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 (e.g., 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 parents 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 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).
- Schedule for Affective Disorders and Schizophrenia for School-Age Children—Present and Lifetime Version (K-SADS-PL; Kaufman, Birmaher, Brent, Rao, & Ryan, 1996).
- Child Assessment Schedule (CAS; Hodges, 1993).
- Schedule for Affective Disorders and Schizophrenia for School-Age Children—Epidemiological Version 5 (K-SADS-E5; Orvaschel, 1995).
- Child and Adolescent Psychiatric Assessment (CAPA): Version 4.2—Child Version (Angold, Cox, Rutter, & Simonoff, 1996).

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 con-

tent 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 (e.g., 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, etc.) 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 (e.g., 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* (Zuckerman, 2003) 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)? What types of accommodations have 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 his/her 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? 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?"

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 (e.g., 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.

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

Routines

"Do you have any particular routines (such as 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, etc.)?"
"How long has the child attended this school?"
"What grade is the child in?"
"What type of classroom setting is this (e.g., 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 see 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 (e.g., 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 heart beat 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 when the referral question relates to ADHD. These are the most common:

ADHD Rating Scale–IV (DuPaul, Power, Anastopoulos, & Reed, 1998)
Behavior Assessment System for Children, Second Edition (BASC-2; Reynolds & Kamphaus, 2004)
Behavior Rating Inventory of Executive Functions (BRIEF; Gioia, Isquith, Guy, & Kenworthy, 2000)
Conner's Rating Scales–Revised (CRS-R; Conners, 1997)

"How well does your child pay attention to tasks? Is the child easily distracted? Does he/she frequently daydream? How well is he/she 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?"

"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 he/she 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 thought to 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 her/him 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 he/she 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 agree with each other? Does the child's other parent agree with you about these problems?"

2.4. 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 doctor play abnormal for his/her age? Show inappropriate interest in sexual manners? Expose him-/herself 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?"

2.5. 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 his/her 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'?"

2.6. 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?"
"Have you noticed any problems with the 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 her/him?"
"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.

2.7. Developmental Disorders, Pervasive

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 he/she 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 his/her 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?"

2.8. Disruptive Behavior Disorders

See Section 16.3 for descriptors.

"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 he/she 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? Sexual activity? Gang membership? Frequently getting into fights?"
"How would you describe your child's mood generally? Is she/he 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 (eating disorders) and Section 16.5 (intake disorders).

"Has your child had any eating difficulties? Is he/she a finicky eater? Does he/she 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 his/her 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, bedwetting, 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 his/her difficulties?"

2.11. 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?"

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 he/she 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 Anders (2001) 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 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 prior to the onset of verbal language" (Morrison & Anders, 2001, pp. 43–44). 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 the clinician with historical information (*see Chapters 1 and 2*). However, the clinician 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 to 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, taking blood, etc.). 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 (e.g., 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/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 (i.e., with math, reading, etc.)?"

✓ 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 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?"

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?"

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, like art class 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, cards, etc.)"
"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 grafitti? 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?"

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 football 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.

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 Anders (2001) 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 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 so we can continue our discussion."
"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/(etc.), 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

A. Introducing the Report

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 1/1/07.

Then, under "Other Sources of Information," state:

Teacher was interviewed on 2/2/07.

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.

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.
Taguan 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 2nd-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 Bosnia-Herzegovina, 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 minorities. 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, 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 mother/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 plan (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 . . .
Mrs. 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 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 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 description 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.
Neuropsychological.
Mental status evaluation.
Psychological.
Psychological testing report.

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

Common Referral Sources

Neurologist/pediatric neurologist.
Occupational therapist.
Nurse/clinical nurse specialist/pediatric nurse practitioner.
Parent/mother/father/guardian.
Pediatrician.
Psychologist/psychiatrist/psychotherapist.
School counselor/school psychologist.
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 for presence of learning disorder.
Assess readiness for kindergarten/first grade/etc.
Assess social skills.
Assess treatment progress.
Assess current psychological functioning and eligibility for permanent placement versus independent living.
Better understand the origin of the child's difficulties.
Better understand the child's learning strengths and weaknesses.
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 there is a specific cause for the child's difficulties.
Determine whether behavior problems are due to a psychiatric disorder (if a specific disorder is suspected, name it).
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.
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.
Alcohol/drug abuse: drinking/underage drinking, drug use, drug selling, smoking.
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 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

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

✓ When any cognitive concerns are present, assess for/rule out mental retardation.

