interested/energetic/eager, distracted/anxious, uninterested/bored, angry/hostile, wanting/not wanting to learn new things, fearful of failure.

- ✓ As appropriate, note not only the child's general attitude toward school, but her/his favorite/least favorite subjects and easiest/hardest subjects. Are the subjects offered at the school appropriate/inappropriate for this child's needs?

Child's Attitudes toward Academic Achievement

Child feels that the quality of his/her schoolwork matches his/her abilities/efforts/is satisfactory, views self as underachieving/overachieving, perceives schoolwork as challenging/overwhelming.

Child's school achievement is consistent with/higher than/lower than ability level would indicate.

Child's Attitude toward Teacher

Child likes/does not like/feels neutral about teacher, child feels liked/favored/punished/"picked on"/disliked/treated unfairly by teacher.

Child reports that she/he often feels humiliated at school and that the teacher(s) is/are partly to blame.

Parental Involvement in School

Parents do/do not regularly attend parent-teacher conferences/open houses/other school events, mother/father/both parents active/inactive in school activities, never/rarely/sometimes/often volunteer for classroom/school roles/projects.

Parents are uninvolved in school/have never been in contact with teacher, teacher has never tried to contact parents.

Teacher has tried but been unable to contact/meet with parents.

Dropping Out of School

Note whether child/teen dropped out of school before completing high school, along with factors contributing to dropping out of school:

Suspension, poor grades, lack of motivation, dislike of school, pregnancy, marriage, other (*specify*).

Also note last grade completed, as well as date/month/year of last date of school attendance.

18.5. Teacher

Expectations

Teacher has overly high/high/low/appropriate/inappropriate expectations for students, teacher teaches "down" to students/"over their heads."

Child had a great teacher who did/did not see a need for further evaluation.

Quality of Teaching

Excellent/good/poor, mismatch between child's and teacher's style/academic level.

Teaching Style

Authoritative, permissive, authoritarian, interactive/involving, academically challenging, reinforcing, teacher frequently/sometimes/rarely/never praises students, expresses warmth toward students/is personable with students, is distant/cool with students.

Discipline

Teacher spends much/little time in discipline, teacher has good/poor control of classroom and thus spends little/much time on disciplining students, teacher imposes appropriate/inappropriate/excessive discipline.

Homework/Assignments

As relevant, note the frequency, regularity, quality, and quantity of homework assigned.

Homework is regularly/irregularly/often/sometimes/rarely assigned.

Assignments generally require an excessive/large/average/moderate/small/negligible amount of study time in school/out of school.

Assignments are usually/often/sometimes/rarely/almost never relevant to classwork, assignments tend to be busywork.

Special Education Services

See Section 12.16, "Special Education."

19

Social and Work Relationships, Recreational Activities

19.1. General Social and Developmental Considerations

The initial descriptions at each bullet below are normal developmental patterns in children's social relationships and are drawn from Bee and Boyd (2010) and Bukatko and Daehler (2012).

Infancy

- Infants show signs of being interested in other infants beginning at age 6 months.
Looks at other infants with interest/curiosity/attention/awareness/inquisitiveness/alertness/responsiveness, does not look at other infants, shows no interest in other infants, responds to other infants with indifference/unresponsiveness/apathy/lack of interest.

Preschool

- Activities with friends usually consist of pretend play, game playing, object sharing.
Engages in pretend play/game playing/etc. with friends, shares objects with friends, is unable to engage in pretend play with friends, prefers to play alone, does not share with other children.
- By age 3 or 4 years, children prefer to play with peers rather than alone.

Elementary School

- Playing or being with friends occupies much of children's nonschool time.
Frequently/infrequently plays with friends out of school, plays with friends outside of school for approximately ____ hours/afternoons/days per week, rarely/never has play dates after school.
- Most play is segregated by sexes.

Middle School

- Friendships are motivated by desire for peer acceptance and avoidance of peer rejection.
- Cross-sex friendships are rare, but begin to appear as children enter adolescence.

Adolescence

- Intimacy is important in friendships.
- Adolescents value the ability to self-disclose and share feelings with friends.
- They prefer same-sex friends, although cross-sex friendships are more common than in middle school.

19.2. Play

Parten (1932) has classified children's play as follows:

Unoccupied play—child is unengaged, may stand in corner, looks around room.

Solitary play—child plays alone, engrossed in activity but independent of other children (common at ages 2–3 years).

Onlooker play—child avidly watches other children's play without entering into their experience.

Parallel play—child plays separately from other children, but with similar materials to other children (e.g., two children independently playing on the floor with trucks).

Associative play—play that involves social interaction with very little organizational quality.

Cooperative play—play with social interaction that includes a sense of group identity and organization.

Types of Play

The following grouping includes several of Parten's types (see above), as well as several others.

Solitary play, parallel play, cooperative play, social pretend play or sociodramatic play, rough-and-tumble play, sensory–motor play, practice play, pretend/symbolic play, social play, constructive play, game playing.

Common Difficulties

Often ends up playing alone but would prefer to play with other children.

Becomes anxious in social gatherings with peers (e.g., birthday parties, playground).

Can play fairly well with another child on a one-to-one basis.

Engages frequently in rough play.

Fights frequently with playmates.

Is controlling when playing with friends.

Is easily overstimulated in play.

Tends to drive peers away due to rigid adherence to rules.

19.3. Friendships

Child initiates/accepts/enjoys play dates with peers, is able to compromise well with friends, is a child who can both follow and lead, is well liked and accepted by a wide range of children/most children in the class, has extremely good social skills, makes friends easily, has no difficulty making friends, is seen as a leader by her/his peers, is frequently invited for play dates, social interactions with peers are satisfactory, _____ is said to have many friends.

The child does not make the best choices regarding his/her friendships, is a follower to inappropriate friends, becomes obsessed with certain friends.

Fights frequently with playmates, prefers to play with younger children, has a few adequate friendships/has only one friend, has a history of problems playing with other children.

Child has "no" friends, has difficulty making/keeping friends due to extreme angry outbursts/inability to share/problems reading nonverbal cues/difficulty modulating affect/other (*specify*).

Has a pervasive pattern of detachment from social relationships.

Typically does/does not greet peers when sees them, especially/not especially in community settings.

19.4. Peer Groups/Dating

Types of Peer Social Groups

Popular children, neglected/rejected children, cliques, athletes/"jocks," "druggies," "geeks," "Goths," "dweebs," "brains"/"nerds," "preppies," "loners," "losers," "punks/emos," "fringe," "thespians," "skaters," "outsiders," "hipsters," "scenesters," "mean girls," "rockers," "party-ers."

Positive Peer Group Experiences

Stands up for the "underdog" in peer settings, is well liked/popular/accepted/admired by peers.

Problems with Peer Relationships/Groups

Is often the last to be chosen as a partner in school.

Is teased/"picked on" by several of her/his peers, is bullied, has trouble fitting in with classmates.

Shows relational aggression (e.g., "You can't come to my birthday party").

Has difficulty socializing with peers in one-to-one situations as well as recess/gym class/music class/library.

Substance Use in Peer Groups

Report frequency of drug use, smoking, and underage drinking, as well as the effects of these on functioning. Asking initially about friends'/peer group's substance use is less threatening. Note quantity of each substance consumed per episode.

Dating

Note the age at which dating began; the frequency or pattern of dating behavior, and whether the pattern is appropriate/inappropriate for age/developmental level; and whether the adolescent has an exclusive boyfriend/girlfriend relationship (i.e., is "going steady").

Dating intensity:

Never, seldom/rarely, only for special times (e.g., prom, special dances), "gets together with," interested in more dates but _____ (*specify*), frequently, compulsively/promiscuously, many dating partners, has many/only brief relationships, has had a long-term monogamous relationship since age ____, "going steady."

Other qualities:

Experiences physical/verbal/emotional abuse, is exploited by boyfriend/girlfriend (*describe*), is in relationship that is inappropriate/too serious/too sexual in nature for age, unsatisfying, symbiotic, stable, functional, adequate, satisfying, rewarding, close/tight, intimate, enhancing, loving/fulfilling.

19.5. Work/Employment

Note the employer's name; numbers of hours worked outside of school; type of job; appropriateness of work/job for developmental age; effects of work on school performance (i.e., whether grades are same/lower/higher); and relationship with supervisors/coworkers.

Attitude toward Work

Conscientious/average/negligent, is responsive/resistant toward supervision or constructive feedback, dislikes working, prefers working to attending school.

Work Skills

Performance is/skills are poor/average/good/exceptional, exhibits quite mature/immature work skills/habits for age.

Motivation to Work

Refuses, apathetic/indifferent, is only minimally motivated/compliant/positive/eager, willing to work at tasks seen as monotonous or unpleasant.

Work Attendance

Unreliable/inadequate/minimal/spotty/deficient, has unusual/large number of unexcused absences/calls in sick, seldom/generally punctual for arrival/breaks/lunch hours, performs without excessive tardiness/rest periods/time off/absences/interruptions from psychological symptoms, dependable/responsible.

Relationship to Peers/Coworkers

Avoidant/distant/shy/self-conscious, nervous, conflictual, domineering, submissive, competitive, suspicious, attention-seeking, clowning/immature/provocative, inappropriate, dependent, troublemaker, ridiculing/teasing, friendly.

19.6. Recreational Activities

General Statements

Favorite activities include _____ (*specify*).

Least favorite activities are _____ (*specify*).

Recent changes in activity level from _____ to _____ (*specify*).

Child has no hobbies/no recreational activities, does nothing for relaxation/fun, very few pleasurable activities.

Child takes typical interest in recreation, has active and satisfying recreational life.

Recreation is integrated into school and social life.

Types of Activities

Collections:

Sports/Yu-Gi-Oh/etc. cards, dolls, books, shells, rocks, etc.

Friends:

"Hanging out" with, playing with, going to the movies/the mall/etc. with, playing sports/etc. with.

Games:

Chess, Yu-Gi-Oh, computer games, video games, Game Boy/Nintendo/PlayStation, board games, puzzles, other (*specify*).

Hobbies:

Art/drawing/painting, building things/models, crafts, watching TV, sewing, photography, writing, cooking/baking, other (*specify*).

Music:

Likes listening to music, enjoys playing the piano/guitar/etc., takes piano/guitar/etc. lessons.

Pets:

Plays with pet dog/cat/bird/fish/rabbit/etc., cares for pet.

Playing:

Dolls/dollhouse, playing on scooter/trampoline/other (*specify*), outdoor play, make-believe play, playing at the park, playing dress-up.

Reading:

Enjoys reading/likes being read to, favorite book is _____ (*specify*), favorite types of reading materials are books/magazines/comics/anime/picture books/mysteries/horror/adventure/science fiction/nonfiction/other (*specify*).

✓ Note amount of time child reads in a week, as well as number of books read in last month.

Sports:

Watches on TV, attends/spectates, reads about, discusses.

Participates in ballet, baseball, basketball, biking, bowling, cheerleading, dancing, fishing, golf, gymnastics, hockey, in-line skating, jogging, karate, lacrosse, running, skateboarding, skiing, snowboarding, soccer, softball, swimming, taekwondo, t-ball, tennis, walking, weightlifting.

Quality of sports participation:

Is talented in sports; was noted to be a very good athlete; is star player on the _____ team.

Loves sports and is very coordinated.

Has trouble with good sportsmanship/losing/playing fair/playing within the rules because of problems with emotional arousal/lack of competitive drive/difficulty with social skills/other (*specify*).

Has difficulty participating in sports because of poor gross motor skills and lack of coordination.

Toys:

Legos, K'NEX, dolls, stuffed animals, blocks, cars/trucks, puzzles, other (*specify*).

Volunteering:

Volunteers in church-related activities, with charity-based organizations, other (*specify*).

Organizations

Boy/Girl Scouts, Scouts BSA/Scouting, Boys and Girls Clubs, Camp Fire USA, Cub Scouts/Brownies, 4-H, Frontier Girls, Future Farmers of America (FFA), Junior Achievement, school newspaper, Young Democrats/Republicans, Little League, SpiralScouts International, school clubs (*specify*).

E. Test Results

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20

General Guidelines for Presenting Test Results in a Report

This chapter covers general aspects of presenting test results in a report, including the reporting of scores. It provides the reader with general descriptors common to many tests/evaluations, while Chapters 21–28 address more specific areas of testing/evaluation.

20.1. Validity Statements

The following validity statements apply specifically to test results. (*For general statements about validity, see Section 7.6.*)

Adequate Validity

Throughout the evaluation process, the child appeared to put forth the necessary effort to consider this an adequate interpretation of his/her functioning level and abilities.

During the testing sessions the child exhibited good effort and motivation, and these findings are therefore considered a valid estimate of her/his current cognitive/neuropsychological/psychological status.

_____ (*give name of test*) appears to be a valid measure of intellectual/language/visual-spatial/emotional/other (*specify*) functioning, as the child was an attentive and cooperative participant.

Concentration and attention to the test items were noted to be consistent and appropriate, and thus test results are felt to be an accurate assessment of his/her current level of functioning.

Overall, the current test results are a valid representation of this child's current functioning.

The results of this examination are believed to be a relatively reliable and valid indicator of this child's current functioning. However, it is important to note that testing took place in a quiet, one-on-one situation, which is not representative of a typical classroom environment in which many distracters are present that could challenge the child's concentration and performance.

Inadequate Validity

The severity of this child's inattentiveness/hyperactivity/impulsivity/etc. had a negative impact on her/his test performance; consequently, these data are likely to represent an underestimate of her/his current capacity.

The child did not appear motivated on the testing, and the examiner therefore questions whether the scores are true indications of his/her ability.

When confronted with more difficult tasks, the child refused to continue or did not appear to try her/his best, and consequently the results should be viewed with caution.

20.2. Test Scores: Description

Test results are computed in various ways: as grade equivalents, as percentile ranks, and as scaled and standard scores. When you are reporting test scores, always include an explanation of which type(s) of scores you are using (standard, scaled, etc.), including the mean and standard deviation.

There are no hard and fast rules for how to describe test results. Much depends upon the results; sometimes it may be to the child's advantage to present the scores within a range, but at other times a specific score may be indicated. This is similar for the question of grade equivalents and standard scores: Some tests give results using standard scores, while others give grade equivalents, and still others provide both. There are no specific times when either is appropriate or not appropriate. The decision really depends on personal preference and the type of scores provided by the test itself.

Grade Equivalents

A grade equivalent indicates that a child's performance resembles the average performance at a particular grade level. Grade equivalents are typically presented in decimal form; for example, 4.2 means that the child is functioning at a level typical for a student in the second month of fourth grade.

Percentile Ranks

A percentile rank score compares the child's performance to that of other children his/her age. It represents the percentage of the population who did less well than the child being tested—that is, the percentage of same-age or same-grade peers in a norm group who were found to score below the score obtained by the tested child. For example, a percentile rank of 70 indicates that an individual performed better than 70% of peers taking the test.

Scaled Scores

Scaled scores on subtests are based on comparisons with the scores of same-age peers in a norm group and can range from 1 to 19, with an average of 10 and a standard deviation of 3. Scaled scores between 8 and 12 fall within the average range.

Standard Scores

Standard scores for IQs on the Wechsler scales (at this writing, the WAIS-IV, WISC-V, and WPPSI-IV), and also on the current version of the Stanford-Binet (SB5), have a mean of 100 and a standard deviation of 15. Roughly two-thirds of all individuals will obtain a score between 85 and 115. Standard scores between 85–90 and 110–115 are often considered “average,” although these may be significantly below or above expectations for a particular individual. (*Section 20.5 presents more detailed classification ratings for IQs.*)

Confidence Intervals

A confidence interval (CI) encompasses a standard score plus and minus 1 standard error of measurement (SEM). This range is a ____% confidence band. In other words, one can be confident that ____% of the time the child's "true score" will fall within this range.

20.3. Sample Statements of Test Results

On the _____ (*give name of the test*), the child achieved a Full Scale IQ of _____. The likelihood that his/her true score falls between ____ and ____ is about ____%. This score places him/her in the _____ range of psychometric intelligence. The various scales give information on the student's cognitive functioning in several areas. Scaled scores are measures of subtest skills reported with a mean of 10 and a standard deviation of 3. Composite scores are combinations of scaled scores reflecting an area of functioning (e.g., Verbal Comprehension) and are reported as composite scores with a mean of 100 and a standard deviation of 15. Scores show strengths and weaknesses when compared to other children of this student's age or to his/her own pattern of development.

The child's scores are as follows and are reported as standard scores and percentile ranks for each of the tests. Standard scores have a mean of 100 and a standard deviation of ± 15 . Her/his scores range from the ____ to the ____ percentile.

20.4. Describing Discrepancies on Measures of Intelligence

Child's performance on all indices was consistently in the borderline/average/above-average/below-average/superior range with the exception of his/her performance on the _____ Index, which was significantly higher/lower than his/her performance on the other indices.

Scores indicate that child's performance was significantly better on tasks requiring perceptual reasoning/flexible problem solving/language processing/working memory/processing speed that it was on task requiring perceptual reasoning/flexible problem solving/language processing/working memory/processing speed.

20.5. IQ Classification Ratings

Lezak et al. (2012) give this classification of ability levels, which is also reproduced here with permission:

<i>Classification</i>	<i>z-score*</i>	<i>Percent included</i>	<i>Lower limit of percentile range</i>
Very superior	+2.0 and above	2.2	98
Superior	+1.3 to 2.0	6.7	91
High average	+0.6 to 1.3	16.1	75
Average	± 0.6	50.0	25
Low average	-0.6 to -1.3	16.1	9
Borderline	-1.3 to -2.0	6.7	2
Intellectually disabled	-2.0 and below	2.2	—

*z-score represents how many standard deviations the score deviates from the mean.

21

Tests of Intellectual Functioning

This chapter lists and briefly describes the most commonly used tests of intellectual functioning for children. These descriptions can be used in report writing.

21.1. General Facts about Intelligence Test Scores

Intelligence test scores reflect the following:

- Factual knowledge.
- Learned abilities.
- Problem solving.
- Memory.
- Attention.
- Future learning and academic success.

Intelligence test scores do *not* measure these qualities:

- True innate ability or absolute learning potential.
- Motivation, curiosity, creativity, drive, or determination.
- Study skills.
- Achievement in academic subjects.

21.2. Bayley Scales of Infant and Toddler Development, Third Edition (Bayley-III) *(Bayley, 2005)*

- ✓ Note that although it is listed here in the chapter on intellectual functioning, the Bayley-III is not a measure of specific intellectual ability.

General Description

The Bayley-III is a standardized measure of infant development that determines whether a child is progressing normally or in need of intervention. It is normed for infants and toddlers from ages 1 month to 42 months.

Scales

The Cognitive Scale provides a measure of how a child explores the world around her/him and a measure of problem-solving skills.

The Language Scale measures expressive and receptive communication through observing the child's communication skills and asking him/her to identify pictures and objects, follow directions, and answer questions.

The Motor Scale measures a child's fine and gross motor skills through having her/him complete fine motor tasks such as stacking blocks or reaching and manipulating objects, or by assessing gross motor skills such as head control, crawling, walking, and balance.

The Social Emotional Scale measures a child's social-emotional milestones via caregiver report.

The Adaptive Behavior Scale measures (through caregiver report) a child's daily living skills such as communication skills, functional preacademic skills, and self-direction.

21.3. Detroit Tests of Learning Aptitude—Fifth Edition (DTLA-5)

(Hammill, McGhee, & Ehrler, 2018)

General Description

The DTLA-5 is a measure of general intellectual ability for children ages 6:0 through 17:11 years.

It includes 12 subtests: Humanities/Social Studies, Science/Mathematics, Word Opposites, Word Associations, Geometric Matrices, Geometric Sequences, Sentence Imitation, Word Span, Design Reproduction, Reversed Letters, Trail Making, and Rapid Naming.

21.4. Comprehensive Test of Nonverbal Intelligence—Second Edition (CTONI-2) *(Hammill, Pearson, & Wiederholt, 2009)*

General Description

The CTONI-2 is a test of nonverbal reasoning abilities for individuals ages 6:0 through 89:11 years that is particularly useful with children for whom other intelligence tests are either inappropriate or biased.

Subtests

Pictorial Analogies.

Geometric Analogies.

Pictorial Categories.

Geometric Categories.

Pictorial Sequences.

Geometric Sequences.

Composite Scores

Scores are generally reported as one or more of three composites or Scales as follows:

The Pictorial Scale is a composite of the three subtests that use familiar pictured objects in the test format.

The Geometric Scale is a composite of the three subtests that use unfamiliar designs as stimuli.

The Full Scale composite is a combination of performance on all six subtests.

21.5. Differential Ability Scales—Second Edition (DAS-II)

(Elliott, 2007)

General Description

The DAS-II is a measure of overall cognitive functioning for individuals ages 2:6 through 17:11 years.

Sample Statements

The child was administered the DAS-II to assess his/her overall intellectual functioning. The Cognitive Battery of the DAS-II is composed of subtests that yield a General Conceptual Ability (GCA) score, as well as Verbal, Nonverbal Reasoning, and Spatial Cluster scores. These scores have a mean of 100 and a standard deviation of 15. In addition, the DAS-II includes a set of diagnostic subtests, which test memory and information-processing abilities. Subtest scores are reported as *T*-scores, which have a mean of 50 and a standard deviation of 10.

On the DAS-II the child achieved a GCA score of ____, which places her/him at the ____ percentile relative to age-mates. This index is a composite score of three factors on which she/he scored as follows: Verbal Cluster of ____, ____ percentile; Nonverbal Reasoning Cluster of ____, ____ percentile; and Spatial Cluster of ____, ____ percentile.

Factors

The Verbal Cluster is a measure of verbal concepts, vocabulary development, expressive language ability, and general knowledge base.

The Nonverbal Reasoning Cluster is a measure of fluid intelligence and nonverbal ability.

The Spatial Cluster is a measure of spatial perception, visual-spatial imagery, and visual-motor coordination.

Core Subtests

Early Number Concepts is a measure of early mathematical ability (e.g., counting, identifying numbers).

Matching Letter-Like Forms is a test of the ability to match items that are similar to letters.

Matrices is a test of nonverbal inductive reasoning and the perception of visual detail and spatial orientation in drawings.

Naming Vocabulary is a test of the ability to name pictorial stimuli.

Pattern Construction is a test of nonverbal reasoning and spatial visualization skills, where the child is asked to construct block designs in response to a stimulus picture.

Phonological Processing measures knowledge of sounds and ability to manipulate sounds.

Picture Similarities is a test of inductive reasoning ability, where the child is asked to match pictures based on their conceptual similarities.

Rapid Naming assesses ability to quickly integrate visual symbols with phonological naming skills.

Recall of Designs assesses short-term visual-spatial memory, perception of spatial orientation, and retention and retrieval of whole visual images.

Sequential and Quantitative Reasoning is a test designed to assess a child's ability to understand sequences of numbers and abstract symbols.

Verbal Comprehension is a measure of the ability to perform simple one- and two-step directives (e.g., "Put a house on each side of the car" or "Give me all the things that have hair").

Verbal Similarities is a test of verbal inductive reasoning.

Word Definitions is a test of a child's knowledge of word meanings as demonstrated through spoken language.

Diagnostic Subtests

Recall of Digits is a test of short-term auditory memory.

Speed of Information Processing is a subtest requiring rapid and efficient visual search.

Recall of Objects (Immediate and Delayed) is a task that requires the child to learn a visually presented list of items over a course of three trials.

21.6. Kaufman Adolescent and Adult Intelligence Test (KAIT)

(Kaufman & Kaufman, 1993)

General Description

The KAIT is a test of intelligence for individuals ages 11–85+ years. It assesses crystallized and fluid abilities, as well as mental status and memory.

Core Battery Scales

The Crystallized Scale assesses word knowledge, verbal concept formation, acquired knowledge, and verbal comprehension.

The Fluid Scale measures the ability to learn and apply new information and logical reasoning.

Additional Measures

Four Extended Battery subtests measures immediate versus delayed memory.

A Supplementary Mental Status measure permits an estimate of mental functioning for severely impaired individuals.

21.7. Kaufman Assessment Battery for Children, Second Edition (KABC-II)

(Kaufman & Kaufman, 2004)

General Description

The KABC-II is a test of intelligence and achievement for individuals ages 3:0 through 18:11 years.

Scales

The Sequential Processing and Short-Term Memory Scale measures a child's ability to solve problems by remembering sequentially presented information.

The Simultaneous/Visual Processing Scale measures a child's ability to solve problems that require the processing of many stimuli at once.

The Learning Ability/Long-Term Storage and Retrieval Scale measures a child's ability to store and retrieve newly learned information.

The Planning/Fluid Reasoning Scale measures a child's nonverbal reasoning skills such as inferential thinking and inductive/deductive reasoning skills.

The Knowledge/Crystallized Ability Scale measures a child's ability to store general knowledge and information, such as vocabulary.

21.8. Stanford–Binet Intelligence Scales, Fifth Edition (SB5)

(Roid, 2003)

General Description

The SB5 is an assessment instrument that provides a Full Scale IQ, a Verbal IQ, a Nonverbal IQ, and five Composite Scores. Scores are provided as standard scores with a mean of 100 and a standard deviation of 15. The SB5 is normed on individuals ages 2 to 85+ years.

Content Areas

Fluid Reasoning measures verbal and nonverbal reasoning skills.
 Knowledge measures acquired knowledge, such as vocabulary, as well as procedural knowledge.
 Quantitative Reasoning measures numerical reasoning ability.
 Visual–Spatial Processing measures visual–spatial and nonverbal concept formation.
 Working Memory measures verbal and visual auditory attention and memory skills.

21.9. Test of Nonverbal Intelligence—Fourth Edition (TONI-4)

(Brown, Sherbenou, & Johnsen, 2010)

General Description

The TONI-4 is a test that measures nonverbal intelligence, such as nonverbal problem-solving and abstract reasoning abilities. It uses pointing responses to measure general intelligence and is normed on individuals ages 6:0 through 90:11 years.

21.10. Wechsler Abbreviated Scale of Intelligence—Second Edition (WASI-II)

(Pearson Assessments, 2011)

General Description

The WASI-II provides an estimate of IQ and includes those subtests from the WISC-IV and WAIS-IV that have the highest loadings on *g* (general intelligence). It is a brief test of intelligence designed for individuals ages 6:0 through 90:11 years.

Subtests See Sections 21.11 and 21.12 for more information on these subtests.

Vocabulary.
 Similarities.
 Block Design.
 Matrix Reasoning.

21.11. Wechsler Adult Intelligence Scale—Fourth Edition (WAIS-IV)

(Wechsler, 2008)

General Description

The WAIS-IV is a test of intellectual ability for individuals ages 16:0 through 90:11 years.

Sample Statement

This adolescent's WAIS-IV profile indicates a Full Scale IQ of _____. His/her Full Scale IQ falls in the _____ range, higher than _____% of peers in his/her age group. The Full Scale

IQ can be further broken down into four Index scores (Verbal Comprehension, Perceptual Reasoning, Working Memory, and Processing Speed).

Index Scores

The Verbal Comprehension Index is a composite of tests measuring vocabulary and the use of language to reason and solve problems.

The Perceptual Reasoning Index is a composite of subtests involving visual analysis and reasoning.

The Working Memory Index is a composite of subtests measuring the ability to maintain verbally presented information in conscious awareness, perform some mental manipulation or operation with it, and produce a result.

The Processing Speed Index is an indication of the rapidity with which an individual can mentally process simple or routine information without making errors.

Subtests

Arithmetic is a test of mental arithmetic and numerical reasoning ability.

Block Design is a test of visual–spatial ability and nonverbal concept formation.

Cancellation is a measure of perceptual speed, processing speed, and visual selective attention.

Comprehension is a measure of social judgment.

Digit Span is a test of immediate auditory attention and memory.

Coding is a test of visual–motor coordination, attention, visual scanning and tracking, and cognitive flexibility.

Information is a test of a person's fund of general information and long-term memory for information.

Letter–Number Sequencing is a test of short-term auditory memory, attention, and information processing.

Matrix Reasoning is a test of perceptual reasoning ability.

Similarities is a test of conceptual reasoning, as defined by the capacity to ascribe commonalities between two objects or concepts.

Symbol Search is a test of perceptual discrimination, attention and concentration, and cognitive flexibility.

Visual Puzzles is a test of nonverbal reasoning and the ability to analyze and synthesize visual stimuli.

Vocabulary is a test of word knowledge, fund of information, verbal concept formation, and language development.

21.12. Wechsler Intelligence Scale for Children— Fifth Edition (WISC-V) *(Wechsler, 2014)*

General Description

The WISC-V is a test of intellectual ability for children and adolescents ages 6:0 through 16:11 years.

Sample Statements

In order to assess overall level of intellectual functioning, the child was administered the WISC-V. This instrument comprises a set of subtests that yield a Full Scale IQ score, as well as Verbal Comprehension, Visual Spatial, Fluid Reasoning, Working Memory, and Processing

Speed Index scores. IQ and Index scores share the same scale (i.e., a mean of 100 and a standard deviation of 15).

The results of the current examination indicate that he/she is performing within the _____ range of overall intellectual functioning (WISC-V Full Scale IQ = _____, _____ percentile).

The WISC-V is a battery of 10 to 21 subtests that provide a profile of intellectual strengths and weaknesses as well as overall intellectual functioning. It is divided into subtests that require a spoken response, and other subtests that require the child to do something with her/his hands.

Index Scores

The Verbal Comprehension Index measures the ability to make sense of complex verbal information and use verbal abilities to solve novel problems.

The Visual Spatial Index measures the ability to evaluate visual details and understand visual spatial relationships.

The Fluid Reasoning Index is a measure of the ability to fluidly understand conceptual relationships among visual or quantitative items.

The Working Memory Index is a measure of attention, concentration, working memory, and mental alertness.

The Processing Speed Index measures the ability to process simple or routine information rapidly without making errors; it calls for cognitive flexibility, psychomotor speed, and visual selective attention.

The WISC-V also includes supplementary composites: the Quantitative Reasoning Index, Auditory Working Memory Index, Nonverbal Index, General Ability Index, Cognitive Proficiency Index, Naming Speed Index, Symbol Translation Index, and Storage and Retrieval Index. See below for the subtests that constitute these factors.

Subtests

The description of each subtest below is followed by the Index score(s) to which it contributes, in italics. If a subtest contributes to the Full Scale IQ, its description ends with an asterisk (*).

Arithmetic is a measure of numerical accuracy, reasoning, and mental arithmetic. *Quantitative Reasoning Index.*

Block Design measures visual organization and analysis of part-whole spatial relationships. *Visual Spatial, Nonverbal, General Ability Indexes.**

Cancellation is a measure of visual alertness and visual scanning ability. *Processing Speed Index.*

Coding assesses visual-motor coordination, speed, and concentration. *Processing Speed, Cognitive Proficiency Indexes.**

Comprehension provides a general measure of verbal reasoning, comprehension of social situations, and social judgment, as well as knowledge of conventional standards of social behavior. *Verbal Comprehension Index.*

Delayed Symbol Translation is a subtest where the child translates symbols into words or phrases, using recalled verbal-visual pairs from the Immediate Symbol Translation subtest. *Symbol Translation Index.*

Digit Span is a measure of immediate auditory memory and sequencing. *Working Memory, Cognitive Proficiency Indexes.**

Figure Weights is a measure of fluid reasoning and inductive reasoning skills. *Fluid Reasoning, Nonverbal, General Ability Indexes.**

Immediate Symbol Translation is a measure of verbal-visual associative memory. *Symbol Translation Index.*

Information measures the ability to recall factual information. *Verbal Comprehension Index*.

Letter–Number Sequencing is a measure of a child's short-term memory, as well as concentration and attention skills. *Working Memory, Auditory Working Memory Indexes*.

Matrix Reasoning is a measure of nonverbal problem-solving ability, inductive reasoning, and visual processing. *Fluid Reasoning, Nonverbal, General Ability Indexes*.*

Naming Speed Literacy is a test where the child names objects, letters, colors, and/or numbers as quickly as possible. *Naming Speed Index*.

Naming Speed Quantity is a test where a child is asked to rapidly name the quantity of squares within a series of boxes. *Naming Speed Index*.

Picture Concepts is a measure of fluid reasoning and perceptual organization. *Fluid Reasoning Index*.

Picture Span is a test of visual working memory. *Working Memory, Cognitive Proficiency, Nonverbal Indexes*.

Recognition Symbol Translation is a test where a child is asked to select the correct translation from a group of response options, using recalled verbal–visual pairs from the Immediate Symbol Translation subtest. *Symbol Translation Index*.

Similarities measures the ability to abstract meaningful concepts and relationships from verbally presented material. *Verbal Comprehension, General Ability Indexes*.*

Symbol Search is a measure of visual discrimination, scanning speed, and sequential tracking of simple visual information without a primary motor component. *Processing Speed, Cognitive Proficiency Indexes*.

Visual Puzzles is a measure of mental, nonmotor constructional ability where the individual views a puzzle and selects three response options that would reconstruct the puzzle. *Visual Spatial, Nonverbal Indexes*.

Vocabulary assesses word knowledge, verbal comprehension, ability to verbalize meaningful concepts, and long-term memory. *Verbal Comprehension, General Ability Indexes*.*

21.13. Wechsler Preschool and Primary Scale of Intelligence— Fourth Edition (WPPSI-IV) *(Wechsler, 2012)*

General Description

The WPPSI-IV is a test of intellectual ability for children ages 2:6 through 7:7.

Sample Statement

The child is currently functioning in the _____ range of intelligence, with a Full Scale IQ of ____ on the WPPSI-IV. This places him/her at the ____ percentile relative to others in his/her age group. He/she achieved a Verbal Comprehension Index of ____ (____ percentile) and a Visual Spatial Index of ____ (____ percentile), indicating somewhat/significantly better/similar performance on verbal comprehension tasks than/as on nonverbal tasks such as perceptual organization/immediate problem-solving ability.

Index Scores

The Fluid Reasoning Index is a measure of the ability to fluidly understand conceptual relationships among visual or quantitative items.

The Processing Speed Index measures the ability to process simple or routine information rapidly without making errors; it calls for cognitive flexibility, psychomotor speed, and visual selective attention.

The Verbal Comprehension Index assesses a child's ability to reason with words and process verbal information.

The Visual Spatial Index measures a child's understanding of perceptual organization and non-verbal reasoning. On subtests within this scale, the child is asked to manipulate visually abstract and concrete materials.

The Working Memory Index measures attention, concentration, working memory, and mental alertness.

The WPPSI-IV includes three ancillary index scales: the Vocabulary Acquisition, Nonverbal, and General Ability Indexes. See below for the subtests that constitute particular factors.

Subtests

The following are the WPPSI-IV subtests for children ages 2:6 to 3:11: Receptive Vocabulary, Information, Picture Naming, Block Design, Object Assembly, Picture Memory, and Zoo Locations. The subtests for children ages 4:0 to 7:7 include Information, Similarities Vocabulary, Comprehension, Block Design, Object Assembly, Matrix Reasoning, Picture Concepts, Picture Memory, Zoo Location, Bug Search, Cancellation, and Animal Coding. Brief descriptions of the subtests follow. The description of each subtest below is followed by the Index score(s) to which it contributes, in italics. If a subtest contributes to the Full Scale IQ for the 2:6–3:11 age group, its description ends with an asterisk (*). If a subtest contributes to the Full Scale IQ for the 4:0–7:7 age group, its description ends with a hash mark (#). Descriptions of subtests contributing to the Full Scale IQ for both age groups end with both symbols.

Animal Coding is a processing speed test where the child is asked to mark shapes that correspond to pictured animals. *Processing Speed, Nonverbal Indexes.*

Block Design is an abstract visual–motor task, where the child is asked to assemble a design with the help of a visual model. *Visual Spatial, Nonverbal, General Ability Indexes.*#*

Bug Search is a test of processing speed where the child marks the bug in the search group that matches the target bug. *Processing Speed, Nonverbal, Cognitive Proficiency.#*

Cancellation is a measure of processing speed where a child is asked to mark target items within a visual array of objects. *Processing Speed, Cognitive Proficiency, Nonverbal Indexes.*

Comprehension is a measure of practical knowledge and judgment. *Verbal Comprehension, General Ability Indexes.*

Information requires the child to answer a broad range of questions dealing with factual information; performance on this test may be influenced by cultural opportunities, outside interests, reading, and school learning. *Verbal Comprehension, General Ability Indexes.*#*

Matrix Reasoning is a measure of general nonverbal intelligence. *Fluid Reasoning, Nonverbal, General Ability Indexes.#*

Object Assembly requires a child to assemble puzzles; it measures a child's skill at synthesis (i.e., the ability to put things together to form familiar objects), as well as visual–motor coordination. *Visual Spatial, Nonverbal, General Ability Indexes.**

Picture Concepts is a measure of abstract, categorical reasoning ability. *Fluid Reasoning, Nonverbal, General Ability Indexes.*

Picture Memory is a test of visual working memory. *Working Memory, Nonverbal, Cognitive Proficiency Indexes.*#*

Picture Naming is a test of expressive language ability. *Vocabulary Acquisition Index.*

Receptive Vocabulary is a test of word knowledge. *Vocabulary Acquisition Index.**

Similarities is a test of verbal reasoning and concept formation. *Verbal Comprehension, General Ability Indexes.#*

Vocabulary is a test of word knowledge. *Verbal Comprehension General Ability Indexes.*

Zoo Locations is a test of spatial working memory. *Working Memory, Cognitive Proficiency Indexes.*

21.14. Wide Range Intelligence Test (WRIT)

(Glutting, Adams, & Sheslow, 2000)

General Description

The WRIT is a brief measure of cognitive ability for individuals ages 4:0 through 85:11 years.

Subtests

Vocabulary is a measure of verbal knowledge, where the child is asked to define words.

Verbal Analogies is a measure of conceptual ability, where the child is asked to complete a series of analogies.

Matrices is a measure of nonverbal reasoning ability, where the child is asked to complete a maze by picking one from a group of choices.

Diamonds is a test of visual-spatial ability, where the child is asked to use diamond-shaped pieces to construct designs.

21.15. Woodcock-Johnson IV (WJ IV) Tests of Cognitive Abilities

(Skrank, McGrew, Mather, & Woodcock, 2014)

General Description

The WJ IV Tests of Cognitive Abilities constitute a battery for measuring general intellectual ability and specific cognitive skills in persons ages 2-90+ years.

Sample Statements

On the standard battery of the WJ IV Tests of Cognitive Abilities, the child received a General Intellectual Ability score of ____ (____ percentile), which placed her/him in the _____ range for children her/his age.

The WJ IV Tests of Cognitive Abilities were administered to provide a general overview of the child's cognitive abilities and of strengths and weaknesses in his/her learning style.

The WJ IV Tests of Cognitive Abilities were given in order to further assess the child's ability to process information through different learning channels.

