Psychological Evaluation

Name: A

Examiners: Jyoti Kolodziej, M.Ed., Robin Shamsaie, Ph.D., HSPP

Date of Birth: XX/XX/2002

Dates of Evaluation: 9/08/2011, 9/9/11, 9/12/2011, 9/13/11, 9/15/11, 9/27/11, 10/4/11, 10/13/11

Admission Screening Summary

Reason for Referral: A was seen as a treatment team request for an additional evaluation for differential diagnosis purposes. Specifically, A's treatment team wants to know whether she has an Autism Spectrum Disorder.

Assessment Procedures:

Cumulative File Review
Classroom Observation
Parent Interview – Autism Diagnostic Interview, Revised (ADI-R)
Adaptive Behaviors Assessment System, 2nd Edition (ABAS-II)
    Parent (Dorm Supervisor & Mother) Rating Scales
    Teacher Rating Scales
Autism Diagnostic Observation Schedule (ADOS)
Gilliam Asperger's Disorder Scale (GADS)
    Parent (Dorm Supervisor & Mother)
    Teacher
Behavior Assessment System for Children, 2nd Edition (BASC-2)
    Parent (Dorm Supervisor & Mother) Rating Scales (PRS-C)
    Teacher Rating Scales (TRS-C)
Childhood Autism Rating Scale, 2nd Edition, High Functioning (CARS-2 HF)
Sensory Profile – Caregiver Questionnaire
    Parent (Dorm Supervisor)
    Teacher

Background Information:

Records indicate that A is in the 3rd grade. She previously attended Sample School in Sample, Indiana. According to a Case Conference summary dated 4/20/2011, she does receive special services in school due to an Emotional Disability classification. There is record of a re-evaluation planning discussion, resulting in agreement that no new testing was needed for programming or eligibility purposes. Her next triennial review is 10/1/2014. Within the Individual Education Program (IEP), it is noted that A is bright and working at benchmark academically. Annual goal included understand, comply, and follow procedures for expected behavior 4 of 5 times. Speech goal was also noted with direct services recommended.
Records note A has received extensive services within her home community including multiple acute hospitalizations, all of which have failed to promote a positive change in her behavior. She

was referred to Sample Residential Treatment Facility by her mother, with the agreement of her physician at Sample Center. Referral information indicates she has been diagnosed with Oppositional Defiant Disorder, Anxiety Disorder, Mood Disorder, NOS, PTSD and Rule Out of Reactive Attachment Disorder in the past. According to referral information, staff at Sample Center questioned whether A might also have Asperger's Disorder.

A's current treatment program is based on the following diagnoses:

Axis I: 296.90 Mood Disorder, NOS (by history and current)
313.81 Oppositional Defiant Disorder (by history and current)
300.00 Anxiety Disorder, NOS (by history)
309.81 Post Traumatic Stress Disorder (by history)
Rule-out Asperger's Disorder
Axis II: V71.09
Axis III: Deferred
Axis IV: School difficulties, Peer relations difficulties, Sibling discord, Parents are divorced
Axis V: GAF = 22 (upon admission)

A has been treated with a variety of psychotropic medications, most recently Kapvay and Abilify.

Upon her admission to Sample Residential Treatment Facility, A was administered a brief measure of academic achievement. On the Kaufman Test of Educational Achievement, 2nd Edition (KTEA-II), A's academic skills were within the Average range for writing and reading, but were Above Average in math (Brief Reading = 108, Brief Math = 126, Comprehensive Writing = 101). Previous records suggest A functions within the average range of cognitive ability.

Behavioral Observations: The evaluation was conducted over a period of eight days in the Psychiatric Residential Treatment Facility on Sample Residential Treatment Facility's campus. A cooperated with the testing process as a whole. She was pleasant, compliant, and generally cooperative throughout the evaluation. She was fully oriented. Her mood was generally euthymic with a broad range of affect. Her speech was coherent, logical and goal directed, with a noted articulation difficulty (/r/, /th/). Her attention and focus were adequate for task completion. Results of the evaluation are believed to be a fair representation of her current functioning.