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.
Inadequate emotional reactions.
Immature emotional self-regulation, seems less emotionally mature than peers.
Imaginary playmates/fantasy.
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.
Refuses to do schoolwork.
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.
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.
Hypotonia/hypertonia.
Hearing problems.
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.
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 multipeer 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/Asperger's disorder/nonverbal learning disability; determine whether child demonstrates characteristics consistent with those found in people with autism/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 understanding spoken language.
Problems comprehending and retaining information.
Word retrieval problems.

B. Background and History

9

History of Current Symptoms

The "Background Information" section of a report generally includes information provided by parents, 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 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.

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 Anders (2001) 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.
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 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) **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.
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.

Vital sign	*0*	*1*	*2*
Appearance	Blue, pale	Body pink, extremities blue	Completely pink
Pulse	Absent	Slow (below 100)	Over 100
Grimace	No response	Grimace	Vigorous cry
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 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 Korea, 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's 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.

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 (1995) provides 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.
Eczema/other skin problems.
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's 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** _____ (name of disorder/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) **symptoms from** _____ **to** _____ (dates).
No significant mental health problems were reported, except for _____ **at age** _____.

11

Developmental and Family History

This chapter covers pertinent aspects of a child's developmental and family history, as well as providing listings of age-appropriate developmental milestones in various areas.

11.1. General Statements

Developmental milestones were all generally considered to be within normal limits.
Developmental milestones were acquired within age expectations.
Developmental milestones were within normal limits, with the exception of _____ (specify).
Developmental milestones were reportedly delayed.
Parents report that certain developmental milestones were late (specify).
Parents report delayed acquisition of both motor and communication developmental milestones.
The child was described by her/his mother as acquiring developmental milestones early.

11.2. Adaptive Skill Development

Statements about Specific Skills/Problems

Bedwetting	**Daytime/nighttime bedwetting occurred at age ____.** **History of enuresis at age ____.**
Bottle	**Gave up bottle at age ____.**
Dressing	**Dressing skills were mastered at age ____.**
Eating	**Became a picky eater at age ____.** **Fed him-/herself finger food at age ____ months.** **Ate with spoon/fork at age ____.** **Was a good/poor eater as an infant/toddler/child/adolescent.**
Nightmares	**Nightmares began at age ____.** **The onset of nightmares at age ____ coincided with _____ (specify event).**

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, 1997; 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, 1997; 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, 1969; Bee, 1997; Santrock, 1997):

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, 1997; 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 with whom the child was living with at each location (e.g., 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.

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 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 parent's 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 (↔ *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 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