Clusters

The WJ IV Tests of Cognitive Abilities include the following Clusters:

- General Intellectual Ability.
- Brief Intellectual Ability.
- Gf-Gc Composite.
- Comprehension-Knowledge.
- Comprehension-Knowledge Extended.
- Fluid Reasoning Visual Processing.
- Fluid Reasoning Extended.
- Short-Term Working Memory.
- Short-Term Working Memory Extended.
- Cognitive Processing Speed.
- Perceptual Speed.
- Auditory Processing.
- Auditory Memory Span.
- Long-Term Retrieval.

Number Facility.
Cognitive Efficiency.
Cognitive Efficiency Extended.

Subtests

Analysis–Synthesis is a test of fluid reasoning.

Concept Formation evaluates a child's ability to find commonalities and rules in a series of items, and the ability to draw conclusions or make inferences.

General Information is a measure of general knowledge.

Letter–Pattern Matching is a perceptual speed task where the individual is asked to locate and circle two identical letter patterns in a row of six patterns.

Memory for Words asks a child to listen and then repeat a series of unrelated words; it provides a measure of short-term auditory memory.

Nonword Repetition is a measure of phonological and auditory processing.

Number–Pattern Matching is a test of perceptual processing speed.

Number Series is a test of quantitative and inductive reasoning.

Numbers Reversed asks a child to repeat a series of digits backward.

Object–Number Sequencing is a measure of short-term auditory working memory.

Oral Vocabulary asks a child to provide synonyms and antonyms for words presented orally by the examiner; it tests the breadth and depth of previously learned information.

Pair Cancellation is a measure of attention/concentration and processing speed.

Phonological Processing is a measure of auditory processing that is essential to fluent reading skills.

Picture Recognition is a test of short-term visual recall, where the child is asked to scan a series of pictures and then identify previously observed items.

Story Recall is a test of verbal memory where the individual is asked to recall information from auditorily presented stories.

Verbal Attention is a test of working memory and attentional control.

Visual–Auditory Learning asks a child to associate a name with an illustration.

Visual Closure asks a child to identify illustrations with missing parts.

Visualization is a measure of spatial processing.

22

Achievement Measures

This chapter lists and briefly describes the most commonly used achievement measures for children. These descriptions can be used in report writing. The chapter also includes descriptors for achievement-ability discrepancies.

22.1. Academic Performance Descriptions

Overall Performance

_____ performed well within/significantly above/significantly below intellectual, age, and grade expectations across measures of single-word reading, reading comprehension, spelling, and math calculation.

Reading

General Statements

_____’s reading skills are variable and ranged from below average/low average/average to average/above average/superior.

_____’s sight word reading vocabulary and ability to apply phonics skills in order to read nonwords was measured within the _____ range.

_____ performed within the _____ range on a task that assessed his/her ability to efficiently read single words and sentence-length material.

_____’s ability to answer questions about paragraph-length text was measured within the _____ range.

Good Performance

The child’s reading skills are quite well developed, as indicated by his/her strong performance on the _____ (*give name of test*).

Comprehension skills were a strength and were measured within the _____ range on a reading comprehension test, reflecting his/her strong reasoning skills.

Poor Performance

On tests of reading comprehension, she/he was noted to rely on pictures for sentence comprehension and to guess on many of the items.

The child’s performance indicates that he/she is struggling with attaining the basic skills and concepts necessary to the acquisition of reading.

Her/his performance on tests of reading indicates that she/he does not have the reading skills typically acquired by the beginning/middle/end of ____ grade.
 _____ often skipped, added, or replaced function words, and used visual similarity rather than the full phonological code to pronounce multisyllabic words.

Writing

Good Performance

Writing skills were grade-appropriate/advanced for age, were within/above the average range. Spelling skills on a dictation task measured within/below/above age/grade expectations. The child's ability to produce sentences to specific demands measured within/above/below the average range.

Poor Performance

Writing skills were notable for letter reversals (e.g., b for d) and substitutions of upper- for lower-case letters in words and in his/her name. Qualitative assessment of spelling performance indicated errors of letter reversal and omission, as well as vowel substitution. The child's score on tests of writing were reduced, due to errors in punctuation and grammar.

Math

Good Performance

The child's ability to solve math word problems that required knowledge of time/measurement/money was a relative strength and measured within the _____ range of scores. The child performed within/above age/grade expectations on a structured computational task that required addition/subtraction/multiplication/division/fractions/decimals/negative numbers/basic algebra.

Poor Performance

The child's ability to calculate single-digit math facts quickly and accurately was reduced on a timed task, reflecting weaknesses in processing speed and mental set shifting.

22.2. Achievement–Ability Discrepancies

No Discrepancy

_____ 's overall performance on the achievement tests indicates achievement commensurate with expectations in all areas and is not indicative of a formal learning disability.

Discrepancy

_____ 's overall level of educational achievement is significantly higher/lower than his/her overall level of intellectual development, based on his/her performance on the _____ (*name of test*).

22.3. Gates–MacGinitie Reading Tests, Fourth Edition (GMRT-4)

(MacGinitie, MacGinitie, Maria, & Dreyer, 2002)

General Description

The GMRT-4 includes measures of Prereading and Beginning reading abilities, as well as timed tests of reading that correspond to a child's grade level (e.g., Level 1 corresponds with the first-grade level). Level 1 uses multiple-choice pictures as answers, while Levels 2 through High School use multiple-choice words, phrases, or sentences as answers.

Subtests

The Vocabulary subtest presents a child with a series of written target words; for each one, he/she needs to determine which of five other words or phrases are closest in meaning to the target word.

The Comprehension subtest asks a child to read a series of written passages; following each passage, the child answers written multiple-choice questions pertaining to the passages' meanings.

Sample Statements

On the GMRT-4 (Level ____), the child was required to read several stories and answer detailed questions about the material. He/she performed above/at/below grade expectations, at a grade equivalent of ____, which placed him/her at the ____ percentile compared to same-age peers.

(For Level 1:) Ability to comprehend what she/he reads was assessed by administering the GMRT-4. On the Vocabulary subtest, the child was asked to find which of several words corresponded to the picture (in a series of items). On the Comprehension subtest, she/he was asked to read a series of short stories, and for each one, to answer questions about its meaning by selecting from three pictorial choices.

(For the Beginning Reading Skills Level:) His/her performance on this test indicated that for all areas assessed—including ability to recognize initial consonants and consonant clusters in words, ability to recognize vowel sounds, ability to utilize sentence context to read, and ability to identify final consonants and consonant clusters—he/she performed at the ____ percentile.

22.4. Gray Oral Reading Tests—Fifth Edition (GORT-5)

(Wiederholt & Bryant, 2012)

General Description

The GORT-5 is a timed test of oral reading rate, accuracy, fluency, and comprehension, in which the child is asked to read passages of increasing difficulty aloud.

Sample Statements

The GORT-5 was administered to evaluate the child's reading rate, accuracy, fluency, and comprehension. She/he was asked to read several passages out loud. An overall reading ability computed for each passage by combining the fluency score (rate plus accuracy) with the comprehension score.

Performance on the passage scores of the GORT-5 is far above/below grade expectations.

Performance on this test reveals that the rate and accuracy of his/her contextual reading are at

the ____ percentile for children his/her age, and that his/her reading level is at/above/below what would be expected for a child at the end of ____ grade.

Poor Performance

Oral reading was labored and slow, even on simple passages.

Reading was not always fluent, because the child was impulsive/did not attend to what she/he was reading/had difficulty decoding words.

The child's performance indicated that this task was much too difficult for him/her, as he/she was unable to read any of the passages.

The child skipped words or phrases/repeated words or phrases/had trouble sounding out unfamiliar words/substituted or omitted words.

22.5. Lindamood Auditory Conceptualization Test, Third Edition (LAC-3) *(Lindamood & Lindamood, 2004)*

General Description

The LAC-3 is a test of phonological processing that requires the child to represent sounds with colored blocks and then manipulate those blocks as the order of the sounds is changed; it assesses underlying auditory analysis skills, which are important to phonetic reading skills and success.

Sample Statements

The child's phonological skills were assessed through administration of the LAC-3, where he/she was presented with phonemes in isolated patterns or syllable patterns and was asked to use blocks to indicate the number, sequence, and similarity/difference of sounds.

Poor Performance

She/he had difficulty perceiving distinct consonant, vowel, and combination sounds and then sequencing these sounds by associating them with different-colored blocks.

His/her performance was equivalent to the suggested minimum for children at the beginning/middle/end of kindergarten and far below grade expectations. Children scoring below minimum recommended scores have been found to have difficulty meeting grade-level reading expectations.

22.6. Nelson–Denny Reading Test *(Brown, Fishco, & Hanna, 1993)*

General Description

The Nelson–Denny Reading Test is a measure of vocabulary, comprehension, and reading rate for adolescents (grade 9 and up) and adults.

Subtests

The Comprehension subtest asks the individual to read a series of written passages. After each passage, the person responds to multiple-choice pictures pertaining to the passage's meaning. The first minute of the Comprehension subtest is used to determine reading rate.

The Vocabulary subtest asks the individual to read target words and determine which of five other words are closest in meaning to the target words.

22.7. Slosson Test of Reading Readiness *(Perry & Vitali, 1991)*

General Description

The Slosson is a screen of reading readiness abilities that includes the ability to name upper- and lower-case letters, match upper- and lower-case letters, match word forms, provide rhymes for words, identify beginning sounds in words, sequence a story, and provide opposites.

22.8. Test of Early Mathematics Ability—Third Edition (TEMA-3)

(Ginsburg & Baroody, 2003)

General Description

The TEMA-3 is a measure of math and premath abilities such as numbering skills, numeral literacy, understanding of number facts, calculation skills, and understanding of number concepts.

Sample Statements

The child performed in the average/above-average/below-average range on the TEMA-3, a measure of early mathematical abilities (e.g., counting, identifying numbers, simple addition).

On the TEMA-3, _____ performed at the ____ percentile, with a Math Quotient of ____.

22.9. Test of Irregular Word Reading Efficiency (TIWRE)

(Reynolds & Kamphaus, 2007)

General Description

The TIWRE assesses a child's ability to read phonetically irregular words.

22.10. Test of Reading Comprehension—Fourth Edition (TORC-4)

(Brown, Weiderhold, & Hammill, 2009)

General Description

The TORC-4 is a measure of reading comprehension for children ages 7:0 to 17:11 years.

Subtests

- Relational Vocabulary
- Sentence Completion
- Paragraph Construction
- Text Comprehension
- Contextual Fluency

The five subtests are combined to form a composite called the Reading Comprehension Index, a standard score with a mean of 100 and a standard deviation of 15. This index represents students' ability to understand contextual printed material.

22.11. Test of Word Reading Efficiency—Second Edition (TOWRE-2)

(Torgesen, Wagner, & Rashotte, 2012)

General Description

The TOWRE-2 is a measure of a child's ability to pronounce words accurately and fluently.

Subtests

The Sight Word Efficiency subtest requires the child to read as many words as possible within 45 seconds.

The Phonemic Decoding subtest requires the child to read as many nonwords as possible within 45 seconds.

22.12. Test of Written Language—Fourth Edition (TOWL-4)

(Hammill & Larsen, 2009)

General Description and Subtests

The TOWL-4 is a measure of writing competence that includes the following subtests: Vocabulary, Spelling, Punctuation, Logical Sentences, Sentence Combining, Contextual Conventions, Story Composition.

For the Spontaneous Writing portion of the TOWL-4, a child is asked to write a story describing a scene. This story provides the scores for the Contextual Conventions and Story Composition subtests. This test is a good indicator of the child's ability to write stories/essays and take notes in class.

The Contrived Writing score is a measure of a child's ability to write in a contrived format, such as writing a sentence that incorporates a certain word or writing sentences from dictation.

The Overall Writing score is a measure of a student's contrived and spontaneous writing abilities.

Good Performance

On the TOWL-4 Story Construction subtest, the child was able to formulate a reasonably coherent story.

The child's overall performance on the TOWL-4 indicated good written vocabulary and writing skills.

Poor Performance

On the TOWL-4, the child's written output was markedly below expectations based on age and grade level. His/her simple story was unreadable due to numerous spelling errors.

Qualitatively, her/his handwriting was quite poor, and her/his written narrative contained numerous spelling errors.

22.13. Wechsler Individual Achievement Test—Third Edition (WIAT-III)

(Wechsler, 2009a)

General Description

The WIAT-III is a comprehensive, individually administered battery for assessing achievement in a wide variety of curriculum areas.

Subtests

Listening Comprehension assesses receptive language skills; a child listens to a word or sentence and points to a picture that describes the word or sentence, or looks at a picture and responds with the correct word.

Early Reading Skills assesses prereading skills such as letter naming, sound identification, and generating rhyming words.

Reading Comprehension is a measure of the ability to comprehend what has been read; a child is asked to read sentences and short paragraphs and answer questions about these passages, such as the main idea, specific details, or the order of events.

Math Problem Solving is a test of a child's ability to solve oral or written mathematical problems regarding time, money, measurement, graph reading, and geometry.

Alphabet Writing Fluency is a test of automaticity in written letter formation where the child is asked to write as many letters as he/she can without a 30-second time period.

Sentence Composition is a measure of sentence formulation skills and syntactic ability.

Word Reading is a measure of speed and accuracy of word recognition.

Essay Composition is a measure of spontaneous, compositional writing skills within a 10-minute time limit.

Pseudoword Decoding is a measure of phonetic decoding skills.

Numerical Operations is a test of a child's ability to complete written math problems correctly, including addition, subtraction, multiplication, and division.

Oral Expression is a measure of speaking vocabulary, word retrieval, oral syntactic knowledge, and short-term auditory memory.

Oral Reading Fluency measures speed, accuracy, fluency and prosody of oral reading.

Spelling is a measure of the ability to spell orally presented words correctly.

Math Fluency—Addition measures the speed and accuracy of a child's ability to add.

Math Fluency—Subtraction measures the speed and accuracy of a child's ability to subtract

Math Fluency—Multiplication measures the speed and accuracy of a child's ability to multiply.

22.14. Wide Range Achievement Test, Fifth Edition (WRAT5)

(Wilkinson & Robertson, 2017)

General Description

The WRAT5 is a measure of achievement in the areas of reading, spelling, and arithmetic.

Subtests

Word Reading measures a child's ability to read printed words or identify letters.

Sentence Comprehension measures a child's ability to comprehend written sentences through the use of a modified cloze technique.

Spelling measures a child's ability to spell dictated letters or words.

Math Computation measures a child's basic math skills such as counting, solving simple oral problems, or completing written math problems.

A Reading Composite score is obtained by combining the standard scores on Word Reading and Sentence Comprehension.

22.15. Woodcock–Johnson IV (WJ IV) Tests of Achievement

(Schrank, Mather, & McGrew, 2014)

See Section 21.15 for information about the WJ IV Tests of Cognitive Abilities.

General Description

The WJ IV Tests of Achievement are individually administered tests that measure educational achievement.

Subtests

Test 1: Letter–Word Identification is a measure of reading skills that asks a child to identify isolated letters and words.

Test 2: Applied Problems is a test of quantitative ability that requires a child to analyze and solve practical problems in mathematics. The information is presented to the child both orally and in written text.

Test 3: Spelling measures a child's ability to write letters and words that are presented orally to her/him.

Test 4: Passage Comprehension measures a child's ability to read a short passage and identify a missing key word; it assesses comprehension and vocabulary skills.

Test 5: Calculation is a paper-and-pencil test of quantitative abilities, such as the ability to comprehend mathematical concepts and perform numerical operations such as subtraction, addition, multiplication, and division.

Test 6: Writing Samples measures a child's skill in writing responses to a variety of demands; the child is not judged on the mechanics of writing, but rather on the quality of his/her written expression.

Test 7: Word Attack is a test that requires a child to sound out nonsense words; it measures phonics skills.

Test 8: Oral Reading is a measure of story-reading accuracy and prosody.

Test 9: Sentence Reading Fluency is a measure of silent reading rate.

Test 10: Math Facts Fluency is a timed measure of simple math computation ability.

Test 11: Sentence Writing Fluency is a timed (5-minute) test that requires a child to formulate as many short sentences as she/he can from words and pictures grouped to stimulate sentence production; it is a good indication of a child's ability to write stories, essays, and take notes in class.

Test 12: Reading Recall is a measure of reading comprehension where a child is asked to read a short passage silently and then retell as much of the story as he/she can recall.

Test 13: Number Matrices is a measure of quantitative reasoning.

Test 14: Editing requires a child to identify and correct errors in written passages (e.g., punctuation, word use, capitalization); it focuses on language development and English usage.

Test 15: Word Reading Fluency is a measure of vocabulary knowledge and semantic fluency where a child has 3 minutes to mark the two words that go together in each row.

Test 16: Spelling of Sounds is a measure of phonological and orthographic coding ability.

Test 17: Reading Vocabulary measures comprehension at the single-word level; it requires a child to read isolated words and supply antonyms or synonyms in response to the words presented.

Test 18: Science measures a child's knowledge of the sciences such as biology, chemistry, and physics.

Test 19: Social Studies measures a child's knowledge of history, geography, political science, and psychology.

Test 20: Humanities measures a child's knowledge of art, music, and literature.

22.16. Woodcock Reading Mastery Tests, Third Edition (WRMT-III)

(Woodcock, 2011)

General Description

The WRMT-III is a test battery of reading skills.

Subtests

Letter Identification is a test of the ability to identify upper- and lower-case letters.

Listening Comprehension is a measure of the ability to comprehend spoken language.

Oral Reading Fluency is a measure of reading fluency.

Passage Comprehension is a structured test of reading comprehension; it consists of short passages (one or two sentences) with a word missing that the examinee is requested to supply.

Phonological Awareness measures phonological skills such as letter–sound matching, rhyme production, sound blending, and sound deletion.

Rapid Automatic Naming measures simple verbal speed and accuracy.

Word Attack measures the ability to apply phonetics to written language when presented with nonsense words.

Word Identification is a test of the ability to read isolated words.

Word Comprehension measures a child's knowledge of synonyms, antonyms, and analogies.

23

Tests of Language Functioning

This chapter lists and briefly describes the most commonly used tests of language functioning for children. Suggested phrasings for reporting results are also given. See also the following sections of Chapters 21 and 22 for descriptions of subtests and composites that measure language ability: Sections 21.5 (DAS-II Word Definitions, Similarities); 21.11 and 21.12 (WAIS-IV and WISC-V Similarities, Vocabulary, Comprehension, Information); 21.12 (WISC-V Word Reasoning and Verbal Comprehension Index); and 22.13 (WIAT-III Listening Comprehension).

23.1. Boston Naming Test—Second Edition (BNT-2)

(Kaplan, Goodglass, & Weintraub, 2001)

General Description

The BNT-2 is a test of confrontation naming.

Sample Statements

Word retrieval skills on the BNT-2 were average/high average/below average/etc. (____/60; mean = ____; standard deviation = ____).

Vocabulary knowledge was assessed by administering a test of basic expressive language skills, the BNT-2.

Expressive vocabulary was assessed on the BNT-2, a test in which the child is presented with a series of line drawings of objects (e.g., wheelchair, camel, cactus) and is asked to provide a name for each one.

On the BNT-2, which evaluates naming and word retrieval, the child scored within the _____ range for his/her age.

Confrontation naming on the BNT-2 was in the _____ range.

23.2. Bracken Basic Concept Scale: Expressive—Third Edition (BBCS-3) *(Bracken, 2006)*

General Description

The BBCS-3 is a measure of children's receptive language skills and language concept acquisition.

23.3. Clinical Evaluation of Language Fundamentals— Fifth Edition (CELF-5) *(Semel, Wiig, & Secord, 2013)*

General Description

The CELF-5 assesses a child's knowledge of word meanings, knowledge of word and sentence structure (morphology and syntax), and the recall and retrieval of spoken language (memory).

Sample Statements

Language form and content were evaluated on the CELF-5.

Word meanings (semantics), word and sentence structure (morphology and syntax), and recall of spoken language (auditory memory) were evaluated on the CELF-5.

23.4. Controlled Oral Word Association Test (COWAT) *(Benton, 1968)*

General Description

The COWAT assesses verbal fluency by measuring responses to both phonemic cues (FAS) and semantic cues (Animals).

Sample Statements

The child was administered the COWAT, consisting of two tests of verbal fluency that require the individual to initiate and sustain attention. On a test of letter fluency, he/she was asked to rapidly generate a list of words beginning with each of three letters. On a category fluency task, he/she was asked to rapidly generate a list of animals within a time limit.

The child performed in the _____ range on a task that required her/him to generate words to a phonemic cue (FAS = ____ words; ____ percentile) and semantic cue (Animals = ____ words; ____ percentile).

On the FAS subtest, word fluency was low-average/average/high-average/etc. (____ words in 3 minutes).

On the Animals subtest, semantic fluency was within/below/above normal limits (____ animals in 1 minute).

23.5. Expressive One-Word Picture Vocabulary Test, Fourth Edition (EOWPVT-4) *(Martin & Brownell, 2011a)*

General Description

The EOWPVT-4 measures the ability to fluently name pictures of familiar objects.

Sample Statements

On a test of expressive vocabulary (the EOWPVT-4), the child achieved a score of _____, indicating vocabulary skills above/at/below age level.

23.6. Expressive Vocabulary Test, Third Edition (EVT-3) *(Williams, 2018)*

General Description

The EVT-3 is a measure of expressive vocabulary and word retrieval skills.

Sample Statements

The EVT-3 was given to assess the child's single-word expressive vocabulary knowledge and related word retrieval abilities. On the test, he/she was presented with a series of pictures and given this carrier phrase for each one: "Tell me another word for _____."

On the EVT-3 the child is shown a series of pictures, one at a time. For each picture, a word is provided to describe the picture, and the child is asked to give another word that means the same thing.

23.7. Illinois Test of Psycholinguistic Abilities— Third Edition (ITPA-3) *(Hammill, Mather, & Roberts, 2001)*

General Description

The ITPA-3 is a measure of children's spoken and written language, including oral language, writing, reading, and spelling.

23.8. Oral and Written Language Scales, Second Edition (OWLS-II)

(Carrow-Woolfolk, 2011)

General Description

The OWLS-II is a test of receptive and expressive language.

Subtests

Listening Comprehension provides a measure of vocabulary, grammar skills, and verbal thinking skills.

Oral Expression measures the accuracy of the structure of language and the capacity to articulate and elaborate ideas.

Reading Comprehension measures the linguistic accuracy of reading.

Written Expression assesses the ability to use correct writing conventions.

23.9. Peabody Picture Vocabulary Test—Fifth Edition (PPVT-5)

(Dunn, 2019)

General Description

The PPVT-5 is a test of single-word receptive vocabulary.

Sample Statements

The PPVT-5 tests receptive vocabulary by asking the child to select the picture that illustrates each word read by the examiner.

The PPVT-5 was administered to assess the child's single-word receptive vocabulary skill knowledge. He/she was asked to point to each stimulus item named, from a field of four pictures.

The PPVT-5 assesses knowledge of general word meaning by asking the child to identify words through pointing to the corresponding picture. The test is also a good indicator of verbal intelligence.

23.10. Receptive One-Word Picture Vocabulary Test, Fourth Edition (ROWPVT-4) *(Martin & Brownell, 2011b)*

General Description

The ROWPVT-4 is a measure of receptive vocabulary skills.

Sample Statements

The ROWPVT-4 was given to assess the child's single-word receptive vocabulary skills. On this test, the child was asked to choose a picture that best matched a target word given by the examiner.

23.11. Test of Adolescent and Adult Language—Fourth Edition (TOAL-4) *(Hammill, Brown, Larsen, & Wiederholt, 2007)*

General Description

The TOAL-4 is a measure of language functioning that includes tests of listening, speaking, reading, writing, spoken language, written language, vocabulary, grammar, receptive language, and expressive language.

23.12. Test for Auditory Comprehension of Language—Fourth Edition (TACL-4) *(Carrow-Woolfolk, 2014)*

General Description

The TACL-4 is a measure of auditory comprehension of receptive language, which assesses knowledge such as syntax, sentence structure, oral vocabulary, and morphemes.

Sample Statement

The TACL-4 was administered to further assess the child's understanding of specific word and sentence structures.

23.13. Test of Early Language Development—Fourth Edition (TELD-4) *(Hresko, Reid, & Hammill, 2018)*

General Description

The TELD-4 is a measure of oral language for very young children.

Subtests

Expressive Language assesses a child's ability to produce oral language (e.g., semantics, syntax).
Receptive Language assesses a child's understanding of spoken language.

**23.14. Test of Language Development—Intermediate:
Fourth Edition (TOLD-I:4)** *(Newcomer & Hammill, 2008a)***General Description**

The TOLD-I:4 is a measure of overall language abilities for older children (ages 8:0 to 12:11).

Subtests

Relational Vocabulary measures the ability to identify the relationship among three words. Morphological Comprehension assesses the ability to recognize ungrammatical spoken language.

Multiple Meanings measures the child's ability to generate different meanings for a word. Picture Vocabulary is an assessment of the ability to understand the meaning of two-word spoken phrases.

Sentence Combining measures the ability to combine two to four short, simple sentences into one complex or compound sentence without changing the meaning.

Word Ordering assesses the ability to construct a meaningful sentence from a set of words presented orally in a random sequence.

**23.15. Test of Language Development—Primary:
Fourth Edition (TOLD-P:4)** *(Newcomer & Hammill, 2008b)***General Description**

The TOLD-P:4 is a measure of verbal comprehension and expression abilities at the single-word and sentence levels for young children (ages 4:0 to 8:11).

Subtests

Morphological Completion is a test of the ability to use common English morphology.

Syntactic Understanding is a test of the ability to understand sentence meaning.

Oral Vocabulary is a test that asks the child to provide definitions for words.

Word Analysis measures the ability to segment words into phonemic units.

Picture Vocabulary is a test of word knowledge.

Relational Vocabulary is a test of the ability to understand the relationship between two words.

Sentence Imitation is a measure of short-term memory that asks a child to repeat sentences.

Word Articulation assesses the ability to articulate speech sounds.

Word Discrimination assesses the ability to discriminate speech sounds.

24

Memory Tests

This chapter lists and briefly describes the most commonly used tests of memory functioning for children. These descriptions can be used in report writing. For memory subtests of broader cognitive/intelligence batteries, see Chapter 21.

24.1. Benton Visual Retention Test, Fifth Edition (BVRT-5)

(Sivan, 1991)

General Description

The BVRT-5 assesses difficulties in memory, motor behavior, and spatial orientation.

24.2. Children's Memory Scale (CMS) *(Cohen, 1997)*

General Description

The CMS is a comprehensive battery of memory tests; it includes assessment of memory in visual and verbal modalities, and in immediate and recall conditions.

Subtests

General Memory is a measure of a child's ability to recall general information.

Numbers requires the recall of numbers both forward and backward.

Sequencing includes a variety of tasks involving sequencing (e.g., listing months backward or counting backward from 20 to 1).

Stories assesses a child's immediate recall of details presented in a story that has been read to him/her. The child is then asked to recall them again following a delay.

Stories—Delayed Recognition Format presents facts in the story in a yes–no format.

Verbal Memory includes a measure of story memory, as well as a measure of ability to remember verbal paired associates.

Word Pairs presents a child with word pairs (related as well as unrelated) over three repeated trials. Memory is tested after each of the trials by cuing with the first word in each pair, as well as in a free-recall paradigm in immediate- and delayed-recall conditions.

24.3. List-Learning Tests

The California Verbal Learning Test—Children's Version (CVLT-C; Delis, Kramer, Kaplan, & Ober, 1994) is used for ages 6–17.

The California Verbal Learning Test, Third Edition (CVLT-3; Delis, Kramer, Kaplan, & Ober, 2017) is used for ages 16 through 90:0.

The Children's Auditory Verbal Learning Test–2 (CAVLT-2; Talley, 1993) is used for ages 6–17 as an alternative to, or instead of, the CVLT-C.

General Description

The CVLT-C/CVLT-3/CAVLT-2 is a test of verbal learning and memory where the child is asked to listen to a list of words and then recall as many of the words as possible over five trials and in short and long delayed-recall conditions.

Sample Statements

The child's performance on the CVLT-C/CVLT-3/CAVLT-2, a test of learning and memory, fell above/at/below the mean for ability to recall information after short/long delays under conditions of free/cued/recognition recall.

On the CVLT-C/CVLT-3/CAVLT-2, the individual is asked to recall a list of 16 items presented repeatedly over five learning trials. Memory for the list is tested after each presentation, after presentation of an interference list (i.e., short delay), and again after a long delay, in free-recall, cued-recall, and recognition memory conditions. Normal performance on this measure is characterized by a positive learning curve—that is, with additional items recalled after successive learning trials. Also, performance is generally better on cued- than free-recall trials, and recognition is typically better than recall.

Common Errors

Passive learning strategy (e.g., reliance on serial order of list as opposed to semantic categorization), difficulty with sustained attention (e.g., shown by fewer items recalled over time), perseverations, poor retention over time, vulnerability to interference.

24.4. Rey Auditory Verbal Learning Test (RAVLT)

(Forrester & Geffen, 1991)

General Description

The RAVLT is a test of verbal learning where the child is asked to learn a 15-word list over five learning trials, followed by one recall and one recognition trial after an interference condition.

Rey–Osterrieth Complex Figure Test (ROCF) *See Section 25.9.*

24.5. Wechsler Memory Scale—Fourth Edition (WMS-IV)

(Wechsler, 2009b)

General Description

The WMS-IV is a comprehensive test battery that assesses visual and auditory memory.

24.6. Wide Range Assessment of Memory and Learning, Second Edition (WRAML2) *(Adams & Sheslow, 2003)*

General Description

The WRAML2 is a test battery that measures a child's ability to actively learn and memorize a variety of auditory and visual information.

Subtests

Design Memory is a test of spatial memory, where a child is asked to study sequences of geometric designs for 5 seconds and then wait 10 seconds before drawing them.

Finger Windows is a test of immediate recall for nonverbal, visual-spatial sequences.

Number-Letter asks a child to repeat strings of letters and numbers of increasing length.

Picture Memory measures visual attention and memory, as well as the ability to keep visual information in working memory; a child is asked to look at four scenes for 10 seconds each, and then immediately after presentation to identify elements that have been added or changed.

Sentence Memory is a measure of verbal memory skills for simple material.

Sound-Symbol is a test of visual and auditory memory, where a child is asked to recall the sound that is paired with a symbol.

Story Memory is a test where a child has to listen to and repeat short paragraphs.

Symbolic Working Memory is a test of visual working memory skills.

Verbal Learning is a test of auditory working memory, where information is presented in a list that the child hears four times; it includes Delay Recall and Delay Recognition conditions.

Verbal Working Memory is a test of auditory working memory, where the child hears a string of words and is asked to recall them in a certain categorical order.

25

Tests of Visual–Spatial and Motor Skills

This chapter lists the most commonly used tests of visual–spatial and motor functioning for children. Brief descriptions of many of these tests are offered and can be used in report writing.

25.1. Beery–Buktenica Developmental Test of Visual–Motor Integration, Sixth Edition (Beery VMI)

(Beery, Buktenica, & Beery, 2010)

General Description

The Beery VMI asks a child to copy simple geometric forms (e.g., circle, square) that are developmentally normed. It assesses visual–motor integration, which is the degree to which visual perception and finger–hand movements (e.g., fine motor movements) are well coordinated. The test can be administered to individuals from age 2 years through adulthood.

Sample Statements

The Beery VMI requires the child to copy progressively complex designs. His/her performance fell in the _____ range (____ percentile; ____-year, ____-month age equivalent).

This test consists of 24 geometrical forms that are copied in a developmental sequence, from simple to more complex. The child copied these forms with pencil and paper from examples.

On the Beery VMI, the child copied geometric figures of ascending difficulty in a structured format. His/her performance on the VMI indicated no/little/some/much difficulty on this task.

The child was administered the VMI, a test in which the child is asked to draw a series of increasingly complex figures (i.e., progressing from simple geometric shapes to figures that require integration of different parts), each of which is scored according to a set of developmental norms. The child achieved a standard score of ____ on this test, placing him/her at the ____th percentile as compared to age-mates and at an age equivalent of ____ years, months.

Common Problems

Spatial confusion, lack of precision in copying designs, poor attention to detail, problems reproducing angled shapes/three-dimensional designs/designs where lines change directions, difficulty paying attention to visual detail/integrating parts into whole/making diagonals.

25.2. Bender Visual–Motor Gestalt Test, Second Edition (Bender–Gestalt II) *(Brannigan & Decker, 2003)*

General Description

The Bender–Gestalt is a test originally published in 1938 by Lauretta Bender, MD. It is a brief test of visual–motor integration that can provide information about an individual's development and psychological functioning. The test can be administered beginning at age 4 years through adulthood.

Sample Statements

The child completed the Bender–Gestalt II, a visual–motor skill screening that required him/her to copy several geometric figures and patterns.

The Bender–Gestalt II required the child to copy a series of geometric figures on paper with a pencil.

The Bender–Gestalt II showed some/many/no signs of visual–motor difficulties, as the child copied each of the figures with minimal/several/numerous distortions.

Common Problems

Difficulties with regulating size/forming angles/spatial planning, problems with organization of figures on page, figures drawn on one small portion of page, wavy lines.

25.3. Bruininks–Oseretsky Test of Motor Proficiency, Second Edition (BOT-2) *(Bruininks & Bruininks, 2006)*

General Description

The BOT-2 assesses a child's skill levels in the areas of gross motor performance, fine motor performance, bilateral integration, and coordination. Both quality of skill and completion within a time frame are considered; the test is normed for individuals ages 4–21.

Sample Statements

The child's motor performance was evaluated with the BOT-2, a measure of speed, agility, balance, strength, bilateral coordination, and upper-limb coordination.

Subtests

Balance requires a child to balance on one foot with eyes open and with eyes closed, to perform other balancing tasks, and to walk on the floor as well as on a balance beam.

Bilateral Coordination assesses the ability to perform reciprocal and symmetrical arm and leg motions.

Fine Motor Integration assesses the ability to copy shapes.

Fine Motor Precision assesses the ability to coordinate precise hand and visual movements, such as cutting out a circle.

Manual Dexterity measures the ability to perform fine motor tasks quickly.

Running Speed and Agility measures speed and dexterity during a shuttle run.

Strength assesses arm, shoulder, abdominal, and leg strength through tasks such as a broad jump, push-ups, and sit-ups.

Upper-Limb Coordination includes bouncing and catching a tennis ball, as well as arm and finger coordination items.

25.4. Finger Tapping or Finger Oscillation Test *(Reitan & Wolfson, 1993)*

General Description

The Finger Tapping/Finger Oscillation Test is designed to measure motor control and requires kinesthetic ability, motor speed, and visual–motor coordination.

Sample Statements

On the Finger Tapping Test, the child performed similarly/slightly faster/slightly slower with his/her left/right hand, at the ____ percentile, indicating below-average/normal/above-average simple fine motor speed.

The Finger Oscillation Test required _____ to repeatedly tap a device with the index finger of each hand over several repeated trials, and over these trials his/her rate of tapping was calculated.

25.5. Grip Strength or Hand Dynamometer *(Reitan & Wolfson, 1993)*

General Description

The Grip Strength or Hand Dynamometer task requires a child to squeeze a dynamometer with each hand and is used to detect differences in hand strength.

25.6. Grooved Pegboard *(Matthews & Kløve, 1964)*

General Description

The Grooved Pegboard task is a manipulative dexterity test consisting of 25 holes with randomly positioned slots. Pegs with a key along one side must be rotated to match the hole before they can be inserted. The test can be administered from age 5 years through adulthood.

Sample Statements

The child's performance was normal/abnormal on a test of fine motor dexterity and motor planning (Grooved Pegboard).

Common Problems

Filling in the pegboard in a very disorganized fashion, a significant number of drops.

25.7. Hooper Visual Organization Test *(Hooper, 1983)*

General Description

The Hooper Visual Organization Test is a measure of visual closure; the child is asked to identify a picture (e.g., saw, flower) that has been cut up into pieces and arranged in separate parts on the stimulus page. The test can be administered from age 5 years through adulthood.

25.8. Judgment of Line Orientation *(Benton, Hannah, & Varney, 1975)*

General Description

The Judgment of Line Orientation task requires a child to judge the location and directionality of a series of lines; it is a measure of pure spatial judgment. The test can be administered from age 7 years through adulthood.

25.9. Rey–Osterrieth Complex Figure Test (ROCF) *(Lezak et al., 2012)*

General Description

The ROCF is used to assess visual–spatial constructional ability and visual memory. The copy component of this test requires a child to reproduce a complex line drawing on a blank sheet of paper while the drawing is in full view; the delayed-recall component of the test requires him/her to draw the figure from memory 30 minutes subsequent to seeing the figure. The test can be administered from age 6 years through adulthood.

Sample Statements

Memory performance was assessed by asking the child to draw the ROCF from memory, both immediately and again following a 30-minute delay.

The child was administered the Rey Osterrieth, a test of complex spatial reasoning, visual organization, and constructional skills. The copy is scored quantitatively (based on accuracy of the copy) and in addition, qualitative observations are made as to the individual's organizational approach.

Good Performance

The child utilized a configural approach in the reproduction for the ROCF, and her/his overall performance was within the average/above-average range.

He/she demonstrated a well-organized approach to his/her copy of the design.

Overall, the child demonstrated age-appropriate visual skills (visual perception, planning, and organization, as well as memory).

Poor Performance

The child's copy of the figure was quite segmented, suggesting that she/he does not yet have the visual-perceptual ability to appreciate the larger organizational elements in a visual stimulus, but rather processes detail by detail.

Although the child did succeed in recalling parts of the overall organizing structure, the details were placed in a haphazard manner, suggesting a loss of information regarding the organization of the design.

His/her memory of the figure was poor and evidenced difficulty in understanding the wholeness of the figure.

The child's copy of the figure was characterized by a disorganized approach; specifically, she/he failed to appreciate the figure's overall organizing structure and instead proceeded in a piecemeal fashion, indicating poor ability to grasp and encode the figural information.

Common Problems

Figure lacks a sense of coherence/gestalt, poorly organized, fragmentation, difficulty in understanding the wholeness of the figure, misalignments/distortion errors, difficulty determining where to start and how to approach the drawing, added details that were not a part of the design, impulsive style.

Problems on the ROCF may indicate difficulty with executing multistep behaviors, problems in attending to environmental complexity, trouble seeing the "big picture," problems with work completion and time management.

ROCF Scoring Systems

Bernstein, J. H., & Waber, D. (1996). *Developmental scoring system for the Rey–Osterrieth Complex Figure*. Odessa, FL: Psychological Assessment Resources.

Meyers, J. E., & Meyers, K. R. (1995). *Rey Complex Figure Test and Recognition Trial (RCFT)*. Odessa, FL: Psychological Assessment Resources.

Stern, R. A., Javorsky, D. J., Singer, E. A., Singer Harris, N. G., Somerville, J. A., Duke, L. M., et al. (2002). *The Boston Qualitative Scoring System (BQSS) for the Rey–Osterrieth Complex Figure*. Odessa, FL: Psychological Assessment Resources.