Classroom Observation: A two hour unstructured observation of A was completed on Friday, September 9, 2011 from 1:40 p.m. to 2:40 p.m. and Monday, September 12, 2011 from 9:00 a.m. to 10:00 a.m. in Mrs. B's classroom and in the indoor recreational area. The observation spanned a period including a Reading Lesson, transitions, free activity-time, and a Language Lesson. Upon entering the classroom, the writer sat down at the teacher's aid's desk which was behind A's desk.

A was attending and following along with the reading. During an instructional time period lasting thirty minutes, A was off-task 10 times, looking around the room, flipping through her book when required to follow along, talking out of turn, and out of seat. A talked out of turn four times. At other times during class, when choosing to participate, A raised her hand to speak. A was further observed playing kick-ball with her peers inside the recreation area. During free activity-time, A played kick-ball with two peers. She encouraged and directed her peers during play. Throughout the 30 minutes of play in free activity-time, A corrected peers on several occasions for failing to follow rules with a vocalized correction made every 2-3 minutes. A insisted that peers follow rules after staff guided students to play with kick-balls independently, aiming against a far wall. She created rules for students to follow during this free play, made rule corrections, and discussed rules with peers. A peer complained to staff of A's rule corrections. A appeared to be unable to use perspective taking when discussing the situation with the peer and staff.

On the morning of September 12, 2011, A was observed during a reading lesson, circle time, and a language lesson. A followed along appropriately in the book, while the class was taking turns reading aloud. A had a good range of affect in her facial expressions during the observation. During the second observation, A did not speak out of turn. She raised her hand every time she participated by speaking in coherence with the classroom instruction. A enthusiastically participated to read aloud and answered comprehension questions that the teacher posed to the class. A listened to the rules, but made no contact with other students during this time.

Throughout the observation period, A was able to maintain focus on required tasks and made decent transitions in between activities. A showed little emotion, so it was difficult to tell whether she was enjoying the activities. There was one moment during her reading lesson on the second day's observation that she made an exclamation, stating "ohhh" in regard to the material, as she was observed to be reading ahead of the class. Overall, A was able to control her behavior in the classroom. A was observed to be off-task only when the instructor was not giving direct instruction and/or attended to another student, during both observations.

Childhood Autism Rating Scale, 2nd Edition High-Functioning (CARS-2-HF)

Based on behavioral observations made over a period of two days, A was assessed to have minimal to mild symptoms of Autism Spectrum Disorder. A's intelligence is better than that exhibited by typical peers.

A had moderately impaired social-emotional understanding, showing an understanding of facial expressions, tone of voice, and body language only when these cues are exaggerated. When observed during her free activity-time, A is likely to ignore or misunderstand expressions or perspectives of others. She has mildly to moderately abnormal relationships with her peers, with some difficulty with some give-and-take interactions during her free activity-time. With direction, A is able to interact with peers, moving beyond her own interest in correctly following rules. A was observed to have difficulty with imaginative play and mildly inappropriate interest in the use of kick-balls, requiring that she and her peers follow rules when throwing a ball up in the air independently from each other. This also demonstrated her mildly abnormal adaptation to change and a variety of interests projected by her peers, preferring the use of rules when

throwing kick-balls up in the air. A had mildly abnormal fear or anxiety, being overly sensitive to rule violations when playing with kick-balls. A's emotional expressions and regulation of expressions appear to be age-appropriate and situation-appropriate by word and behavior, including emotional variation such as happy, sad, proud, anxious, and so on. A's affect was sometimes flat during direct instruction. During circle time and her language lesson, her affect appeared to have more variation.

A moves her body with the same ease, agility, and coordination as a typical person of the same age. Her visual behavior and eye contact, integrated with verbal and nonverbal communication skills, is normal and appropriate for her age. Her listening behavior, used with other senses, is normal and appropriate for her age. Her response to taste, smell, and touch is appropriate with some exploration into new objects in age-appropriate way. A's verbal and nonverbal communication is normal, age, and situation appropriate. A is able to understand the meaning of information presented either pictorially, in writing or verbally, with abilities to attend to relevant versus irrelevant details and integrates this information into a meaningful overview.