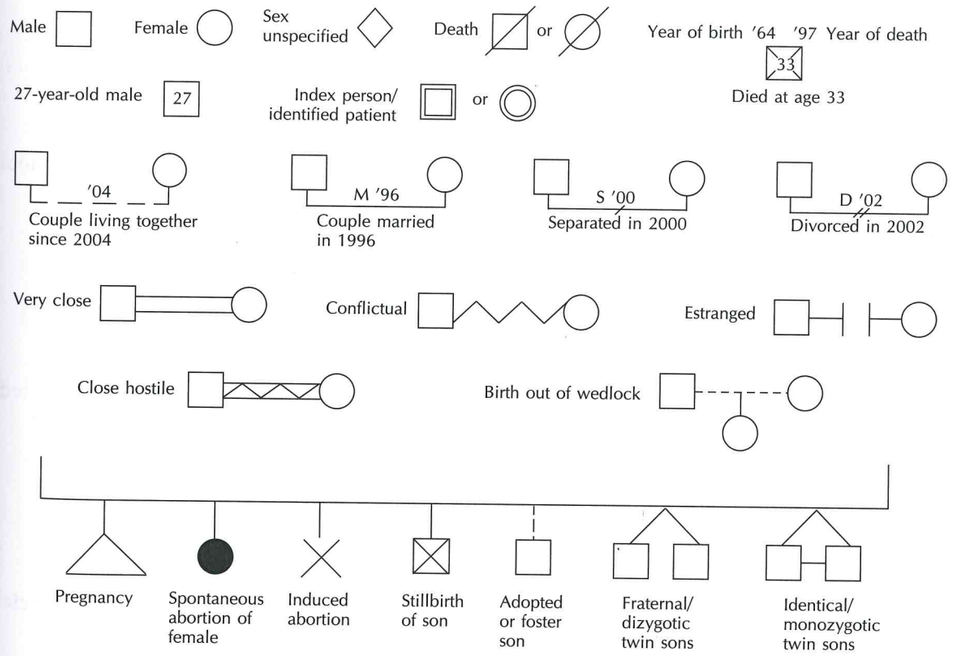
Sibling rivalry is nonexistent/typical/intense.
Rivalry increased with onset of birth of sibling/divorce of parents/other event (specify).
The child had difficulty adjusting to birth of sister/brother, but now has good relationship with her/him.
The child responded positively to birth of new brother/sister.

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 (2005). 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, 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) ____.

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 daycare 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.

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.

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 _____ 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, 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 Plans

See Section 35.9 for a sample individualized education plan (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

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 ↔ *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 to height	Lanky
Scrawny	Diminutive	Within usual range	Long-limbed
Too thin	Slim		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 table for height, weight, and head circumference for children.
Height/weight is average/below average/above average for age, at the ____ percentile 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, sniffling, 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 *(↔ 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	Hip
	Shabby	Unsoiled	The latest thing
Caked with mud/etc.	Frayed	Tasteful	Cool
Smelly	Threadbare	Well put together	Meticulous
Dusty	Worn	Clothes-conscious	Immaculate
Musty	Unzippered	Careful dresser	Overdressed
	Unbuttoned	In good taste	Seductive
	Rumpled		Revealing

Dirty	Disheveled	Neat	Stylish
	Disheveled		Flashy
	Clean but worn		
	Torn		
	Baggy		

13.3. Demeanor/Presence/Style *(↔ 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	
Solitary	Hesitant	Reserved	Calm	Affected
Aloof	Suspicious	Humble	Relaxed	Histrionic
Dejected	Wary	Subdued	Open	Abnormal
	Edgy	Restrained	Pleasant	Idiosyncratic
	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/counterproductive 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, Fifth Edition (Beery VMI)
Bender Visual–Motor Gestalt Test (Bender Gestalt)
Bruininks–Oseretsky Test of Motor Proficiency, Second Edition (BOT-2)
Developmental Test of Visual Perception, Second Edition (DTVP-2)
Developmental Test of Visual Perception–Adolescent and Adult (DTVP-A)
Finger Tapping or Finger Oscillation Test

Grooved Pegboard
Rey–Osterrieth Complex Figure
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, "hunkered 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 BOT-2.*

Bruininks–Oseretsky Test of Motor Proficiency, Second Edition (BOT-2)
Peabody Developmental Motor Scales–Second Edition
Test of Gross Motor Development–Second Edition (TGMD-2)

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	Hyperverbal
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 the ideas

she/he expressed 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."
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.
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 (EOWPVT), 2000 Edition
Illinois Test of Psycholinguistic Abilities—Third Edition (ITPA-3)
Peabody Picture Vocabulary Test—Third Edition (PPVT-III)
Receptive One-Word Picture Vocabulary Test (ROWPVT), 2000 Edition
Test of Early Language Development—Third Edition (TELD-3)
Test of Language Development—Intermediate: Third Edition (TOLD-I:3)
Test of Language Development—Primary: Third Edition (TOLD-P:3)

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 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