Other Tests of Visual–Spatial Ability

See the following sections of Chapters 21, 24, and 26 for more information about these tests, subtests, and composites that measure visual–spatial ability:

21.5: DAS-II Matrices, Recall of Designs, Pattern Construction, Matching Letter-Like Forms, Copying, Spatial Cluster.

21.11 and 21.12: WAIS-IV and WISC-V Block Design, Matrix Reasoning, Visual Puzzles, Visual Spatial Index.

24.6: WRAML2 Picture Memory, Design Memory.

26.8: NEPSY-II Arrows, Visual Precision, Finger Tapping, Imitating Hand Positions, Manual Motor Sequencing, Block Construction, Design Copying, Geometric Puzzles, Picture Puzzles, Route Finding.

26.13: Tactual Performance Test (TPT).

26

Measures of Executive and Neuropsychological Functioning

This chapter lists the most commonly used tests of executive and neuropsychological functioning for children, as well as descriptions that can be used in report writing. Since the number of tests in this category is quite large, and assessment in this area requires specialized training, this chapter is not meant to provide exhaustive coverage.

26.1. Definition of Executive Functions

"Executive functions" include skills such as attention, impulse control, working memory, and organization.

26.2. Aphasia Screening Test *(Reitan & Wolfson, 1985)*

General Description

The Aphasia Screening Test measures expressive and receptive language functioning; letter identification; and the ability to perform lateralized hand functions, copy simple shapes, and solve simple arithmetic problems.

26.3. Children's Category Test *(Boll, 1993)*

General Description

The Children's Category Test is a measure of nonverbal concept formation and use of feedback information to form and test hypotheses, as well as the ability to adapt behavior in response to corrective feedback. This test can be administered to children and adolescents ages 5–17 years.

Common Problems

Performance problems may indicate cognitive inflexibility, difficulty in the ability to develop/test/modify hypotheses.

26.4. Conners Continuous Performance Test 3rd Edition (Conners CPT 3) and Conners Kiddie Continuous Performance Test 2nd Edition (Conners K-CPT 2) *(Conners, 2014, 2015)*

General Description

The Conners CPT 3/K-CPT 2 is a computerized measure of the ability to sustain attention over time and to inhibit impulsive responses.

Sample Statements

On the Conners CPT 3/K-CPT 2, _____'s performance was within the above-average/average/below-average range for all aspects of the testing, indicating (un)satisfactory attention. *(Indicate whether the child was on or off medication at the time of testing.)*

_____ 's performance on the CPT 3/K-CPT 2 was poor/good and provides strong evidence that she/he does/does not typically struggle with attentional difficulties.

26.5. Gordon Diagnostic System *(Gordon, 1998)*

General Description

The Gordon Diagnostic System includes several tasks that test sustained attention and the ability to inhibit responses.

Subtests

The Vigilance Test requires a child to pay attention to a repetitive stimulus.

The Distractibility Task requires a child to attend to a specific set of stimuli and screen out competing stimuli.

26.6. Halstead–Reitan Neuropsychological Test Battery for Older Children and Reitan–Indiana Neuropsychological Test Battery for Children *(Reitan & Wolfson, 1985, 1992)*

General Description

Both the Halstead–Reitan and Reitan–Indiana consist of several subtests or scales, each intended to assess one or more neuropsychological abilities. This battery can be administered to adolescents age 15 years and older, with a children's version for ages 9–14 years.

Subtests

Children's Category Test *(see Section 26.3)*.

Tactual Performance Test (TPT) *(see Section 26.13)*.

Finger Tapping or Finger Oscillation Test *(see Section 25.4)*.

Aphasia Screening Test *(see Section 26.2)*.

Matching Pictures Test.

Individual Performance (Matching Figures, Star, Matching V's, Concentric Squares).
 Marching Test.
 Progressive Figures Test.
 Color Form Test.
 Target Test.
 Seashore Rhythm Test (*see Section 26.9*).
 Speech Sounds Perception Test (*see Section 26.10*).
 Trail Making Test (Parts A and B) (*see Section 26.16*).
 Sensory-Perceptual Examination.
 Tactile Finger Recognition.
 Fingertip Number Writing.
 Tactile Form Recognition.
 Grip Strength or Hand Dynamometer (*see Section 25.5*).

26.7. Luria-Nebraska Neuropsychological Battery-II (LNNB-II) and Luria-Nebraska Neuropsychological Battery—Children's Revision (LNNB-C) (*Golden, 1987*)

General Description

Both the LNNB-II and LNNB-C are designed to assess a broad range of neuropsychological functioning and measure a variety of sensory-motor, perceptual, and cognitive abilities. There are 11 scales: motor functions, rhythm, tactile functions, visual functions, receptive speech, expressive speech, writing, reading, arithmetic, memory, and intellectual processes. This battery can be administered to individuals ages 13 years and older.

26.8. NEPSY-II (*Korkman, Kirk, & Kemp, 2007*)

General Description

The NEPSY-II is a developmental neuropsychological test battery that evaluates six domains: Executive Function and Attention, Language, Sensorimotor, Visuospatial Processing, Memory and Learning, and Social Perception. This battery can be administered to children and adolescents ages 3-16 years.

26.9. Seashore Rhythm Test (*Reitan & Wolfson, 1993*)

General Description

In the Seashore Rhythm Test, a child is presented with pairs of tone patterns and has to identify whether the patterns in each pair are the same or different; it is a measure of sustained attention and the ability to perceive and compare rhythmical patterns.

26.10. Speech Sounds Perception Test (*Reitan & Wolfson, 1993*)

General Description

In the Speech Sounds Perception Test, a child is presented with a series of nonsense words on an audio recording and is asked to identify each spoken nonsense word from among a written list of choices.

26.11. Stroop Color and Word Test (*Golden, 1978*)**General Description**

The Stroop is a formal test of cognitive inhibition, impulse control, and concentration; it assesses the ability to filter out irrelevant information and attend to the relevant information in a given task or situation, with scores for speed and accuracy in three conditions. This test is normed for ages 5 years through adulthood.

26.12. Symbol Digit Modalities Test (SDMT) (*Smith, 1982*)**General Description**

The SDMT is a symbol-coding task (similar to the Coding subtest of the WISC-V/WAIS-IV) that provides a measure of processing speed and attention. This test is appropriate for ages 8 years through adulthood.

26.13. Tactual Performance Test (TPT) (*Reitan & Wolfson, 1993*)**General Description**

The TPT is a measure of tactile form recognition, psychomotor problem solving, memory for shapes, and spatial thinking. This test can be administered to individuals from ages 5 years through adulthood.

Sample Statement

On the TPT, the child completed a formboard blindfolded three times (using his/her dominant hand, nondominant hand, and both hands on the respective trials). The task assesses form discrimination, kinesthesia, coordination of arm movement, manual dexterity, and visualization of spatial configurations. After completing the third trial, the child was asked to draw what he/she thought the board looked like without ever having seen it.

26.14. Test of Variables of Attention (TOVA) (*Greenberg, 1990*)**General Description**

The TOVA is a visual and auditory performance test that assesses attention and impulse control that can be administered to individuals ages 4 years and up.

26.15. Token Test for Children—Second Edition (TTFC-2)

(*McGhee, Ehrler, & DiSimoni, 2007*)

General Description

The TTFC-2 is a test of auditory comprehension that has a child manipulate tokens in response to instructions from the examiner (e.g., "Put the red triangle next to the yellow circle"). The test is normed for ages 3–12 years.

26.16. Trail Making Test, Parts A and B *(Spreeen & Strauss, 1991)*

General Description

The Trail Making Test is a test of efficiency in following two sequential procedures; it measures higher-order executive functions such as planning, ability to change cognitive set, sequencing, and integrative abilities, as well as visual scanning skills and accuracy under the pressure of time. A children's version of this test is normed for ages 8–15 years, and an adult version is normed for ages 16 years through adulthood.

Sample Statements

To further assess attention, the child was administered the Trail Making Test; this test includes two parts (A and B), both of which are basically connect-the-dots tasks involving numbers and (in Trails B) letters as well. Aside from motor planning, these tasks require a good deal of visual attention, scanning, and an ability to "shift set."

The child was given the Trail Making Test, a measure of visual scanning speed, psychomotor speed, sequencing ability, and visual attention and concentration. Part B of this test is a more specific measure of cognitive flexibility.

The Trail Making Test is an attention task that also has a perceptual–motor component. On the more simplistic Trails A, which requires the attention to a single attribute, the child's performance was superior/excellent/good/normal/average/adequate/mixed/poor. On the more complex Trails B, which requires the attention to two attributes simultaneously, the child's performance was in the superior/excellent/good/normal/average/adequate/mixed/poor range.

Good Performance

The Trail Making Test is a paper-and-pencil task that requires the child to connect randomly distributed circles in a specific order. On Trails A the circles are connected in numerical order, while in Trails B the circles are connected in alternating numerical–alphabetical order. The child's performance on both parts of the test was average/above average, indicating no problems with the executive and visual functions tapped by the test.

Poor Performance

Poor performance on Trails B indicates difficulties in shifting set. Such difficulties are typically manifested as problems in making transitions, cognitively and/or behaviorally.

Overall, his/her performance times were significantly below average, indicating sequencing and visual scanning difficulties.

Results lend support to the examiner's observations of difficulty with focused and sustained attention.

Processing speed and set shifting were explored on Trails A and B, where her/his scores on Trails A fell within the average range (____ percentile) indicating normal processing speed abilities on this test, but where her/his scores on Trails B fell within the below average range (____ percentile), indicating a relative weakness with shifting set.

26.17. Wisconsin Card Sorting Test (WCST) *(Heaton, 1981)*

General Description

The WCST requires abstract concept formation, flexibility in thinking, and the ability to use new information in a problem-solving task. In this test, the individual is asked to sort cards

according to criteria (e.g., color, form, number) that she/he must figure out from feedback provided on each sort. The test is normed for individuals age 6:6 years through adulthood.

Sample Statements

The child was given the computer-administered version of the WCST, a test of abstract reasoning abilities in which the individual is asked to sort computerized images of cards. The cards vary from one another in shape, number, and color or elements printed on each one. The individual is not told the sorting criteria, nor is he/she told that a criterion shifts during the task. Rather, the only feedback given is the computer's response of "right" or "wrong."

The WCST is designed to assess abstract concept formation and the ability to shift and maintain mental set. It is considered a measure of executive functions, in that it requires the ability to develop and maintain an appropriate problem-solving strategy across changing stimulus conditions in order to achieve a future goal.

The child's performance on the WCST, which requires the utilization of feedback presented in a trial-and-error method to solve problems, fell within the superior/excellent/good/average/normal/below-normal/below-average/poor/impaired range.

Good Performance

His/her overall accuracy placed him/her at the ____ percentile as compared to age-matched norms, and there was no indication of perseverative tendencies, providing evidence for a high degree of cognitive flexibility.

The child was able to complete all six categories on this task, suggesting no deficits in the areas of pattern analysis, cognitive flexibility, and tolerance for frustration.

The child was very quick to understand the organizational structure of the game, and maintained excellent attention while executing the game strategy. Overall, her/his performance on these tasks does not suggest that she/he has attentional, organizational, or planning difficulties.

Poor Performance

The child lost set ____ times (____ percentile), suggestive of attentional difficulties.

The child was unable to continue to apply the principle required to do the task; he/she had a tendency toward perseverative thinking/responses.

Other Measures of Executive Functioning

See the following sections of Chapters 21, 23, and 24 for more information about these tests, subtests, and composites that measure executive functioning:

21.5: DAS-II Speed of Information Processing, Recall of Objects (Immediate and Delayed), Recall of Digits.

21.11 and 21.12: WAIS-IV and WISC-V Processing Speed Index, Digit Span, Picture Span, Arithmetic, Letter-Number Sequencing.

23.4: COWAT FAS and Animals.

24.3: CVLT-C, CVLT-3, and CAVLT.

24.6: WRAML2 Sentence Memory, Story Memory.

27

Measures of Emotional and Personality Functioning

This chapter lists and briefly describes the most commonly used tests of emotional and personality functioning for children. Also included are phrases that can be used to characterize children's responses on various projective measures. Phrases used to describe various emotional symptoms in children can be found in Chapter 15.

“Projective tests” are measures that are used to evaluate a child's psychological or emotional health; they are based on the assumption that individuals project their unconscious feelings and personalities when responding to ambiguous stimuli. Clinicians will often use projective testing when there are unanswered questions regarding a child's behavior or feelings about a situation. See Section 3.10 for questions used in projective assessments.

27.1. General Statements

A projective screening was done to assess underlying attitudes, concerns, and mood, as well as personality variables that might be having an impact on school/home/social performance. The child's responses were rather short and not very descriptive. *(Such responses may reflect guardedness or concrete verbal formation.)*

Unimpaired Emotional Functioning

Personality test data suggest that the child is currently in adequate contact with reality and fairly well aware of the conventional.
Projective measures indicated that the child demonstrated a capacity for empathy and emotional expression.

Impaired or Compromised Emotional Functioning

Although assessment of emotional and personality functioning reveals no evidence of formal thought disorder or psychosis, she/he is clearly experiencing emotional turmoil and great difficulties with impulse control.
On measures of personality functioning, the child shows moderate similarity to individuals who present with depression/anxiety/bipolar disorders/etc.

The personality tests showed suggestions of possible functioning along the borderline–narcissistic continuum, with some self-focusing suggestive of narcissistic features.

Results of testing indicated an emotionally constricted young girl/boy who attempts to deny and avoid emotional needs and drives.

The child's responses on a variety of the tests indicated a concerning level of depression/anxiety/mood dysregulation/poor self-locus of control/problems with authority figures/boredom/posttraumatic stress/fears.

With regard to projective responses, the child seems to view the world as a hostile and unpredictable place where he/she often feels powerless to change.

Results of projective testing indicate that the child is likely to have fewer psychological resources than other children her/his age and may feel flustered and overwhelmed by life's ups and downs.

Evidence from a number of sources, such as _____ (*specify*), raised concerns about this child's level of emotional functioning.

The projective testing suggested that the child's affective world seems marked by feelings of self-doubt, sadness, and painful rumination.

Results of the personality testing suggest that the child is an anxious boy/girl who is struggling with a complex matrix of issues, including social immaturity/depression/anxiety/discomfort with strong emotions/lowered self-regard/poor self-esteem/normal developmental conflicts/etc.

Child commonly expressed themes of sadness and fear when presented with affective stimuli.

27.2. Draw-A-Person or Human Figure Drawing

General Description

On the Draw-A-Person/Human Figure Drawing test, the child is asked to draw a picture of a person. It provides an indication of how the child feels about him-/herself.

Scoring and Suggestions

Qualitative scoring is based on the number of body parts presented, the proportion of various parts to the whole, and other aspects (e.g., the presence of clothing). The Draw-A-Person also gives a developmental/cognitive level; the cognitive and emotional levels are scored according to separate systems. Directions include “Draw the *whole* person” and “Draw the best way you know how” (or something to that effect).

In reports, comment on the following:

- Elaboration of figure.
- Detail of figure relative to age and intellectual expectations.
- Gender (male, female, indeterminate).
- Who is portrayed in the drawing (the child, a relative, etc.).

27.3. Kinetic Family Drawing

General Description

On the Kinetic Family Drawing test, the child is typically asked to draw a picture of her/his family doing something. It provides insight into child's perception of her/his family unit.

Suggestions

In reports, comment on the following:

- Which family members are portrayed.
- Cohesiveness of family activity.
- Emotional content in the picture.
- Whether the child spontaneously draws the family members doing something together or apart.

27.4. Kinetic School Drawing

General Description

On the Kinetic School Drawing test, the child is asked to draw a picture that includes him-/herself, his/her teacher, and a friend or two doing something at school.

Suggestions

In reports, comment on the following:

- Who and what are portrayed in the picture.
- The cohesion (or lack of cohesion) between persons in the picture.
- Emotional content in the picture.

27.5. House–Tree–Person Drawing

General Description

The House–Tree–Person drawing is used to assess visual–motor abilities and creativity.

Suggestions

In reports, comment on the following:

- Orientation of components, proportionality, space, and detail.
- Creativity (or lack of it).

27.6. Rorschach *(Rorschach, 1921/1942)*

General Description

The Rorschach is a perceptual–cognitive task where subjects are presented with 10 inkblots and are asked about each, "What might this be?" In responding to the inkblots, the person tells what she/he sees in each one and then reports what features in the inkblot made it look that way. The subject's problem-solving approach reflects key dimensions of his/her psychological traits and states.

Rorschach Scoring Systems

Each Rorschach response is scored and interpreted according to specific criteria. The Exner system (Exner, 2002) is the most commonly used system. Norms can be found for children as young as 5 years.

Statement for an Invalid Protocol

The child's completed Rorschach protocol only contained ____ responses. The protocol is thus considered invalid and should be interpreted with caution.

Statement for a Valid Protocol

The Rorschach was of average length, indicating that the child put forth good effort on this task.

Sample Interpretive Statements

The possible interpretive statements for the Rorschach are nearly limitless. The following statements are only provided as examples of how Rorschach results can be used in report writing.

The child's approach to the task revealed an "ambitent" coping style, indicating that she/he has a limited capacity to form and implement coping strategies for dealing with problems in life. She/he tends to switch between exerting an independent decision-making style at times of stress and withdrawing from stressors altogether.

The child has a limited ability to recognize and deal with his/her feelings comfortably, and may tend to avoid or withdraw from expression of strong feelings.

The child's emotional resources are less than needed and therefore create the potential for stress overload, impulsivity, and unpredictability when she/he is confronted with new and unfamiliar situations, especially when her/his poor coping strategies are taken into account.

The child's responses on the Rorschach indicate that he/she has a unique way of interpreting the world, which may lead him/her to misunderstand or distort others' motives.

Child vacillates between trying to think through problems (i.e., "intraversive") and looking outward, toward others for support (i.e., "extraversive") as methods of coping with stress.

Despite an inconsistent coping style, child demonstrates adequate psychological resources to cope with the stresses in her/his life without becoming overloaded.

27.7. Selected Apperception Tests

Roberts Apperception Test for Children, Second Edition (Roberts-2)

(Roberts, 2005)

General Description

The Roberts-2 is a subjective instrument in which a child is asked to tell stories about various ambiguous interpersonal situations, depicted on large picture cards. It can be used for children ages 6–17 years.

Suggestions

In reports, comment on the following:

- Social reasoning difficulties, such as trouble picking up on the nuances of social situations and/or understanding conflicting social cues.
- Trouble making sense of a particular scene in which each character seems to be having a different feeling.
- Perseverative and concrete social reasoning (e.g., carrying over the same theme from one scene to another).
- Difficulty making inferences about why people might behave or respond in the pictures.

Thematic Apperception Test (TAT) and Children's Apperception Test (CAT)

(Murray, 1971 [TAT]; Bellak & Bellak, 1949 [CAT])

General Description

On the TAT/CAT, the child is asked to create stories about various scenes shown to him/her. The CAT can be used for children beginning at age 5 years.

Sample Statements

On the TAT/CAT, the child was asked to tell a story for a series of ____ different pictures. The TAT/CAT pictures depict situations and relationships related to the social and emotional development of children, as well as more ambiguous pictures. Her/his stories were then judged for emotional content and common themes.

The TAT/CAT is a projective test that attempts to illuminate issues a child may be experiencing. The child was asked to tell stories about various pictures.

The TAT/CAT asks a child to create stories based on a series of presented drawings. The child's responses and stories can be used to characterize his/her state of mind.

UNREMARKABLE PERFORMANCE

The child's responses did not indicate any evidence of cognitive or perceptual distortions. In general, the child's responses were appropriate to the content of the pictures depicted and did not identify any problematic areas in his/her functioning.

Her/his stories show that she/he feels at ease with/interactive with peers, and that it is important for her/him to look very capable in front of peers.

His/her stories show that he/she is able to accept limits from adults.

Child's stories were appropriate in depth and action.

REMARKABLE PERFORMANCE

Overall, the child's stories suggest that she/he does not perceive her-/himself as being frequently happy. In most of her/his stories, the characters were either angry or sad.

His/her stories show that he/she has a difficult time accepting and controlling aggressive feelings toward his/her peers.

Her/his stories show that she/he lacks the ability to postpone gratification of demands/to control negative impulses.

When first presented with pictures, the child often asked questions about what certain objects were, indicating that he/she was uncomfortable with ambiguity and wanted details before constructing a story.

Themes of sadness and fear were evident in stories.

Possible Problems

Difficulty generating stories; problems with verbal expression.

Trouble making sense of scenes that included children/adults; difficulty interpreting and integrating complex social information.

Difficulty tolerating ambiguity.

Inability to complete the task because child provided concrete descriptions of scene as opposed to stories/tended to describe the picture instead of telling a story.

Inability to deduce what individuals in cards may be feeling or thinking.

Common Themes

Children who hate school/are struggling with school/do not have a positive attitude toward academic learning/are unmotivated to achieve in school.

Children who are not frequently happy; characters who are typically angry/sad.

Children who demonstrate a closeness and connectedness with mother/father/parental figures and who tend to seek him/her/they out for comfort; parents and children who experience a high amount of conflict.

Adults who are perceived as having good intentions but who cannot meet a child's needs.

Children who have difficulty accepting and controlling aggressive feelings toward peers/problems with peer acceptance; children who lack strategies for learning to become group members.

Children who are disciplined/punished and feel ashamed/sad/angry at themselves for behaving in ways that they know are wrong.

Children who tend to engage in power struggles/be oppositional/have difficulty accepting limits/push the limits with adults; children who are well aware of social norms and rules, but who are not willing or able to adhere to them; main characters who are oppositional/disobey parents/act out in school and at home.

Children with feelings of low self-esteem.

Children who are unable to delay gratification of demands/control negative impulses.

Children who are bored/are depressed/are sad/exhibit morbid thinking.

(Positive themes:) Children who feel pride/happiness; when stories involve conflict, characters who are able to resolve their difficulties.

27.8. Sentence Completion Tests

Many different sentence completion tests (both published and unpublished) exist. Well-known published tests include the following:

Rotter Incomplete Sentence Blanks (Rotter & Rafferty, 1950).

Sacks Sentence Completion Test (Sacks & Levy, 1950). *A sample sentence completion test can be found in Section 40.5.*

General Description

On a sentence completion test, a child is asked to finish a number of incomplete sentence stems (either orally or in writing). It provides types of information about attitudes and social-emotional well-being that are thought to be difficult to obtain in direct questionnaire formats.

Suggestions

In reports, comment on the following:

- Self-concept.
- Level of engagement with friends and family.
- Acknowledgment of strengths and weaknesses.

Sample Statement

The child's responses on this sentence completion test raised some concerns about self-esteem/feelings of social isolation/parental conflict/negativity/abuse by family members/etc.

28

Behavior Rating Scales and Tests of Adaptive Functioning

The first part of this chapter lists and briefly describes the most commonly used behavior rating scales; these can be used by parents and teachers (and sometimes by older children or adolescents to rate themselves). The second part of this chapter lists and briefly describes tests of adaptive functioning, typically used when there are questions about developmental abilities and disabilities.

BEHAVIOR RATING SCALES

28.1. General Statements

The child's parents and teacher(s) completed a number of questionnaires related to behavior and attention. The responses on the measures were all within the normal/abnormal/etc. range.

The child's mother/father completed the questionnaires specified above/below. Her/his ratings indicated that the child is/is not experiencing any significant behavioral difficulties.

28.2. ADD-H Comprehensive Teacher's Rating Scale (ACTeRS), Second Edition *(Ullman, Sleator, & Sprague, 1991)*

General Description

The ACTeRS is a self-report checklist for ADD-H (now ADHD) diagnostic criteria. It can be used for children in kindergarten through grade 8.

Sample Statements *See Section 28.3, below.*

28.3. ADHD Rating Scale–5 *(DuPaul, Power, Anastopoulos, & Reid, 2016)*

General Description

The ADHD Rating Scale–5 lists each of the diagnostic criteria for ADHD and asks a parent/teacher to rate a child on each symptom. It can be used for individuals ages 5–17 years.

Sample Statements

The child's mother/father/teacher completed the ADHD Rating Scale–5. Her/his responses indicate that the child exhibits few difficulties with hyperactivity or inattention.

Scores on the ADHD Rating Scale–5 indicated significant problems with inattention/hyperactivity/impulsivity.

The parent/teacher responses indicate that the child meets the diagnostic criteria for ADHD, combined/predominantly inattentive/predominantly hyperactive–impulsive presentation, with ____ out of 9 inattentive symptoms endorsed and ____ out of 9 hyperactive–impulsive symptoms endorsed.

28.4. Battelle Developmental Inventory, Second Edition Normative Update (BDI-2 NU) *(Newborg, 2016)*

General Description

The BDI-2 NU measures developmental skills in children in five domains: Personal–Social, Adaptive, Motor, Communication, and Cognitive. The BDI-2 NU can be administered to children from birth through 8 years.

28.5. Behavior Assessment System for Children, Third Edition (BASC-3) *(Reynolds & Kamphaus, 2015)*

General Description

The BASC-3 assesses a child or adolescent's behavioral and emotional functioning at school and at home. It includes three measures: the Parent Rating Scales (PRS), the Teacher Rating Scales (TRS), and the Self-Report of Personality (SRP). The checklists are appropriate for individuals ages 2–22 years.

Sample Statements

The child/adolescent/mother/father/teacher completed the BASC-3 SRP/PRS/TRS. His/her/their ratings indicate clinically significant/at-risk scores on the following subscales: _____ *(specify)*.

TRS and PRS Subscales

Activities of Daily Living measures a child's self-help and self-care skills.

Adaptability measures a child's ability to adapt to changes in his/her environment.

Aggression is a measure of aggressive behaviors (fighting, etc.).

Anxiety measures the tendency to be anxious, nervous, or fearful.

Attention Problems assesses the tendency to daydream or be easily distracted.

Atypicality measures unusual behaviors, such as those associated with psychoticism (e.g., visual or auditory hallucinations) or extreme immaturity.

Conduct Problems measures antisocial or delinquent behaviors, such as truancy, alcohol/drug use, lying, and stealing.

Depression assesses feelings of depression, such as sadness, unhappiness, and stress.

Functional Communication measures a child's "real-world" communication skills.

Hyperactivity measures hyperactivity, impulsivity, and the tendency to act before thinking.

Leadership measures a child's competencies in school and social settings, such as the ability to interact well with others.

Learning Problems assesses problems with completing or understanding schoolwork.

Negative Emotionality measures a child's tendency to overreact negatively to minor changes in daily routines or activities.

Resiliency measures a child's ability to handle stress through both internal and external support.

Social Skills measures a child's interpersonal skills.

Somatization measures the tendency to have somatic complaints.

Study Skills measures the skills that are important to academic success.

Withdrawal measures a child's tendency to withdraw from or avoid social contact with others.

Additional SRP Subscales

The SRP includes self-report versions of the Anxiety, Attention Problems, Atypicality, Depression, Hyperactivity, and Somatization subscales from the PRS and TRS, as well as several additional subscales:

Alcohol Abuse measures alcohol use and tendency toward or symptoms of alcohol abuse (on the College version only).

Anger Control measures the tendency to become irritated or angry quickly and/or an inability to regulate and control one's emotions.

Attitude to School measures a child's feelings about school (e.g., satisfaction/dissatisfaction); high scores are associated with feelings of resentment toward school.

Attitude to Teachers measures a child's perception of teachers, with high scores indicating dislike of teachers.

Ego Strength indicates whether the child has a strong sense of personal identity.

Interpersonal Relations measures a child's perception of her/his social relationships with peers.

Locus of Control measures a child's perception of who controls his/her life, with high scores indicating an external locus of control (e.g., child feels that success or failure is determined by forces outside his/her control) and low scores indicating an internal locus of control (e.g., child has a feeling of control over his/her own destiny).

Mania measures difficulty in controlling "racing" thoughts, and the tendency toward extended periods of heightened arousal.

Relations with Parents indicates whether the child has positive or negative feelings toward her/his parents.

School Maladjustment measures a child's view of his/her difficulties in school.

Self-Esteem measures a child's satisfaction with her-/himself.

Self-Reliance assesses a child's belief in his/her abilities, perseverance, and persistence (or lack thereof).

Sensation Seeking measures a child's tendency to be a risk taker or engage in potentially hazardous activities.

Sense of Inadequacy assesses a child's belief in her/his ability to succeed or achieve in academic and personal endeavors.

Social Stress measures a child's stress level, such as feelings of tension and pressure, as well as his/her coping resources.

Test Anxiety measures anxiety and fear surrounding academic tests.

28.6. Behavior Rating Inventory of Executive Function, Second Edition (BRIEF2) *(Gioia, Isquith, Guy, & Kenworthy, 2015)*

General Description

The BRIEF2 is a parent and teacher rating of executive functions for children ages 5–18 years. A self-report version is also available for older children and adolescents ages 11–18 years.

Sample Statement

The parents/teacher/child completed the BRIEF, a questionnaire that assesses executive functioning.

Subscales

Emotional Control assesses a child's ability to control or modulate emotions.

Inhibit assesses a child's ability to control impulses and appropriately stop her/his own behavior.

Initiate measures a child's ability to begin a task or activity or independently generate ideas.

Monitor measures a child's ability to check his/her work and keep track of his/her performance while doing a task.

Organization of Materials assesses behaviors such as a child's leaving her/his playroom a mess, leaving a trail of belongings wherever she/he goes, or leaving messes that others have to clean up.

Plan/Organize assesses a child's ability to anticipate future events, set goals, and determine the steps needed to complete tasks.

Self-Monitor measures a child's ability to recognize the impact of his or her own actions on others

Shift assesses a child's ability to make transitions freely from one situation or activity to another and to use flexibility in solving problems.

Task-Completion (found only on the Self-Report Form) measures a child's ability to complete a task once it has been started.

Task-Monitor (found only on the Parent and Teacher Forms) assesses a child's tendency to check for small, careless mistakes while completing tasks.

Working Memory measures a child's ability to stick with an activity and remember what is needed to complete an activity.

28.7. Behavior Rating Inventory of Executive Function—Preschool Version (BRIEF-P) *(Gioia, Espy, & Isquith, 2003)*

General Description

The BRIEF-P is a parent and teacher measure of executive functions in preschool-age children (ages 2–5 years).

Subscales

Inhibit, Shift, Emotional Control, Working Memory, Plan/Organize. *(See Section 28.6, above, for descriptions.)*

28.8. Child Behavior Checklist (CBCL), Teacher's Report Form (TRF), and Youth Self-Report (YSR) *(Achenbach & Rescorla, 2001)*

General Description

The CBCL, TRF, and YSR are components of the Achenbach System of Empirically Based Assessment (ASEBA); they provide a cross-informant assessment of behavior. Although each one can be used on its own, the scales are most frequently given together. The CBCL is given to parents of a child or adolescent, the TRF is given to a teacher, and the YSR is completed by an adolescent (ages 11–18).

Sample Statements

The child's mother/father/teacher completed the CBCL/TRF, which assesses many different aspects of child behavior and emotional adjustment.

The CBCL/TRF is a behavioral rating instrument completed by parents/teachers, in which numerous descriptors are rated as "not true," "somewhat true," or "very true." Descriptor ratings are quantified and indexed onto the appropriate scale.

The adolescent completed the YSR, which assessed his/her behavior as it relates to constructs such as anxiety, self-esteem, depression, attitude to school, and relations with parents.

28.9. Children's Depression Inventory 2 (CDI 2) *(Kovacs, 2010)*

General Description

The CDI 2 is a self-report measure of depressive symptoms for children ages 7–17. It provides a Total score as well as four factor scores: Negative Mood/Physical Symptoms, Interpersonal Problems, Ineffectiveness, and Negative Self-Esteem.

28.10. Conners 3rd Edition (Conners 3) *(Conners, 2008)*

General Description

The Conners 3 is a set of questionnaires for assessing a child's or adolescent's behavioral and emotional functioning. It includes long and short forms of rating scales for parents and teachers, as well as of a self-report scale for adolescents ages 12–17.

Subscales

Aggression indicates whether the child displays violent or destructive tendencies.

Executive Functioning focuses on a child's ability to start, manage, and complete goal oriented tasks.

Family Relations indicates if children feel they are not loved or treated justly by their parents.

Hyperactivity/Impulsivity measures the degree to which a child is prone to restless or impulsive actions.

Inattention measures the degree to which a child struggles to maintain attention or concentration.

Learning Problems indicates if the child is displaying difficulties academically.

Peer Relations indicates if a child is struggling to make or maintain friendships or social connections.

Index Scores

The Conners 3 ADHD Index identifies children at risk for ADHD.

The Conners 3 Global Index assesses whether a child is prone to emotional responses or behaviors (e.g., anger, crying, outbursts, restlessness, impulsivity) that would be atypical for her/his age.

28.11. Devereux Scales of Mental Disorders (DSMD)

(Naglieri, LeBuffe, & Pfeiffer, 1994)

General Description

The DSMD assesses whether a child or adolescent is experiencing (or is at risk for) a behavioral or emotional disorder and includes the following scales: Conduct, Attention/Delinquency, Anxiety, Depression, Autism, and Acute Problems.

28.12. Millon Adolescent Personality Inventory (MAPI)

(Millon, Green, & Meagher, 1982)

General Description

The MAPI is a self-report measure based on Millon's theory of personality for adolescents ages 13–18 years; it includes eight Personality Style scales, eight Expressed Concerns scales, and four Behavioral Correlates scales.

Subscales

Personality Style scales: Introversive, Inhibited, Cooperative, Sociable, Confident, Forceful, Respectful, and Sensitive.

Expressed Concerns scales: Self-Confident, Personal Esteem, Body Comfort, Sexual Acceptance, Peer Security, Social Tolerance, Family Rapport, and Academic Confidence.

Behavioral Correlates scales: Impulse Control, Societal Compliance, Scholastic Achievement, and Attendance Consistency.

28.13. Minnesota Multiphasic Personality Inventory—Adolescent Restructured Form (MMPI-A-RF)

(Archer, Handel, Ben-Porath, & Tellegen, 2016)

General Description

The MMPI-A is an adolescent version of the well-known MMPI. It includes 10 basic scales and 15 content scales, and can be given to adolescents ages 14–18 years.

Subscales

Basic scales: Hypochondriasis, Depression, Hysteria, Psychopathic Deviate, Masculinity–Femininity, Paranoia, Psychasthenia, Schizophrenia, Hypomania, and Social Introversion.

Content scales: Anxiety, Obsessiveness, Depression, Health Concerns, Alienation, Bizarre Mentation, Anger, Cynicism, Conduct Problems, Low Self-Esteem, Low Aspiration, Social Discomfort, Family Problems, School Problems, and Negative Treatment Indicators.

28.14. Revised Children's Manifest Anxiety Scale, Second Edition (RCMAS-2) *(Reynolds & Richmond, 2008)***General Description**

The RCMAS-2 is a self-report measure of anxiety in children; it measures symptoms such as physiological symptoms of anxiety, worry, depressive symptomatology, and somatic complaints.

TESTS OF ADAPTIVE FUNCTIONING

"Adaptive functioning" refers to a child's effectiveness in areas such as social skills, communication, and daily living skills. Tests of adaptive functioning measure how well a child meets the standards of personal independence and social responsibility expected at his/her developmental stage.

28.15. Adaptive Behavior Evaluation Scale—Third Edition (ABES-3)

(McCarney & House, 2017)

General Description

The ABES-3 is a rating scale that assesses the relative strength of behaviors necessary to succeed in both a school and residential setting. There are two versions: one that can be administered to children between the ages of 4 and 12 years, and the other for ages 13–18 years. Each version contains a separate rating scale for school and residential behavior.

28.16. Adaptive Behavior Assessment System, Third Edition (ABAS-3) *(Harrison & Oakland, 2015)***General Description**

The ABAS-3 assesses children and adolescents between the ages of birth through age 21 years in the specific adaptive skills areas specified in the DSM-5 diagnostic criteria for intellectual disability; it includes a Teacher Form, Parent Form, and Adult Form.

Battelle Developmental Inventory, Second Edition (BDI-2)

See Section 28.4.

28.17. Scales of Independent Behavior—Revised (SIB-R)

(Bruininks, Woodcock, Weatherman, & Hill, 1996)

General Description

The SIB-R measures skills needed to function independently in home, school, and community settings.

28.18. Vineland Adaptive Behavior Scales, Third Edition (Vineland-3) *(Sparrow, Cicchetti, & Saulnier, 2016)*

General Description

The Vineland-3 measures personal and social skills used for everyday living in three domains: Communication, Daily Living Skills, and Socialization. There are also optional Maladaptive Behavior and Motor Skills domains. Both interview and rating scale versions of the Vineland-3 are available and are normed for ages birth through age 90 years

Sample Statements

The Vineland-3 was given to determine whether the child meets the standards of personal independence and social responsibility expected for a child her/his age.

The child's mother/father/teacher/guardian completed the Parent/Caregiver/Teacher Form of the Vineland-3, for the purpose of determining what the child does to take care of him-/herself. It is a measure of typical performance, not maximal performance.

The Interview Form of the Vineland-3 was completed, with the child's mother/father/teacher/guardian as the informant. Three adaptive behavior domains were assessed: Communication, Daily Living Skills, and Socialization. Two optional Vineland domains, Motor Skills and Maladaptive Behavior, can also be assessed.

Domains

Communication measures skills such as knowing one's home address, birthday, and telephone number.

Daily Living Skills measures skills such as toileting, answering the phone, looking both ways before crossing the street, and showering/bathing independently.

Maladaptive Behavior provides a measure of internalizing and externalized problem behaviors as well as critical items.

Motor Skills measures fine and gross motor skills

Socialization measures skills such as the ability to follow rules in simple games, apologizing for mistakes, and responding appropriately when being introduced to someone.

F. Ending the Report

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29

Diagnostic Statements/Impressions

Diagnoses are a kind of professional shorthand for integrating many kinds of data. In most cases, your diagnosis should follow from and summarize the data you have reported earlier. Most diagnostic statements are made in the “Summary” section of the report (see Chapter 30). A diagnosis also orients your readers to the recommendations for treatment planning that typically follow it in a report (see Chapter 31).

Generally, offer only the most important one or two diagnoses, unless diagnosis was the reason for the referral, you are in training, or your setting requires a fuller listing. When appropriate, you should include an original DSM-5 (or an ICD-10) diagnosis, and any “rule-outs” or other qualifications. Offer a “diagnostic impression” if you are not qualified to offer a formal diagnosis, or if you are quite uncertain.

29.1. Original DSM-5 Codes

Diagnostic classification systems are useful because they provide a way for mental health practitioners to communicate with one another, offer a framework for researching disorders, and help guide treatment decisions for particular disorders (Clark, Watson, & Reynolds, 1995).

The original coding system in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), developed by the American Psychiatric Association (2013), is still a widely used classification system in educational and other nonmedical settings in the United States. (See Section 29.2, below, for an explanation of the original DSM-5 vs. the ICD-10 codes.)

29.2. ICD-10 Codes

The *International Classification of Diseases*, 10th revision (ICD-10), Chapter V: Mental and Behavioral Disorders (World Health Organization, 1992), is the most widely used classification system in the world and is a system that covers both medical and psychological disorders.