Evaluation Results and Interpretation:

Adaptive Behavior:

Adaptive Behavior Assessment System, 2nd Edition (ABAS-II)

The Adaptive Behavior Assessment System, 2nd Edition (ABAS-II) is a tool used to assess the daily, functional skills of personal independence and social responsibility of individuals from school-age to adult. The parent and teacher forms are used with students in grades K-12 or ages 5-21 years. Results are obtained in ten adaptive skill areas and are reported as scaled scores. The General Adaptive Composite, or an overall adaptive behavior score, is also obtained. Scores of 90-109 are considered average. Parent rating forms were completed by A's mother, residential supervisor in her living unit, and classroom teacher. They were subsequently returned, scored and interpreted by the examiner.

	Parent A		**Parent D**		**Teacher B**	
	Standard Score	Percentile	Standard Score	Percentile	Standard Score	Percentile
General Adaptive Composite	**70**	**2**	**62**	**1**	**117**	**87**
Conceptual Composite	78	7	80	99	115	89
Social Composite	66	1	58	0.3	105	63
Practical Composite	84	14	58	0.3	93	32

	A		D		B	
Adaptive Skills Area	Scaled Score		Scaled Score		Scaled Score	
Communication	5		6		9	
Community Use	10		2		13	
Functional Academics	7		6		14	
Home/School Living	3		3		13	
Health and Safety	7		2		12	
Leisure	5		2		13	
Self-Care	7		6		12	
Self-Direction	3		4		12	
Social	1		1		10	

According to the results from the ABAS-II, Mrs. A and Ms. D scored A's current behavior as falling within the extremely low, borderline, and below average ranges, indicating that A's adaptive behavior appears to be consistently deficient across home settings. Scores were relatively variable across all three raters. Mrs. B's responses may reflect the more structured setting of a classroom in placement that A currently works in, with more one-on-one instruction with class sizes of ten or less. Areas of relative weakness for A are Social, Communication, Home Living, Leisure, and Self-Direction according to her mother and residential supervisor. Areas of relative weakness for A are Communication and Social according to her classroom teacher, mother, and residential supervisor. Areas of relative strength for A are Functional Academics, Self-Care, Community Use, and School Living according to her classroom teacher, mother, and residential supervisor. Intervention in the other areas (i.e., home living, self-direction, social skills, communication, leisure, etc.) is needed to assist A in developing these necessary skills.

Autism Diagnostic Observation Schedule (ADOS)

The Autism Diagnostic Observation Schedule (ADOS) is a semi-structured, standardized assessment of communication skills, social interaction, and the ability to use imaginative play. The ADOS consists of standard activities that allow the examiner to observe behaviors that have been identified as important in the diagnosis of autism spectrum disorders at different developmental levels and chronological ages. The ADOS incorporates the use of planned, as well as unstructured, social occasions in which a behavior of a particular type is likely to appear. Structured activities and materials provide standard contexts in which social interactions, communication, and other behaviors relevant to autism spectrum disorders are observed. The ADOS was used to gather additional information regarding A's social, emotional, and adaptive functioning.

Scores are obtained in four areas: Communication, Reciprocal Social Interaction, Imagination/Creativity, and Stereotyped Behaviors and Restricted Interests. Scores from the Communication and Social Interaction areas are used to identify A's at risk for autism and autism spectrum disorders. In the Communication area, the cut-off score for autism is 3, while the cut-off score for autism spectrum disorder is 2. In the Reciprocal Social Interaction area, the cut-off score for Autism is 6, while the cut-off score for autism spectrum disorder is 4. A Total

Communication score and Social Interaction score added together which falls between 7-9 is considered to be within the autism spectrum range, while a combined score of 10 or higher is within the autism range.

Domain	Score
Communication	0
Reciprocal Social Interaction	3
Communication + Reciprocal Social Interaction	3

* Autism Spectrum Range **Autism Range

Results of the ADOS indicate that the behaviors that A displayed during the observation are not scored within the autism range. Her language was generally complex with variations in pitch and intonation. There was no demonstration of echolalia or use of odd words and phrases observed. A generally responded appropriately to the examiner's comments and prompts. A was able to report both routine and non-routine events during the conversation when prompted with natural exchanges and elaborations when prompted. She exhibited appropriate use of gestures, eye contact, and facial expression during conversation. A appeared to enjoy several activities and interactions with the examiner. She was able to communicate her own emotions and offered identification of others' emotions with and without prompts.