(↔ *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			
Solicitous			

Negative Behaviors

(↔ *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	Uncompromising	Obstinate	Cantankerous	Hateful
Reserved	"In a bad mood"	Rigid	Contrary	Irate	Spiteful
Reticent	Cross	Intransigent	Stubborn	Cross	Malevolent
Recalcitrant	Petulant	Detached	Manipulative	Livid	Mean
Resistive	Resentful	Subtle	Demanding	Enraged	Nasty
Reluctant	Sullen	Hostile	Imposing	Bad-mannered	Cruel
Inaccessible	Broody	Uncooperative	Insistent	Foul-mouthed	Sadistic
Distant	"Out of sorts"	"Sick and tired"	Indignant	Vulgar language	Vicious
Remote	"In a funk"	Noncompliant	Confrontational		Disparaging
Withdrawn	Snippy		Presumptuous		
Withholding	Balky		Frustrated		
Avoidant	Pouty		Complaining		
	Peevish		Domineering		
	Snappish		Rude		
	Grouchy		Nagging		

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, etc.) 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		Self-directed	Problems remaining seated
Sluggish		Thoughtful	

Passive	Inattentive	Normal	Hyperactive
Restrained	Daydreaming	Concentrated	Constant activity
Unresponsive	Distracted	Adequate	Constantly interrupted
Slow-moving	Careless	Motivated	Squirming
Listless	Unmindful	Engaging	Restless
Apathetic	Forgetful	Inquisitive	Easily overstimulated
Dull	Absent-minded	Interested	"Hyper"
Uninvolved	Scatterbrained	"All ears"	"Wired"
Uninvested	Unfocused	Focused	Agitated
Sluggish	Dreamy	Listening carefully	Restless
Worked slowly	Inconsistent	Alert	Overly energetic
"In slow motion"	Varied with tasks	Paying attention	Overexcited
Slow reactions	Low attending skills	"On the ball"	Twitchy
Slowed	Had great difficulty following directions	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 his/her 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 and 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, when presented with difficult problems, child coped well.

Adequate:

Often became discouraged by difficult items but persevered.
Showed some frustration to 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.
Often when challenged, she/he would develop a defeatist attitude.
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 *(↔ 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 emotional energy	Disinhibited
Impassive	Apathetic	Low-key	Integrated	Euthymic
Aloof	Uninterested	Contained		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 comportment 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 (e.g., 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
"Snippy"	Excitable	Incensed	Argumentative
Complaining	Erratic	Very angry	Seething

Annoyed	**Unpredictable**	**Irate**	**Hostile**
Cranky	Ill-tempered	Mad	Threatening
Resentful	"Whiny"	Livid	Belligerent
Grouchy	Short-tempered	Outraged	Bullying
Grumpy		Enraged	Menacing
Disagreeable		"Beside him-/herself"	Harassing
Ill-humored		Piqued	
"Prickly"		"Burned up"	
Grudging		Chronically angry	
Bristled			
Restive			
"Bothered"			
Sarcastic			
Disgruntled			
Miffed			
Displeased			

15.3. Anxiety *See also Section 15.7, "Obsessive–Compulsive Disorder."*

Relevant DSM-IV-TR Codes

300.23	Social Phobia
300.29	Specific Phobia
300.02	Generalized Anxiety Disorder
300.3	Obsessive–Compulsive Disorder
309.81	Posttraumatic Stress Disorder
308.3	Acute Stress Disorder
293.84	Anxiety Disorder Due to a General Medical Condition (GMC)
300.00	Anxiety Disorder Not Otherwise Specified (NOS)
309.24	Adjustment Disorder With Anxiety
300.01	Panic Disorder Without Agoraphobia
300.21	Panic Disorder With Agoraphobia
300.22	Agoraphobia With History of Panic Disorder
309.21	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 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 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 misinterpretation 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*). 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 (RCMAS)
Internalizing Symptoms Scale for Children (ISSC)

Multidimensional Anxiety Scale for Children–Revised (MACS-R)
Screen for Childhood Anxiety-Related Emotional Disorders–Revised (SCARED-R)
State–Trait Anxiety Inventory for Children (STAIC)