The bulk of this chapter (see Sections 29.3–29.4) lists diagnoses that can typically be applied to children and adolescents, together with the appropriate original DSM-5 and ICD-10 code numbers. The chapter does not cover all diagnoses that are found in DSM-5, just those that are typically applied to children. First, you will find “Neurodevelopmental Disorders,” with these disorders listed in the

order given in DSM-5. This list is followed by an alphabetized listing of other disorders that can be applied to children and adolescents.

For each diagnosis listed in this chapter, the original DSM-5 code is presented first, followed by the ICD-10 code (in parentheses), followed by the DSM-5 diagnostic label and subtypes/specifiers when indicated. When DSM-5 was published in 2013, both the DSM-5 and ICD-10 codes were listed, in anticipation of the belated adoption of ICD-10 in the United States. Since October 1, 2015, the original DSM-5 codes are no longer being used in psychiatry and other branches of medicine. ICD-10 codes are now exclusively used for billing submissions in order to meet government- and insurer-imposed coding requirements in the United States.

Subtypes and Specifiers

Subtypes and specifiers are used to increase the specificity of a diagnosis. “Subtypes” are subgroupings within a diagnosis and are indicated by the instruction to “*specify* whether.” “Specifiers” are indicated by the instruction “*specify*” or “*specify* if.” For example, within the category of attention-deficit/hyperactivity disorder (ADHD), the examiner is asked to *specify* whether it is a combined presentation, a predominantly inattentive presentation, or a predominantly hyperactive-impulsive presentation, and then to *specify* the current severity as mild, moderate, or severe.

29.3. Neurodevelopmental Disorders

Intellectual Disabilities

____.____	(____.____)	Intellectual disability (intellectual developmental disorder) <i>Specify</i> current severity:
319	(F70)	Mild
319	(F71)	Moderate
319	(F72)	Severe
319	(F73)	Profound
315.8	(F88)	Global developmental delay
319	(F79)	Unspecified intellectual disability (intellectual developmental disorder)

Communication Disorders

315.39	(F80.2)	Language disorder
315.39	(F80.0)	Speech sound disorder
315.35	(F80.81)	Childhood-onset fluency disorder (stuttering) Note: Later-onset cases are diagnosed as 307.0 (F98.5), adult-onset fluency disorder.
315.39	(F80.82)	Social (pragmatic) communication disorder
307.9	(F80.9)	Unspecified communication disorder

Autism Spectrum Disorder

299.0	(F84.0)	Autism spectrum disorder <i>Specify</i> if: Associated with a known medical or genetic condition or environmental factor; associated with another neurodevelopmental, mental or behavioral disorder
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Specify current severity for Criterion A and Criterion B: Requiring very substantial support, requiring substantial support, requiring support

Specify if: With or without accompanying intellectual impairment, with or without accompanying language impairment, with catatonia (use additional code 293.89 [F06.1])

Attention-Deficit/Hyperactivity Disorder

____.____	(____.____)	Attention-deficit/hyperactivity disorder <i>Specify</i> whether:
314.01	(F90.2)	Combined presentation
314.00	(F90.0)	Predominantly inattentive presentation
314.01	(F90.1)	Predominantly hyperactive-impulsive presentation
		<i>Specify</i> if: In partial remission
		<i>Specify</i> current severity: Mild, moderate, severe
314.01	(F90.8)	Other specified attention-deficit/hyperactivity disorder
314.01	(F90.9)	Unspecified attention-deficit/hyperactivity disorder

Specific Learning Disorder

____.____	(____.____)	Specific learning disorder <i>Specify</i> if:
315.00	(F81.0)	With impairment in reading (<i>specify</i> impaired subskills: word reading accuracy, reading rate or fluency, reading comprehension)
315.2	(F81.81)	With impairment in written expression (<i>specify</i> impaired subskills: spelling accuracy, grammar and punctuation accuracy, clarity or organization of written expression)
315.1	(F81.2)	With impairment in mathematics (<i>specify</i> impaired subskills: number sense, memorization of arithmetic facts, accurate or fluent calculation, accurate math reasoning)
		<i>Specify</i> current severity: Mild, moderate, severe

Motor Disorders

315.4	(F82)	Developmental coordination disorder
307.3	(F98.4)	Stereotypic movement disorder <i>Specify</i> if: With self-injurious behavior, without self-injurious behavior <i>Specify</i> if: Associated with a known medical or genetic condition, neurodevelopmental disorder, or environmental factor <i>Specify</i> current severity: Mild, moderate, severe

Tic Disorders

307.23	(F95.2)	Tourette's disorder
307.22	(F95.1)	Persistent (chronic) motor or vocal tic disorder <i>Specify</i> if: With motor tics only, with vocal tics only
307.21	(F95.0)	Provisional tic disorder
307.20	(F95.8)	Other specified tic disorder
307.20	(F95.9)	Unspecified tic disorder

Other Neurodevelopmental Disorders

315.8	(F88)	Other specified neurodevelopmental disorder
315.9	(F89)	Unspecified neurodevelopmental disorder

29.4. Disorders Found in Children and Adolescents but Not Exclusive to Them

Anxiety Disorders

309.21	(F93.0)	Separation anxiety disorder
312.23	(F94.0)	Selective mutism
300.29	(____.____)	Specific phobia
		<i>Specify if:</i>
	(F40.218)	Animal
	(F40.228)	Natural environment
	(____.____)	Blood-injection-injury
	(F40.230)	Fear of blood
	(F40.231)	Fear of injections and transfusions
	(F40.232)	Fear of other medical care
	(F40.248)	Situational
	(F40.298)	Other
300.23	(F40.10)	Social anxiety disorder (social phobia)
		<i>Specify if:</i> Performance only
300.01	(F41.0)	Panic disorder
____.____	(____.____)	Panic attack specifier
300.22	(F40.00)	Agoraphobia
300.02	(F41.1)	Generalized anxiety disorder
____.____	(____.____)	Substance/medication-induced anxiety disorder
		Note: See the criteria set and corresponding recording procedures in DSM-5 itself for substance-specific codes and for original DSM-5 and ICD-10 coding
		<i>Specify if:</i> With onset during intoxication, with onset during withdrawal, with onset after medication use
293.84	(F06.4)	Anxiety disorder due to another medical condition
300.09	(F41.8)	Other specified anxiety disorder
300.00	(F41.9)	Unspecified anxiety disorder

Bipolar and Related Disorders

____.____	(____.____)	Bipolar I disorder
____.____	(____.____)	Current or most recent episode manic
296.41	(F31.11)	Mild
296.42	(F31.12)	Moderate
296.43	(F31.13)	Severe
296.44	(F31.2)	With psychotic features
296.45	(F31.73)	In partial remission
296.46	(F31.74)	In full remission
296.40	(F31.9)	Unspecified
296.40	(F31.0)	Current or most recent episode hypomanic

296.45	(F31.71)	In partial remission
296.46	(F31.72)	In full remission
296.40	(F31.9)	Unspecified
_____	(____.____)	Current or most recent episode depressed
296.51	(F31.31)	Mild
296.52	(F31.32)	Moderate
296.53	(F31.4)	Severe
296.54	(F31.5)	With psychotic features
296.55	(F31.75)	In partial remission
296.56	(F31.76)	In full remission
296.50	(F31.9)	Unspecified
296.7	(F31.9)	Current or most recent episode unspecified
296.89	(F31.81)	Bipolar II disorder
		<i>Specify</i> current or most recent episode: Hypomanic, depressed
		<i>Specify</i> course if full criteria for a mood episode are not currently met: In partial remission, in full remission
		<i>Specify</i> severity if full criteria for a mood episode are not currently met: Mild, moderate, severe
301.13	(F34.0)	Cyclothymic disorder
		<i>Specify</i> if: With anxious distress
_____	(____.____)	Substance/medication-induced bipolar and related disorder
		Note: See the criteria set and corresponding recording procedures in DSM-5 itself for substance-specific codes and for original DSM-5 and ICD-10 coding
		<i>Specify</i> if: With onset during intoxication, with onset during withdrawal
293.83	(____.____)	Bipolar and related disorder due to another medical condition
		<i>Specify</i> if:
	(F06.33)	With manic features
	(F06.33)	With manic- or hypomanic-like episode
	(F06.34)	With mixed features
296.89	(F31.89)	Other specified bipolar and related disorder
296.80	(F31.9)	Unspecified bipolar and related disorder

Depressive Disorders

296.99	(F34.81)	Disruptive mood dysregulation disorder
_____	(____.____)	Major depressive disorder
_____	(____.____)	Single episode
296.21	(F32.0)	Mild
296.22	(F32.1)	Moderate
296.23	(F32.2)	Severe
296.24	(F32.3)	With psychotic features
296.25	(F32.4)	In partial remission
296.26	(F32.5)	In full remission
296.20	(F32.9)	Unspecified
_____	(____.____)	Recurrent episode
296.31	(F33.0)	Mild
296.32	(F33.1)	Moderate
296.33	(F33.2)	Severe
296.34	(F33.3)	With psychotic features

296.35	(F33.41)	In partial remission
296.36	(F33.42)	In full remission
296.30	(F33.9)	Unspecified
300.4	(F34.1)	Persistent depressive disorder (dysthymia) <i>Specify</i> if: In partial remission, in full remission <i>Specify</i> if: Early onset, late onset <i>Specify</i> if: With pure dysthymic syndrome; with persistent major depressive episode; with intermittent major depressive episodes, with current episode; with intermittent major depressive episodes, without current episode <i>Specify</i> current severity: Mild, moderate, severe
625.4	(N32.81)	Premenstrual dysphoric disorder
____.____	(____.____)	Substance/medication-induced depressive disorder Note: See the criteria set and corresponding recording procedures in DSM-5 itself for substance-specific codes and for original DSM-5 and ICD-10 coding <i>Specify</i> if: With onset during intoxication, with onset during withdrawal
293.83	(____.____)	Depressive disorder due to another medical condition <i>Specify</i> if:
	(F06.31)	With depressive features
	(F06.32)	With major depressive-like episode
	(F06.34)	With mixed features
311	(F32.89)	Other specified depressive disorder
311	(32.9)	Unspecified depressive disorder

Disruptive, Impulse-Control, and Conduct Disorders

313.81	(F91.3)	Oppositional defiant disorder <i>Specify</i> current severity: Mild, moderate, severe
312.34	(F63.81)	Intermittent explosive disorder
____.____	(____)	Conduct disorder <i>Specify</i> whether:
312.81	(F91.1)	Childhood-onset type
312.82	(F92.1)	Adolescent-onset type
312.89	(F91.9)	Unspecified onset <i>Specify</i> if: With limited prosocial emotions <i>Specify</i> current severity: Mild, moderate, severe
312.22	(F63.1)	Pyromania
312.33	(F63.2)	Kleptomania
312.89	(F91.8)	Other specified disruptive, impulse-control, and conduct disorder
312.9	(F91.9)	Unspecified disruptive, impulse-control, and conduct disorder

Dissociative Disorders

300.14	(F44.81)	Dissociative identity disorder
300.12	(F44.0)	Dissociative amnesia <i>Specify</i> if: With dissociative fugue
300.13	(F44.1)	Depersonalization/derealization disorder
300.15	(F44.89)	Other specified dissociative disorder
300.15	(F44.9)	Unspecified dissociative disorder

Elimination Disorders

307.6	(F98.0)	Enuresis <i>Specify</i> whether: Nocturnal only, diurnal only, nocturnal and diurnal
307.7	(F98.1)	Encopresis <i>Specify</i> whether: With constipation and overflow incontinence, without constipation and overflow incontinence
____.____	(____.____)	Other specified elimination disorder
788.39	(N39.498)	With urinary symptoms
787.60	(R15.9)	With fecal symptoms
____.____	(____.____)	Unspecified elimination disorder
788.30	(R32)	With urinary symptoms
787.60	(R15.9)	With fecal symptoms

Feeding and Eating Disorders

307.52	(____.____)	Pica
	(F98.3)	In children
	(F50.89)	In adults
307.53	(F98.21)	Rumination disorder
307.59	(F50.82)	Avoidant/restrictive food intake disorder
307.1	(____.____)	Anorexia nervosa
		<i>Specify</i> whether:
	(F50.01)	Restricting type
	(F50.02)	Binge-eating/purging type
307.51	(F50.2)	Bulimia nervosa
307.51	(F50.81)	Binge-eating disorder
307.59	(F50.89)	Other specified feeding or eating disorder
307.50	(F50.9)	Unspecified feeding or eating disorder

Gender Dysphoria

____.____	(____.____)	Gender dysphoria
302.6	(F64.2)	Gender dysphoria in children <i>Specify</i> if: With a disorder of sex development
302.85	(F64.0)	Gender dysphoria in adolescents and adults <i>Specify</i> if: With a disorder of sex development <i>Specify</i> if: posttransition Note: Code the disorder of sex development if present, in addition to gender dysphoria
302.6	(F64.8)	Other specified gender dysphoria
302.6	(F64.9)	Unspecified gender dysphoria

Neurocognitive Disorders

____.____	(____.____)	Delirium Note: See the criteria set and corresponding recording procedures in DSM-5 itself for substance-specific codes and for original DSM-5 and ICD-10 coding <i>Specify</i> whether:
____.____	(____.____)	Substance intoxication delirium

_____	(____.____)	Substance withdrawal delirium
292.91	(____.____)	Medication-induced delirium
293.0	(F05)	Delirium due to another medical condition
292.0	(F05)	Delirium due to multiple etiologies
		<i>Specify if:</i> Acute, persistent
		<i>Specify if:</i> Hyperactive, hypoactive, mixed level of activity
780.09	(R41.0)	Other specified delirium
780.9	(R41.0)	Unspecified delirium
_____	(____.____)	Major neurocognitive disorder due to traumatic brain injury
_____	(____.____)	Note: For original DSM-5, code first 907.0, late effect of intracranial injury without skull fracture; for ICD-10, code first 506.2X95, diffuse traumatic brain injury with loss of consciousness of unspecified duration, sequela
294.11	(F02.81)	With behavioral disturbance
294.10	(F02.80)	Without behavioral disturbance
331.83	(G31.84)	Mild neurocognitive disorder due to traumatic brain injury
_____	(____.____)	Major neurocognitive disorder due to another medical condition
		Note: Code first the other medical condition
294.11	(F02.81)	With behavioral disturbance
294.10	(F02.80)	Without behavioral disturbance
331.83	(G31.84)	Mild neurocognitive disorder due to another medical condition
_____	(____.____)	Major neurocognitive disorder due to multiple etiologies
		Note: Code first all the etiological medical conditions (with the exception of vascular disease)
294.11	(F02.81)	With behavioral disturbance
294.10	(F02.80)	Without behavioral disturbance
331.83	(G31.84)	Mild neurocognitive disorder due to multiple etiologies
799.59	(R41.9)	Unspecified neurocognitive disorder

Obsessive–Compulsive and Related Disorders

300.3	(F42.2)	Obsessive–compulsive disorder
		<i>Specify if:</i> Tic-related
300.7	(F45.22)	Body dysmorphic disorder
		<i>Specify if:</i> With muscle dysmorphia
300.3	(F42.3)	Hoarding disorder
		<i>Specify if:</i> With excessive acquisition
312.39	(F63.3)	Trichotillomania (hair-pulling disorder)
698.4	(F42.4)	Excoriation (skin-picking) disorder
_____	(____.____)	Substance/medication-induced obsessive–compulsive and related disorder
		Note: See the criteria set and corresponding recording procedures in DSM-5 itself for substance-specific codes and for original DSM-5 and ICD-10 coding
		<i>Specify if:</i> With onset during intoxication, with onset during withdrawal, with onset after medication use
294.8	(F06.8)	Obsessive–compulsive and related disorder due to another medical condition
		<i>Specify if:</i> With obsessive–compulsive disorder-like symptoms, with appearance preoccupations, with hoarding symptoms, with hair-pulling symptoms, with skin-picking symptoms

300.3	(F42.8)	Other specified obsessive–compulsive and related disorder
300.3	(F42.9)	Unspecified obsessive–compulsive and related disorder

Schizophrenia Spectrum and Other Psychotic Disorders

297.1	(F22)	Delusional disorder <i>Specify</i> whether: Erotomanic type, grandiose type, jealous type, persecutory type, somatic type, mixed type, unspecified type <i>Specify</i> if: With bizarre content
298.8	(F23)	Brief psychotic disorder <i>Specify</i> if: With marked stressors(s), without marked stressor(s), with postpartum onset
295.40	(F20.81)	Schizophreniform disorder <i>Specify</i> if: With good prognostic features, without good prognostic features
295.90	(F20.9)	Schizophrenia
____.____	(____.____)	Schizoaffective disorder <i>Specify</i> whether:
295.70	(F25.0)	Bipolar type
295.60	(F25.1)	Depressive type
____.____	(____.____)	Substance/medication-induced psychotic disorder Note: See the criteria set and corresponding recording procedures in DSM-5 itself for substance-specific codes and for original DSM-5 and ICD-10 coding <i>Specify</i> if: With onset during intoxication, with onset during withdrawal
____.____	(____.____)	Psychotic disorder due to another medical condition <i>Specify</i> whether:
293.81	(F06.2)	With delusions
293.82	(F06.0)	With hallucinations
293.89	(F06.1)	Catatonia associated with another mental disorder (catatonia specifier)
293.89	(F06.1)	Catatonic disorder due to another medical condition
293.89	(F06.1)	Unspecified catatonia Note: Code first 781.99 (R29.818), other symptoms involving nervous and musculoskeletal systems
298.8	(F28)	Other specified schizophrenia spectrum and other psychotic disorder
298.9	(F29)	Unspecified schizophrenia spectrum and other psychotic disorder

Sleep–Wake Disorders

780.52	(F51.01)	Insomnia disorder <i>Specify</i> if: With non-sleep disorder mental comorbidity, with other medical comorbidity, with other sleep disorder
780.54	(F51.11)	Hypersomnolence disorder <i>Specify</i> if: With mental disorder, with medical condition, with another sleep disorder
____.____	(____.____)	Narcolepsy <i>Specify</i> whether:
347.00	(G47.419)	Narcolepsy without cataplexy but with hypocretin deficiency
347.01	(G47.411)	Narcolepsy with cataplexy but without hypocretin deficiency

347.00	(G47.419)	Autosomal dominant cerebellar ataxia, deafness, and narcolepsy
347.00	(G47.419)	Autosomal dominant narcolepsy, obesity, and type 2 diabetes
347.10	(G47.429)	Narcolepsy secondary to another medical condition
327.23	(G47.33)	Obstructive sleep apnea hypopnea
307.46	(____.____)	Non-rapid eye movement sleep arousal disorder
		<i>Specify</i> whether:
	(F51.3)	Sleepwalking type
		<i>Specify</i> if: With sleep-related eating, With sleep-related sexual behavior (sexsomnia)
	(F51.4)	Sleep terror type
307.47	(F51.5)	Nightmare disorder
		<i>Specify</i> if: During sleep onset
		<i>Specify</i> if: With associated non-sleep disorder, with associated other medical condition, with associated other sleep disorder
327.42	(G47.52)	Rapid eye movement sleep behavior disorder
333.94	(G25.81)	Restless legs syndrome

Somatic Symptom and Related Disorders

300.82	(F45.1)	Somatic symptom disorder
		<i>Specify</i> if: With predominant pain
		<i>Specify</i> if: Persistent
		<i>Specify</i> current severity: Mild, moderate, severe
300.7	(F45.21)	Illness anxiety disorder
		<i>Specify</i> whether: Care-seeking type, care-avoidant type
300.11	(____.____)	Conversion disorder (functional neurological symptom disorder)
		<i>Specify</i> symptom type:
	(F44.4)	With weakness or paralysis
	(F44.4)	With abnormal movement
	(F44.4)	With swallowing symptoms
	(F44.4)	With speech symptom
	(F44.5)	With attacks or seizures
	(F44.6)	With anesthesia or sensory loss
	(F44.6)	With special sensory symptom
	(F44.7)	With mixed symptoms
		<i>Specify</i> if: Acute episode, persistent
		<i>Specify</i> if: With psychological stressor (specify stressor), without psychological stressor
316	(F54)	Psychological factors affecting other medical conditions
		<i>Specify</i> current severity: Mild, moderate, severe, extreme
300.19	(F68.10)	Factitious disorder (includes factitious disorder imposed on self, factitious disorder imposed on another)
		<i>Specify</i> : Single episode, recurrent episodes
300.89	(F45.8)	Other specified somatic symptom and related disorder
300.82	(F45.9)	Unspecified somatic symptom and related disorder

Substance-Related and Addictive Disorders

Alcohol-Related Disorders

____.____	(____.____)	Alcohol use disorder
		<i>Specify</i> current severity:

305.00	(F10.10)	Mild
303.90	(F10.20)	Moderate
303.90	(F10.20)	Severe
303.00	(____.____)	Alcohol intoxication
	(F10.129)	With use disorder, mild
	(F10.229)	With use disorder, moderate or severe
	(10.929)	Without use disorder
291.91	(____.____)	Alcohol withdrawal
	(F10.239)	Without perceptual disturbances
	(F10.232)	With perceptual disturbances
____.____	(____.____)	Other alcohol-induced disorders
291.9	(F10.99)	Unspecified alcohol-related disorder

Caffeine-Related Disorders

305.90	(F15.929)	Caffeine intoxication
292.0	(F15.93)	Caffeine withdrawal
____.____	(____.____)	Other caffeine-induced disorders
292.9	(F15.99)	Unspecified caffeine-related disorder

Cannabis-Related Disorders

____.____	(____.____)	Cannabis use disorder
		<i>Specify</i> current severity:
305.20	(F12.10)	Mild
304.30	(F12.20)	Moderate
304.30	(F12.20)	Severe
292.89	(____.____)	Cannabis intoxication
		Without perceptual disturbances
	(F12.129)	With use disorder, mild
	(F12.229)	With use disorder, moderate or severe
	(F12.929)	Without use disorder
		With perceptual disturbances
	(F12.122)	With use disorder, mild
	(F12.222)	With use disorder, moderate or severe
	(F12.922)	Without use disorder
292.0	(F12.288)	Cannabis withdrawal
____.____	(____.____)	Other cannabis-induced disorders
292.9	(F12.99)	Unspecified cannabis-related disorder

Hallucinogen-Related Disorders

____.____	(____.____)	Phencyclidine use disorder
		<i>Specify</i> current severity:
305.90	(F16.10)	Mild
304.60	(F16.20)	Moderate
304.50	(F16.20)	Severe
____.____	(____.____)	Other hallucinogen use disorder
		<i>Specify</i> the particular hallucinogen
		<i>Specify</i> current severity:

305.30	(F16.10)	Mild
304.50	(F16.20)	Moderate
304.50	(F16.20)	Severe
292.89	(____.____)	Phencyclidine intoxication
	(F16.129)	With use disorder, mild
	(F16.229)	With use disorder, moderate or severe
	(16.929)	Without use disorder
292.89	(____.____)	Other hallucinogen intoxication
	(F16.129)	With use disorder, mild
	(F16.229)	With use disorder, moderate or severe
	(F16.929)	Without use disorder
292.89	(F16.983)	Hallucinogen persisting perception disorder
_____	(____.____)	Other phencyclidine-induced disorders
_____	(____.____)	Other hallucinogen-induced disorders
292.9	(F16.99)	Unspecified phencyclidine-related disorder
292.9	(F16.99)	Unspecified hallucinogen-related disorder

Inhalant-Related Disorders

_____	(____.____)	Inhalant use disorder
		<i>Specify</i> the particular inhalant
		<i>Specify</i> current severity:
305.90	(F18.10)	Mild
304.60	(F18.20)	Moderate
304.60	(F18.20)	Severe
292.89	(____.____)	Inhalant intoxication
	(F18.129)	With use disorder, mild
	(F18.229)	With use disorder, moderate or severe
	(F18.929)	Without use disorder
_____	(____.____)	Other inhalant-induced disorders
292.9	(F18.99)	Unspecified inhalant-related disorder

Opioid-Related Disorders

_____	(____.____)	Opioid use disorder
		<i>Specify</i> if: On maintenance therapy, in a controlled environment
		<i>Specify</i> current severity:
305.50	(F11.10)	Mild
304.00	(F11.20)	Moderate
304.00	(F11.20)	Severe
292.89	(____.____)	Opioid intoxication
		Without perceptual disturbances
	(F11.129)	With use disorder, mild
	(F11.229)	With use disorder, moderate or severe
	(F11.929)	Without use disorder
		With perceptual disturbances
	(F11.129)	With use disorder, mild
	(F11.122)	With use disorder, moderate or severe
	(F11.922)	Without use disorder
292.0	(F11.23)	Opioid withdrawal
_____	(____.____)	Other opioid-induced disorders
292.9	(F11.99)	Unspecified opioid-related disorder

Sedative-, Hypnotic-, or Anxiolytic-Related Disorders

____.____	(____.____)	Sedative, hypnotic, or anxiolytic use disorder <i>Specify</i> current severity:
305.40	(F13.10)	Mild
304.10	(F13.20)	Moderate
304.10	(F13.20)	Severe
292.89	(____.____)	Sedative, hypnotic, or anxiolytic intoxication
	(F13.129)	With use disorder, mild
	(F13.229)	With use disorder, moderate or severe
	(F13.929)	Without use disorder
292.0	(____.____)	Sedative, hypnotic, or anxiolytic withdrawal
	(F13.239)	Without perceptual disturbances
	(F13.232)	With perceptual disturbances
____.____	(____.____)	Other sedative-, hypnotic, or anxiolytic-induced disorders
292.9	(F13.99)	Unspecified sedative-, hypnotic, or anxiolytic-related disorder

Stimulant-Related Disorders

____.____	(____.____)	Stimulant use disorder <i>Specify</i> current severity:
____.____	(____.____)	Mild
305.70	(F15.10)	Amphetamine-type substance
305.60	(F14.10)	Cocaine
305.70	(F15.10)	Other or unspecified stimulant
____.____	(____.____)	Moderate
304.40	(F15.20)	Amphetamine-type substance
304.20	(F14.20)	Cocaine
304.40	(F15.20)	Other or unspecified stimulant
____.____	(____.____)	Severe
304.40	(F15.20)	Amphetamine-type substance
304.20	(F14.20)	Cocaine
304.40	(F15.20)	Other or unspecified stimulant
292.9	(____.____)	Stimulant intoxication <i>Specify</i> the specific intoxicant:
292.89	(____.____)	Amphetamine or other stimulant, without perceptual disturbances
	(F15.129)	With use disorder, mild
	(F15.229)	With use disorder, moderate or severe
	(F15.929)	Without use disorder
292.89	(____.____)	Cocaine, without perceptual disturbances
	(F14.129)	With use disorder, mild
	(F14.229)	With use disorder, moderate or severe
	(F14.929)	Without use disorder
292.89	(____.____)	Amphetamine or other stimulant, with perceptual disturbances
	(F15.122)	With use disorder, mild
	(F15.222)	With use disorder, moderate or severe
	(F15.922)	Without use disorder
292.89	(____.____)	Cocaine, with perceptual disturbances
	(F14.122)	With use disorder, mild
	(F14.222)	With use disorder, moderate or severe
	(F14.922)	Without use disorder
292.0	(____.____)	Stimulant withdrawal

		<i>Specify</i> the specific substance causing the withdrawal syndrome
	(F15.23)	Amphetamine or other stimulant
	(F14.23)	Cocaine
_____	(____.____)	Other stimulant-induced disorders
292.9	(____.____)	Unspecified stimulant-related disorder
	(F15.99)	Amphetamine or other stimulant
	(F14.99)	Cocaine

Tobacco-Related Disorders

_____	(____.____)	Tobacco use disorder
		<i>Specify</i> if: On maintenance therapy, in a controlled environment
		<i>Specify</i> current severity:
305.1	(Z72.0)	Mild
305.1	(F17.200)	Moderate
305.1	(F17.200)	Severe
292.0	(F17.203)	Tobacco withdrawal
_____	(____.____)	Other tobacco-induced disorders
292.9	(F17.209)	Unspecified tobacco-related disorder

Other (or Unknown) Substance-Related Disorders

_____	(____.____)	Other (or unknown) substance use disorder
		<i>Specify</i> current severity:
305.90	(F19.20)	Mild
304.90	(F19.20)	Moderate
304.90	(F19.20)	Severe
292.89	(____.____)	Other (or unknown) substance intoxication
	(F19.129)	With use disorder, mild
	(F19.229)	With use disorder, moderate or severe
	(F19.292)	Without use disorder
292.0	(F19.239)	Other (or unknown) substance withdrawal
_____	(____.____)	Other (or unknown) substance-induced disorders
292.9	(F19.99)	Unspecified other (or unknown) substance-related disorder

Trauma- and Stressor-Related Disorders

313.89	(F94.1)	Reactive attachment disorder
		<i>Specify</i> if: Persistent
		<i>Specify</i> current severity: Severe
313.89	(F94.2)	Disinhibited social engagement disorder
		<i>Specify</i> if: Persistent
		<i>Specify</i> current severity: Severe
309.81	(F43.10)	Posttraumatic stress disorder (includes posttraumatic stress disorder for children 6 years and younger)
		<i>Specify</i> whether: With dissociative symptoms
		<i>Specify</i> if: With delayed expression
308.3	(F43.0)	Acute stress disorder
_____	(____.____)	Adjustment disorder
		<i>Specify</i> whether:
309.0	(F43.21)	With depressed mood
309.24	(F43.22)	With anxiety

309.28	(F43.23)	With mixed anxiety and depressed mood
309.3	(F43.24)	With disturbance of conduct
309.4	(F43.25)	With mixed disturbance of emotions and conduct
309.9	(F43.20)	Unspecified
309.89	(F43.8)	Other specified trauma- and stressor-related disorder
309.9	(F43.9)	Unspecified trauma- and stressor-related disorder

29.5. Other Conditions That May Be a Focus of Clinical Attention

Relational Problems

Problems Related to Family Upbringing

V61.20	(Z62.820)	Parent-child relational problem
V61.8	(Z62.891)	Sibling relational problem
V61.8	(Z62.29)	Upbringing away from parents
V61.29	(Z62.898)	Child affected by parental relationship distress

Abuse and Neglect

Child Maltreatment and Neglect Problems

CHILD PHYSICAL ABUSE, CONFIRMED

995.54	(T74.12XA)	Initial encounter
995.54	(T74.12XD)	Subsequent encounter

CHILD PHYSICAL ABUSE, SUSPECTED

995.54	(T76.12XA)	Initial encounter
995.54	(T76.12XD)	Subsequent encounter

CHILD SEXUAL ABUSE, CONFIRMED

995.53	(T74.22XA)	Initial encounter
995.53	(T74.22XD)	Subsequent encounter

CHILD SEXUAL ABUSE, SUSPECTED

995.53	(T76.22XA)	Initial encounter
995.53	(T76.22XD)	Subsequent encounter

CHILD NEGLECT, CONFIRMED

995.52	(T74.02XA)	Initial encounter
995.52	(T74.02XD)	Subsequent encounter

CHILD NEGLECT, SUSPECTED

995.52	(T76.02XA)	Initial encounter
995.52	(T76.02XD)	Subsequent encounter

CHILD PSYCHOLOGICAL ABUSE, CONFIRMED

- 995.51 (T74.32XA) Initial encounter
- 995.51 (T74.32XD) Subsequent encounter

CHILD PSYCHOLOGICAL ABUSE, SUSPECTED

- 995.51 (T76.32XA) Initial encounter
- 995.51 (T76.32XD) Subsequent encounter

Educational Problems

- V62.3 (Z55.9) Academic or educational problem

Problems Related to Other Psychosocial, Personal, and Environmental Circumstances

- V61.7 (Z64.0) Problems related to unwanted pregnancy
- V62.89 (Z65.4) Victim of terrorism or torture
- V62.22 (Z65.5) Exposure to disaster, war, or other hostilities
- V15.59 (Z91.5) Personal history of self-harm
- V71.02 (Z72.810) Child or adolescent antisocial behavior
- V15.81 (Z91.19) Nonadherence to medical treatment
- 278.00 (E66.9) Overweight or obesity
- V65.2 (Z76.5) Malingering
- V62.89 (R41.83) Borderline intellectual functioning

30

Summary of Findings and Conclusions

30.1. General Information

The summary of findings and conclusions is the place to offer your integration of history, findings, or observations, as well as your understanding of the child's current and likely future functioning in the areas most relevant to the referrer's needs. If there is a referral question about assessment or diagnosis, it is likely to be answered here. However, for referral questions seeking a disposition, "Recommendations" (see Chapter 31) may be a more appropriate heading.

Summaries should be brief (ideally one to two paragraphs), although longer summaries are more common in lengthy neuropsychological evaluations. Summaries are almost always included in reports written for medical settings. Although the summary is otherwise considered optional, it is generally a good idea to include a review of the results, particularly if the report is lengthy. Because there will always be readers who need or want to read only a brief summary, be sure to include the information or conclusions with the most important implications for the client.

A summary should do the following:

- Restate the referral information and important identifying data (e.g., the child's name, age, and grade).
- Highlight the most pertinent findings.
- Be concise and easy to read.
- Not include any new information pertaining to the history.

Morrison and Flegel (2016) provide the following outline for summarizing case formulation material:

- Briefly restate the material, such as identifying data, symptoms, course of illness, and mental status.
- List the differential diagnoses, with arguments for and against each diagnosis on the list.
- Indicate the best diagnosis.
- List the factors contributing to the patient's difficulties, such as family history and/or environment.
- Indicate any additional information that may be needed to confirm the diagnosis (records, consultation with other treating professionals, etc.).
- Provide an outline of the treatment plan.
- Indicate the prognosis, to the extent that this is possible.

A summary can also be structured by answering a series of questions such as these:

1. Why was the child seen in this clinic/office?
2. What does the cognitive/neuropsychological/academic testing reveal?
3. What strengths were noted in his/her cognitive/neuropsychological/academic profile?
4. What weaknesses were noted in her/his cognitive/neuropsychological/academic profile?
5. What do the personality and behavioral data reveal?
6. Is there evidence of a disability?
7. What can be done to help the child?

30.2. General Summary Paragraphs and Statements

Paragraphs Summarizing Findings and Diagnoses

The child is a ____-year-old male/female who was found to have cognitive skills that ranged from the average/low-average/above-average (*list specific areas such as verbal comprehension, working memory, nonverbal reasoning, processing speed*) to average/low-average/above-average (*list areas*) to the average/low-average/above-average range. Overall, his/her cognitive skills fall in the below/low-average/average/above-average/superior range. Academic achievement indicated skills below/commensurate with/above expectations. _____ were areas of weakness, while _____ were areas of strength.

The child is a(n) _____ (*state positive adjective—e.g., enjoyable*) ____-grade student. She/he was cooperative/uncooperative during the testing. The results are considered a valid measure of her/his functioning. Her/his strengths include _____ (*list strengths*). _____ (*list weaknesses*) are challenges for the child.

The child, age ____, was referred for _____ (*state reason*). He/she scored in the high-average/average/low-average/poor range on all/nearly all of the tests, with the exception of _____ (*give names of tests and levels of performance*). Strengths were exhibited in _____ (*list strengths*). According to the child's parent/teacher, testing results correlate with his/her performance in school. He/she is an excellent/quick/eager/motivated/thoughtful/interested/attentive/good/etc. learner who demonstrates difficulty with reading/attention/oppositional behaviors/hyperactivity/math/language processing/etc.

The child is a ____-year-old female/male who is in the ____ grade at the _____ School in _____ (*give city, state*). She/he was referred for evaluation because of _____. Her/his overall intellectual abilities, as measured by the (*give test name*), are in the _____ range. There was/was not a significant difference between the child's scores on the _____ (*specify two or more*) scales/factors, indicating no evidence of a learning disability/evidence for dyslexia/a specific learning disorder/etc. Academic achievement skills were commensurate with/slightly/moderately/significantly discrepant from expectations. Tests of expressive vocabulary indicated _____, while tests of expressive vocabulary indicated _____. Auditory memory was found to be _____, and tests of attention were _____. Visual-spatial and visual-motor skills were _____. Behavior rating scales indicated _____. Results were consistent with a diagnosis of _____.

Treatment Summary Statements

Treatment was very successful/partially successful/minimally helpful.

The child has benefited considerably from therapeutic interventions.

The treatment has been successful in treating the following symptoms: _____.

The child did not benefit from treatment/had a negative treatment outcome.

The child's symptoms have worsened/stayed the same/shown no improvement/improved considerably.

The remainder of this chapter presents examples of summary paragraphs for some of the most commonly evaluated disorders seen in children. It is not meant to be an exhaustive or definitive guide, but rather to provide the reader with possible ways of structuring summaries for different diagnoses.

30.3. For ADHD

_____ is a ____-year-old female/male who is in grade _____. Her/his overall intellectual abilities, as measured by the _____ (*give name of test*), are in the average to high-average range. _____'s performance was stronger/weaker/about the same on tests requiring skills gained from the environment than/as on tests tapping visual-spatial and spatial reasoning skills. Academic achievement was commensurate with or exceeded expectations based on her/his cognitive ability. _____ was an area of considerable strength for her/him. Tests of visual-motor skills were within the average range. Results of this evaluation indicate that the child meets criteria for attention-deficit/hyperactivity disorder (ADHD), combined presentation. This is not a specific learning disability, but a more pervasive disability that appears to affect her/his performance in a variety of settings. She/he demonstrates difficulties on tasks requiring sustained concentration and focus and presents with organizational difficulties and some impulsive responding. The child's performance on a number of tests of executive functions was below expectations based on his/her estimated ability.

The child is a ____-year-old boy/girl of overall average/low-average/etc. intelligence whose test protocol is indicative of strengths in _____, as well as relative weaknesses in _____. His/her background history, overall test protocol, behavioral observations, and parent teacher reports support a diagnosis of ADHD, combined presentation/predominantly inattentive presentation/predominantly hyperactive/impulsive presentation, which interferes with his/her ability to function in the classroom setting at a level commensurate with his/her abilities.

Results are consistent with a diagnosis of ADHD, combined presentation (original DSM-5 code 314.01/ICD-10 code F90.2). _____'s symptoms of ADHD have a global impact on his/her ability to sustain attention, exercise self-control, and complete tasks in an efficient and organized manner. Symptoms of ADHD were evident in ratings of his/her daily functioning at home and school, his/her weak performance on cognitive tests involving attention, and behavioral observations during this evaluation. _____ requires supports at home and school to address his/her attention problems and bolster his/her executive functioning skills.

Overall, _____'s symptom presentation is consistent with difficulties with sustained attention. More specifically she/he demonstrates several hyperactive, impulsive, and inattentive symptoms in both the home and school setting. Importantly, it is clear that these difficulties are impacting her/his school performance and place her/him at risk for developing additional difficulties including low self-esteem and interpersonal difficulties. A diagnosis of ADHD-C is warranted at this time.