She displayed insight into various social relationships, such as friendship, as well as her role within those relationships. She had some limited insight into adult relationships, such as marriage. A showed a sense of responsibility for her own actions. Additionally, she showed responsiveness to social situations and reciprocal social communication. A exhibited no difficulty incorporating creativity and imagination into the activities. She did not exhibit unusual sensory interests (e.g., only using one toy), hand mannerisms, specific topic interests, self-injurious behavior or compulsions/rituals during the evaluation.

Gilliam Asperger's Disorder Scale (GADS)

The Gilliam Asperger's Disorder Scale (GADS) is a rating scale designed to identify Asperger's Disorder in children and adolescents and provides an overall score that reveals the likelihood that an individual has Asperger's Disorder. Rating forms were completed by A's mother, residential supervisor in her living unit, and her classroom teacher. They were subsequently returned, scored and interpreted by the examiner. The following table provides a summary of scores. A score of 80 or higher indicates a high or probable case of Asperger's Disorder. Scores ranging from 70-79 are considered to be borderline and scores of 69 or less indicate a low probability or no probability of Asperger's Disorder.

	Parent Mrs. A		Parent Ms. D		Teacher Mrs. B	
	SS	%ile	SS	%ile	SS	%ile
Asperger's Disorder Quotient	**90**	**25**	**67**	**1**	**58**	**<1**
Social Interaction	8	25	6	9	2	<1
Restricted Patterns of Behavior	9	37	5	5	5	5
Cognitive Patterns	6	9	4	2	3	1
Pragmatic Skills	11	63	5	5	5	5

According to the results obtained from this questionnaire, Mrs. A responses suggest that there is a high probability; Ms. D's and Mrs. B's responses suggest that there is a low or no probability that A's behaviors are related to Asperger's Disorder.

Sensory Profile

The Sensory Profile is a caregiver questionnaire that measures a child's sensory processing abilities linked to functioning performance in daily life. Items describe a child's response to various sensory experiences. Certain patterns of performance are indicative of difficulties with sensory processing and performance. Scores are rated as Typical Performance, Probable Difference or Definite Difference. Both A's dorm supervisor and classroom teacher completed the profile.

	Parent D		Parent B	
SECTION - CRITERIA	**Score**	**Classification**	**Score**	**Classification**
Tactile Sensitivity	27	Probable Difference	33	Typical Performance
Taste/Smell Sensitivity	16	Typical Performance	19	Typical Performance
Movement Sensitivity	12	Probable Difference	15	Typical Performance
Underresponsive/Seeks Sensation	24	Probable Difference	32	Typical Performance
Auditory Filtering	20	Probable Difference	27	Typical Performance
Low Energy/Weak	22	Definite Difference	30	Typical Performance
Visual/Auditory Sensitivity	19	Typical Performance	17	Probable Difference
Total	140	Definite Difference	173	Typical Performance

A's dorm supervisor reported areas regarding A's tactile and movement sensitivity. Ms. D also reported a probable difference in comparison to A's peers regarding areas of sensation seeking and auditory filtering. Ms. D reported a definite difference between A and peers her age in low energy. Ms. D, A's dorm supervisor, noted a definite difference between A and peers her age in overall behavior. However, A's classroom teacher found a majority of behaviors in typical

performance, except for visual and auditory sensitivity. Results are unclear from the sensory profiles.

Parent Interview: A semi-structured parent interview was conducted with Mrs. A, A's mother on September 27, 2011.

Per Mrs. A's report, there is a history of depression, maternally and paternally. One of A's half-brothers has been diagnosed with an Attention Deficit Hyperactivity Disorder and is not prescribed any medications. A's oldest half-brother has been diagnosed with an Anxiety Disorder and Bipolar Disorder and she received special services through elementary school including speech therapy. A's half-sister had been diagnosed with Oppositional Defiant Disorder and she has received wrap-around services, several placements, and a medication regime.