15.4. Bipolar Disorders

Relevant DSM-IV-TR Codes

296.0x	Bipolar I Disorder, Single Manic Episode
296.40	Bipolar I Disorder, Most Recent Episode Hypomanic
296.4x	Bipolar I Disorder, Most Recent Episode Manic
296.6x	Bipolar I Disorder, Most Recent Episode Mixed
296.5x	Bipolar I Disorder, Most Recent Episode Depressed
296.7	Bipolar I Disorder, Most Recent Episode Unspecified
296.89	Bipolar II Disorder
301.13	Cyclothymic Disorder
296.80	Bipolar Disorder NOS

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 DSM-IV-TR Codes

296.2x	Major Depressive Disorder, Single Episode
296.3x	Major Depressive Disorder, Recurrent
300.4	Dysthymic Disorder
311	Depressive Disorder NOS
309.0	Adjustment Disorder With Depressed Mood

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, problems 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-IV-TR, 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, 2000).

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 parent 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 *(↔ 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	Changeable	Grave	"Nothing to live for"
"Blue"	Melancholic	Beaten down	Tormented
Down-hearted	Volatile	Explosive	Unbalanced
"Low"/low-spirited	Angst-ridden	Disconsolate	Giving up hope

Sad	Very sad/irritable	Despairing	Suicidal
Troubled	Distressed	Profoundly unhappy	"No light at the end of
Somber	Gloomy	"On the edge"	the tunnel"
"Down"	"Fed-up"	Inconsolable	Hopeless
Tearful	Desolate	Miserable	In grave pain
Cheerless	Distraught	Sorrowful	Funereal
Dour	Unstable	Suffering	Morbid
Dispirited	Forlorn	Morose	
Dismayed	Bitter	Woeful	
Downcast	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 of Depression

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 one knows 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.

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). 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 (CDI)
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

Relevant DSM-IV-TR Code

300.3 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 (e.g., kitchen knives, iron, stove, gas taps, etc.).
Completing sequence of activities correctly, restarting from the beginning if necessary (e.g., homework project, 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 third leading cause of death in the 15–19 age group in the United States, preceded only by accidents and homicide (Anderson, 2002). 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*) are 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-IV-TR 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 DSM-IV-TR codes

314.00	ADHD, Predominantly Inattentive Type
314.01	ADHD, Predominantly Hyperactive–Impulsive Type
314.01	ADHD, Combined Type
314.9	ADHD NOS

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). A sudden onset of ADHD (as opposed to lifelong characteristics that are present before the age of 7 years) would rule out true ADHD. Thus 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, 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, 1997).
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.

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/incessantly, 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.

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 Inattentive Type or Hyperactive–Impulsive Type.
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 Type/Inattentive Type/Hyperactive–Impulsive Type. 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, Second Edition (BASC-2)
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)
Personality Inventory for Children, Second Edition

NARROW-BAND SCALES

ADD-H Comprehensive Teacher Rating Scale (ACTeRS), Second Edition
ADHD Rating Scale–IV
Behavior Rating Inventory of Executive Functions (BRIEF)
Child Symptom Inventory
Conners' Rating Scales–Revised (CRS-R)
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 II (CPT-II)
Conners' Kiddie Continuous Performance Test (K-CPT)
d2 Test of Attention
Gordon Diagnostic System (Gordon, 1983)
Stroop Color and Word Test
Test of Variables of Attention (T.O.V.A and T.O.V.A.-A)
Trails A and B
Visual Search and Attention Task (VSAT)
Wisconsin Card Sorting Test

16.2. Communication Disorders *See also Section 13.6, "Speech and Language Skills."*

Relevant DSM-IV-TR Codes

315.31	Expressive Language Disorder
315.31	Mixed Receptive–Expressive Language Disorder
315.39	Phonological Disorder
307.0	Stuttering
307.9	Communication Disorder NOS
313.23	Selective Mutism

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 (2000) note the following developmental aspects of stuttering:

Most stutterers are identified between ages 2 and 7 years, with peak onset at 5 years, and nearly all are identified by age 10 years.
Disturbance usually begins gradually, with a waxing and waning course.