30.4. For ASD

The child is a ____-year-old male/female who is in the _____ grade and who was referred for evaluation due to problems with social awareness and poor social skills. His/her overall intellectual abilities as measured by the _____ (*give name of test*) are in the _____ range. Factor scores indicated a strength in _____. Academic achievement in reading and spelling was _____, while performance on tests of math was _____. Tests of language were primarily within the _____ range. Tests of visual memory were _____, while tests of auditory memory were _____. The child had dif-

ficulties on tasks that demanded spatial relationship ability/visual perception/visual–motor integration skills/organization/etc. Results from the testing, and previous history, also indicate that he/she meets criteria for autism spectrum disorder (ASD). Findings from the Autism Diagnostic Observation Schedule, Second Edition (ADOS-2) indicated that he/she demonstrates several behaviors consistent with ASD, such as (*a partial list of possible behaviors*):

- Brief and inconsistent eye contact during social interactions.
- Few bids to engage with the examiner.
- Play that is solitary in nature.
- No examples of pointing to objects around the room.
- Marked language delay.
- Variable response to name being called.
- Few requesting or showing behaviors.
- Pronoun confusion (e.g., “you–I” confusion) and neologisms.
- Repetitive and idiosyncratic speech (e.g., repetitively reciting lines from movies).
- Unusual sensory behaviors (e.g., smelling own hands, smelling objects).

In review, the child’s behavioral and social skills weaknesses, including problems with social awareness/poor social comprehension/poor emotional insight/inflexible adherence to routines/obsessional tendencies/stereotyped behaviors, etc. are all consistent with a diagnosis of ASD. In addition, his/her history of poor gross–motor coordination/sensory integration problems/dyscalculia/etc. is also frequently observed in people with ASD.

30.5. For Depression

The child is a ____-year-old girl/boy whose cognitive strengths fell in the _____ domain and whose cognitive weaknesses were within the _____ domain. Expressive language was _____, while attention and concentration were _____. Projective findings suggest that she/he is currently struggling with deep feelings of sadness and anxiety; has a tendency to be socially isolated and emotionally withdrawn; and is experiencing feelings of guilt and low self-worth. Results of projective and behavioral measures indicate that the child is suffering from major depression, a disorder that often manifests as increased sadness, irritability, and social difficulty in children.

30.6. For Writing Disabilities/Dysgraphia

The child is a ____-year-old right-/left-handed boy/girl who was evaluated to address concerns regarding his/her current academic performance. His/her general intellectual abilities fell within the _____ range. Within the academic domain, a significant discrepancy was seen between _____’s general intellectual ability and his/her performance on academic measures of written language. His/her performance on these achievement measures was also ____ grade level(s) below his/her current academic placement. Thus this discrepancy meets the diagnostic criteria for specific learning disorder with impairment in written expression/dysgraphia. In contrast, the child’s performance on tests of reading and math was consistent with his/her expected level of performance.

30.7. For Reading Disabilities/Dyslexia

_____ is a ____-year-old male/female whose general intellectual abilities are in the _____ range. Test results and prior history indicate that he/she meets criteria for

specific learning disorder with impairment in reading/dyslexia. His/her achievement in reading fluency and spelling is significantly below grade level and highly discrepant from what would be expected on the basis of his/her general intellectual ability. When one considers that _____ is a boy/girl with strong potential for learning, the deficits in reading and spelling are even greater, since he/she has the ability to be performing at/well above grade level in these areas. In addition, math skills, particularly math fluency, are significantly weak/strong/grade appropriate. _____ demonstrated strong/weak executive function skills and some/no difficulties with memory, attention, or processing speed. _____ is a motivated student with a positive attitude toward learning, but is clearly frustrated by his/her reading difficulties and is understandably confused as to why certain academic tasks are difficult for him/her.

The child is a ____-year-old female/male who was found to have intellectual abilities in the average/below-average/above-average range. She/he appears to have a reading disability, in that her/his performance on a variety of reading measures was significantly discrepant from expectations based on IQ. The child's reading speed is slow when compared with individuals of his/her age; reading comprehension was significantly below expectations as well. In addition to these difficulties, she/he has marked difficulties reading nonsense words, which indicates problems with basic phonemic processing. The pattern of this child's scores and the types of errors she/he made are highly characteristic of individuals with dyslexia.

The child is a ____-year-old male/female of above-average/average/below-average intelligence who is in the ____ grade. Test results and history indicate that he/she has specific learning disorder with impairment in reading (dyslexia), as his/her achievement in reading and spelling is significantly below grade level and discrepant from what would be expected on the basis of his/her general intellectual ability. Timed reading tests and nonword reading were particularly difficult for him/her. It will be important for future instructors to be made aware of the nature of the child's learning disability, so that they can assist him/her in maximizing the development of strengths and not unduly penalize him/her for deficiencies.

Overall, results are consistent with a specific learning disorder with impairment in reading (dyslexia). _____ is bright and has been able to compensate in some/many respects for her/his learning difficulties, but a slow reading rate and inefficiencies in reading skills remain. She/he displays a pattern of high-level deficits often seen in children with strong intellectual abilities. In addition, there are concerns with certain aspects of executive functions, such as processing speed/memory/attention/organization/etc.

30.8. For Intellectual Disability

The child is a ____-year-old female/male who currently attends _____ school. She/he is currently functioning in the range of mild/moderate/severe/profound intellectual disability, with widespread cognitive difficulties consistent with this picture. She/he shows executive/planning problems such as difficulty maintaining and switching cognitive set/increased perseveration/a segmented approach to complexity/concreteness of thought/difficulty seeing the logical cause and effect between details/problems with planning ability/etc.). Deficits were also seen in visual and auditory memory/expressive and receptive language/visual constructional ability/etc. On tests of achievement, the child's performance fell at the _____ level. Her/his social maturity as measured on the Vineland-3 is equivalent to that of a ____-year-old.

30.9. For NLD

Although NLD is not a DSM-5 diagnosis (*see Section 16.6*), it is still often used as a descriptive category by psychologists, and thus examples are included here.

The child is a ____-year-old boy/girl of high/above-average/average/below-average/normal/limited intelligence who is in the ____ grade. Testing indicates that he/she meets all the primary criteria for a nonverbal learning disability (NLD), including significantly stronger language skills as compared to nonverbal and spatial skills; relative academic weaknesses in calculation and reading comprehension skills; relative difficulty in visual-motor tasks; a history of motor planning and graphomotor output difficulties; concreteness of thought; and problems reading nonverbal/social cues that affect social reasoning. In addition, most children with NLD have associated executive function impairments, such as variable attention, impulsivity, perseverative tendencies, and organizational problems. This child shows evidence of sensory dysfunction as well, which is also often typical for children with NLD. Finally, like most individuals with NLD, he/she appears more adept at dealing with verbal information that is more rote in nature and experiences greater difficulty with organizing and conceptualizing verbal material.

_____'s profile indicated relative problems with nonverbal problem solving. Results of the current evaluation indicate stronger language skills as compared to nonverbal and spatial abilities. Individuals with this type of learning profile appear to have the most difficulty with the perception, analysis, integration, and storage of nonverbal information. In addition, her/his performance varies considerably as a function of the degree of structure inherent in instruction and task materials. This type of learning style can affect virtually every aspect of _____'s life that requires her/him to understand the "gist" of a situation. It can also exacerbate a natural disposition toward feelings of anxiety.

30.10. For Processing Speed Weaknesses

Overall, _____'s performance is not consistent with any form of specific learning disorder, but his/her relative difficulties with processing speed indicate that he/she will very likely experience some frustration in school. Tasks that should be quick and easy for _____ may feel overwhelming, as he/she may take longer and work harder than most of his/her peers to complete these tasks. _____ has age-appropriate intellectual skills, and it may appear that he/she should be capable when asked to complete tasks with a specific time limit. However, some tasks (particularly rote tasks that need to be completed in a specified time limit or tasks that necessitate having to give verbal responses quickly) may be more challenging for him/her.

In terms of learning challenges, _____'s ability in processing speed was quite slow, and she/he displayed relative difficulty in the ability to accurately plan and execute motor movements as they relate to copying various symptoms. Given unlimited time, _____'s performance is much stronger. It is important to note that given his/her slow processing speed, he/she is working longer and harder and expending more mental energy to cope with his/her studies than his/her peers.

30.11. Positive Summary Statements for Ending Reports, Regardless of Diagnosis

Finally, _____ does have some important resources for coping, including parents who are very interested in helping him/her, an engaging disposition, and a strong motivation for learning, despite any difficulties with attention/reading/math/processing speed/etc. He/she is receptive to feedback and structured teaching interactions, and seems to enjoy challenging him-/herself and learning.

While reports of this nature tend to focus on weaknesses, _____ does possess important areas of strength that should not be overlooked. She/he is a very likeable, creative, and

intelligent child/adolescent. Her/his strong verbal/nonverbal/reasoning/etc. skills are assets that will help ensure her/his ability to make good use of any interventions. In addition, she/he has very caring and committed family members who are highly invested in supporting her/his development in all areas (e.g., academic, emotional, interpersonal). These are all factors that will increase her/his resilience and help her/him overcome any future challenges.

Overall, teachers and parents should strive to provide _____ with both appropriate challenges (to address her/his strong _____ skills) and appropriate accommodations (to help with any _____ challenges) and make efforts to insure successful experiences whenever possible.

In conclusion, it was a pleasure to meet and work with _____. _____ is motivated to achieve academically and to experience positive relationships and needs to be recognized for the effort she/he is expending to meet her/his own expectations. She/he can be supported by acknowledging and focusing on her/his effort (regardless of outcome) as well as by setting goals which are achievable, but increasingly challenging, to increase the amount of success she/he experiences while supporting further growth.

31

Recommendations

The “Recommendations” section of a report is often the most important section, as the primary purpose of an evaluation is to determine how best to intervene in a particular case. This chapter provides lists of possible recommendations for common childhood psychological problems. They reflect the treatments that have been found effective for different disorders. Of course, each child is unique, and the recommendations chosen should reflect the child’s particular pattern of strengths and weaknesses. Providing a comprehensive listing of treatment parameters is beyond the scope of this book; however, this chapter does include many of the most common strategies for particular disorders. These strategies are the ones that have been shown to be effective as treatment or compensatory measures and are often used in individualized education programs (IEPs). The reader is encouraged to consult the resources listed in Section 36.3 for comprehensive treatment information.

31.1. For ADHD

Classroom Strategies

- Assign preferential seating in the classroom (seating close to the teacher or work areas, and away from any visual or auditory distractions).
- Provide both written and oral directions for tests/projects.
- Give brief, concise directions.
- Break tasks into small components and provide clear, explicit, step-by-step instructions, especially when new material is introduced.
- Break long tasks into multiple short tasks. This is most effective when immediate reinforcement is provided for reaching each subgoal of a larger goal in learning.
- Use accompanying visual aids whenever possible in the classroom; use several sensory modalities of instruction to maintain attention and increase learning.
- Teach the child how to use an assignment book.
- Encourage the child to repeat, rephrase, and demonstrate instructions, to enhance comprehension and attention to tasks.
- Allow additional time if needed to complete assignments; provide homework modification in terms of the amount of work assigned and/or the amount of time an assignment should take.
- Reduce sources of distraction in the classroom.
- Have the child use attention-grabbing/self-monitoring devices, such as a highlighter.
- Provide consistency and structure through the use of daily schedules, standard seating arrangements, and clearly defined classroom expectations.

- Minimize unnecessary stressors; assign tasks that can be successfully completed.
- Remind the child at the beginning of the day to turn in homework or take homework out of his/her backpack/locker; remind the child at the end of the day about what he/she needs for school and home the next day.
- Offer one-to-one instruction time, especially before tests.
- Give a study sheet with key words/concepts prior to tests.
- Interact frequently with the child in the classroom to maintain her/his involvement; use voice, proximity, and touch.
- Frequently elicit questions and opinions from the child to maintain his/her involvement in an activity.
- Allow the child to audio-record lectures for later review.
- Schedule more frequent parent-teacher conferences to review progress.
- Tutor the child in specific course content when needed.
- Develop a subtle cue for use between the child and the teacher, to remind the child to place additional focus on his/her work without leading to public embarrassment.

Homework Strategies

- Have the child check in once a day with a person who will supervise homework.
- Establish a system for monitoring the accomplishment of daily assignments through behavioral contracting.
- When assigning homework, be sure that the child can complete the amount of homework assigned.
- Schedule a “homework time” and help the child organize his/her free time to facilitate homework completion.
- Give the child an assignment sheet to complete each day, instead of having the child copy the entire assignment off the board; she/he circles or checks off each type of homework when it is finished. See the example below.

Date: 4/10/19

1. Spelling: Write each spelling word in a sentence for Wednesday. ____
Study spelling words for Friday test. ____
2. Math: Do problems 7 through 15 on page 47 in math workbook. ____
3. Geography: Read Chapter 6 and answer questions at end of chapter. ____

Other Strategies

- Refer the child to a physician for medication evaluation. Medications such as Ritalin and Metadate (methylphenidate); Adderall and Dexedrine (amphetamine compounds); and Strattera (atomoxetine) are frequently prescribed.
- Recommend behavior therapy and/or parent management training.

31.2. For Anxiety

- Recommend cognitive-behavioral therapy and instruction in self-regulation skills (e.g., coping skills to manage anxiety).
- Refer the child to a physician for medication evaluation.
- If the child has tendency to be withdrawn, pair her/him with a “study buddy” or encourage involvement in a small group.

- Provide the child with positive feedback and reassurance; offer constructive criticism in private.
- Reduce emphasis on competition and perfection.
- Provide structure, predictability, routines, and consistency.
- Aim to reduce anxiety-provoking situations for the child at school, such as singling him/her out or using tight time constraints.
- Allow extra time when needed. Time constraints and “rushing” may overwhelm and immobilize the child.
- Balance stressful activities with low-stress, high-pleasure activities. Do not schedule too many stressful events into one day.

31.3. For ASD

- Recommend specialized therapies, such as speech and language, occupational, and/or physical therapies.
- Refer to a structured language-based program and/or specialized placement program specifically designed for children with ASD.
- Provide behavior therapy to address concerns regarding self-stimulation, aggression, and/or disruptive behavior.
- Provide social skills training.
- Provide a consistent schedule. Try to have mealtime, bedtime, etc., occur at the same time and in the same order every day. Inform the child of any deviations from the routine ahead of time, and explain the reason for the change. When traveling away from home, make the new environment as comfortable and familiar as possible.
- Recommend parent support groups and other parent resources.
- Refer for medication evaluation.
- Recommend consultation with a pediatric neurologist, who may recommend follow-up tests such as genetic testing.
- Provide applied behavior analysis (ABA) for support as needed at home and in school.

31.4. For Conduct Problems/ODD

- Provide a structured behavioral program both at home and at school.
- Recommend consistent, predictable behavior management (including a united parental front in regard to expectations and discipline).

31.5. For Depression (Unipolar and Bipolar)

- Recommend individual cognitive-behavioral therapy and/or family therapy.
- Structure the environment so that the child feels more competent, successful, and important; make the appropriate classroom/curricular adjustments to prevent unnecessary stress, frustration, or anger.
- Refer for medication evaluation.

31.6. For Writing Disabilities/Dysgraphia

- Provide tutoring that addresses prewriting components (e.g., brainstorming for ideas, verbal rehearsal, and outlining), writing clear sentences, developing a theme, proofreading, and revision of drafts.

- Provide support for the organization of ideas through the use of webs (to help group and order ideas) and the use of outlines (to organize and sequence ideas).
- Provide the child with checklists for proofreading.
- Have the child use a computer as much as possible; teach typing skills necessary to become competent on the computer.
- Provide extra time on tests that involve writing.
- Reduce writing requirements; give the child the opportunity to express his/her creative ideas without the barrier of handwriting, such as permitting oral book reports.
- Have the child use a hand-held speller or engage the help of a scribe.
- If the child is more successful using cursive writing than printing, encourage the use of cursive.
- Adjust expectations for fine motor activities to match the child's best efforts.
- Minimize copying activities by providing information or activities on worksheets or hand-outs rather than on the board.
- Assign follow-up activities that reduce a child's writing requirements (paired talking activities, cooperative small-group work, instructional games, short-answer/matching/multiple choice activity sheets, etc.).
- Access the support of an occupational therapist for specific treatment recommendations.
- Recommend direct instruction in a handwriting course, such as *Handwriting without Tears*.

31.7. For Reading Disabilities/Dyslexia

Tutoring in a phonics-based, multisensory approach to reading (typically provided individually, multiple times per week) has been shown to be the most effective treatment for dyslexia. Approaches found to be effective in treating dyslexia include the Wilson (www.wilsonlanguage.com), Lindamood-Bell (<https://lindamoodbell.com>), and Orton-Gillingham (www.orton-gillingham.com) programs.

Classroom Modifications

- Allow extra time on tests.
- Allow taking tests in an oral format when appropriate.
- Do not penalize the child for spelling errors.
- Assist with note taking and copying from the board, such as allowing the child to use teacher-made notes or to audio-record lectures for later review.
- Have the child use a word processor with spell-checking capabilities as much as possible, and/or a hand-held speller for in-class work.
- Allow exemption from a foreign language requirement, or, when this is not possible, encourage the child/adolescent to learn a foreign language that is phonetic (such as Spanish).

Strategies for a College-Age Student

- Encourage the student to take a reduced course load.
- Allow extra time for taking tests and completing assignments.
- Have the student use Kurzweil Education's or other computerized reading assistance systems.
- Recommend audiobooks.

Spelling Strategies

- Provide the child with consistent exposure to various word games or puzzles (e.g., cross-words, find-a-word games, Jumble, Scrabble).
- Provide the child with a spelling dictionary.
- Recommend commercially available spelling games to help practice encoding and rule use.
- Encourage the use of a word processor or a hand-held speller (see above).

Reading Comprehension Strategies

- Use scaffolded instruction, such as providing verbal prompts and visual examples/models.
- Prior to reading, provide focusing questions (e.g., “who,” “what,” “where,” “when,” “why,” and “how”) that direct the child’s attention to salient formation and set a purpose for reading.
- Provide structural aids for reading assignments (e.g., comprehension questions prior to reading, a story map or web to be filled out while the child is reading, a skeletal outline of the reading).

31.8. For Eating Disorders

- Recommend individual and family therapy.
- Ensure medical stabilization.
- Recommend group therapy.

31.9. For Mathematics Disabilities/Dyscalculia

- Provide direct special education services and/or tutoring support in mathematics.
- Provide compensatory strategies, such as written “recipes” for complex math problems, or the use of graph paper for the alignment of columns.
- Provide the student with a more concrete, hands-on approach to learning math concepts.
- Make math practically oriented, emphasizing real-life skills such as cooking and shopping.
- Provide the child with instruction in evaluating which operations are required in calculations; in determining whether information given in a problem is pertinent or nonessential; and in estimating and checking answers against the estimates to evaluate their reasonableness.

31.10. For Memory Problems

- Create a system to help the child remember information, using things such as key words, mnemonic cues, or unique personal cues.
- Practice strategies of rehearsal and delayed control to gradually increase the amount of time the child must remember a command.
- Rehearse information frequently.
- Have the child use visually cued organizational supports (pictures, graphic displays, written prompts, etc.) to remember daily activities, assignments, etc.

31.11. For Intellectual Disability

- Recommend special education services, including educational services and vocational training.
- Provide direct instruction in safety, self-care, and social skills.
- Recommend math and other instruction that focuses on life skills training (e.g., use of money, time).
- Provide on-the-job training.
- Recommend occupational, speech, or physical therapy as needed.

31.12. For NLD

- Provide tutoring or resource room support in areas of weakness, such as math, reading comprehension, or written expression.
- Provide occupational therapy for problems with visual-spatial ability.
- Provide child with assistance in reading charts, graphs, and the like, if visual-spatial deficits are present.
- Recommend counseling or psychotherapy focusing on self-esteem and coping strategies.
- Provide group social skills training, as well as social skills facilitation throughout the school day.
- Provide child with opportunities to socialize with peers in appropriate ways (community recreational activities, sports, Scouts, etc.).
- Tailor course choices to accentuate strengths and avoid weaknesses.
- Use educational software to enhance skills in areas of weakness.
- Make classroom accommodations, such as those suggested for children with ADHD (*see Section 31.1*).
- Offer clear, concise information about tests and assignments.

31.13. For OCD

- Recommend cognitive-behavioral therapy.
- Refer for medication evaluation.

31.14. For Social Difficulties

- Provide group training in social skills for positive peer relationships.
- Encourage the child to become involved in activities and school-related functions to promote positive relationships.

31.15. For Processing Speed Weaknesses

- Provide more time to complete assignments, tests, and quizzes.
- Teach the student how to tell time.
- Encourage the student to take time to “think it through,” “mull it over,” or “give it some thought,” as he/she is likely to process ideas more effectively over time.

31.16. Positive Recommendations, Regardless of Diagnosis

Be generous with praise. Find opportunities to build up _____’s self-esteem.

Continue to encourage _____ in areas in which she/he succeeds. Every child needs an area in which to shine. This is particularly important for children with learning/attention/emotional differences, as they often encounter frustration in school/home.

It is recommended that _____ continue to participate in extracurricular activities (e.g., sports, music, arts) where she/he can continue to gain confidence in his/her abilities and gain pleasure from his/her pursuits.

31.17. Recommendations for Further Assessment

Follow-up testing in approximately ____ years is recommended to monitor the child's progress, evaluate the success of recommended interventions, and update interventions to address changing academic demands.

This child should be reevaluated neuropsychologically in about ____ years to determine his/her academic status and to adjust recommendations as needed.

A follow-up assessment should be pursued in ____ years.

32

Closing Statements

32.1. Current Expectations

Prognostic statements are very rarely seen in child and adolescent reports. More typically seen are suggestions of what could be expected of the child in the near future in academic, social, and home settings. You should be extremely cautious about making long-range predictions, but when making such predictions you should do the following:

- Restate the child's level of functioning.
- Indicate, in light of the child's level of functioning, what he/she can be expected to accomplish with and without service interventions.
- Indicate the degree of confidence in your predictions.

The child's progress and prognosis are/may be limited by her/his diagnosis/condition/motivation/cognition/abilities/etc. However, positive prognostic indicators include motivation for treatment, cognitive/academic/etc. abilities, family/school/social support, history of progress, well-developed relationship with therapist, etc. I am quite confident that with the appropriate treatments (such as those mentioned in the recommendations), he/she will continue to make excellent progress.

32.2. Value of the Information

I hope that this information is helpful to you.

I hope that this information proves useful to you as you support this child's education and development.

I hope this information will be useful to you as you consider this case's/child's/adolescent's needs and will aid you in your tasks/evaluation/treatment/decisions.

I hope that this information will be sufficient for you to judge this child's situation.

In the hope that these data will prove of assistance . . .

32.3. Thanking the Referrer

Thank you very much for the opportunity to see this very pleasant young man/young woman/boy/girl. Please do not hesitate to call with any questions or concerns.

The consultant wishes to thank the staff at the _____ School for allowing this observation to take place.

Thank you for the opportunity to evaluate _____ (*child's name*).

Thank you for this interesting referral.

Thank you for the referral of this appealing young man/young woman/boy/girl.

32.4. Follow-Up Care

I would like to see him/her again in follow-up, in ____ months/years.

_____ should return in _____ for a follow-up evaluation. We will contact his/her parents several months in advance, by mail, so they may call to schedule a follow-up appointment.

The child's family is asked to follow up with Dr. _____ in ____ days/weeks/months.

I have explained to the parents that I would be pleased to attend a team meeting at the child's school, if they would find that helpful.

32.5. Continued Availability

If I can be of any further assistance, please feel free to call me at _____ (*give phone number*).

If there are any questions regarding this evaluation or the content of this report, please feel free to contact the evaluator at the following number: _____.

I would be happy to assist this child and her/his family further in any way, but particularly in trying to secure the resources necessary to meet the above-mentioned recommendations.

I can be reached to answer any questions that this report may raise at the following number: _____.

Further discussions of these results are available upon request.

Please do not hesitate to contact me at _____ (*insert contact information*) if I can be of further assistance.

Please feel free to contact me if I can provide any further assistance, or can answer any questions you may have concerning this report.

I would be happy to answer any further questions you may have.

If there are questions about this report, please feel free to call me at _____ (*insert phone number*).

Given his/her parents' permission, I would be available to discuss the results of this evaluation. Additional consultation and/or services are available upon request.

Please feel free to talk with me further about any questions or concerns, or if I can be of help in any way.

I would be pleased to discuss the results of this evaluation, given appropriate permission to do so.

32.6. Availability to Schools/Service Providers

I am happy to provide support to teachers or tutors as indicated.

This examiner would welcome any contact with _____'s school and/or service providers to help translate this evaluation into tangible terms.

I am available for discussion with _____'s parent(s) or teacher(s) of specific findings from this examination.

I would be happy to share information from this evaluation with others working with this child, with appropriate consent, or to assist in monitoring the child's progress.

32.7. Concluding Statements

What follow are some positive statements that you can use to conclude the report. Of course, it is quite possible that the evaluation was not a pleasure for you. In that case, it is best either not to comment on this or to use a simple statement such as the following:

Thank you for the opportunity to evaluate _____.

General Statements

It was a pleasure working with _____ and his/her family.

I have enjoyed working with this child and her/his parents/family over the course of this evaluation.

It was my pleasure to work with _____ and participate in his/her treatment.

In conclusion, it was a pleasure to meet and work with _____ and her/his parents.

It was a pleasure working with and getting to know _____.

Statements for Reevaluations

It was a pleasure to see _____ once again, and I hope that the information provided in this report is helpful in providing direction for his/her ongoing educational interventions and accommodations.

Once again, this child was a pleasure to evaluate.

It was a pleasure to work with _____ again and see the progress she/he has made.

32.8. Complimentary Closing and Signature

The signature is often preceded by one of the following types of statements:

Respectfully submitted,

Sincerely,

Yours truly,

The report should be signed by the person(s) who completed the evaluation. If the report was completed under the supervision of another professional, the supervisor should also sign the report. Underneath the signature(s) should be included the following:

- Typed name(s).
- Degree(s).
- Professional title(s) (e.g., Psychologist, School Psychologist).

Add any of these statements as appropriate:

I authorize that my name may be mechanically affixed to this report.

Dictated but not read, to facilitate mailing to you.

Typed and mailed in the doctor's absence.

If my initials do not follow this sentence, this printed report has not been reviewed/edited by me and may contain errors of typing or words that I would have changed.

Part III

Special Circumstances and Useful Resources

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33

Writing for the Schools

This chapter addresses issues important to school evaluations. It includes information about the Individuals with Disabilities Education Improvement Act of 2004 (IDEA 2004) and individualized education programs (IEPs); it also includes information about observations of classroom behavior, as well as possible formats for reports of these observations. See Section 35.9 for a sample IEP, Section 35.10 for a sample classroom observation report, and Section 40.6 for a form for educational assessment of a student's current classroom functioning.

33.1. School versus Agency Referrals

The focus of school referrals generally differs from that of clinic referrals in a few important ways. The focus of a school evaluation is on determining how a child's psychological, learning, or developmental difficulties interfere with his/her ability to function and progress in school. The focus of a clinical evaluation is usually broader, in that the evaluator typically wants to diagnose and/or treat the child's difficulties in a variety of settings. For example, in a child exhibiting severe anxiety, a school psychologist will want to know why the child is anxious at school, whereas a clinical evaluator might want to determine the type of medication or psychotherapy that would be most beneficial. A multidisciplinary team (i.e., a team composed of professionals with diverse specialties, such as nurses, psychologists, special education teachers, general education teachers, the school principal, speech and language therapists, physical therapists, occupational therapists, etc.) is typically involved in school evaluations, but is rarely involved in nonschool evaluations. Finally, triennial evaluations are required in the school setting to determine whether a child still qualifies for special education, whether the placement is appropriate, and what the child's current levels of functioning are.

33.2. Individuals with Disabilities Education Improvement Act of 2004 (IDEA 2004)

Under IDEA 2004 and its predecessors (1990, 1997), all children with disabilities are granted a free and appropriate education (FAPE). To qualify for special education and related services, IDEA specifies that a child must have a disability in one of the categories listed below. According to the law, a child is not eligible for special education services if her/his difficulties are due solely to a lack of instruction or to limited English proficiency.

Disability Categories

- Autism
- Deaf-blindness
- Deafness
- Emotional disturbance
- Hearing impairment
- Intellectual disability
- Multiple disabilities
- Orthopedic impairment
- Other health impairment (including ADHD)
- Specific learning disability (including dyslexia, dyscalculia, dysgraphia, and other learning issues)
- Speech or language impairment
- Traumatic brain injury
- Visual impairment (including blindness)

Important Disability-Related Terms and Definitions

Americans with Disabilities Act (ADA): A law that makes it illegal to discriminate against anyone (a child or an adult) on the basis of a disability.

Behavioral intervention plan (BIP): An individualized plan created for students with behavior problems, which includes information about reinforcement schedules, behavioral interventions, strategies for managing behavior, classroom support, and other interventions as needed.

Early periodic screening, diagnosis, and treatment (EPSDT): Services that are provided to infants and children at risk.

Extended school year (ESY): Services provided outside the normal school year (e.g., during summer vacation) as needed for children with disabilities.

Free and appropriate public education (FAPE): As noted above, IDEA mandates an FAPE for every child.

Full inclusion: The education of children with disabilities in regular classrooms within their local schools.

Functional behavioral analysis (FBA): An assessment that provides information about how a child's situational, environmental, and behavioral factors may contribute to his/her problems.

Individualized education program (IEP): The IDEA requires that every child with a disability have an IEP. (*See Section 33.3, below, for more information on the IEP.*)

Individualized education program team (IEP team): The group of people who is responsible for developing, reviewing, and revising a child's IEP. It usually includes the child's parents and those responsible for implementing the IEP goals.

Individualized family service plan (IFSP): A plan for services for young children (under 3 years of age) and their families; it is similar to an IEP.

Individuals with Disabilities Education Improvement Act of 2004 (IDEA 2004): The current law requiring children with disabilities to be given an FAPE. The original (1990) version of this act, the Individuals with Disabilities Education Act (IDEA), replaced Public Law 94-142, the Education for All Handicapped Children Act of 1975 (*see below*). IDEA was amended in 1997 and 2004.

Least restrictive environment: According to Hallahan and Kauffman (1994), a legal term referring to the fact that exceptional children must be educated in as normal an environment as possible.

Office of Special Education and Rehabilitative Services (OSERS): The U.S. Department of Education agency that is responsible for enforcing IDEA in the public schools.

Public Law 94-142, the Education for All Handicapped Children Act: Superseded by IDEA (*see above*) in 1990, this law was passed in 1975 and mandated an FAPE for every child, regardless of ability or disability.

Regular education initiative (REI): The philosophy that regular education, as opposed to special education, should be the primary means of educating children with disabilities.

Section 504, Rehabilitation Act of 1973: Applies to students who have learning or performance weaknesses that could be deemed “disabilities,” but who are not eligible for special education services.

Services plan: A plan developed for students in private school who are entitled to receive services.

33.3. Individualized Education Program (IEP)

IDEA 2004 requires an IEP to be drawn up by an educational team for every child with a disability who meets the qualifying criteria. The IEP must include a statement of present educational performance, annual goals, special educational and related services to be provided, participation with nondisabled children, participation in statewide and districtwide tests, transition service needs, age of majority, and procedures for measuring progress (IDEA, 1997, 2004).

IEP Meeting

- The IEP meeting is conducted with the purpose of developing the child’s IEP.
- The policy for providing an IEP (such as it relates to funding, administration, and implementation) is stated in IDEA 2004, Part B.
- The meeting to develop a child’s IEP must be held 50 calendar days after it has been determined that the child may need special services.
- Notice for the IEP meeting must include the purpose, time, place, and location of the meeting, as well as who will be in attendance. If the meeting will include transition services for the student, then the student must be invited to attend.
- The IEP team includes the child’s parents; at least one of the child’s teachers; at least one special education teacher; a representative who can provide or supervise special instructions; an individual who can interpret the educational implications of the results (this person may already be a member of the team); any other individuals who may have important information about the child or treatment services; and the child, when indicated.

Content of the IEP

The IEP includes the following components (IDEA, 1997, 2004):

1. A statement of the child’s current level of performance, including information about how the child’s disability may affect her/his ability to access the general curriculum.
2. Annual goals and short-term objectives that will address the child’s educational needs.
3. The services, special education, and aids that will be provided to the child.
4. The extent (if any) to which the child cannot participate with nondisabled children.
5. Any modifications necessary for the child to participate in statewide or districtwide assessments. If it is indicated that the child will not participate in such assessments, then a statement is needed to describe why he/she will not participate.
6. The date services will begin, as well as the frequency, location, and duration of those services.

7. Beginning when the child is 14 years of age, and annually thereafter, a statement of transition needs that focus on the child's course of study. Beginning when the child is 16, a statement of transition services.
8. A statement of how the child's progress toward the goals will be measured.
9. A list of the members present.
10. Signatures of persons in attendance.

33.4. Observations of Classroom Behavior

Observations of children's behavior often constitute an important part of the diagnostic process. Furthermore, such observations are essential to FBA (*see Section 33.2*) and many types of behavioral treatment programs. In general, the following points are important to keep in mind when you are conducting a classroom observation:

- Do not interfere with normal events in the classroom.
- If the focus is on identifying a problem behavior, indicate when the problem behavior(s) occurs, what preceded the behavior, what happened immediately after the behavior occurred, and what affect (if any) it had on the environment.
- Conducting a thorough review of records and interviewing with classroom teacher(s) before the evaluation will help focus the observation.

According to Sattler (1992), the purpose of the school consultation should be to help teachers find solutions to students' problems. Sattler indicates that the consultations should help teachers do the following:

- Modify their behavior.
- Deal more effectively with children, parents, and other school personnel.
- Develop new teaching strategies or curriculum changes.
- Develop ways of documenting changes in behavior over time.

Formats for Classroom Observation Reports

Reason for referral.

Actions taken (e.g., classroom observation, review of records, teacher interview).

Classroom observation.

Conclusions.

Introduction.

Discussion with service providers.

Classroom observation 1.

Impressions/analysis.

Classroom observation 2.

Impressions/analysis.

Discussion with service providers of examiner's observations.

Overall analysis.

Reason for referral.

Evaluation methods.

Summary of record review.

Summary of observations.

Recommendations.

33.5. Behavior Management Plans

See Section 40.7 for a form that can be used in writing a behavior management plan.

Behavior management plans or behavior support plans are documents that define how a child's inappropriate behaviors will be remediated. O'Neill et al. (1997) indicate that a behavior support plan should include the following:

- Description of the problem behavior in operationalized terms.
- Summary statements from a functional assessment.
- Treatment strategies for extinguishing problem behaviors.
- Description of typical routines and difficult situations.
- Plan for monitoring and evaluation.

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Treatment Planning

34.1. About Treatment Planning

Treatment plans identify a child's or adolescent's treatment needs and desired goals, as well as the strategies for achieving those goals. Such plans are typically written after a thorough assessment of needs has been completed. The assessment may include clinical interview(s), record review, testing, observation, and information from collateral sources.

The sequence of clinical practice suggests that a clinician goes from the initial assessment of the child or adolescent to selection of the interventions needed, and then to provision of those interventions, which should result in beneficial outcomes. Treatment planning, however, reflects the sequence for clinical thinking about a case. That sequence starts with assessment and diagnosis and then goes to desired goals; only then—looking at both starting points and desired ending points—does the clinician generate the interventions likely to achieve desired goals. The following discussion looks more closely at how a clinician thinks about treatment and treatment planning.

Assessment, Diagnosis, and Setting Priorities

Treatment planning begins with the assessment of the presenting problem or chief complaint, including the presenting symptoms, mental status, risks, background and history, testing results, and family expectations of treatment and outcome. This leads to diagnosis making. A single diagnosis, however, can encompass a number of different problems, symptoms, and deficits in functioning. The next step is therefore to set priorities (i.e., to rank the problems by importance) jointly with the parents or guardian, and also with an older child or adolescent if she/he is capable of participating in the planning process.

Goals and Objectives

Once there is agreement on the most important problems or symptoms to address, the planning process continues with a consideration of outcomes—goals, objectives, and desired benefits. Clinicians can ask themselves, “If we wish to achieve this goal by this date, what steps need to be taken before then?” Available resources, time, finances, and other considerations can impose limitations on what goals are realistic. Therefore, treatment goals and objectives often need to be selected and prioritized.

Among the criteria for “well-formed treatment goals” offered by Berg and Miller (1992) in regard to substance abuse treatment for adults, but readily adaptable to the present discussion, are the following:

- They must be important to the client (in the present context, the child or adolescent and his/her family).
- They should be small.
- They should be concrete, behavioral, and specific.
- They should focus on the presence rather than the absence of something (e.g., on desired behaviors rather than a lack of dysfunctional behaviors).
- They must focus on the first small steps—on what to do first, on a beginning rather than an end.
- They should be realistic and achievable within the context of the child's (and family's) life.

Once goals are selected, planning can proceed to the choice of interventions, efforts, methods, and means. Treatment planning should logically include the ending of treatment. Managed care organizations (MCOs) may ask what steps have been taken or will be taken to prepare the child and family for treatment termination. (*See Section 34.3, below, for a suggested treatment plan format for MCOs.*)

In writing a treatment plan, you may find yourself struggling between writing a plan that is too general and one that is too specific. A plan that is too general will be an empty exercise that offers no real guidance for treatment. An overly precise plan will require either following it rigidly or continually revising it in light of the realities of practice.

“Goals” are usually understood as long-term destinations, and “objectives” are the steps needed to reach those goals. But because there is no agreement in the field over the exact meaning of “objectives,” you need not be precise in differentiating them from goals. Objectives are usually more behavioral and concrete than goals. Objectives are also shorter-term and more easily measurable. They are usually described in terms of the child's behavior or performance (“The child will be able to . . .”).

Being able to assess change is absolutely crucial. Write desired outcomes in behavioral language. This means describing what a camera would see (actions and expressions), not invisible or intangible factors (e.g., emotions, cognitive processes, history, and intentions). Also avoid very broad or vague terms such as “increase,” “communication skills,” or “depression,” because such terms do not make it clear what might count as change. Tie each objective and goal to the child's presenting limitations of functioning. Make these objectives observable or quantifiable. Frequency, duration, intensity, and latency are the classic dimensions for describing symptomatic behaviors. This objectification allows impartial evaluation.

Finally, avoid jargon, especially words understood only by professionals of a particular orientation. Either use common-language translations of theory, or (preferably) focus on specific symptoms and practical intervention strategies.

Interventions

You can specify interventions by asking yourself questions like these:

- What approaches have been shown to work for this problem?
- What are you trained to do with these kinds of problems? (If you lack the skill in these areas, do not try to fake it. Get the necessary training, or refer the child to a competent professional who has such training.)
- What techniques address the symptoms presented?
- How are these techniques implemented? (How often, for how long, with what tools?)
- What will you expect the child to do?