Mrs. A's pregnancy with A was described unremarkable and full-term. Mrs. A reported that she smoked cigarettes but did not experience any illnesses while pregnant with A. A was reported to experience long crying spells, lasting 8-10 hours every evening, ending when she was six months old. From six months through the age of five, A rocked herself to self-sooth, hitting her head repeatedly against the wall, at times. A suffered no broken bones or major injuries throughout her childhood.

A's developmental milestones for motor skills were reportedly achieved within a normal age range. However, Mrs. A noted that by the age of two, she knew A was "different," especially when compared to the development of her neighborhood peers. At the age of three, A was reported to take her clothes off outside when she was angry. A's tantrums included kicking, screaming, hitting others, and would last for hours, which continue to take place at home. A's language was delayed and she did not begin to use words meaningfully until she was between two and three years old. A began to use two-three word phrases between ages two and three when at speech therapy with First Steps. An area of difficulty for A is sarcasm and jokes, according to Mrs. A. A continues to struggle with her expressive vocabulary at times, unable to pronounce some words correctly. A has received services with Head Start, but has been asked to leave on multiple occasions for violent and aggressive behavior.

Mrs. A described A as a young girl that worries and gets anxious when she is angry. Mrs. A indicated that A frequently gets anxious in vehicles, needing to hold onto something during the rides. From the ages of three through seven, A was reported to panic in vehicles, concerned that people were chasing her. Mrs. A expressed concern that A becomes violent when things do not go her way or gets frustrated. A's emotions were described as exceptionally moody. She has been physically aggressive toward her sisters and brother when she would get frustrated or when things would not go her way.

Regarding A's behaviors, routines, and interests, Mrs. A reported that A has difficulty sharing and taking turns. When playing pretend with clothes and food, or drawing, A "shows off things that she's done or made," but does not play with a sibling or a peer. When planning to change A's routines, Mrs. A indicated that she tells her about the planned change as it approaches and

keeps her busy during the routine change. Even with planning changes in routine, Mrs. A indicated that A gets anxious about change.

Regarding A's social development, Mrs. A reported that A did not make eye contact and does not look at her or others' faces when holding a conversation. A is reported to like to talk and break rules by talking out in class. Mrs. A indicated that A appears to play along side of her peers, instead of with them, at school and when in girl scouts. Mrs. A indicated that A mentions friends from school but is unable to report their names or describe their physical appearances. She does not appear to care if someone is listening when she is talking to them in conversation. Mrs. A noted her belief that A was strongly attached to her both in the past and currently. According to Mrs. A, A appears to acknowledge others, but does not show empathy.

Concerning sensory issues and ritualized behavior, her mother reported that as a toddler and currently, A "smells everything" (e.g. couches, clothing). According to Mrs. A, she has had ongoing difficulty with the way her clothing felt, indicating a need to wear jeans. When in second and third grade, A expressed a need to wear a light jacket when she was out of the home and at school. Even in the summer, she wore the light jacket. During the winter, A wore a coat over the light jacket. When out in public and out of routine, A was reported to get physically sick (e.g. diarrhea, vomiting, stomach pains). Mrs. A reported that A also seems to be in motion at all times.

A is described as a smiling and happy young girl. A is reported to like playing the following: pretend with food and clothing; video and computer games; drawing; and coloring. Mrs. A listed areas of concern for A including: emotional issues; aggression; violence; interactions with siblings and friends; interactions with peers; impulsivity; and her placement in special education classrooms without interaction with girls.

Social-Emotional Functioning:

The Behavior Assessment System for Children, 2nd Edition (BASC-2) measures the degree to which parents and teachers perceive whether problematic behavior is focused internally, externally, globally and adaptively. Parent and teacher rating forms were distributed to A's residential supervisor in her living unit as well as her classroom teacher, respectively. They were subsequently returned, scored and interpreted by the examiner.

The following table provides a summary of scores. Clinical and Adaptive scale scores ranging from 41-59 are considered average. Clinical scale scores 60-69 are considered At Risk, while those greater than or equal to 70 are Significant. Adaptive scale scores 31- 40 are At Risk while those less than or equal to 30 are Significant.