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—Second Edition
Expressive One-Word Picture Vocabulary Test (EOWPVT), 2000 Edition
Expressive Vocabulary Test (EVT)
Multilingual Aphasia Examination
Oral and Written Language Scales (OWLS)
Peabody Picture Vocabulary Test—Third Edition (PPVT-III)
Receptive One-Word Picture Vocabulary Test (ROWPVT), 2000 Edition
Test of Early Language Development, Third Edition (TELD-3)

Test of Language Development–Primary: Third Edition (TOLD-P:3)
Test of Language Development–Intermediate, Third Edition (TOLD-I:3)
Test of Word Finding–Second Edition (TWF-2)

16.3. Disruptive Behavior Disorders

See also Section 16.1, "Attention-Deficit/Hyperactivity Disorder (ADHD)."

Relevant DSM-IV-TR codes

312.81	Conduct Disorder, Childhood-Onset Type
312.82	Conduct Disorder, Adolescent-Onset Type
312.89	Conduct Disorder, Unspecified Onset
313.81	Oppositional Defiant Disorder
312.9	Disruptive Behavior Disorder NOS

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, resentfulness, 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/joyriding, 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. Eating Disorders

Relevant DSM-IV-TR codes

307.1	Anorexia Nervosa
307.51	Bulimia Nervosa
307.50	Eating Disorder NOS

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.

Assessment of Eating Disorders

The Eating Disorder Inventory-2 (EDI-2) 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 and Intake Disorders

For eating disorders, see Section 16.4, "Eating Disorders."

Relevant DSM-IV-TR codes

787.6	Encopresis With Constipation and Overflow Incontinence
307.7	Encopresis Without Constipation and Overflow Incontinence
307.6	Enuresis

307.52 Pica
307.53 Rumination Disorder
307.59 Feeding Disorder of Infancy or Early Childhood

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).

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.

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). 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 mental retardation than in those with normal intelligence.

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 Act (IDEA).

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 (DAS-II)
Kaufman Assessment Battery for Children, Second Edition (KABC-II)
Kaufman Brief Intelligence Test, Second Edition (KBIT-2)
Stanford–Binet Intelligence Scale, Fifth Edition (SB5)
Wechsler Adult Intelligence Scale–Third Edition (WAIS-III)
Wechsler Intelligence Scale for Children–Fourth Edition (WISC-IV)
Wechsler Preschool and Primary Scale of Intelligence–Third Edition (WPPSI-III)
Woodcock Johnson III (WJ III) Tests of Cognitive Abilities

Tests of Academic Achievement

DABERON Screening for School Readiness–Second Edition
Diagnostic Achievement Battery–Second Edition
Diagnostic Achievement Test for Adolescents–Second Edition

Wechsler Individual Achievement Test–Second Edition (WIAT-II)
Wide Range Achievement Test, Fourth Edition (WRAT4)
Woodcock–Johnson III (WJ III) Tests of Achievement
Young Children's Achievement Test (YCAT)

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.
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 < $ ____).
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 Disorder (Dyscalculia)

Relevant DSM-IV-TR Code

315.1 Mathematics Disorder

Assessment of Mathematics Disorder

Comprehensive Mathematical Abilities Test
KeyMath–Revised: A Diagnostic Inventory of Essential Mathematics
Test of Early Mathematics Ability–Third Edition (TEMA-3)
Test of Mathematical Abilities–Second Edition (TOMA-2)

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 problems, 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 math disorder, 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/Reading Disorder)

The terms "dyslexia," "reading disabilities," and "reading disorder" are often used interchangeably. However, the DSM uses "reading disorder," and much of the research literature uses "dyslexia." The term "reading disabilities" encompasses everything.