Offer specific descriptors of the mode of treatment (individual, group, family, school-based, etc.), the treatment orientation or modality (cognitive, interpersonal, psychodynamic, structural, etc.), particular techniques (social skills training, perspective training, systematic desensitization, etc.),

and the clinical targets of treatment (problems in social relationships, fears/phobias, conduct problems, oppositional behaviors, etc.).

34.2. A Checklist of Strengths

Alternative terms for “strengths” include the following:

General:

Assets, resources, capacities, talents, competencies, unrecognized resources, protective/generative factors.

Physical:

Healthy, energetic, normal weight/size, eats/sleeps well, fit, in good physical shape, physical development is appropriate for age, active.

Cognitive:

Can attend/concentrate/recall, has planning and organizational abilities, academic competence, strong intellectual skills, well-developed verbal/nonverbal/analytical skills, academic skills that are advanced for age, creative/imaginative/artistic/inventive/talented/adaptable/flexible/compliant/resourceful, common-sensical, accurately appraises demands.

Affective:

Aware of feelings in self and others, comfortable with feelings, appropriately expressive, shows range of affects, tolerates emotional stress/distress, high frustration tolerance, can self-soothe.

Interpersonal:

Socially skilled/competent, respectful/polite, tolerant of others, accepts/offers feedback, helpful/cooperative/accommodating, supportive/caring of others, popular/likeable/well-liked, admired by her/his peers, friendly, comfortable, outgoing/extroverted, sense of humor, shares, helpful, socially sensitive, aware of impact on others, good listener/empathic, shows concern for others, supports others.

34.3. A Treatment Plan Format for Managed Care Organizations (MCOs)

The following is adapted with permission from Zuckerman (2019, pp. 340–343).

- I. Identification of client(s) and providers.
 - A. Purpose: Preauthorization for initial certification *or* concurrent review for reauthorization.
- II. Case formulation/overview.
 - A. Presenting problem(s)/chief complaint/chief concern. *For questions to ask, see Chapters 1–4; for referral reasons, see Chapter 8.*
 - B. Background of presenting problem(s) and current situation. *All elements needing clinical attention are conceived of as either stressors, diatheses, or abnormal behaviors. Behaviors may become new stressors. See Chapter 9 for current symptoms, Chapter 10 for medical and psychiatric background, Chapter 11 for developmental and family history, and Chapter 12 for academic and school history.*

- C. Previous treatments. *Again, see Chapter 10 for medical and psychiatric background.*
 - D. Brief summary of mental status evaluation results.
 - E. Functional limitations and impairments.
 - F. Strengths.
 - G. Diagnoses. *See Chapter 29.*
 - H. Current assessment of knowable risks. *Suicide, homicide, and violence are risks of greatest concern to both clinicians and MCOs. Of only slightly less concern to MCOs are substance use disorders.*
 - I. Recommended level of care. *See Chapter 31.*
- III. Treatment concerns.
- A. Progress in current treatment to date. *Use this section when seeking reauthorization for a continuation of your services. These concurrent reviews function like progress reports.*
 - B. Treatment plan.
 - 1. Additional consultations or evaluations. *This section states what further information the treatment provider needs to know and how that information can be obtained. For example, additional testing or consultants may be necessary.*
 - 2. Treatment objectives and goals. *For each problem or concern to be treated, specify:*
 - a. *The behaviors to be changed.*
 - b. *The planned interventions (who does what, how often, with what recourses; modality, frequency, duration).*
 - c. *Observable indicators of improvements (these are the behavioral goals; report expected number of session to achieve each indicator).*
 - d. *The level of problem behaviors expected at discharge.*
 - e. *Review date.*
 - 3. Other current treatment providers. *(For each professional, list name, location, phone, and treatments being provided.)*
- IV. Signature.

34.4. Tabular Treatment Plan Formats

Maxmen and Ward (1995) note that treatment plans should include the following:

1. Type of treatment (e.g., group, individual, family, etc.).
2. Frequency and amount of treatment (e.g., weekly/biweekly/etc.; number of weeks/months that therapy will continue).
3. Specific problems that will be the focus of the treatment.
4. Specific goals of treatment.
5. The timing of the treatments (e.g., focusing on acute problems before more chronic ones).

Each clinician, agency, funder, and monitor seems to have a different preferred format for treatment plans. Many of them use a tabular format—that is, a page turned sideways (if necessary) and divided into columns. For example, Wiger (1999) suggests a three-column format for the treatment plan:

(First column:) **Problems/Symptoms** *(problems to be addressed in treatment)*

(Second column:) **Goals/Objectives** *(treatment outcomes in observable terms)*

(Third column:) **Strategies** *(treatment interventions to be used during therapy)*

Below are other commonly used headings for such columns, plus a set of headings for a fourth column:

(First column:) **Behaviors to Be Changed, Diagnosis-Related Symptoms.**

(Second column:) **Outcome, Objective Sought/Desired/Expected, Output, Observable Indicators**

of Improvement, Symptom-Related Goals, Focus of Treatment, Short-Term Goal, Discharge Level of Problem Behavior, Performance.

(Third column:) Intervention, Resources to Be Employed, Methods, Treatments, Means, Tactics, Efforts, Inputs.

(Fourth column:) Time Frame, Date of Evaluation, Date of Initiation, Target Date, Completion Date, Expected Number of Sessions to Achieve Objective, Date of Review/Reevaluation/Progress Evaluation.

In the fourth (time frame) column, specify the target as a certain number of treatment sessions if you can, since clients may miss meetings during a specified time period. Similarly, it is preferable to offer a review date rather than an achievement or completion date.

Other columns may include the following:

Intensity, Frequency, Duration of Treatment.

Child's Strengths or Assets, Degree of Involvement.

Liabilities, Resistances/Barriers to Change (*in the child or elsewhere*).

Wilson's Social Work Model

Wilson's (1980) social work model can be applied to child psychotherapy. The model includes these elements:

The ideal means of meeting the needs of the child and family.

Realistic actions that can be taken to meet these needs.

The child's and/or the parent's willingness and ability to carry out these treatment plans.

Progress made or not made since the plan was written.

What you will now do differently.

The Analytical Thinking Model

This model (also described by Wilson, 1980) can be a useful way of thinking about and analyzing your work with a particular child or family:

1. Review in your mind everything you know about the case.
2. Make a list of the 10–15 key facts of the case.
3. Imagine what feelings the child or family might have about the situation, considering the perceptions of all involved parties:
 - a. At whom or what might the feelings be directed?
 - b. Why might each party feel that way?
 - c. What would be the behavioral manifestations of those feelings?
4. Who are the child's/family's "significant others" (i.e., support network)?
5. Develop a treatment plan:
 - a. List all the possible outcomes of treatment (whether realistic or not).
 - b. Label each as realistic or not.
 - c. For each realistic goal, list the subgoals or objectives to be achieved, and put them in any necessary sequence.
 - d. State the exact treatment techniques that would accomplish the subgoals.
 - e. Rank the goals in a time sequence, so that you know where to start.
 - f. Estimate the time needed to achieve each goal.

Write a summary of the main thoughts of steps 2 through 4, and discard all the material except this and the lists developed in step 5.

34.5. A Children's Residential Agency Format

- I. Identifying information: Name, date of birth, date of admission, agency, primary worker.
- II. Data and needs.
 - A. Education.
 - B. Medical/physical status.
 - C. Contacts (legal, family, etc.).
 - D. Personal development (goals):
 1. Personal hygiene.
 2. Peer relationships.
 3. Adult relationships.
 4. Group relationships.
 5. Specialized treatments/therapies/support.
 6. Specific events.
- III. Treatment/program adjustments (to methods).
 - A. Major incidents.
 - B. Routine adjustments.
 - C. Level changes (levels of programming).
 - D. Attitude and motivation.
 - E. Target summary (and changes in targets).
- IV. Family support and follow-up care.

35

Report Formats and Sample Reports

This chapter provides formats for various types of reports, as well as some sample reports. For more information about school reports (as well as some school report formats), see Chapter 33, “Writing for the Schools.” For more information on treatment plans (and some treatment plan formats), see Chapter 34, “Treatment Planning.”

35.1. Standard Formats for Child Reports

A report should meet the needs of its readers, not the writer. The reader of child reports may include a varied population, such as the child’s parents, school personnel, a pediatric neurologist, the child’s tutor, and/or a pediatrician. Although it may be difficult to try to meet the needs of all the potential readers of a report, the evaluator can attempt to do this by (1) providing one or more concise referral questions; (2) describing the history in the client’s (i.e., parent’s and/or child’s) language to the extent possible; (3) describing the results of the evaluation, using as little jargon as possible; and (4) providing recommendations that can be clearly understood by most persons who will read the report.

The sequential structure of Part II of this book can be used as a format for a child report. (*See also Table 1 in this book’s Introduction.*) Use your agency’s or your own letterhead with credentials of relevance. Give the title or type of report as the heading. Then provide the following:

- Name of child or adolescent; case/identification number; child’s/adolescent’s age, gender, and birth date.
- Date(s) of examination(s) and report.
- Evaluator’s name (if not the same as the name on the letterhead), and supervisor’s name if appropriate.
- Name of person or agency to whom the report is to be sent, if someone other than the parent or legal guardian.

Rivas-Vasquez, Blais, Rey, and Rivas-Vasquez (2001) recommend 12 content areas that should be covered in an initial evaluation. These 12 areas are listed below, with some additions and some comments on assessing them in children and adolescents.

1. Identifying information.
2. Chief complaint or concern.

In the client's language (usually the parent's language, but may also include the child's, depending on his/her age and cognitive ability).

Referral source and reason for referral.

3. History of present illness or problem.
Symptoms, treatments, conflicts.
4. Medical history.
Conditions, medications, treatments, treaters, nutrition.
5. Prior psychiatric history.
6. Substance abuse history.
Typically only pertains to adolescent patients and is not usually commented on in children below the age of 13–14 years.
7. Family psychiatric and substance abuse histories.
8. Psychosocial history.
Traumas, educational functioning, developmental history, legal issues.
9. Mental status examination.
Appearance, behavioral observations.
Mood and affect.
Cognitive functions.
10. Psychometric database (when applicable).
Summary of findings.
11. Diagnostic impression.
Case formulation/summary.
Reliability or cautions.
Diagnoses.
12. Treatment plan or recommendations.
Referrals.
Resources.
Motivation for and barriers to treatment.

Rivas-Vasquez et al. (2001) state: “The outline presented above is intended to allow clinicians to structure the documentation of the initial diagnostic evaluation in order to produce a clinical and legal record that can attest to the work that was performed. It will also serve to outline the psychologist's diligence and thoroughness, serve as a communication between health care providers, and satisfy reimbursement requirements for third party payers” (p. 199).

Lewis (2002) points out that since the purposes of consultations differ, so should the content of reports, and that usually a limited number of the items listed above is more appropriate. He adds that the accepted practice in a given setting shapes the content.

Sattler (2018) indicates that a report should have nine sections, as listed below:

1. **Identifying information:** Include information such as child's name, date of birth, gender, age, grade in school, date(s) of assessment(s), and date of report.
2. **Assessment instruments:** List both formal and informal assessment measures.
3. **Reason for referral:** State the reason for the referral, as well as the referral source and relationship of referral source to the child.
4. **Background information:** Include pertinent information from the child's history that has been provided through interviews with the child, parents, teacher, and any others, as well as information provided from previous evaluations.
5. **Observations during the assessment:** Include your observations of the child during the assessment process.
6. **Assessment results and clinical impressions:** Provide a review of the assessment findings, including information about reliability and validity.
7. **Recommendations:** Provide recommendations based on your findings.

8. **Summary:** Give a short, integrated review of the findings of the evaluation.
9. **Signature:** Include your professional title and degree, along with your name and signature. If you are completing this report under supervision, your supervisor's name, title, degree, and signature should also be included.

35.2. Child Assessment Format

Jenkins, Tinsley, and Van Loon (2001) offer this format for the psychiatric assessment interview of a child, which is adapted by permission. This format is also quite adaptable to report writing, and the same sequence can be used.

Beginning the Interview and Establishing Rapport

1. Meet the child and accompanying adult(s).
2. Find out why the child thinks she/he is being seen.
3. Discuss the nature and procedures of the interview.
4. Explain that information given is confidential, with the exception of protecting the child and others from imminent harm.

Developmental History

Note that the structure of the evaluation should include individual interviews with the parents.

Family

1. Child's attitude toward each parent.
2. Child's relationship with siblings.
3. Family psychiatric history.
4. History of each parent's childhood.
 - a. Relationships with parents and siblings.
 - b. Discipline methods used; evidence of abuse or dysfunction.
 - c. Level of education and current occupation.
5. Circumstances of child's birth; if adopted, circumstances and motivation for adoption.

Developmental Milestones

1. Physical.
 - a. Pregnancy, delivery, feeding, and weaning; neonatal illnesses.
 - b. Early or significant medical illnesses or injuries.
 - c. Neuromuscular development of speech and motor milestones (sitting, standing, walking, first words, play).
2. Behavioral.
 - a. Toilet training and other training—response to discipline, methods used.
 - b. Reactions to beginning day care and school.
 - c. Sleep patterns, sleep disturbances.
 - d. Phobias.
 - e. Habit disorders (e.g., bedwetting and thumb sucking).

Significant Events

Ask about moves, parental illnesses/death/divorce, family violence, and so forth.

Current Level of Functioning

1. School performance.
2. Hobbies and extracurricular activities.
3. Peer relationships.
4. Relationships with adults other than parents.
5. Unusual habits and habit disorders.
6. Aims and ambitions.
7. Current health and medications.

Interview with the Child: Possible Topics of Discussion***Child's Ideas about the Problem***

1. Expectations for outcome.
2. What the child would like to change in self or others.
3. "What problems have we not talked about yet?"

Symptom Review

1. Vegetative symptoms.
2. Anxiety symptoms.
3. Psychotic symptoms.
4. Suicidal ideation, other self-destructive acts.
5. Ruminations or acts of violence.
6. Substance abuse.
7. Victimization experiences.

Mental Status Exam***Drawings***

1. House-Tree-Person.
2. Self-portrait.
3. Kinetic Family Drawing.
4. Person-in-the-Rain.

Other Information That May Be Sought

1. Psychological testing.
2. Medical consultations—pediatric, neurological.
3. School records, interview with teachers.
4. Interviews with other significant adults (noncustodial parents, grandparents, social worker).
5. Records of previous treatment or evaluations.

35.3. Psychiatric Evaluation Format

Psychiatric evaluations do not typically include formal test measures. Instead, there is an emphasis on mental status, psychiatric history, and diagnosis. The following is a possible format for a psychiatric evaluation:

- Patient's name.
- Date of birth.

Date(s) of evaluation(s).
 Names of parents/guardians.
 Telephone number of home where child resides.
 Clinician(s): Name(s) and identifying information.
 Sources of information.
 History of present illness.
 Previous medical history.
 Previous psychiatric history.
 Developmental history.
 Social history.
 Mental status exam.
 Appearance and behavior.
 Speech.
 Mood and affect.
 Thought processes.
 Thought content.
 Insight.
 Judgment.
 Diagnostic formulation.
 Predisposing factors.
 Precipitating factors.
 Perpetuating factors.
 Protective factors.
 DSM-5 impressions.
 Recommendations.
 Signature(s)/date(s).

35.4. Format for a Functional Behavioral Analysis (FBA) Report

An FBA is an amalgamation of techniques that have the same purpose: identifying the variables that control a behavior, and using that knowledge to design individualized interventions (Steege, Pratt, Wickerd, Guarre, & Watson, 2019). Steege and colleagues (2019, pp. 220–223) indicate that an FBA report should include the following:

Identifying information.
 Evaluation dates.
 The reason for the referral.
 The purposes of the FBA.
 The assessment procedures used.
 Relevant background information.
 The results of the assessment.
 Identification and description of the interfering behaviors.
 Documentation of current levels of the interfering behaviors.
 A graphic display of the interfering behaviors.
 Behavior-analytic interviews.
 Behavior-analytic observations.
 Experimental analyses.
 Synthesis of the results.
 Behavior-analytic treatment assessments.
 Summary of the results, including hypothesis statements about the function(s) of the target interfering behaviors.

An interpretive session with the child's parent(s)/guardian(s).
 Recommendations for the team's consideration.

35.5. Neuropsychological Evaluation Formats and Sample Report

Report Format

Neuropsychological evaluation reports are typically lengthy documents that can vary considerably from clinician to clinician. A comprehensive report for a neuropsychological evaluation of a fictitious 13-year-old is given on pages 306–312. Immediately below is another possible format for a report of a comprehensive neuropsychological evaluation. Reports of briefer evaluations may only include only some of the following sections.

- Identifying information (child's name, date, etc.).
- Referral/background information.
- Current school program/status.
- Tests administered.
- Behavioral observations.
- Summary of neuropsychological findings.
 - Cognitive functioning.
 - Language skills.
 - Visual–spatial and visual–motor functioning.
 - Memory.
 - Attention/other executive functions.
- Summary of social and emotional functioning.
- Summary of educational findings.
 - Reading.
 - Written language.
 - Math.
- Summary and implications.
- Recommendations.

35.6. Progress Notes

Progress notes are typically completed at the end of each therapy session. Longer notes, sometimes titled “Progress Summary,” are completed at various times during treatment (e.g., every 12 weeks), often at the request of an insurance company or agency policy. A sample progress summary for Jim Smith, a fictitious child, can be found on page 313. A sample format for progress notes follows. (*See also Section 40.8 for a reproducible blank progress note form.*)

Sample Format

1. Presenting problem(s) or diagnosis/diagnoses (e.g., diagnostic label[s] with original DSM-5 and/or ICD-10 diagnosis code[s]).
2. Type of therapy (e.g., family, individual, group).
3. Description of client.
 - a. Physical status.
 - b. Psychological status.
4. General focus of interview.
 - a. Topics discussed.
 - b. Goals addressed.
 - c. Behavior change in child or family, if any.

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Date of report: September 23, 2019

Neuropsychological Evaluation

Name: Tanya Smith

Date of birth: 8/20/2006

Date of evaluation: 9/23/2019

Age at testing: 13 years, 1 month

Date of parent feedback: 10/21/2019

REASON FOR REFERRAL

Tanya Smith, a right-handed, 13-year-old female, was referred for this evaluation to determine whether she might meet criteria for ADHD, given a history of problems with attention. At the time of this evaluation, Tanya was beginning the seventh grade in the Anytown Public Schools.

BACKGROUND INFORMATION

Tanya was born at 40 weeks' gestation after an uneventful pregnancy and delivery, weighing 7 pounds, 10 ounces. Developmental milestones were reportedly within normal limits. Early history is significant for difficulties with fine motor skills. Medical history is unremarkable. Family history is significant for anxiety, ADHD, and learning disabilities.

Tanya attended preschool beginning at age 3 years. Behavioral issues with attention were noted as early as preschool. Tanya is currently described as a disorganized student. She is easily distracted, and she has difficulty sustaining attention, organizing her work, and following directions. She requires ongoing repetition of instructions in the classroom. In terms of academic work, Tanya enjoys reading but has difficulty with comprehension. She has poor handwriting and struggles to organize the content of an essay when working independently.

Tanya's parents are concerned because she can at times have difficulty managing her emotions and can push limits. However, they noted that she is a bright young woman who usually gets along well with her peers and is generally happy.

Tanya lives with her parents and two brothers (ages 14 and 8 years). Her mother is a homemaker, and her father is a businessman. In her free time, Tanya enjoys chorus, art, and hanging out with her friends.

EXAMINATION PROCEDURES

Interview

Wechsler Intelligence Scale for Children—Fifth Edition (WISC-V)

Wechsler Individual Achievement Test—Third Edition (WIAT-III)

Beery–Buktenica Developmental Test of Visual–Motor Integration, Sixth Edition (Beery VMI)

Rey–Osterrieth Complex Figure Test (ROCF)

Wide Range Assessment of Memory and Learning (WRAML2)

(continued)

Conners Continuous Performance Test 3 (CPT 3)

Wisconsin Card Sorting Test (WCST)

Behavior Assessment System for Children, Third Edition (BASC-3)

Behavior Rating Inventory of Executive Function, Second Edition (BRIEF2)

ADHD Rating Scale-5

BEHAVIORAL OBSERVATIONS

Tanya presented as a well-groomed, cooperative, and friendly young girl. She easily established rapport with the examiner. Eye contact was appropriate, and mood was cheerful. She appeared quite motivated to do well and exhibited adequate concentration in this very structured environment. Overall, Tanya appeared to put forth good effort on all the tests administered. The results of the present evaluation are thus thought to be valid.

TEST RESULTS

General Intellectual Functioning

The WISC-V is used to assess the cognitive abilities of children ages 6–16 years. The WISC-V consists of 10 primary subtests, which are used to derive five composite or Index scores (Verbal Comprehension, Visual Spatial, Fluid Reasoning, Working Memory, and Processing Speed); the Full Scale IQ score is derived from 7 of these 10 primary subtests. Subtest scores have a mean of 10 and a standard deviation of 3; scores between 8 and 12 are considered average. Composite scores have a mean of 100 and a standard deviation of 15; scores between 90 and 109 are considered average.

Composite Score Summary

Scale	Composite score	Percentile rank	Qualitative description
Verbal Comprehension Index	117	87th	High average
Visual Spatial Index	118	88th	High average
Fluid Reasoning Index	121	92nd	Very high
Working Memory Index	103	58th	High average
Processing Speed Index	110	75th	Average
Full Scale IQ	116	86th	High average
General Ability Index	121	92nd	Very high

On this administration of the WISC-V, Tanya's General Ability Index was within the very high range for her age.

Verbal Comprehension Index: Subtest Scores Summary

Subtests	Scaled score	Percentile rank
Similarities	15	95th
Vocabulary	12	75th

Tanya demonstrated superior performance on a test of verbal reasoning and concept formation (Similarities) and high average performance on a test of word knowledge and verbal concept formation (Vocabulary).

(continued)

Visual Spatial Index: Subtest Scores Summary

Subtests	Scaled score	Percentile rank
Block Design	13	84th
Visual Puzzles	13	84th

The Visual Spatial Index measures a child's ability to integrate and synthesize part-whole relationships, as well as attention to visual detail and visual-motor integration. When

Tanya was asked to view a model and/or picture and use two-color blocks to re-create the design shown (Block Design), her performance fell in the high average range. Her performance was similar on a task that required her to view a complete puzzle and select three responses that, when combined, reconstructed the puzzle (Visual Puzzles).

Fluid Reasoning Index: Subtest Scores Summary

Subtests	Scaled score	Percentile rank
Matrix Reasoning	15	95th
Figure Weights	12	75th

Tanya's fluid reasoning was particularly strong on a test of visual reasoning (Matrix Reasoning) and high average on a test of quantitative reasoning (Figure Weights).

Working Memory Index: Subtest Scores Summary

Subtests	Scaled score	Percentile rank
Digit Span	12	75th
Picture Span	11	63rd

Working memory skills, or the ability to exert mental control, fell within the average to high average range for Tanya. Mental control is the ability to attend to and hold information in short-term memory while performing some other operation or manipulation with it. Tanya demonstrated high average ability on the Digit Span subtest, a test of short-term auditory memory, and average performance on a test of visual working memory (Picture Span).

Processing Speed Index: Subtest Scores Summary

Subtests	Scaled score	Percentile rank
Coding	8	25th
Symbol Search	13	84th

Tanya's speed of processing fell within the average range. On the Symbol Search subtest, Tanya was required to inspect several sets of symbols and indicate if special target symbols appeared in each set. A direct set of speed and accuracy, the subtest assesses scanning speed and sequential tracking of simple visual information. On a test that required more complex visual-motor coordination (Coding), Tanya demonstrated more difficulty.

Achievement Testing

Tanya had just begun the seventh grade at the time of the evaluation. In the table below, both her achieved and predicted standard scores are provided (mean = 100, standard deviation = 15), as well as the correspond-

(continued)

ing percentiles (compared to grade- and age-mates) and grade equivalents for the achieved scores. An asterisk would indicate that the difference between achieved and predicted scores is statistically significant, with the probability that this difference could be accounted for by chance alone either less than .01 (indicated by **) or less than .05 (indicated by *).

WIAT-III subtest	Achieved standard score	Predicted standard score	Percentile	Grade equivalent
Reading Comprehension	119	114	90th	>12.9
Word Reading	110	115	58th	12.7
Essay Composition	109	112	73rd	10.6
Essay Composition: Grammar & Mechanics	95	112	37th	7.1
Pseudoword Decoding	125	109	95th	>12.9
Numerical Operations	132	111	98th	>12.9
Spelling	134	113	99th	>12.9
Math Fluency—Addition	116	108	86th	>12.9
Math Fluency—Subtraction	110	113	75th	>12.9
Math Fluency—Multiplication	117	111	87th	>12.9

Composite scores	Achieved standard score	Predicted standard score	Percentile	Qualitative description
Total Reading	109	113	73rd	Average
Basic Reading	126	112	96th	Above average
Reading Comprehension & Fluency	111	111	77th	Average
Math Fluency	117	109	87th	Above average

Tanya displays age-appropriate academic skills, and her skills are commensurate with her above-average potential for learning.

Visual Construction

There were no reported or apparent difficulties with visual acuity or with attention to left and right visual fields; nor were concerns noted with object recognition or location in topographic space. Tanya’s performance on the WISC-V Block Design subtest fell in the high average range.

Tanya’s score with regard to accuracy of her copy of the ROCF was significant for being segmented. She had difficulty appreciating the overall organizational structure and tended to focus on copying components of the figure, resulting in distortions in some of the main structural elements (e.g., lacking an overall rectangle, diagonal lines). Her quantitative score fell below the 1st percentile for the copy and delay portions of the test.

Executive Functions

In the area of executive functions, which include attention, impulse control, working memory, and organization, Tanya was found to have some concerns. Of note, this is the skill area most affected by and related to ADHD. In this area, Tanya’s most significant weakness was found within the area of visual organization, as indicated by her performance on the ROCF. She also demonstrated some relative difficulty on the WCST, a test of nonverbal working memory, problem solving, set maintenance, and cognitive flexibility, which required her to identify a changing rule for sorting cards. On the WCST, her performance fell within the average range (total errors, 37th percentile; categories completed, 4), but Tanya had some difficulty identifying

(continued)

an initial strategy for correctly sorting the cards (trials to complete 1st category, 31; 11th–16th percentile).

The Conners CPT 3 is a deliberately tedious, computer-administered measure of an individual's sustained and differential attention. This test required Tanya to respond quickly and correctly to letters presented on the screen and inhibit responses to a specific target letter. On the CPT 3, her clinical index of 82.75 indicated a response pattern more characteristic of highly inattentive children who have a diagnosis of ADHD than of children her age who do not have this diagnosis. Her high numbers of omission and commission errors, and her slow and inconsistent reaction times, are indicators of inattention.

Tanya was administered several subtests from the WRAML2, where her scores indicated relatively weak attention/concentration skills as compared to high average visual and verbal memory skills. In regard to visual memory, Tanya's performance on the ROCF (described above) fell below the 1st percentile. Her approach was segmented and indicative of difficulty with organization of complex visual information.

Behavior Rating Scales

Tanya's parents completed the BASC-3, BRIEF2, and ADHD Rating Scale–5, where their scores were indicative of ADHD, combined presentation. In addition, teacher rating scales were consistent with a diagnosis of ADHD, combined presentation. On the BASC-3, teacher reports were also consistent with anxiety that appears to be somewhat situationally driven. Finally, on the BRIEF2, Tanya's teacher endorsed problems in the following areas: inhibiting her behavior, shifting tasks, controlling her emotions, using working memory, planning and organizing tasks and materials, and monitoring her behavior.

DIAGNOSTIC IMPRESSION

314.01 (F90.2) Attention-deficit/hyperactivity disorder, combined presentation

SUMMARY AND RECOMMENDATIONS

Tanya Smith is a 13-year-old female who was referred for a neuropsychological evaluation by her parents. Tanya has a history of inattention and of executive function weaknesses. The purposes of this evaluation were to obtain information regarding Tanya's strengths and weaknesses, and to assist with educational and treatment planning.

Tanya is a sweet and curious young adolescent who presents with several areas of strength. Her intellectual abilities fall solidly within the high average to very high range. Additionally, many neuropsychological functions are age-appropriate or advanced for her age, such as her verbal and nonverbal reasoning skills. Despite these strengths, some key areas of concern emerged. Behavior rating scales indicated that Tanya meets the criteria for ADHD, combined presentation. That is, she shows difficulties with sustained attention and organization. At school, she has been noted to have difficulties with working memory, as well as with inhibiting her behavior, shifting tasks, controlling her emotions, planning and organizing tasks and materials, and monitoring her behavior.

Given her profile, Tanya is at risk for difficulties in the following specific areas:

- Note taking
- Organization of verbal information
- Proofreading
- Preparing for and taking tests
- Understanding lengthy or complex text/language
- Report writing
- Integration of information
- Retention of information over time

Thus her overall educational program should address the following needs:

(continued)

- Disorganization and study skills
- Potential problems with written expression
- Problems with executive functioning, particularly as they relate to academic subjects such as completing complex assignments.

Tanya's difficulties with her attention and executive function skills interfere with her day-to-day life. That is, these combined difficulties are having an adverse impact on her academic functioning (e.g., inconsistent effort, trouble with work completion/initiative). However, Tanya is an outgoing young woman with strong social skills and a supportive family environment.

Based on the information acquired during the evaluation, the following recommendations are made:

1. Tanya would benefit from tutoring aimed at study skill development. This tutoring should focus on helping her to structure her assignments and organize written material in the form of highlighting, note taking, outlining, and summarizing. It is recommended that Tanya's actual assignments be used in providing this tutoring, so that she will be learning how to structure the work she is assigned in academic classes. The use of strategies such as goal sheets, priority lists, checklists, assignments calendars, Post-it notes, and organizers should be helpful. She should also learn to break down large tasks into more manageable steps. For example, with respect to book chapters, she would benefit from generating an outline for use in organizing the material. The outline should remind her to jot down main ideas, supporting facts, and important details.
2. Like many individuals with ADHD, Tanya tends to show impatience and easy boredom with routine, unexciting tasks. Thus these tasks, when they are required, may need to be done in fairly short segments with specified break times.
3. Note taking will be difficult for Tanya because of the attentional and organizational strategies needed to take good notes. Tanya should make use of strategies such as audio recording or use of a scribe, as well as previewing outlines for lectures so that she will have a "structure" for what will be presented.
4. In general, to enhance Tanya's attention and concentration, her teachers are encouraged to implement some or all of the following strategies:
 - a. Give her seating in the front row, center chair.
 - b. Provide both written and oral instructions for tests/projects.
 - c. Give her written timelines with interim due dates for aspects of large assignments.
 - d. Provide written outlines or lists of key words/concepts while lecturing.
 - e. Allow her to take frequent breaks.
 - f. Give frequent feedback.
 - g. Give brief, concise directions.
 - h. Offer one-to-one instruction time, especially before tests.
 - i. Give her study sheets with key words/concepts prior to tests.
 - j. Break tasks into their smaller components.
 - k. Implement multisensory teaching techniques as much as possible.
 - l. Encourage Tanya to keep an assignment book.
 - m. Allow Tanya to audio-record lectures for later review.
 - n. Provide clear structure, limits, and expectations, and consistent work times and work spaces, both at school and at home. This will be of great benefit to Tanya. It should include a discrete list of tasks and a plan for completing those tasks both during the school day and at home.
 - o. Tanya should benefit from a weekly "map" or schedule of assignments, expectations, and activities. A large wall calendar and planning book will be very good supports.
5. Positive feedback will be essential for success. Also, having a personal niche of expertise will be very important for Tanya. It will be important for her to continue participating actively in endeavors (both academic and social) that provide her with opportunities to demonstrate her strengths to herself and to others.
6. Eliciting Tanya's thoughts about the quality of her work, and discussing her strong areas and goals for

(continued)

the next assignment, will be excellent strategies for developing appropriate goals and methods for self-assessment. Tanya should be enlisted to help set personal goals and challenges for some assignments or tasks and for her coursework. As she may not know what to expect of herself, it will be important to guide her carefully. This should be followed by careful ongoing assessment of how she is doing with meeting those goals, and development of further strategies as needed for meeting those goals.

7. Tanya and her parents should consult with her physician regarding whether medication could be helpful in treating her symptoms of ADHD.
8. It will be important for Tanya to keep in mind her talents and cognitive strengths, as well as any areas of weakness. It will be increasingly up to Tanya to advocate for herself in getting assistance when she needs it. Tanya has some remarkable strengths (both cognitive and interpersonal), and it will be important that she learn to appreciate and use these strengths.
9. Follow-up testing in approximately 3 years is recommended to monitor Tanya's progress, evaluate the success of recommended interventions, and update interventions to address changing academic demands.

It was a pleasure to meet Tanya and her family. Please feel free to contact me should any questions arise (999-555-5555).

Helen Brodsky, PhD

Signature

10/21/19

Date

Jane Brown, PhD
Psychologist
100 N. Main Street, Suite 301
Anytown, State 22222

Phone: (999) 555-5555

Fax: (999) 555-5556

State License #12345

Date of report: March 29, 2019

Progress Summary

Child's name: Jim Smith

Date of birth: 4/15/06

Parents: Bill and Linda Smith

Date treatment initiated: 11/5/18

Home address (mother):

Date of summary: 3/29/19

5 Rintel Road
Anytown, Anystate 12345

Home address (father):

456 Elm Street
Anytown, Anystate 12345

Jim Smith has been participating in individual 50-minute therapy sessions with his psychologist, Dr. Jane Brown (myself). These sessions are conducted at my office. Jim initially presented with symptoms of anxiety, panic attacks, and school refusal.

Jim's goals included (1) a significant decrease in his panic attacks and (2) better school attendance. In regard to the first goal, he has quickly acquired coping skills since his initial assessment in November; he can now control his panic attacks to the point where he is experiencing fewer than one a month. However, he continues to need cognitive-behavioral therapy to address his continued difficulties with consistent school attendance. One barrier to progress in these areas is a lack of consistent adherence to the treatment protocol by Jim's father. Jim's parents are divorced, and Jim stays with his father one week a month; although his mother has followed the suggestions by Jim's treatment team, his father does not consistently require Jim to go to school. In order for treatment to be successful, therapy will have to include a component that will assist Jim's father in acquiring the skills and knowledge he needs to help Jim successfully conquer his school refusal issues.

He demonstrates many excellent abilities, such as strong intellectual and cognitive skills and a desire to please. He is a true delight to work with and continues to make much improvement in the skills that are being addressed. It is recommended that Jim participate in 10–12 more therapy sessions targeting issues related to school refusal. It will probably be necessary to do an *in vivo* session or two in Jim's school on a day when he has spent the previous night at his father's house. An effort should be made to engage Jim's father in treatment; it would be extremely helpful if he could attend two sessions of therapy with Jim to help develop a plan that will address the school refusal on the weeks Jim lives with his dad.

Jane Brown, PhD

Signature

3/29/2019

Date

5. Plans for future sessions.
 - a. Homework assigned, if any.
6. Plans for contacting other professionals, if relevant, and documentation of consent.

35.7. Treatment Summaries

A treatment summary reviews the client's current standing in treatment or summarizes a client's treatment at termination or upon her/his transfer to another clinician or program. A sample treatment summary for Cindy Pope, a fictitious adolescent, can be found on pages 315–316.

35.8. Formats for Discharge or Closing Summaries

Formats for Outpatient Treatment

Format 1

- Child's name.
- Date of summary.
- Date of birth.
- Treatment dates.
- Presenting problems.
- Goals of therapy.
- Achievement of goals.
- Remaining problems.
- Reason for termination.
- Final diagnosis.
- Disposition.
- Signature and date.

Format 2

- Child's name.
- Date of birth.
- Age.
- Therapist's name.
- Attending psychologist or psychiatrist (if any).
- Medical record number.
- Background information.
- Treatment goals and mode of treatment.
- Treatment attendance.
- Course of therapy.
- Family and environmental factors affecting treatment.
- DSM-5 diagnosis.
- Impressions and recommendations.
- Signature(s).

Format for Inpatient Treatment

- Child's name.
- Medical record number.
- Date of birth.
- Date of admission.

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State License #12345

Date of report: July 2, 2019

Treatment Summary

Name: Cindy Pope

Date of birth: 6/9/04

Date of summary: 7/2/19

IDENTIFYING INFORMATION

Cindy is a 15-year-old female who was referred to Dr. Martin Dorn (myself) for the treatment of depression.

BACKGROUND

Cindy's prenatal and birth histories were normal. She was born after a full-term pregnancy; her weight was 8 pounds, 4 ounces. Developmental milestones were within normal limits. Elementary and middle school histories indicated good academic achievement, and Cindy has never needed any special school accommodations.

Cindy's parents indicated that her symptoms began in eighth grade, subsequent to the parents' separation. Before then, according to her parents, she had been an "open-hearted, fun-loving girl who loved to be around people." About 3 months after her parents' separation, Cindy began spending large amounts of time by herself in her room. She lost interest in her friends and in gymnastics, a sport about which she was quite passionate. Her symptoms of sadness became worse once she began ninth grade, where she felt overwhelmed by the new academic demands and the "social scene" of high school.

ASSESSMENT

In an initial interview with Cindy, she reported a history of depressed mood, together with such symptoms as difficulty sleeping, decreased school performance, and a lack of energy. She felt that these symptoms had increased since she started high school and were impinging on daily functioning. Her primary concern was a lack of friends, while her parents' primary concern was her poor school performance. Her behavioral presentation in the initial interview was consistent with her report of depression, in that she was tearful and sad when discussing school and friendships. In addition to these symptoms, the patient endorsed a history of difficulties with concentration.

DIAGNOSIS

The results of the initial interview suggested that Cindy was suffering from major depression. She had few coping resources to deal with her negative emotions. Cognitive-behavioral therapy was recommended to address her symptoms. In terms of her strengths, Cindy presented with strong intellectual and vocabulary skills, a high motivation for treatment, the capacity for self-reflection, and a family who was obviously concerned about her.

Diagnosis: 296.22 (F32.1) Major depressive disorder, single episode, moderate

TREATMENT

Cindy was treated over a 6-month period in 20 sessions of individual therapy and four family meetings. These sessions were primarily based on a cognitive-behavioral approach.

(continued)

Treatment Summary

July 2, 2019

page 2

The purpose of the initial two sessions was to engage in discussions that would foster rapport. This included gathering information about Cindy's family history and emotional functioning. Cindy's response to these sessions indicated that she developed rapport quite easily and was very motivated to "get better."

The following two sessions focused on developing a set of treatment goals to address Cindy's depression. The goals included decreasing her feelings of sadness, as well as increasing her self-esteem, social relationships, school performance, and extracurricular activities. The patient was encouraged to collaborate in setting these goals—including helping to identify the specific behaviors that she wanted to change, such as "having more friends" and "doing better in algebra and biology."