Behavior Assessment System for Children – 2nd Edition (BASC-2) Results:

	T-Score PRS – Ms. D	T-Score TRS - Mrs. B	T-Score PRS – Mrs. `A
School Problems	NA	41	NA
Attention Problems	NA	44	NA
Learning Problems	NA	40	NA
Internalizing Problems	53	50	86**
Anxiety	50	45	69*
Depression	68*	55	83**
Somatization	39	50	84**
Externalizing Problems	71**	46	76**
Hyperactivity	61*	46	78**
Aggression	75**	48	73**
Conduct	70**	45	70**
Behavioral Symptoms Index	71**	48	83**
Atypicality	68*	43	78**
Withdrawal	65*	55	78**
Attention Problems	61*	44	67*
Adaptive Skills	30*	59	30*
Adaptability	32*	56	28**
Social Skills	31*	56	35*
Leadership	31*	56	38*
Study Skills	NA	64	NA
Functional Communication	30*	59	28**
Activities of Daily Living	39*	NA	34*

*** = At Risk for problems without intervention**
****=Clinically Significant**

Mrs. B, A's classroom teacher, and Ms. D, the residential supervisor in her dorm, each completed the BASC-2. Mrs. B completed the Teacher's Rating Scale for Adolescents (BASC-2-TRS-A), while Ms. D completed the Parent Rating Scale for Adolescents (BASC-2-PRS-A). Both Mrs. B's and Ms. D's ratings appear to be valid, consistent, and not affected by overly-negative responding. It is noted that these ratings were administered in a highly structured treatment facility. It is possible that the ratings completed by both respondents reflected A's behaviors in relation to her current set of peers at the treatment facility rather than those of same-age peers in a less-restrictive setting.

Ms. D, the dorm supervisor, and Mrs. A agreed that A is at-risk and clinically significant in several areas. Both Ms. D and Mrs. A indicated that A has clinically significant behavioral symptoms index and externalizing problems including: aggression and conduct problems. Both Mrs. D and Mrs. A agree that an area of concern for A is her hyperactivity. Both Ms. D and Mrs.

A indicated that A has a concerning internalizing problem in depression. Ms. D and Mrs. A agree that A has concerning behaviors in her atypicality, withdrawal, and attention problems. Mrs. A believes that A has clinically significant problems in somatization, while being at-risk for anxiety. Mrs. A and Ms. D agree that A is at-risk for adaptive skills including: social skills, leadership, and activities of daily living. Mrs. A believes that A has clinically significant problems in adaptability and functional communications. Ms. D believes that A is at-risk for concerns in adaptability and functional communications. Mrs. B's ratings suggest that A's emotional and adaptive behavior is similar to other peers her age.

Behavior Assessment System for Children – 2nd Edition (BASC-2) SRP-A

The Behavior Assessment System for Children, 2nd Edition (BASC-2) SRP-A measures the degree to which an adolescent perceives her or her problematic behavior is focused internally, externally, globally and adaptively. A completed the rating scale on September 13, 2011 in the Psychiatric Residential Treatment Facility on Sample Residential Treatment Facility's campus.

The following table provides a summary of scores. Clinical and Adaptive scale scores ranging from 41-59 are considered average. Clinical scale scores 60-69 are considered At Risk, while those greater than or equal to 70 are Significant. Adaptive scale scores 31- 40 are At Risk while those less than or equal to 30 are Significant.

Behavior Assessment System for Children – 2nd Edition (BASC-2) SRP-A Results

	T-Score
School Problems	53
Attitude to School	54
Attitude to Teachers	52
Sensation Seeking	--
Internalizing Problems	50
Atypicality	44
Locus of Control	60*
Social Stress	48
Anxiety	51
Depression	50
Sense of Inadequacy	46
Somatization	--
Inattention/Hyperactivity	51
Attention Problems	49
Hyperactivity	53
Emotional Symptoms Index	49
Personal Adjustment	49
Relations with Parents	44
Interpersonal Relations	56
Self-Esteem	55
Self-Reliance	43

A's responses appeared to be valid, consistent, not overly patterned, and in a manner that suggests she answered honestly.