Relevant DSM-IV-TR Code

315.00 Reading Disorder

Assessment of Reading Disabilities *See Chapter 22 for more details about several of these tests.*

Classroom Reading Inventory–Eighth Edition
Comprehensive Test of Phonological Processing (CTOPP)
Gates–MacGinitie Reading Tests, Fourth Edition (GMRT-4)
Gray Oral Reading Tests, Fourth Edition (GORT-4)
Gray Silent Reading Tests
Lindamood Auditory Conceptualization Test, Third Edition (LAC-3)
Nelson–Denny Reading Test
Rosner Auditory Analysis Test
Test of Early Reading Ability–Third Edition (TERA-3)
Test of Reading Comprehension–Third Edition (TORC-3)
Woodcock Reading Mastery Tests–Revised (WRMT-R)

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 with a learning disability in the area of 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 reading disorder (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 dyslexia.

Nonverbal Learning Disability (NLD)

NLD is not a DSM-IV-TR diagnosis, although it can be coded as 315.9, Learning Disorder NOS.

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 and the TONI-3 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 (CTONI)
Raven's Progressive Matrices
Test of Nonverbal Intelligence, Third Edition (TONI-3)
Universal Nonverbal Intelligence Test

Symptoms

Higher Verbal IQ/Verbal Comprehension Index than Performance IQ/Perceptual Reasoning Index.
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 IQ and Performance IQ 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 Performance IQ than Verbal IQ 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.

Disorder of Written Expression (Dysgraphia)

Relevant DSM-IV-TR code

315.2 Disorder of Written Expression

Assessment of Written Expression

Test of Early Written Language–Second Edition
Test of Handwriting Skills
Test of Written Language–Third Edition (TOWL-3)

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. Mental Retardation

Relevant DSM-IV-TR Codes

317	Mild Mental Retardation
318.0	Moderate Mental Retardation
318.1	Severe Mental Retardation
318.2	Profound Mental Retardation
319	Mental Retardation, Severity Unspecified

Characteristics of Mental Retardation by Diagnostic Category

Mild Mental Retardation

IQ of 50–55 to 70.
Speech is typically similar in structure to that of individuals without mental retardation, but is often concrete in content.
Individuals can expect to achieve up to 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 mental retardation have the mild form.

Moderate Mental Retardation

IQ of 35–40 to 50–55.
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 mental retardation have the moderate form.

Severe Mental Retardation

IQ of 20–25 to 35–40.
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 mental retardation have the severe form.

Profound Mental Retardation

IQ below 20–25.
Individuals lack verbal language, but may be able to indicate needs through vocalizations/behaviors.
About 1–2% of individuals diagnosed with mental retardation 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 Mental Retardation

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, hydroencephaly, 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 handicaps, 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.
Stereotypies/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 mental retardation.
The results of today's evaluation place the child's overall level of intellectual functioning within the mild/moderate/severe/profound range of Mental Retardation, 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 mentally retarded range of intelligence, with widespread cognitive and adaptive difficulties consistent with this picture.

Assessment of Mental Retardation

Assessment of mental retardation typically involves the administration of a standard intelligence test. (*See Chapter 21 for more information about IQ tests.*) Since a diagnosis of mental retardation 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 mental impairment.

Tests of Adaptive Functioning

AAMR Adaptive Behavior Scales–Residential and Community: Second Edition (ABS-RC:2)
AAMR Adaptive Behavior Scales–School: Second Edition (ABS-S:2)
Adaptive Areas Assessment (AAA)
Vineland Adaptive Behavior Scales, Second Edition (Vineland-II)

Assessments for Children with Severe Disabilities

A Developmental Assessment for Students with Severe Disabilities–Second Edition (DASH-2)
Assessment for Persons Profoundly or Severely Impaired (APPSI)

16.8. Movement and Tic Disorders

Relevant DSM-IV-TR Codes

307.23	Tourette's Disorder
307.22	Chronic Motor or Vocal Tic Disorder
307.21	Transient Tic Disorder
315.4	Developmental Coordination Disorder
307.3	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. Pervasive Developmental Disorders