The subsequent sessions were primarily devoted to teaching Cindy cognitive and behavioral strategies that would address her feelings of depression. In the final sessions before discharge, the focus was on reviewing what she had learned and how this had resulted in decreased symptoms of depression. We discussed the elements of her treatment that had enabled her to make these changes; Cindy indicated that cognitive restructuring was particularly helpful. Termination issues were explored in the last two sessions, and a plan was developed that Cindy could follow if she experienced any recurrence of depressive symptoms. The prognosis for Cindy is excellent.

Martin Dorn, PsyD

7/2/19

Name of Clinician

Date

Psychologist

License or Title

Date of discharge.
Treatment unit.
Treating physician.

History of present illness.
Mental status on admission.
Physical exam and laboratory data.
Consultations.
Hospital course.

Condition on discharge.
Aftercare plan.
Discharge medications.
Discharge diagnoses.
Signature.
Date.

35.9. Sample Individualized Education Program (IEP)

A sample IEP for Bonnie O'Hara, a fictitious child, can be found on pages 318–319.

35.10. Sample Classroom Observation Report

A sample classroom observation report for Thomas Jones, a fictitious child, can be found on pages 320–321.

Individualized Education Program

IEP Dates: From _____ to _____

CHILD AND SCHOOL INFORMATION

Name: Bonnie O'Hara

School ID #: XX123

Date of birth: 03/07/2012

School: Grove Elementary

Grade: 1

Primary language: English

Language of instruction: English

PARENT/GUARDIAN INFORMATION

Name(s): John and Laura O'Hara

Relationship to student: Parents

Address: 16 Main Street

Home telephone: 400-222-2222

Primary language of parent(s): English

PARENT AND/OR STUDENT CONCERNS

It is often difficult for Bonnie to concentrate in the classroom. She has trouble attending during large-group activities. Transitions are difficult for her, and outbursts can occur when she is feeling frustrated. Her gross and fine motor skills are also quite weak.

STUDENT STRENGTHS

Bonnie is a caring and personable young child who is capable of thoughtfulness and compassion. She has become more serious about academics and works hard to complete her work. She is becoming more interested in fine and gross motor activities at home and at school. She has strengths in receptive and expressive vocabulary.

HOW DOES THE DISABILITY AFFECT PROGRESS?

Bonnie has difficulty being flexible in social and academic situations. She has a hard time stopping one activity to change to another. She often misses directions or instructions because she is distracted. Her impulsivity affects her interactions with others and her work in the classroom. Her poor motor skills are affecting her ability to learn writing skills.

CURRENT PERFORMANCE LEVELS/MEASURABLE ANNUAL GOALS

Goal 1

Current Performance Level

Bonnie is learning to write her name, but has trouble copying shapes, letters, and numbers.

Measurable Annual Goal

Bonnie will develop her small motor skills and visual-motor skills to a more age-appropriate level.

(continued)

Objectives

- Bonnie will learn to write her name in appropriate upper- and lower-case letters.
- Bonnie will write the numbers 0–9 in correct formation.
- Bonnie will begin to write upper- and lower-case letters of the alphabet.

Goal 2

Current Performance Level

Bonnie is often distracted in large-group teaching settings. She may miss directions or part of a lesson because she is not focused.

Measurable Annual Goal

Bonnie will pay attention in a large-group situation for an appropriate amount of time.

Objectives

- Bonnie will sit in a large group and actively participate for 10 minutes.
- Bonnie will raise her hand and answer questions appropriately in large-group settings.
- Bonnie will focus her attention on the teacher and other children speaking in a large-group setting.

SERVICE DELIVERY

Occupational therapy once a week for 30 minutes.

ASSESSMENT PARTICIPATION

No statewide or districtwide assessments are scheduled during this period.

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Date of report: October 25, 2019

Classroom Observation Report

Name: Thomas Jones

Date of birth: 7/14/10

Parents: Mary/William Jones

Age: 9 years, 3 months

School: Valley Elementary

Date of observation: 10/25/19

Grade: 4th

Evaluator: Maria Ramirez

REASON FOR REFERRAL

To provide direct information about Thomas's adjustment and performance in his current grade setting.

BACKGROUND INFORMATION

A review of school records indicates that Thomas was found to be eligible for receipt of special education support services in first grade, as he presented with a reading disability. He was also diagnosed with ADHD by his doctor. On previous testing, Thomas scored within the average range on tests of intellectual ability, but weaknesses were seen on tests of word decoding, spelling, and attention/other executive functions. Thomas currently receives special reading assistance as well as classroom accommodations.

ACTION TAKEN

1. Reviewed school and medical records.
2. Consulted with classroom teacher.
3. Conducted classroom observation.

CONSULTATION WITH TEACHER

Discussion with Ms. Carley before the classroom observation indicates that Thomas is currently receiving four 45-minute individual reading tutoring sessions per week with the Wilson method. Ms. Carley indicated that she feels Thomas is making very good progress. Thomas also receives math support three times a week, as well as occupational therapy to help him with fine motor and writing skills.

CLASSROOM OBSERVATION

Fourth-grade classroom with Ms. Carley, 9:15 A.M.

At the start of the observation, Thomas was seated at his desk, quietly reading a book as the students filed into the classroom. The classroom is set up in what appears to be a very comfortable arrangement. Couches and comfortable chairs surround the work area, which consists of desk clusters. Computer centers and blackboard centers are located around the room. When the teacher was ready to begin the day, she announced that all students should clear their desks and listen carefully to the schedule for the day. A discussion then transpired as to how the day would progress. The day would begin with activity centers where the children

(continued)

would rotate from one center to another, and the teacher asked the students to listen carefully to learn which activity center they would be working at.

Thomas complied with the instructions immediately. He waited patiently until he and four other children were directed to go to a table at the side of the room and work with the assistant teacher on a math activity. Each of the five students was given coins and asked to determine what kinds of coins would be needed to purchase various items that were placed on the table. Once the children found the correct answers they were asked to find other ways they could purchase the items, as well as how to purchase the items using the smallest number of coins. Thomas worked diligently and did an appropriate job of determining the correct answers. At one time, another group became quite loud, and Thomas became distracted; however, he came back to task with appropriate redirection from the teacher.

About 25 minutes into the center activities, it was time for Thomas to leave the classroom to go to the resource room for tutoring. He walked to the reading room, which is a short distance down the hallway. The work area consisted of a corner of a sunny room, which was set up in a typical Wilson fashion with a table, chairs, and cards. The teacher gave the observer a copy of her lesson for the day, which began with a review of the previous day's lesson. The reading tutor, Mrs. Ruppert, began with a traditional review of vowel sounds, and Thomas was asked to identify digraphs and blends from the felt board. He was then asked to read each base word, and then an analysis of the word itself was conducted. The tutoring continued according to Mrs. Ruppert's lesson plan. Thomas was very motivated and appeared quite pleased when he was recognized for a job well done. Thomas worked well with Mrs. Ruppert on a one-to-one basis.

CONCLUSIONS

1. Thomas followed all teacher directives as soon as they were given.
2. The Wilson implementation was of very high quality, and the combination of this approach and his specific reading teacher appear to be creating a very favorable reading experience for Thomas.
3. Thomas thrived when given positive reinforcement for the successes he received.
4. Thomas's classroom situation appears to be an ideal setting for him this year. The fact that the class does spend time in rotations seems quite favorable for Thomas, for several reasons. First of all, it allows him the opportunity to move around and not become overly stifled by sitting at his desk for the entire day. It also offers him a great opportunity to interact in both social and learning activities with his peers. He is exposed to consistent peer modeling, in conjunction with excellent teacher direction, and both factors are viewed as promoting his learning.
5. Thomas was easily distracted by the behaviors of his peers in the classroom, but was able to get back on task with a teacher directive.
6. Thomas did give the impression that he wanted very much to respond successfully to all requests that were given to him by his teachers, and he worked hard to achieve expected results on his assignments.

Overall, in the opinion of this observer/consultant, the current plan that is being implemented for Thomas does put him on a pathway that affords him the opportunity to begin compensating for his developmental dyslexia and simultaneously to remain abreast within a classroom situation that is both appropriate and stimulating to him.

Maria Ramirez, PhD

10/25/19

Name of Clinician

Date

School Psychologist

Title

36

Resources for Professionals

36.1. Professional Organizations

www.aacap.org

The website of the American Academy of Child and Adolescent Psychiatry provides information for the Academy's members, other professionals, and families about developmental, behavioral, and mental disorders in children. For professionals, the website provides information on current research, practice guidelines, managed care information, descriptions of awards and fellowships, and conference information. For parents, the website provides information on child and adolescent psychiatry, as well as fact sheets on various disorders.

www.aap.org

The website of the American Academy of Pediatrics provides information about issues relevant to the physical, mental, and social health of infants, children, and adolescents. It is useful for both parents and professionals who are interested in obtaining information about health and children.

www.academyofct.org

The official website of the Academy of Cognitive Therapy provides professionals with current information about cognitive therapy. It also provides assistance for consumers in finding a certified cognitive therapist.

www.nacbt.org

The official website of the National Association of Cognitive-Behavioral Therapists provides up-to-date information related to cognitive-behavioral therapy for professionals, as well as self-help cognitive-behavioral products and techniques for the general public.

www.psychiatry.org

The website of the American Psychiatric Association provides information relevant to issues related to general psychiatric practice, including continuing educational opportunities, current research, and archival journal data.

www.apa.org

The official website of the American Psychological Association provides information for psychologists and other interested persons on current topics in psychology. The website provides information about conferences, continuing education, recent publications, and ethics.

www.psychologicalscience.org

The official website of the Association for Psychological Science provides information for professionals and students, including recent research and advocacy.

36.2. Test Publishers

Educational and Industrial Testing Service
 P.O. Box 7234
 San Diego, CA 92167
www.edits.net

Harvard University Press
 79 Garden Street
 Cambridge, MA 02138
www.hup.harvard.edu

Jastak Associates
 (Products are now published by Psychological Assessment Resources [PAR], Inc.; see below)

Lafayette Instrument Company
 3700 Sagamore Parkway North
 Lafayette, IN 47904
www.lafayetteinstrument.com

Multi-Health Systems (MHS), Inc. (in Canada)
 3770 Victoria Park Avenue
 Toronto, ON M2H 3M6 Canada
www.mhs.com

Multi-Health Systems (MHS), Inc. (in the United States)
 P.O. Box 950
 North Tonawanda, NY 14120-0950
www.mhs.com

Pearson Assessments (subsuming the former American Guidance Service, Psychological Corporation, and many others)
 Multiple cities
www.pearsonschool.com (for Pearson Education), www.pearsonclinical.com (for Pearson Clinical)

PRO-ED
 8700 Shoal Creek Boulevard
 Austin, TX 78757-6897
www.proedinc.com

Psychological Assessment Resources (PAR), Inc.
 16204 North Florida Avenue
 Lutz, FL 33549
www.parinc.com

Reitan Neuropsychology Laboratory
 1419 East Bayview Drive
 Tempe, AZ 85283
www.mcssl.com/store/reitan-neuropsychology-laboratory

Riverside Publishing
 3800 Golf Road, #100
 Rolling Meadows, IL 60008
www.riversidepublishing.com

Western Psychological Services
 625 Alaska Avenue
 Torrance, CA 90503-5124
www.wpspublish.com

36.3. Treatment Resources

The resources listed in this section provide guidelines for treating particular populations or disorders.

- Benjamin, C. L., Connor, B. T., Kendall, P. C., & Puleo, C. M. (2011). CBT for childhood anxiety and substance use at 7.4 year follow-up: A reassessment controlling for known predictors. *Journal of Anxiety Disorders*, *25*, 690–696.
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- Crone, D. A., Hawken, L. S., & Horner, R. H. (2015). *Building positive behavior support systems in schools* (2nd ed.). New York: Guilford Press.
- Dishion, T. J., & Kavanagh, K. (2003). *Intervening in adolescent problem behavior*. New York: Guilford Press.
- Franklin, M. E., Freeman, J. B., & March, J. S. (2019). *Treating OCD in children and adolescents: A cognitive-behavioral approach*. New York: Guilford Press.
- Friedberg, R. D., & McClure, J. M. (2015). *Clinical practice of cognitive therapy with children and adolescents: The nuts and bolts* (2nd ed.). New York: Guilford Press.
- Garcia-Lopez, L. J., La Greca, A. M., Marttunen, M., & Ranta, K. (Eds.). (2015). *Social anxiety and phobia in adolescents: Development, manifestation and intervention strategies*. Cham, Switzerland: Springer International.
- Hsiao, R. C., Schoenfelder, E., & Wu, S. S. (2016). Cognitive behavioral therapy and motivational enhancement therapy. *Child and Adolescent Psychiatric Clinics of North America*, *24*, 629–643.
- Kauffman, J. M., Mostert, M. P., Trent, S. C., & Hallahan, D. P. (2006). *Managing classroom behavior: A reflective case-based approach* (4th ed.). Boston: Allyn & Bacon.
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- Kearney, C. A. (2005). *Social anxiety and social phobia in youth: Characteristics, assessment and psychological treatment*. New York: Springer.
- Kearney, C. A., & Albano, A. M. (2018). *When children refuse school: A cognitive-behavioral therapy approach (therapist guide)* (3rd ed.). New York: Oxford University Press.
- Kendall, P. C. (Ed.). (2012). *Child and adolescent therapy: Cognitive-behavioral procedures* (4th ed.). New York: Guilford Press.
- Kendall, P. C. (Ed.). (2018). *Cognitive therapy with children and adolescents: A casebook for clinical practice* (3rd ed.). New York: Guilford Press.
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- McMahon, R. J., & Forehand, R. L. (2003). *Helping the noncompliant child: Family-based treatment for oppositional behavior* (2nd ed.). New York: Guilford Press.
- Orvaschel, H., Hersen, M., & Faust, J. (2001). *Handbook of conceptualization and treatment of childhood psychopathology*. Oxford, UK: Elsevier Science.
- Pina, A. A., Silverman, W. K., & Viswesvaran, C. (2008). Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents. *Journal of Clinical Child and Adolescent Psychology*, *37*, 105–130.
- Reinecke, M. A., Dattilio, F. M., & Freeman, A. (Eds.). (2006). *Cognitive therapy with children and adolescents* (2nd ed.). New York: Guilford Press.
- Ring, J. J., Avrit, K. L., & Black, J. L. (2017). Take flight: The evolution of an Orton–Gillingham-based curriculum. *Annals of Dyslexia*, *67*(3), 383–400.
- Robin, A. L., & Foster, S. L. (1989). *Negotiating parent–adolescent conflict: A behavioral-family systems approach*. New York: Guilford Press.
- Shaywitz, S. (2003). *Overcoming dyslexia: A new and complete science-based program for reading problems at any level*. New York: Knopf.
- Spafford, C. S., & Grosser, G. S. (1995). *Dyslexia: Research and resource guide*. Boston: Allyn & Bacon.
- Vaughn, S., & Bos, C. S. (2015). *Strategies for teaching students with learning and behavior problems* (9th ed.). Upper Saddle River, NJ: Pearson.
- Volkmar, F. R., Rogers, S. J., Paul, R., & Pelphrey, K. A. (Eds.). (2014). *Handbook of autism and pervasive developmental disorders* (4th ed.). Hoboken, NJ: Wiley.
- Weisz, J. R., & Kazdin, A. E. (Eds.). (2017). *Evidence-based psychotherapies for children and adolescents* (3rd ed.). New York: Guilford Press.

36.4. Forensic Resources

Child Abuse

- Billick, S. B., & Tedeschi, F. K. (2017). Pediatric PTSD: Clinical, forensic, and diagnostic understanding. *Journal of the American Academy of Psychiatry and the Law*, *45*, 161–169.
- Nader, K. (2008). *Understanding and assessing trauma in children and adolescents: Measures, methods, and youth in context*. New York: Routledge.

Custody Evaluations

- Ackerman, M. J. (2006). *Clinician's guide to child custody evaluations* (3rd ed.). Hoboken, NJ: Wiley.
- Hynan, D. J. (2014). *Child custody evaluation: New theoretical applications and research*. Springfield, IL: Charles C Thomas.
- King, E. H. (2018). Child custody evaluations. In J. N. Butcher & P. C. Kendall (Eds.), *APA handbook of psychopathology: Vol. 2. Child and adolescent psychopathology* (pp. 559–588). Washington, DC: American Psychological Association.
- Lorandos, D., Bernet, W., & Sauber, S. R. (Eds.). (2013). *Parental alienation: The handbook for mental health and legal professionals*. Springfield, IL: Charles C Thomas.
- Otto, R. K. (2000). The use of psychological testing in child custody evaluations. *Family and Conciliation Courts Review*, *38*, 312–340.

Forensic Psychology (General)

- Aldridge, M. (2007). The questioning of child witnesses by the police and in court: A linguistic comparison. In J. Cotterill (Ed.), *The language of sexual crime* (pp. 63–82). New York: Palgrave Macmillan.
- Barsky, A. E. (2012). *Clinicians in court: A guide to subpoenas, depositions, testifying, and everything else you need to know* (2nd ed.). New York: Guilford Press.

- Brodsky, S. L. (2013). *Testifying in court: Guidelines and maxims for the expert witness* (2nd ed.). Washington, DC: American Psychological Association.
- Flynn, M. H. (1997). The good, the bad, and the useless: Writing reports that are helpful to the courts. *TCA Journal*, 25, 41–49.
- Pantell, R. H. (2017). The child witness in the courtroom. *Pediatrics*, 139(3), e20164008.
- Quinn, K. M. (1986). Competency to be a witness: A major child forensic issue. *Bulletin of the American Academy of Psychiatry and the Law*, 14, 311–321.
- Ribner, N. G. (Ed.). (2002). *The California School of Professional Psychology handbook of juvenile forensic psychology*. San Francisco: Jossey-Bass.
- Van Dorsten, B. (Ed.). (2002). *Forensic psychology: From classroom to courtroom*. New York: Kluwer Academic/Plenum.

36.5. Assessment Resources

- Lezak, M. D., Howieson, D. B., Bigler, E. D., & Tranel, D. (2012). *Neuropsychological assessment* (5th ed.). New York: Oxford University Press.
- Strauss, E., Sherman, E. M. S., & Spreen, O. (2006). *A compendium of neuropsychological tests* (3rd ed.). New York: Oxford University Press.
- Wilson, H. K., & Braaten, E. B. (Eds.). (2019). *The Massachusetts General Hospital guide to learning disabilities: Assessing learning needs of children and adolescents*. New York: Humana Press.

36.6. Other Useful Websites

www.eric.ed.gov

The Education Resources Information Center (ERIC) is a national information system that is funded by the U.S. Department of Education. The organization provides a centralized bibliographic database of journal articles and other published and unpublished education materials. The website allows the reader to search the ERIC database.

www.nimh.nih.gov

The website of the National Institute of Mental Health provides information about clinical trials, funding opportunities, and recent research. It has information for the general public, for practitioners, and for researchers.

37

Resources for Parents

The number of websites and other useful resources for parents is quite large. This chapter is not meant to provide an exhaustive list.

37.1. General Resources

Braaten, E. (2011). *How to find mental health care for your child*. Washington, DC: American Psychological Association.

Braaten, E., & Felopulos, G. (2004). *Straight talk about psychological testing for kids*. New York: Guilford Press.

Faraone, S. V. (2003). *Straight talk about your child's mental health: What to do when something seems wrong*. New York: Guilford Press.

Kazdin, A. E. (2013). *The everyday parenting toolkit: The Kazdin method for easy, step-by-step, lasting change for you and your child*. Boston: Houghton Mifflin Harcourt.

Webster-Stratton, C. (2005). *The incredible years: A trouble-shooting guide for parents of children aged 2–8 years*. Seattle, WA: Incredible Years.

Wilens, T. E., & Hammerness, P. G. (2016). *Straight talk about psychiatric medications for kids* (4th ed.). New York: Guilford Press.

<https://effectivechildtherapy.org>

A website developed by the Society of Clinical Child and Adolescent Psychology to provide the public as well as professionals with information regarding the mental health treatments with the strongest scientific support, and thus are most likely to work.

www.ccbd.net

The Council for Children with Behavioral Disorders sponsors this website. The organization promotes educational services, provides professional support, encourages research, and disseminates current information about children with behavioral disorders.

www.cdc.gov/ncbddd/childdevelopment/positiveparenting

The Centers for Disease Control and Prevention provide parents with information on child and adolescent development, as well as positive parenting tips and guidance around issues of health and safety across various developmental stages.

www.cec.sped.org

The website of the Council for Exceptional Children is relevant not only for parents, but for teachers and other service professionals who are interested in issues regarding children with disabilities, exceptionality, or giftedness. The website provides information about public policy and advocacy, publications and products, and professional standards and accreditation.

www.ase.tufts.edu/cfw

The Child and Family WebGuide site is operated by Tufts University and lists websites of interest to parents and professionals. All the sites on the WebGuide have been evaluated by graduate students or faculty members in child development. The WebGuide is organized by categories (family/parenting; education/learning; typical child development; health/mental health; resources/recreation) and by age.

www.childadvocate.net

The Child Advocate is a website that “serves the needs of children, families and professionals while addressing mental health, medical, educational, legal and legislative issues.” It provides information on specific topics such as “ADHD and Brain Imaging,” as well as a special link to disaster help for parents and children.

www.ffcmh.org

The website of the National Federation of Families for Children’s Mental Health provides information (including lists of publications, links to relevant websites, and a list of local chapters) about helping children with mental health difficulties.

https://infoaboutkids.org

This website was developed as a collaboration among seven divisions of the American Psychological Association to develop an internet resource center focusing on healthy development in four broad, overlapping areas: body, mind, emotions, and relationships. Given the sheer number of websites available about children, adolescents, and families, it can be difficult to know which sites provide reliable information. This website holds a high standard and includes only information that is supported by rigorous research.

www.mghclaycenter.org

The Clay Center for Young Healthy Minds at Massachusetts General Hospital is a web-based resource providing information for parents and caregivers about the psychological development and emotional well-being of children, adolescents, and young adults who struggle with behavioral, emotional and/or learning challenges.

www.nami.org

The website of the National Alliance on Mental Illness provides general information about “severe” mental illnesses, such as schizophrenia and other psychotic disorders, bipolar disorders, anxiety disorders, ASD, ADHD, and others. It also lists ways for people to become active in policies that affect persons with mental illness.

www.nichd.nih.gov

The Eunice Kennedy Shriver National Institute of Child Health and Human Development website includes information and links to additional resources on many topics and conditions relevant to child and adolescent development, including ASD, traumatic brain injury, and learning disabilities.

www.nimh.nih.gov

The National Institute of Mental Health website includes information regarding mental health conditions including signs and symptoms, risk factors, and available treatments.

www.our-kids.org

The Our-Kids organization is a group of parents, caregivers, and others who are working with children with disabilities. Its website provides information about support lists, homemade equipment, recommended books, and other internet resources for caregivers.

www.psychiatry.pitt.edu

The website of the Department of Psychiatry at the University of Pittsburgh School of Medicine includes information about clinical care, education, and research, as well as lectures and conferences that may be of interest to parents.

37.2. For ADHD

- Barkley, R. A. (2013). *Taking charge of ADHD: The complete, authoritative guide for parents* (3rd ed.). New York: Guilford Press.
- Hallowell, E., & Ratey, J. (2011). *Driven to distraction: Recognizing and coping with attention deficit disorder from childhood through adulthood*. New York: Anchor Books.
- Zeigler Dendy, C. A. (2006). *Teenagers with ADD and ADHD: A parents' guide* (2nd ed.). Bethesda, MD: Woodbine House.

<https://add.org>

The website of the Attention Deficit Disorder Association provides information for individuals and families touched by ADHD, as well as the professionals who treat them. The website includes links to articles, lists of relevant conferences, and an ADDA Store.

www.chadd.org

The organization Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD) operates this website, which is devoted to providing information about ADHD, including public policy, legal rights, answers to frequently asked questions, and current research.

37.3. For Anxiety Disorders

- Chansky, T. E. (2000). *Freeing your child from obsessive-compulsive disorder: A powerful, practical program for parents of children and adolescents*. New York: Crown.
- Chansky, T. E. (2014). *Freeing your child from anxiety: Practical strategies to overcome fears, worries, and phobias and be prepared for life—from toddlers to teens* (rev. ed.). New York: Harmony Books.
- Dacey, J. S., Mack, M. D., & Fiore, L. B. (2016). *Your anxious child: How parents and teachers can relieve anxiety in children*. Chichester, UK: Wiley.
- Last, C. G. (2006). *Help for worried kids: How your child can conquer anxiety and fear*. New York: Guilford Press.
- Rapee, R., Spence, S., Cobham, V., & Wignall, A. (2000). *Helping your anxious child: A step-by-step guide for parents*. Oakland, CA: New Harbinger.

<https://adaa.org>

The website of the Anxiety and Depression Association of America includes members such as clinicians and researchers who treat and study anxiety disorders and individuals with anxiety disorders and their families. The website offers information about anxiety disorders, self-help tools, information about professional development and clinical trials, and information about support groups.

www.bu.edu/card

The Center for Anxiety and Related Disorders at Boston University is one of the country's leading anxiety disorder research and treatment centers. Its website provides information about empirically validated treatment approaches.

<https://iocdf.org>

The website of the International Obsessive-Compulsive Disorder Foundation provides information about the organization and about obsessive-compulsive symptoms, medications, and treatment, as well as bimonthly newsletters with the very latest in information on research, resources, and recovery.

www.worrywisekids.org

This website was created by Dr. Tamar Chansky with the goal of providing parents, educators, and mental health professionals with comprehensive, user-friendly information on the full range of

anxiety disorders. The website includes information regarding how to identify symptoms or “red flags,” as well as how to find effective treatments.

www.childanxiety.net

The Child Anxiety Network website was created by Dr. Donna Pincus to provide thorough, user-friendly information about child anxiety. The website also seeks to guide parents or concerned adults who are not sure where to turn for professional help for their child or a child they know.

37.4. For ASD

Hart, C. (1993). *Parent's guide to autism*. New York: Pocket Books.

Ozonoff, S., Dawson, G., & McPartland, J. (2015). *A parent's guide to Asperger syndrome and high-functioning autism* (2nd ed.). New York: Guilford Press.

Seroussi, K. (2002). *Unraveling the mystery of autism and pervasive developmental disorders*. New York: Broadway Books.

Szatmari, P. (2004). *A mind apart: Understanding children with autism and Asperger syndrome*. New York: Guilford Press.

www.autism-society.org

The website of the Autism Society of America provides information about autism, autism resources, research, and local chapters. Information is also provided in Spanish.

www.autismspeaks.org

Founded in 2005 by the grandparents of a child with autism, Autism Speaks engages in fundraising and advocacy for ASD, in addition to raising awareness of this disorder. The Autism Speaks website provides a wealth of information and resources.

www.feat.org

The Families for Early Autism Treatment (FEAT) website provides information for parents, as well as for educators and other professionals, about autism. Although this website is geared toward individuals in Northern California, it provides links to other FEAT websites in various areas of the United States.

https://medicine.yale.edu/childstudy/research/clinical/autism_neurodevelopment

This website is operated by the Yale Child Study Center's Autism and Neurodevelopment Pod, a clinical and research program serving children with ASD. The website is frequently updated and includes information about the clinic and the disorders it treats, research studies, resources, and publications.

37.5. For Bipolar Disorders

Fristad, M. A., & Arnold, J. S. G. (2004). *Raising a moody child: How to cope with depression and bipolar disorder*. New York: Guilford Press.

Papolos, D., & Papolos, J. (2007). *The bipolar child: The definitive and reassuring guide to childhood's most misunderstood disorder* (3rd ed.). New York: Broadway Books.

www.dbsalliance.org

This website is operated by the Depression and Bipolar Support Alliance; it provides information about mood disorders, as well as information about local support groups and chapters.

37.6. For Conduct Problems/ODD

- Barkley, R. A., & Benton, C. M. (2013). *Your defiant child: Eight steps to better behavior* (2nd ed.). New York: Guilford Press.
- Greene, R. (2014). *The explosive child: A new approach for understanding and parenting easily frustrated, chronically inflexible children*. New York: HarperCollins.
- Kazdin, A. E. (2009). *The Kazdin Method for parenting the defiant child*. Boston: Houghton Mifflin.
- Nichols, M. P. (2004). *Stop arguing with your kids: How to win the battle of wills by making your child feel heard*. New York: Guilford Press.
- Riley, D. (2002). *The defiant child: A parent's guide to oppositional defiant disorder*. Cutten, CA: Taylor.

37.7. For Depression

- Koplewicz, H. (2002). *More than moody: Recognizing and treating adolescent depression*. New York: Putnam.
- Mondimone, F. M., & Kelly, P. (2015). *Adolescent depression: A guide for parents* (2nd ed.). Baltimore: Johns Hopkins University Press.

<https://adaa.org>

The website of the Anxiety and Depression Association of America includes members such as clinicians and researchers who treat and study depressive disorders and individuals with depressive disorders and their families. The website offers information about depression, self-help tools, information about professional development and clinical trials, and information about support groups.

37.8. For Drug Abuse

www.nida.nih.gov

This website is sponsored by the National Institute on Drug Abuse. It provides information for students and young adults, parents and teachers, and researchers and health professionals about how to prevent and treat drug addictions. It also provides information about publications and funding. The website is also available in Spanish.

www.healthychildren.org/English/ages-stages/teen/substance-abuse/Pages/default.aspx

An internet resource for parents provided by the American Academy of Pediatrics, healthychildren.org provides information on a range of pediatric health and wellness issues. The page on substance abuse (the link above is for this page in English; there is also a Spanish version) includes several articles and audio clips covering topics such as alcohol use, steroids, inhalants, and how to locate a drug treatment program.

37.9. For Reading Disabilities/Dyslexia

- Adelizzi, J. U., & Goss, D. B. (2001). *Parenting children with learning disabilities*. Westport, CT: Bergin & Garvey.
- Clark, D. B., & Uhry, J. (1995). *Dyslexia: Theory and practice of remedial instruction*. Timonium, MD: York Press.
- Shaywitz, S. (2003). *Overcoming dyslexia: A new and complete science-based program for reading problems at any level*. New York: Knopf.

<https://dyslexiaida.org>

The International Dyslexia Association operates this website, which provides a wealth of information on dyslexia for educators, parents, and individuals with dyslexia. One strength of the website is that it provides information for specific populations with dyslexia, such as college students, teens, children, and adults.

www.dyslexia.yale.edu

The Yale Center for Dyslexia and Creativity's website provides information geared toward individuals with dyslexia, parents, and educators regarding what dyslexia is and how best to treat/support it. The website also provides an excellent section called "Success Stories," which describes dyslexic Nobel-prize winners, actors, and CEOs.

37.10. For Eating Disorders

Berg, F. M. (2001). *Children and teens afraid to eat: Helping youth in today's weight-obsessed world* (3rd ed.). Hettinger, ND: Healthy Weight Network.

Claude-Pierre, P. (1997). *The secret language of eating disorders*. New York: Vintage.

Lock, J., & le Grange, D. (2015). *Help your teenager beat an eating disorder* (2nd ed.). New York: Guilford Press.

Neumark-Sztainer, D. (2005). *"I'm, like, so fat!": Helping your teen make healthy choices about eating and exercise in a weight-obsessed world*. New York: Guilford Press.

www.anred.com

Anorexia Nervosa and Related Eating Disorders, Inc., sponsors this website; it provides current information about anorexia nervosa, bulimia nervosa, and binge eating, including self-help tips and information about recovery and prevention.

www.nationaleatingdisorders.org

The National Eating Disorders Association is a leading organization advocating for and supporting individuals and families affected by eating disorders. The association's website provides copious informational resources, including videos and webinars; it also facilitates care for those in need, including a confidential helpline.

37.11. For Giftedness

<https://aagc.ssri.duke.edu>

The website of the American Association for Gifted Children is devoted to understanding the needs and capabilities of these children. It provides news about current research in giftedness and resources for gifted children. The website is affiliated with Duke University.

37.12. For Learning Disabilities in General

Fisher, G., & Cummings, R. (1995). *When your child has LD (learning differences): A survival guide for parents*. Minneapolis, MN: Free Spirit.

www.advocacyinstitute.org

The Advocacy Institute describes itself as "dedicated to the development of products, projects and services that work to improve the lives of people with disabilities." The website provides information about resources, services, and special subjects (e.g., choosing a college) for individuals with disabilities, including learning disabilities.

www.disabilityrights.org

This website, developed by the Council for Disability Rights, is devoted to providing information about the rights of people with disabilities, including learning disabilities; it covers topics such as the Americans with Disabilities Act, “A Parent’s Guide to Special Education,” and taking action. The organization has closed its offices, but its website remains as a reference that provides the reader with information on topics relevant to those with disabilities.

<https://ldaamerica.org>

This website is operated by the Learning Disabilities Association of America. It provides resources for parents and information about political and advocacy issues.

www.ldonline.org

This website provides information about many types of learning disabilities, the latest research in the field, and issues related to parents and teachers.

www.nclld.org

This very comprehensive website, maintained by the National Center for Learning Disabilities, provides information about many types of learning disabilities (including dyslexia, dyscalculia, dyspraxia, dysgraphia, and processing disorders) as well as ADHD. It also includes information about advocacy and research.

www.understood.org

This website provides a wealth of information for parents regarding learning and attention difficulties; it seeks to empower parents to understand their children’s issues, relate to their experiences, and make effective choices that promote their children’s development.

37.13. For Intellectual Disability

Cunningham, C. (1996). *Understanding Down syndrome: An introduction for parents*. Cambridge, MA: Brookline Books.

Harris, J. C. (2010). *Intellectual disability: A guide for families and professionals*. New York: Oxford University Press.

www.aaid.org

The American Association on Intellectual and Developmental Disabilities is an organization devoted to promoting research, policies, and practices for individuals with intellectual disabilities. Its website provides links to current policy research, news, and resources.

www.thearc.org

This website, operated by The Arc of the United States, is for people interested in developmental disabilities. It provides information about developmental disabilities, ways to get involved with the organization, and resources.

37.14. For NLD

Stewart, K. (2007). *Helping a child with nonverbal learning disorder or Asperger’s disorder: A parent’s guide* (2nd ed.). Oakland, CA: New Harbinger.

www.nlda.org

This website is operated by the Nonverbal Learning Disorders Association and includes information about NLD, including diagnostic criteria and interventions.

37.15. For Writing Disabilities/Dysgraphia

Cicci, R. (1995). *What's wrong with me?: Learning disabilities at home and at school*. Toronto: York Press.
Richards, R. G. (1998). *The writing dilemma: Understanding dysgraphia*. Riverside, CA: RET Center Press.

www.lwtears.com

This is the website of Learning Without Tears, which includes a section on Handwriting Without Tears: A Complete Handwriting Curriculum for All Children. The website section provides information about the curriculum and allows parents and clinicians to order the curriculum directly.

38

Medications

38.1. Common Medications by Generic and Trade Names

This section lists some of the more common drugs used to treat psychiatric conditions in childhood and adolescence. It is not meant to be an exhaustive list. Also, do not assume that the uses listed are the only ones for these drugs.

Use this list to find both the generic and trade (or brand) names for a drug when you have only one name or the other, and to learn the drug's major uses. The first column lists both generic and trade names in alphabetical order. The second column gives the trade name for each generic name, and the generic name for each trade name, listed in the first column. Uncapitalized words are generic names; capitalized words are trade or brand names. (For example, amitriptyline is the generic name for the trade name Elavil. It is used as an antidepressant and is one of the tricyclics.) The third column lists the drugs' major uses.