A's ratings suggest that she perceives that she experiences normal amounts of emotional symptoms, similar to peers her age. Specifically, a reported area at-risk in her self-report is her locus of control, which indicates that she may not believe that she has control over several areas in her life. A perceives that her adaptive behaviors are similar to most peers her age. A critical items endorsed on this rating scale included: I feel sad (often); I hate school (sometimes); I feel like my life is getting worse and worse (sometimes); and other people make fun of me (sometimes).

Evaluation Results and Interpretation:

It is recognized that A was not evaluated in a natural environment. It is noted that results may be influenced by the environment in the psychiatric residential treatment facility (PRTF) within which she was evaluated.

Summary and Recommendations:

Previous records suggest A functions within the average range of cognitive ability. Academic achievement is within the average to above average range, with a strength in math, according to a previously administered brief measure.

A was seen as a treatment team request for an additional evaluation for differential diagnosis purposes. Specifically, A's treatment team wants to know whether A has an Autism Spectrum Disorder. The evaluation was completed over a period of eight days within a month's time and the following is a summary of the obtained results.

A was administered several evaluative measures related to disorders on the Autism Spectrum (i.e., ADOS, GADS, Sensory Profile, CARS-2-HF), adaptive behavior (i.e., ABAS-II) and a social-emotional measure to assess her current functioning (i.e., BASC-2). ADOS scores indicate that the behaviors that A displayed during observation are within the average range. According to the ratings on the Gilliam Asperger's Disorder Scale (GADS), A's probability for having Asperger Syndrome was perceived as a "low probability" by Mrs. B and Ms. D. Mrs. A's responses suggest that there is a "high possibility" that A's behaviors are related to Asperger's Disorder. While there is some inconsistency between all three raters, it does seem that A's classroom teacher and dorm supervisor agree there is a low possibility that A has an Asperger's Disorder.

Results of the ratings on the Sensory Profile indicated some difficulty with sensory processing according to A's dorm supervisor, Ms. D, with areas of probable and definite difference in comparison to her peers. However, Mrs. B, A's classroom teacher, reported typical performance in most areas, except a probable difference in comparison to her peers in her visual and auditory sensitivity, which was not an area that Ms. D had noted in the Sensory Profile. Each rater noted different areas and corresponding intensities. As such, A likely processes certain sensory

information differently than others and may struggle to perceive other's emotions and struggle with some motor weaknesses.

Regarding adaptive behavior as measured by the ABAS-II, Mrs. A and Ms. D scored A's current behavior as falling within the extremely low, borderline, and below average ranges, indicating that A's adaptive behavior appears to be consistently deficient across home settings. Mrs. B's responses may reflect the more structured setting of a classroom in placement that A currently works in, with more one-on-one instruction with class sizes of ten or less. Mrs. B's ratings suggest that A's emotional and adaptive behavior is similar to other peers her age. Areas of relative strength for A are Functional Academics, Self-Care, Community Use, and School Living according to her classroom teacher, mother, and residential supervisor. Intervention in the other areas (i.e., home living, self-direction, social skills, communication, leisure, etc.) is needed to assist A in developing these necessary skills.

Measures of social-emotional functioning revealed that A's responses on a self-report measure indicated areas of at-risk concern regarding locus of control, indicating that she may not believe that she has control over several areas in her life.

A has some clinically significant and at-risk concerns in the areas of global behavior difficulties (i.e., aggression, conduct problems) as well as an expressed need for intervention in at-risk and clinically significant adaptive skills (i.e., functional communication, adaptability) as reported by her mother and dorm supervisor. The dorm supervisor and mother agreed that A displays both significant and at-risk behaviors in several areas; however, each rater noted the concern to their respective setting.

According to her treatment review team, A's prognosis is guarded outside of a secure psychiatric treatment facility due to A's history of verbal aggression, physical aggression, defiance at home and at school including non-compliance, and threats to harm others. It was noted that A is currently beginning to identify and recognize her behaviors and the need to change; however, she continues to struggle with following all directives.