Pervasive developmental disorders have essentially the same core features: delays in development (particularly language and communication skills), impaired social skills, and difficulty with symbolic play and imagination. Differential diagnoses can be difficult with these disorders, but some generalities are as follows. Children with Asperger's disorder are typically recognized later than those with autism (in whom symptoms are seen before age 3 years), those with Rett's disorder (in whom there is normal development for 5–12 months), or those with childhood disintegrative disorder (CDD) (in whom development is normal for up to 2 years). Normal or above-average IQ is typical in children with Asperger's disorder, while children with autism frequently have low to below-average IQ, and children with Rett's and CDD exhibit a loss of previously acquired skills. Communication is typically not significantly delayed in children with Asperger's disorder, while children with autism and Rett's have impaired communication, and children with CDD have a loss of previously acquired skills. Stereotypies are common to all of these disorders. The NOS diagnosis (see below) is used when a child does not meet criteria for a more specific pervasive developmental disorder, but when there are some symptoms present.

Relevant DSM-IV-TR Codes

299.00	Autistic Disorder
299.80	Rett's Disorder
299.10	Childhood Disintegrative Disorder
299.80	Asperger's Disorder
299.80	Pervasive Developmental Disorder NOS

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 a pervasive developmental disorder, such as autism or Asperger's disorder.
Although the child has some symptoms that are consistent with Asperger's disorder she/he does not appear to meet full diagnostic criteria.

Current testing is consistent with a diagnosis of Asperger's disorder, 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 Asperger's disorder.
Results from this testing, and previous history, indicate that the child meets criteria for an autism spectrum disorder such as Asperger's disorder. 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 Asperger's disorder.
Given the test data, historical information, and behavioral observations, a diagnosis of autistic disorder appears to be warranted. The key features of autistic disorder include a marked and sustained impairment in communication; markedly abnormal or impaired development in social interactions; and restricted, repetitive, and stereotyped patterns of behavior, interests and activities.
The child exhibits behavior consistent with a diagnosis of a pervasive developmental disorder, 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 autism, 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 Pervasive Developmental Disorders

Asperger Syndrome Diagnostic Scale (ASDS)
Autism Behavior Checklist
Autism Diagnostic Interview–Revised (ADI-R)
Autism Screening Instrument for Educational Planning–Second Edition (ASIEP-2)
Behavioral Observation Scale (BOS) for Autism
Childhood Autism Rating Scale (CARS)
Gilliam Asperger's Disorder Scale (GADS)
Gilliam Autism Rating Scale (GARS)

16.10. Schizophrenia and Other Psychotic Disorders

Relevant DSM-IV-TR Codes

295.30	Schizophrenia, Paranoid Type
295.10	Schizophrenia, Disorganized Type

295.20	Schizophrenia, Catatonic Type
295.90	Schizophrenia, Undifferentiated Type
295.60	Schizophrenia, Residual Type
295.40	Schizophreniform Disorder
295.70	Schizoaffective Disorder
297.1	Delusional Disorder
298.8	Brief Psychotic Disorder
297.3	Shared Psychotic Disorder
293.xx	Psychotic Disorder Due to a GMC
298.9	Psychotic Disorder NOS

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 hyperkinesis 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 Disorders

Relevant DSM-IV-TR Codes

307.47	Nightmare Disorder
307.46	Sleep Terror Disorder
307.46	Sleepwalking Disorder
780.59	Breathing-Related Sleep Disorder
780.5x	Sleep Disorder Due to a GMC

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

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, 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 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, 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 or 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, babysitting younger children, care of pets (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.

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) 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, TVs, radios, audiocassette and/or videocassette players/CD 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.

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 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."

Quality of Teaching

Excellent/good/poor, mismatch between child 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 little/much time is spent 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," services.

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 Form

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: _____

(cont.)

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

(cont.)

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 ___

(cont.)

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 valuation: _____

Reason for evaluation: _____

Neuropsychological evaluation: No ___ Yes ___

If yes, name of evaluator: _____ Date of valuation: _____

Reason for evaluation: _____

Neurological evaluation: No ___ Yes ___

If yes, name of evaluator: _____ Date of valuation: _____

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 mental retardation, learning disabilities, schizophrenia, depression, epilepsy, or a bipolar disorder? No ___ Yes ___

If yes, explain: _____

(cont.)

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: _____

(cont.)

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: _____

_____