<i>Medications by generic and trade names</i>		<i>Major uses</i>
Abilify	aripiprazole	Antipsychotic
Adderall	amphetamine & dextroamphetamine	Stimulant
alprazolam	Xanax	Anxiolytic
Ambien	zolpidem	Miscellaneous hypnoanxiolytic
amitriptyline	Elavil	Tricyclic antidepressant
amphetamine & dextroamphetamine	Adderall	Stimulant
Anafranil	clomipramine	Tricyclic antidepressant
aripiprazole	Abilify	Antipsychotic
asenapine	Saphris	Antipsychotic
Atarax	hydroxyzine	Antihistamine, anxiolytic
Ativan	lorazepam	Anxiolytic
atomoxetine	Strattera	Nonstimulant ADHD medication
Benadryl	diphenhydramine	Antihistamine, anxiolytic
bupropion	Wellbutrin	Atypical antidepressant
Buspar	bupirone	Hypnoanxiolytic
bupirone	Buspar	Hypnoanxiolytic
Carbamazepine	Tegretol	Mood stabilizer
Catapres	clonidine	Antihypertensive anxiolytic
Celexa	citalopram	Selective serotonin reuptake inhibitor (SSRI) antidepressant
Chlordiazepoxide	Librium	Anxiolytic
Chlorpromazine	Thorazine	Antipsychotic

<i>Medications by generic and trade names</i>		<i>Major uses</i>
citalopram	Celexa	SSRI antidepressant
Clomipramine	Anafranil	Tricyclic antidepressant
Clonazepam	Klonopin	Hypnoanxiolytic
Clonidine	Catapres, Kapvay	Antihypertensive, anxiolytic (used in treating ADHD)
Clozapine	Clozaril	Antipsychotic
Clozaril	clozapine	Antipsychotic
Concerta	methylphenidate	Stimulant
Cymbalta	duloxetine	Serotonin–norepinephrine reuptake inhibitor (SNRI) antidepressant
Daytrana	methylphenidate	Stimulant
Depakene	valproic acid	Mood stabilizer
Depakote	divalproex	Mood stabilizer
desipramine	Norpramin	Tricyclic antidepressant
Desoxyn	methamphetamine	Stimulant
desvenlafaxine	Pristiq	SNRI antidepressant
Desyrel	trazodone	Atypical antidepressant
Dexedrine	dextroamphetamine	Stimulant
dexmethylphenidate	Focalin	Stimulant
dextroamphetamine	Dexedrine, Dextrostat, ProCentra	Stimulant
Dextrostat	dextroamphetamine	Stimulant
diazepam	Valium	Hypnoanxiolytic
diphenhydramine	Benadryl	Antihistamine, anxiolytic
divalproex	Depakote	Mood stabilizer
duloxetine	Cymbalta	SNRI antidepressant
Effexor	venlafaxine	Atypical antidepressant
Elavil	amitriptyline	Tricyclic antidepressant
escitalopram	Lexapro	SSRI antidepressant
Eskalith	lithium	Mood stabilizer
Fanapt	iloperidone	Antipsychotic
fluoxetine	Prozac	SSRI antidepressant
fluphenazine	Prolixin	Antipsychotic
fluvoxamine	Luvox	SSRI antidepressant
Focalin	dexmethylphenidate	Stimulant
gabapentin	Neurontin	Mood stabilizer
Gabitril	tiagabine	Mood stabilizer
Geodon	ziprasidone	Antipsychotic
guanfacine	Tenex, Intuniv	Antihypertensive (used in treating ADHD)
Halcion	triazolam	Hypnoanxiolytic
Haldol	haloperidol	Antipsychotic
haloperidol	Haldol	Antipsychotic
hydroxyzine	Atarax, Vistaril	Anxiolytic
iloperidone	Fanapt	Antipsychotic
imipramine	Tofranil	Tricyclic antidepressant
Inderal	propranolol	Antihypertensive (used in treating ADHD and tics as well as sleep problems)
Intuniv	guanfacine	Antihypertensive (used in treating ADHD)
Invega	paliperidone	Antipsychotic
Kapvay	clonidine	Antihypertensive, anxiolytic (used in treating ADHD)
Klonopin	clonazepam	Hypnoanxiolytic
Lamictal	lamotrigine	Mood stabilizer
lamotrigine	Lamictal	Mood stabilizer
Latuda	lurasidone	Antipsychotic

<i>Medications by generic and trade names</i>		<i>Major uses</i>
Librium	chlordiazepoxide	Anxiolytic
Lexapro	escitalopram	SSRI antidepressant
lisdexamfetamine	Vyvanse	Stimulant
lithium	Eskalith, Lithonate	Mood stabilizer
Lithonate	lithium	Mood stabilizer
lorazepam	Ativan	Anxiolytic
Ludiomil	Maprotiline	Tricyclic antidepressant
lurasidone	Latuda	Antipsychotic
Luvox	fluvoxamine	SSRI antidepressant
maprotiline	Ludiomil	Tricyclic antidepressant
Mellaril	thioridazine	Antipsychotic
Metadate	methylphenidate	Stimulant
methamphetamine	Desoxyn	Stimulant
methylphenidate	Metadate, Concerta, Ritalin, Daytrana	Stimulant
mirtazapine	Remeron	Atypical antidepressant
Moban	molindone	Antipsychotic
molindone	Moban	Antipsychotic
Nardil	phenelzine	Monoamine oxidase inhibitor (MAOI) antidepressant
Navane	thiothixene	Antipsychotic
nefazodone	Serzone	Atypical antidepressant
Neurontin	gabapentin	Mood stabilizer
Norpramin	desipramine	Tricyclic antidepressant
nortriptyline	Pamelor	Tricyclic antidepressant
olanzapine	Zyprexa	Antipsychotic
oxcarbazepine	Trileptal	Mood stabilizer
paliperidone	Invega	Antipsychotic
Pamelor	nortriptyline	Tricyclic antidepressant
Parnate	tranylcypromine	MAOI antidepressant
paroxetine	Paxil	SSRI antidepressant
Paxil	paroxetine	SSRI antidepressant
perphenazine	Trilafon	Antipsychotic
phenelzine	Nardil	MAOI antidepressant
Pristiq	desvenlafaxine	SNRI antidepressant
ProCentra	dextroamphetamine	Stimulant
Prolixin	fluphenazine	Antipsychotic
propranolol	Inderal	Antihypertensive
Prozac	fluoxetine	SSRI antidepressant
quetiapine	Seroquel	Antipsychotic
Remeron	mirtazapine	Atypical antidepressant
Risperdal	risperidone	Antipsychotic
risperidone	Risperdal	Antipsychotic
Ritalin	methylphenidate	Stimulant
Saphris	asenapine	Antipsychotic
Seroquel	quetiapine	Antipsychotic
sertraline	Zoloft	SSRI antidepressant
Serzone	nefazodone	Atypical antidepressant
Strattera	atomoxetine	Nonstimulant ADHD medication
Stelazine	trifluoperazine	Antipsychotic
Tegretol	carbamazepine	Mood stabilizer
Tenex	guanfacine	Antihypertensive
thioridazine	Mellaril	Antipsychotic
thiothixene	Navane	Antipsychotic
Thorazine	chlorpromazine	Antipsychotic

<i>Medications by generic and trade names</i>		<i>Major uses</i>
tiagabine	Gabitril	Mood stabilizer
Tofranil	imipramine	Tricyclic antidepressant
Topamax	topiramate	Mood stabilizer
topiramate	Topamax	Mood stabilizer
tranylcypromine	Parnate	MAOI antidepressant
trazodone	Desyrel	Atypical antidepressant
triazolam	Halcion	Hypnoanxiolytic
trifluoperazine	Stelazine	Antipsychotic
Trilafon	perphenazine	Antipsychotic
Trileptal	oxcarbazepine	Mood stabilizer
Valium	diazepam	Hypnoanxiolytic
valproic acid	Depakene	Mood stabilizer
venlafaxine	Effexor	Atypical antidepressant
Vistaril	hydroxyzine	Anxiolytic
Vyvanse	lisdexamfetamine	Stimulant
Wellbutrin	bupropion	Atypical antidepressant
Xanax	alprazolam	Anxiolytic
ziprasidone	Geodon	Antipsychotic
Zoloft	sertraline	SSRI antidepressant
zolpidem	Ambien	Miscellaneous hypnoanxiolytic
Zyprexa	olanzapine	Antipsychotic

38.2. Finding Names of Street Drugs

The names of street drugs change frequently and are often local. A list is available online (www.drugabuse.gov/drugs-abuse/commonly-abused-drugs-charts).

38.3. Medication Abbreviations *See also Section 39.9.*

This section lists some abbreviations used in association with medication formulations or prescriptions.

a.c.	Before meals	p.m.	Afternoon, evening
alt. h.	Alternate hours	p.r.n.	As needed, according to necessity
a.m.	In the morning; before noon	q.	Each, every
b.i.d.	Twice a day	q.h.	Every hour
CR	Controlled release	q.i.d., q.d.s.	Four times a day
ER	Extended release	q.1.h.	Every 1 hour
LA	Long-acting	q.12.h.	Every 12 hours
noct.	Night	q.s.	As much as needed, sufficient quantity
o.m.	Every morning	s.i.d.	Once daily
o.n.	Every night	SR	Sustained release
p.c.	After meals	XR	Extended release
p.o.	By mouth		

39

Abbreviations in Common Use

39.1. Assessments and Tests

ABAS-3	Adaptive Behavior Assessment System, Third Edition
ACTeRS	ADD-H Comprehensive Teacher's Rating Scale, Second Edition
ASEBA	Achenbach System of Empirically Based Assessment (includes CBCL, TRF, YSR)
BASC-3	Behavior Assessment System for Children, Third Edition
BBCS:E	Bracken Basic Concept Scale: Expressive
BBCS-3:R	Bracken Basic Concept Scale—Third Edition
BDI-2 NU	Battelle Developmental Inventory, Second Edition Normative Update
BDI-II	Beck Depression Inventory—II
Beery VMI	Beery–Buktenica Developmental Test of Visual–Motor Integration, Sixth Edition
BNT-2	Boston Naming Test—Second Edition
BOT-2	Bruininks–Oseretsky Test of Motor Proficiency, Second Edition
BRIEF2	Behavior Rating Inventory of Executive Functions, Second Edition
Bayley-III	Bayley Scales of Infant and Toddler Development, Third Edition
BVRT-5	Benton Visual Retention Test, Fifth Edition
CARS2	Childhood Autism Rating Scale, Second Edition
CAT	Children's Apperception Test
CAVLT-2	Children's Auditory Verbal Learning Test-2
CBCL	Child Behavior Checklist (part of ASEBA)
CDI 2	Children's Depression Inventory 2
CELF-5	Clinical Evaluation of Language Fundamentals—Fifth Edition
CMS	Children's Memory Scale
Conners CPT 3	Conners Continuous Performance Test 3rd Edition
Conners 3	Conners 3rd Edition
COWAT	Controlled Oral Word Association Test
CTONI-2	Comprehensive Test of Nonverbal Intelligence—Second Edition
CVLT-C	California Verbal Learning Test—Children's Version
CVLT-3	California Verbal Learning Test, Third Edition
DAS-II	Differential Ability Scales—Second Edition
DSMD	Devereux Scales of Mental Disorders
DSS-ROCF	Developmental Scoring System for the ROCF
DTLA-5	Detroit Tests of Learning Aptitude—Fifth Edition

EOWPVT-4	Expressive One-Word Picture Vocabulary Test, Fourth Edition
EVT-3	Expressive Vocabulary Test, Third Edition
GARS-3	Gilliam Autism Rating Scale, Third Edition
GORT-5	Gray Oral Reading Tests—Fifth Edition
ITPA-3	Illinois Test of Psycholinguistic Abilities—Third Edition
KABC-II	Kaufman Assessment Battery for Children, Second Edition
KAIT	Kaufman Adolescent and Adult Intelligence Test
LAC-3	Lindamood Auditory Conceptualization Test, Third Edition
LNNB-C	Luria-Nebraska Neuropsychological Battery—Children's Revision
LNNB-II	Luria-Nebraska Neuropsychological Battery—II
MAPI	Millon Adolescent Personality Inventory
MMPI-A-RF	Minnesota Multiphasic Personality Inventory—Adolescent—Restructured Form
MSE	Mental status exam
OWLS-II	Oral and Written Language Scales, Second Edition
PPVT-5	Peabody Picture Vocabulary Test—Fifth Edition
P-TPT	Portable Tactual Performance Test
RAVLT	Rey Auditory Verbal Learning Test
RCMAS-2	Revised Children's Manifest Anxiety Scale, Second Edition
ROCF	Rey-Osterrieth Complex Figure Test
SB5	Stanford-Binet Intelligence Scales, Fifth Edition
SDMT	Symbol Digit Modalities Test
SIB-R	Scales of Independent Behavior—Revised
STAIC	State-Trait Anxiety Inventory for Children
TACL-4	Test for Auditory Comprehension of Language—Fourth Edition
TAT	Thematic Apperception Test
TED	Tasks of Emotional Development
TELD-4	Test of Early Language Development—Fourth Edition
TEMA-3	Test of Early Mathematics Ability—Third Edition
TOAL-4	Test of Adolescent and Adult Language—Fourth Edition
TOLD-I:4	Test of Language Development—Intermediate: Fourth Edition
TOLD-P:4	Test of Language Development—Primary: Fourth Edition
TONI-4	Test of Nonverbal Intelligence—Fourth Edition
TOVA9	Test of Variables of Attention, Version 9
TOWL-4	Test of Written Language—Fourth Edition
TPT	Tactual Performance Test
TRF	Teacher's Report Form (part of ASEBA)
TTFC-2	Token Test for Children—Second Edition
Vineland-3	Vineland Adaptive Behavior Scales, Third Edition
WAIS-IV	Wechsler Adult Intelligence Scale—Fourth Edition
WASI-II	Wechsler Abbreviated Scale of Intelligence- Second Edition
WCST:CV4	Wisconsin Card Sorting Test
WIAT-III	Wechsler Individualized Achievement Test—Third Edition
WISC-V	Wechsler Intelligence Scale for Children—Fifth Edition
WJ IV	Woodcock-Johnson IV
WMS-IV	Wechsler Memory Scale—Fourth Edition
WPPSI-IV	Wechsler Preschool and Primary Scale of Intelligence—Fourth Edition
WRAML2	Wide Range Assessment of Memory and Learning, Second Edition
WRAT5	Wide Range Achievement Test, Fifth Edition
WRMT-III	Woodcock Reading Mastery Tests, Third Edition
WRMT-R/NU	Woodcock Reading Mastery Tests—Revised-Normative Update
YSR	Youth Self-Report (part of the ASEBA)

39.2. Associations

AACAP	American Academy of Child and Adolescent Psychiatry
AAIDD	American Association on Intellectual and Developmental Disabilities
AAP	American Academy of Pediatrics
ABCT	Association for Behavioral and Cognitive Therapies
APA	American Psychological Association or American Psychiatric Association
APS	American Psychological Society
ASHA	American Speech–Language–Hearing Association
CHADD	Children and Adults with Attention-Deficit/Hyperactivity Disorder
NACBT	National Association of Cognitive-Behavioral Therapists

39.3. Academic Degrees

BSW	Bachelor of Social Work
CAGS	Certificate of Advanced Graduate Study
DO	Doctor of Osteopathy
EdD	Doctor of Education
MA	Master of Arts
MD	Doctor of Medicine
MS	Master of Science
MSW	Master of Social Work
PhD	Doctor of Philosophy
PsyD	Doctor of Psychology

39.4. Professional Titles, Certifications, and Licensures

Ψi	Psychiatrist
Ψo	Psychologist
ABMP	American Board of Medical Psychotherapists
ABPP	American Board of Professional Psychologists
LMFT	Licensed Marriage and Family Therapist
NCSP	Nationally Certified School Psychologist

Social Work

Titles may differ by state.

ACSW	Academy of Certified Social Workers
CSW	Clinical or Certified Social Worker
LCSW	Licensed Certified Social Worker
LGSW	Licensed Graduate Social Worker
LICSW	Licensed Independent Clinical Social Worker
LSW	Licensed Social Worker
LSWA	Licensed Social Work Associate

Counseling

Titles may differ by state.

CCC	Certified Communication Counselor
CCMHC	Certified Clinical Mental Health Counselor
CRC	Certified Rehabilitation Counselor
LPC	Licensed Professional Counselor
NBCC	National Board Certified Counselor
NCC	National Certified Counselor
NCCC	National Certified Career Counselor
NCSC	National Certified School Counselor

Chemical Dependency Work

Titles may differ by state.

CAC	Certified Alcoholism Counselor
CAS	Certified Addictions Specialist
CCDS	Certified Chemical Dependency Supervisor
CDA	Chemical Dependency Associate
CPS	Certified Prevention Specialist
LCDC	Licensed Chemical Dependency Counselor
MAC	Master Addictions Counselor

Nursing

APRN	Advanced Practice Registered Nurse
BSN	Bachelor of Science in Nursing
CRNP	Certified, Registered Nurse Practitioner
CS	Certified Specialist (in Psychiatric Nursing)
LPN	Licensed Practical Nurse
PHN	Public Health Nurse
RN	Registered Nurse

Allied Health Professions

LPE	Licensed Psychological Examiner
OT	Occupational Therapy/Therapist
OTR	Occupational Therapist, Registered or Licensed
PA	Physician's Assistant
PT	Physical Therapy/Therapist
SLP	Speech and Language Pathologist

39.5. Diagnoses and Conditions

Due to the multitude of abbreviations, only a small sample is included in this section.

A	Anxiety
ADHD	Attention-deficit hyperactivity disorder
AOD	Alcohol and other drugs

ASD	Autism spectrum disorder
BD	Behavioral disorder
BD	Brain damage
BD, Bip	Bipolar disorder
CD	Conduct disorder
CHI	Closed head injury
CP	Cerebral palsy
CUS/CUSc	Chronic undifferentiated schizophrenia
CVA	Cerebral vascular accident
D	Depression
D + A	Drug and alcohol
D + H	Delusions and hallucinations
DM	Diabetes mellitus
EBD	Emotional or behavioral disorder
ED	Emotional disorder
EELD	Early expressive language delay
FAS	Fetal alcohol syndrome
GAD	Generalized anxiety disorder
GD	Gender dysphoria
h/a	Headache
HBP	Hypertension/high blood pressure
HI	Hearing impairment
HIV	Human immunodeficiency virus
ID/IDD	Intellectual disability/intellectual developmental disorder
LBP	Low back pain
LD	Learning disability/learning disorder
MDD	Major depressive disorder
MRELD	Mixed receptive–expressive language disorder
OCD	Obsessive–compulsive disorder
ODD	Oppositional defiant disorder
OSAS	Obstructive sleep apnea syndrome
P	Panic
Pa	Paranoia
PD	Perceptual disturbance
PKU	Phenylketonuria
PTSD	Posttraumatic stress disorder
RAD	Reactive attachment disorder
SAD	Separation anxiety disorder
SLI	Speech and language impairment
sz	Seizures
TBI	Traumatic brain injury
tt	Temper tantrum
VI	Visual impairment

39.6. Educational Services and Educational Laws

AAC	Augmentative/alternative communication
CAI	Computer-assisted instruction
CRF	Community residential facility
EI	Early intervention

ES	Emotional support
ESL	English as a second language
IAES	Interim alternative educational setting
IDEA	Individuals with Disabilities Education Act
IDEA 2004	Individuals with Disabilities Education Improvement Act of 2004
IEP	Individualized education program
IFSP	Individualized family service plan
LRE	Least restrictive environment
LS	Learning support
LSS	Life skills support
MDE	Multidisciplinary evaluation
MDT	Multidisciplinary team
NORA	Notice of recommended assignment
PS	Physical support
Section 504	Section 504 of the Rehabilitation Act of 1973
SIS	Sensory impairment support
SLS	Speech and language support

39.7. Legal Terms

CMM	Corrupting the morals of a minor
CPS	Child protective services
IA	Indecent assault
IDSI	Involuntary deviate sexual intercourse
IVDU	Intravenous drug use/user
UAD	Underage drinking/drinker

39.8. Medical Terms and Tests

CAT scan	Computerized axial tomography scan
CNS	Central nervous system
CT scan	Computerized tomography scan
EEG	Electroencephalogram
fMRI	Functional magnetic resonance imaging
MRI	Magnetic resonance imaging
PET scan	Positron emission tomography scan

39.9. Medication Regimens

b.i.d.	Twice a day	p.r.n.	Whenever needed
h.s.	At night/bedtime	q.d.	Every day
i.m.	Intramuscular	q.i.d.	Four times a day
i.v.	Intravenous	q.q.h.	Every 4 hours
o.m.	Every morning	q.s.	As much as required
p.c.	After meals	t.i.d.	Three times a day
p.o.	By mouth		

39.10. Family Relationships

B	Brother	H	Husband
BF	Boyfriend	HH	Household
BIL	Brother-in-law	Mo	Mother
d	Daughter	S	Sister
Fa	Father	s	Son
GF	Girlfriend	SIL	Sister-in-law
GP ¹	Grandparent	W	Wife

39.11. Treatment-Related Terms

AMA	Against medical advice	P/A	Psychoanalysis
d/c	Discontinue/ed	P/T	Psychotherapy
d/ch	Discharge/ed	PTA	Prior to admission
Dx	Diagnosis	Px	Prognosis
h/o	History of	Rx	Treatment or prescription
HW	Homework	Σ	Summary
Hx	History	Sx	Symptom
I	Intelligence	Th	Therapist
IV	Interview	Tx	Treatment
NOS	Not otherwise specified	WNL	Within normal limits

39.12. General Aids to Recording

\bar{a}	Before (<i>ante</i>)	RTC	Return to clinic
@	At	RTS	Return to school
AO	Anyone	\bar{s} or w/o	Without (<i>sine</i>)
c.	About (<i>circa</i>)	S+S	Signs and symptoms
\bar{c}	With (<i>cum</i>)	w/d	Withdrawal/withdrew
d or d/	Divorced	w/i or \bar{c} /in	Within
D	Died	1°	Primary
d/o	Disorder	2°	Secondary
DNKA	Did not keep appointment	× 3	Times 3
DNS	Did not show	~	Approximate
DOB	Date of birth	Δ	Change
DOD	Date of death	↓	Decreasing/-ed
EO	Everyone	↑	Increasing/-ed
f	Frequency	<	Less, lesser, smaller
FTKA	Failed to keep appointment	>	More, greater, larger
NO	No one	∅ or ⊖	Not present, absent
ntk	Intake	#	Number
\bar{p} or s/p	After, by history (<i>post</i>)	⊕	Present, positive for
Q, ?	Question	∴	Therefore
R/O	Rule out		

¹Grandparents may be further specified as follows: maternal grandmother/grandfather, MGM/MGF; paternal grandmother/grandfather, PGM/PGF.

40

Useful Forms

This chapter contains a number of blank forms that can be used for collecting or recording information. These forms may be reproduced on letterhead and used by clinicians in the course of their work with clients. (See the box at the end of the table of contents for details about downloading these forms.)

40.1. Release of Information Form

See Sections 1.1 and 1.4 for further information about use of this form. This form may be reproduced on your letterhead.

Release of Information

Child's/adolescent's name: _____ Date of birth: _____

When you complete and sign this form, it authorizes this clinic/therapist to release protected information from your and/or your child's clinical records to the person or clinic named below, or to obtain information from this person or clinic. You have the right to revoke this authorization, in writing, at any time by sending notification of this revocation to my office address.

I, _____, give permission to my therapist, _____ (and/or his/her staff), to release/obtain the following information in regard to the above-named minor's psychological treatment and/or evaluation. The particular information to be disclosed/obtained is the following (please be specific):

The information should be disclosed to/obtained from the following (please provide full addresses and telephone numbers):

I understand the statements above, and I voluntarily consent to disclosing/obtaining this information to/from the person or agency named above. I release _____ from any liability that could arise from disclosing/obtaining this information, as long as she/he discloses/obtains the information in accordance with applicable laws.

This authorization shall remain in effect until _____.

Signature of parent or guardian: _____

Signature of child/adolescent (if appropriate): _____

Date: _____

40.2. Developmental History Form

See Chapters 1 and 2 for further information on interviewing parents or guardians. This form may be reproduced on your letterhead.

Developmental History

The purpose of this form is to obtain a detailed understanding of your child's growth and development. Please answer all of the questions below, to the best of your ability. If a question does not apply to your particular situation, leave it blank.

IDENTIFYING INFORMATION

Child's name: _____ Today's date: _____

Child's date of birth: _____ Child's age: _____ Sex: Male ____ Female ____

Home address: _____

Home phone number: _____

PRESENTING PROBLEM

Why are you seeking this evaluation or treatment? _____

When did these problems begin? _____

What are your goals for this evaluation or treatment? _____

PARENTS, SIBLINGS, AND OTHERS IN HOME

Mother's name: _____ Mother's age: _____

Address: _____

Home phone: _____ Work phone: _____

Occupation: _____ (Full-time/part-time?)

Education/highest grade completed: _____

Father's name: _____ Father's age: _____

Address (if different from above): _____

Home phone: _____ Work phone: _____

Occupation: _____ (Full-time/part-time?)

Education/highest grade completed: _____

(continued)

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Developmental History (page 2 of 6)

Does your child have stepparents? No ___ Yes ___

If yes, please complete the following information:

Name(s): _____

Relationship(s) to child: _____

Address(es)/phone(s): _____

Is the child adopted or being raised by persons other than his/her biological parents? No ___ Yes ___

If yes, explain: _____

Name of sibling	Age	Gender	Lives at home?	Nature of relationship with child?
-----------------	-----	--------	----------------	------------------------------------

1. _____	___	___	_____	_____
----------	-----	-----	-------	-------

2. _____	___	___	_____	_____
----------	-----	-----	-------	-------

3. _____	___	___	_____	_____
----------	-----	-----	-------	-------

Please list any others living in the household:

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

FAMILY CIRCUMSTANCES

Who cares for the child when parents or caregivers are at work or gone? _____

With whom does the child currently live? _____

Are the parents divorced or separated? No ___ Yes ___

If yes, who has custody? _____

How often does the noncustodial parent see the child? _____

Family's religious affiliation (optional): _____

How frequently does this child see her/his grandparents? _____

Has the family recently experienced any unusual or stressful events? No ___ Yes ___

If yes, explain: _____

PREGNANCY

Did the mother receive prenatal medical care? No ___ Yes ___

If yes, what kind? _____

Length of pregnancy: _____

Did the mother experience any emotional or medical difficulties during the pregnancy? No ___ Yes ___

If yes, explain: _____

Length of labor: ___ hours Apgar scores: _____

Birth weight: ___ lbs. ___ oz. Length: ___ inches

(continued)

DEVELOPMENT

Was this child breast-fed or bottle-fed? _____ Age weaned: _____

Did the child experience any of the following problems during infancy or toddlerhood? If yes, please explain.

- Colic No ___ Yes ___
- Excessive crying No ___ Yes ___
- Delayed language development No ___ Yes ___
- Unclear speech No ___ Yes ___
- Eating problems No ___ Yes ___
- Delayed fine motor skills No ___ Yes ___
- Delayed gross motor skills No ___ Yes ___

At what approximate age did your child begin exhibiting the following behaviors?

Crawled: _____ Sat alone: _____

Walked independently: _____ Spoke first words: _____

Spoke in sentences: _____ Was toilet trained: _____

For an adolescent, please indicate the following:

Age at onset of puberty: _____ Age at first menstruation (for a girl): _____

Which hand does your child use for writing? _____ Eating? _____

Throwing? _____ Other? _____

Has your child been the victim of abuse? No ___ Yes ___

If yes, please explain: _____

MEDICAL AND PSYCHIATRIC HISTORY

Name of child's primary care physician: _____

Address: _____

Phone: _____

Date of most recent physical exam: _____ Results: _____

Date of most recent dental exam: _____ Results: _____

Date of most recent vision exam: _____ Results: _____

Date of most recent hearing exam: _____ Results: _____

Has the child experienced any of the following medical problems? If yes, please explain.

- Frequent colds No ___ Yes ___
- Frequent ear infections No ___ Yes ___
- Asthma No ___ Yes ___
- Gastrointestinal problems No ___ Yes ___
- Muscle pain No ___ Yes ___
- Skin problems No ___ Yes ___
- Repetitive behaviors (head banging, rocking, etc.) No ___ Yes ___
- Allergies No ___ Yes ___

(continued)

Developmental History (page 4 of 6)

Vision problems No ___ Yes ___
Does your child wear glasses? No ___ Yes ___
Hearing problems No ___ Yes ___
Cerebral palsy No ___ Yes ___
Lead poisoning No ___ Yes ___
Seizures No ___ Yes ___
Congenital problems No ___ Yes ___

Please list any other health concerns: _____

Medication

Is your child currently taking any kind of medication? No ___ Yes ___

If yes, indicate name, dose, and reason for medication: _____

Is your child experiencing any side effects from the medication(s)? _____

Alcohol or Drug Use

Does your child use alcohol or drugs? No ___ Yes ___

If yes, explain: _____

Previous Evaluations

Has your child ever had any of the following evaluations? If yes, please indicate name of examiner, date of examination, and reason for exam.

Psychological or psychiatric evaluation: No ___ Yes ___

If yes, name of evaluator: _____ Date of evaluation: _____

Reason for evaluation: _____

Neuropsychological evaluation: No ___ Yes ___

If yes, name of evaluator: _____ Date of evaluation: _____

Reason for evaluation: _____

Neurological evaluation: No ___ Yes ___

If yes, name of evaluator: _____ Date of evaluation: _____

Reason for evaluation: _____

Treatment History

Has your child ever received counseling or psychiatric treatment? No ___ Yes ___

If yes, indicate dates, name of treating professional, reason for treatment, and effectiveness of treatment: _____

Family's Health

Mother's present health: _____

Father's present health: _____

Has anyone in your family experienced a mental, psychological, or academic problem, such as intellectual disability, learning disabilities, schizophrenia, depression, epilepsy, or a bipolar disorder? No ___ Yes ___

If yes, explain: _____

(continued)

SOCIAL HISTORY

How does your child relate to other children? _____

Does your child prefer to play with younger or older children? No ___ Yes ___

If yes, indicate which (younger or older) and explain: _____

Does your child have a best friend? No ___ Yes ___

How many friends does your child have? _____

RECREATIONAL INTERESTS

Does your child participate in sports or recreational activities outside of school? No ___ Yes ___

If yes, describe: _____

What does your child like to do in his/her free time? _____

Have the child's interests in these activities changed recently? No ___ Yes ___

If yes, please explain: _____

What are your family's favorite activities? _____

BEHAVIORAL SYMPTOMS

Does your child have difficulty with any of the following problems? If yes, please explain.

Has trouble meeting new people; is shy or withdrawn No ___ Yes ___

Is overly anxious No ___ Yes ___

Seems sad or depressed No ___ Yes ___

Has thought of suicide No ___ Yes ___

Refuses to comply with adults' requests or violates parental rules No ___ Yes ___

Has conduct problems No ___ Yes ___

Is physically cruel to other people or animals No ___ Yes ___

Is inattentive No ___ Yes ___

Problems concentrating No ___ Yes ___

Is restless No ___ Yes ___

Makes careless mistakes No ___ Yes ___

Has trouble playing quietly No ___ Yes ___

Has frequent mood shifts No ___ Yes ___

Frustrates easily No ___ Yes ___

Has difficulty managing anger No ___ Yes ___

Has eating problems No ___ Yes ___

Has fears/phobias No ___ Yes ___

Has hallucinations No ___ Yes ___

Has experienced trauma No ___ Yes ___

Has your child ever experienced difficulty with the law? No ___ Yes ___

If yes, explain: _____

(continued)

EDUCATIONAL STATUS AND HISTORY

Current Status

Name of current school: _____ Grade: _____

Type of school: Private _____ Public _____ Home-schooled _____ Other _____

Teacher(s): _____

School address: _____

School phone number: _____

Does your child currently receive any special education services? No _____ Yes _____

If yes, please specify: _____

What grades does the child currently receive? _____

Is this a change from previous years? No _____ Yes _____

If yes, explain: _____

School History

Preschool: At what age? _____ For how many days/hours? _____

Any problems? No _____ Yes _____ If yes, describe: _____

Did the child have difficulty or receive any special education services in any of the following grades? If so, please explain.

Kindergarten No _____ Yes _____

Grades 1–3 No _____ Yes _____

Grades 4–6 No _____ Yes _____

Grades 7–8 No _____ Yes _____

High school No _____ Yes _____

Does your child dislike going to school? No _____ Yes _____

If yes, why? _____

What are your child's favorite subjects? _____

What are your child's least favorite subjects? _____

What is your child's approach to her/his schoolwork (disorganized/organized, irresponsible/responsible, etc.)? _____

WORK HISTORY

Does your child have a job, or is your child involved in a vocational program? No _____ Yes _____

If yes, who is the child's current employer? _____

Child's position: _____ Hours worked per week: _____

40.3. Teacher Questionnaire Form

See Chapter 4 for guidelines on interviewing teachers and obtaining information from them. This form may be reproduced on your letterhead.

Teacher Questionnaire

The purpose of this questionnaire is to obtain a more comprehensive understanding of the academic and social functioning of the child named below. Please answer these questions to the best of your ability. Please return this questionnaire, when completed, to _____.

Teacher's name: _____ Date: _____

Child's name: _____ Grade: _____

School: _____ School phone: _____

School address: _____

What do you see as this child's major problem? _____

How long has this been a problem? _____

How serious do you perceive this child's problems to be? _____

What changes would you like to see happen as a result of this treatment/evaluation? _____

Does this child have any learning disabilities that you are aware of? No ____ Yes ____

If yes, what are they? _____

Does this child receive special tutoring or support? No ____ Yes ____

If yes, please describe: _____

(continued)

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Teacher Questionnaire (page 2 of 2)

Is this child on a Section 504 plan or an IEP? No ___ Yes ___

Has this child ever had special testing in school? No ___ Yes ___

If yes, please explain: _____

Does this child attend school regularly? No ___ Yes ___

Does this child appear motivated for school? _____

Has this child ever had disciplinary action taken against him/her, such as being suspended or expelled? No ___ Yes ___

If yes, explain: _____

What was this child's highest grade on the last report card? _____

What was this child's lowest grade? _____

What do you see as this child's strongest and weakest areas of learning? _____

Does this child participate in extracurricular activities? No ___ Yes ___

If yes, describe: _____

In school, how many friends does this child have? Many ___ A few ___ None ___

Do you have any concerns about this child's social relationships? No ___ Yes ___

If yes, describe: _____

Please list anything else about this child that would be helpful: _____

40.4. Child Assessment Form for Professionals

Guidelines for obtaining information from other professionals can be found in Chapter 4. This form may be reproduced on your letterhead or in a letter format.

Child Assessment Form

Child's name: _____

Child's address: _____

The above-named child has been referred to me for assessment/treatment (*indicate which*). Please fill out this form to the best of your knowledge and ability. If you would like to contact me for further information, my address and phone number are as follows:

My address: _____

My phone: _____

In what capacity do you know this child? _____

For how long have you known this child? _____

Who initiated the referral for this child? _____

What are the referral questions? _____

What do you see as the child's main difficulty? _____

What type of evaluation/treatment do you think is necessary? _____

Does this child carry any current or past DSM-5 diagnoses? No ____ Yes ____

If yes, specify:

Are there any medical or neurological explanations for this child's current behaviors or symptoms? _____

Please list anything else about the child that would be helpful to know: _____

Please describe any pertinent test results (e.g., psychiatric, psychological, medical, or neurological evaluations):

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40.5. Sentence Completion Test

See Section 27.8 for further information on sentence completion tests. This form may be reproduced on your letterhead.

Sentence Completion Test

1. When I see myself in the mirror, I _____.
2. When I'm by myself, _____.
3. The best things about boys is _____.
4. The best thing about me is _____.
5. When my schoolwork is poor, _____.
6. I can't _____.
7. The best thing about school _____.
8. My mother _____.
9. My friends think I _____.
10. When I think about the future, _____.
11. The best thing about my body _____.
12. Most dads _____.
13. No one knows _____.
14. The best thing about girls is _____.
15. The worst thing about school _____.
16. My life would be better if only _____.
17. My father _____.
18. The worst thing about my body _____.
19. Most moms _____.
20. I think most boys are _____.
21. I think most girls are _____.
22. If I had only one wish, _____.
23. When I'm with my family, _____.
24. If only my mom and dad would _____.
25. When I see others do better than I'm doing, _____.
26. Someday I'd like to be _____.
27. I feel guilty when _____.
28. I wish I could forget about _____.
29. Other kids think I'm _____.
30. My family _____.
31. I learn best _____.
32. School is _____.
33. My teachers are _____.
34. My work has been _____.
35. It makes me sad when _____.
36. I am happiest when _____.
37. When I'm with other people, _____.
38. Adults are _____.
39. I feel nervous when _____.
40. I feel happy when _____.

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40.6. Form for Educational Assessment of Student's Current Classroom Functioning

See Section 35.10 for an example of a completed classroom observation report. See also Chapter 33, "Writing for the Schools." This form may be reproduced on your letterhead.

Educational Assessment of Student's Current Classroom Functioning

Student's name: _____ Date of evaluation: _____

School: _____

Person completing form: _____

DESCRIPTION OF STUDENT'S CLASSROOM PERFORMANCE AND BEHAVIOR

1. Positive personal qualities:

This student is capable of _____.

She/he can demonstrate very good _____.

He/she has shown him-/herself to be _____.

2. Student's self-confidence:

This student's academic self-confidence is _____,

which affects her/his ability to _____.

Socially, he/she appears _____,

while athletic confidence appears _____.

3. Class participation:

This student makes his/her presence known in few/many/all activities.

The nature of his/her participation is frequently _____.

4. Activity levels and patterns:

This student has an extremely high/low activity level and is able/unable to sit and listen for extended periods of time.

Verbal activity is _____.

When seated at his/her desk, the student frequently _____.

In less structured settings, her/his activity would be described as _____.

5. Attention to task:

This student's ability to focus tends to be _____.

His/her attention seems to be best in _____ circumstances.

Problems with attention are often seen in _____.

6. Conditions under which performance improves:

This student performs better at _____ times

and in _____ settings.

She/he shows her/his best performance in _____ subjects.

(continued)

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DESCRIPTION OF STUDENT'S BASIC SKILLS

1. Gross and fine motor coordination (body movements, balance, fine drawing, writing, etc.):

This student has very coordinated/poorly coordinated gross motor skills.

She/he is/is not a good athlete.

His/her graphomotor output is _____.

In the art center, she/he demonstrated the ability to _____.

She/he is right/left handed and uses a _____ pencil grip.

2. Learning abilities observed:

My observations would suggest that this student is most comfortable when material is presented verbally/visually didactically/through discussion/in small groups/multisensorially.

When presented with material that has multiple steps, he/she loses focus/cannot process information/relates to the material in a disorganized fashion/is unable to handle _____.

She/he appears to struggle most on _____ types of tasks.

3. Reading skills: Generally at/above/below grade level.

- a. Mechanics:

This student is able/unable to decode, while fluency is _____.

His/her reading is not/is somewhat/is quite effortful.

- b. Comprehension:

In the context of a book discussion, this student shows _____ ability to demonstrate understanding and appreciation of what she/he has read.

When asked to write about what he/she has read, he/she demonstrates grade-appropriate/below-grade-level abilities.

- c. Conceptual skills:

Although this student enjoys reading/being read to, she/he has/has not demonstrated an ability to deal with larger conceptual issues about what she/he has read/heard.

4. Language skills:

- a. Expressive language:

Within the classroom, this student uses his/her verbal ability to _____.

Her/his language skills are/are not at a level expected for a child her/his age, because _____.

- b. Written language skills:

This student's writing tends to be _____.

His/her sentence structure is _____,

and his/her understanding of the writing process is _____.

Writing is/is not a struggle for her/him because _____.

- c. Ability to follow simple and complex directions:

Verbal directions do/do not present a problem for this student.

When dealing with written directions, he/she typically reacts with _____.

(continued)

5. Math skills:

a. Computational skills:

This student's skills in math computation could be described as _____.

Basic facts (multiplication, addition, etc.) are automatic/not automatic.

In multistep problems, she/he demonstrates _____.

b. Problem-solving skills:

This student's math problem-solving skills would be described as _____,

because of _____.

6. Other academic areas (science, social studies, etc.): *(Describe.)* _____

7. Socialization skills:

a. Group:

In group situations, this student's typical behavior would be described as _____.

b. Peers:

This student has many/few/some friends.

His/her play would be described as _____.

c. Adults:

With adults, the student has a tendency to _____.

Her/his behavior with adults in 1:1 settings is typically _____.

In the presence of peers, his/her behavior with adults is often _____.

SUMMARY OF CURRENT FUNCTIONING

In summary, this student's strengths are in the areas of _____

Her/his weaknesses appear to be _____

When both strengths and weaknesses are taken into account, his/her greatest needs in the classroom are _____

40.7. Behavior Management Plan Form

See Section 33.5 for information about preparing behavior management plans. This form may be reproduced on your letterhead.

Behavior Management Plan

Behaviors of concern:

1. _____.
2. _____.
3. _____.
4. _____.
5. _____.

Baseline measurements:

1. _____.
2. _____.
3. _____.
4. _____.
5. _____.

Strengths, interests, and preferences:

1. _____.
2. _____.
3. _____.
4. _____.
5. _____.

Optimal environmental conditions:

1. _____.
2. _____.
3. _____.
4. _____.
5. _____.

(continued)

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Situations that cause unusual stress or that exacerbate negative behaviors:

1. _____.
2. _____.
3. _____.
4. _____.
5. _____.

Proactive teaching and environmental strategies likely to decrease inappropriate behaviors:

1. _____.
2. _____.
3. _____.
4. _____.
5. _____.

Responsive techniques likely to decrease inappropriate behaviors:

1. _____.
2. _____.
3. _____.
4. _____.
5. _____.

Measurements used to evaluate interventions:

1. _____.
2. _____.
3. _____.
4. _____.
5. _____.

40.8. Form for Psychotherapy Progress Notes

See Section 35.6 for information about progress notes and a sample progress summary. This form may be reproduced on your letterhead.

Psychotherapy Progress Notes

Client's name: _____ Date of birth: _____

Date of visit: _____ Type of visit: _____ Person present: _____

Content (list reviewed problems, symptom status, changes/interventions):

Mental status and risk factors:

Clinical impressions:

Diagnosis:

Treatment plan (list targeted problem/goal/intervention, homework assignment, date of next visit, collaboration, etc.):

Therapist's signature

Date

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