In summary, A presents with a complexity of symptoms that makes placing a single diagnosis problematic as it will not likely cover the multitude of social, emotional, and behavioral difficulties. Based on the results of the current evaluation, A does not appear to meet criteria for Asperger's Disorder, nor does she meet criteria for Pervasive Developmental Disorder, Not Otherwise Specified according to the *Diagnostic and Statistical Manual* (DSM-IV-TR) criteria. A's behaviors are not pervasive, across multiple settings. Some of her concerning behaviors may be more suitably described by her Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Anxiety Disorder, and Mood Disorder. The criteria for Asperger's Disorder are as follows:

(I) Qualitative impairment in social interaction, as manifested by at least two of the following:

A. marked impairment in the use of multiple nonverbal behaviors such as eye-to eye gaze, facial expression, body postures, and gestures to regulate social interaction **NO**
B. failure to develop peer relationships appropriate to developmental level **NO**

C. a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest to other people) **NO**
D. lack of social or emotional reciprocity **NO**

(II) Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

A. encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus **NO**
B. apparently inflexible adherence to specific, nonfunctional routines or rituals **NO**
C. stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements) **NO**
D. persistent preoccupation with parts of objects **NO**

(III) The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning. **NO**

(IV) There is no clinically significant general delay in language (e.g., single words used by age 2 years, communicative phrases used by age 3 years). **FALSE, meaningful words did not begin until 2-3 years of age**

(V) There is no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behavior (other than in social interaction), and curiosity about the environment in childhood. **TRUE**

(VI) Criteria are not met for another specific Pervasive Developmental Disorder or Schizophrenia. **TRUE**

Therefore, it is recommended that Student's current diagnosis does not include a Pervasive Developmental Disorder, including Autism Spectrum Disorder and Asperger's Disorder.

The following recommendations are suggested:

1. Due to A's complexity of symptoms, treatment with A should focus on learning appropriate social behaviors and using adaptive coping skills for a variety of situations, especially when frustrated. As such, it is important to allow A time to adjust whenever a transition takes place (i.e., switching classes, introducing a new schedule, etc.).

2. A is encouraged to learn to control her impulsive and disruptive behaviors as well as increase her frustration tolerance. She would benefit from learning healthy methods of coping, self-expression and needs attainment without violating the rights of others and maintaining the safety of self and others.

3. Given A's history of aggressive behaviors, caregivers and other adults in A's life should be mindful of these tendencies and provide the appropriate monitoring of her behavior and intentionally check-in with her to help ensure her safety and the safety of others. A's

therapist should also check in with her periodically concerning her safety and discuss any problematic thoughts and behaviors. A is encouraged to verbalize any harmful or upsetting thoughts with such adults.

4. Therapy should address learning techniques designed to improve problem-solving skills, self-monitoring, self-regulation and impulse control as well as healthy coping skills and relaxation techniques that target her low self-esteem, anxiety, depression, anger, aggression, and impulsivity.

5. Skills training in problem solving, emotional and stress management and positive interpersonal relatedness is recommended. A cognitive-behavioral approach is suggested that assists A in improved cognitive awareness, thought restructuring and the connection between thoughts, feelings, and behaviors. This approach would also provide clear, simple directives with consistent reinforcement of positive behavior as well as logical and natural consequences for negative behavior.

6. Individual therapy may help A understand her unsafe behaviors and strengthen self-esteem using guided imagery and role playing. Therapy should encourage optimism and guide social interest. Therapy may use Thought Charts using an A-B-C model to find Activating events that cause her to have rational or irrational Beliefs, which can lead to emotional and behavioral defeating Consequences. A can then decrease threats to her self-esteem and replace unhealthy beliefs with effective beliefs with support from her counselor and staff.

7. As many visual cues as possible would be helpful including: daily schedules, household rules and expectations, incentives, rewards, and consequences. A visual cuing system can provide reminders for task completion and behavior modification (e.g., red, yellow, green card system; timers; and stress thermometers).

8. Regarding the school setting, A is encouraged to identify one or more support persons within the school that she can utilize as a resource for coping when frustrated.

9. In order to assist with transitions and management of everyday behaviors, it would be beneficial for A's family to learn and utilize behavior management and behavior monitoring techniques. Family therapy is recommended to assist A in generalizing these therapeutic goals and resulting changes to her home community.

10. A should continue to see a psychiatrist to monitor her current medication regimen.

11. Further monitoring is recommended re-clarification of Anxiety Disorder, NOS. A's difficulty coping often appears related to anxiety rather than need for sameness.

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