PROGRESS NOTE

MHlth Assessments signed by Wallinga, Gary, PHD,LP at 10/15/2014 7:37 AM

Author: Wallinga, Gary, PHD,LP
Filed: 10/15/2014 7:37 AM
Status: Signed
Trans ID: 11394219
Trans Time: 9/24/2014 11:13 AM

Service: (none)
Note Time: 10/9/2014 12:00 AM
Editor: Wallinga, Gary, PHD,LP (Psychologist)
Trans Status: Available
Trans Doc Type: MHlth Assessment

Author Type: Psychologist
Note Type: MHlth Assessments
Dictation Time: 10/9/2014 10:17 AM

PSYCHOLOGICAL EVALUATION

NAME: Dominic Kapinos

DATE OF BIRTH: 10/28/01

EVALUATION DATE: 9/8/14, 9/24/14, 10/9/14

REPORT DATE: 10/9/14

REASON FOR REFERRAL: Dominic is a 12-year-old boy referred by Wendi Johnson, MD, his pediatrician, for psychological evaluation of Attention-Deficit Hyperactivity Disorder and anxiety.

EVALUATION PROCEDURES:
Wechsler Intelligence Scale for Children-Fourth Edition
Integrated Visual and Auditory Continuous Performance Test
Behavior Rating Inventory of Executive Functioning
Conners' Rating Scale
Millon Pre-Adolescent Clinical Inventory
Yale-Brown Obsessive-Compulsive Scale
Behavioral Assessment System for Children
Short Sensory Profile
Social Communication Questionnaire

BACKGROUND INFORMATION: Dominic lives with his parents, Lisa and Anthony, in St. Cloud. He has five siblings at home ranging from ages 1 to 15. He also has a half-sister who lives in Kansas. Dominic is described by his parents as being helpful and caring with his smaller siblings but critical and domineering of his brother, Gabrielle (9). Dominic looks up to his older sister, Madeline (15). He is described as having a close and loving relationship with his mother, but he and she tend to "butt heads" because he does not want to listen to her. He seems to adore and emulate his father and seeks his father's approval.

According to Lisa, her pregnancy with Dominic was uneventful, and her health was good. There were no complications during his birth. He weighed 9 pounds, four ounces. He required an average amount of care as an infant. He was an active and insistent toddler, but average in terms of his sociability. He would play alone or with others and engaged in make-believe as well as repetitive play. Dominic reports that he has friends and, in fact, is feeling more socially successful this school year.

Dominic has generally had good health. His hearing, vision, gross and fine motor coordination, and speech and language development have all been good. He has had no chronic health problems other than chronic ear infections when he was very young. He had no medical problems aside from the usual childhood illnesses. He has never been hospitalized. He has been on no medications. Typical bedtime is 9:30. He does not have difficulty falling asleep. He will sometimes watch TV or play video games right up until bedtime. He tends to sleep through the night without disturbance. Dominic does not have any bowel or bladder control problems. His appetite is described as being average. His parents have no concerns about his eating. His mother describes him as being active/alert but notes that some people would describe him as being hyperactive.

MHlth Assessments signed by Wallinga, Gary, PHD,LP at 10/15/2014 7:37 AM (continued)

Dominic is described as being creative, strong-willed and caring. His parents note that he often fails to give close attention to details and makes careless mistakes in his schoolwork or other activities. He often has difficulty sustaining attention on tasks or activities and is easily distracted at times. He does not seem to listen when spoken to directly and does not follow through on tasks or instructions and failed to finish schoolwork or chores. He avoids or dislikes tasks that require sustained mental effort and tends to be forgetful in his daily activities. Dominic is further described as being somewhat fidgety with his hands or his feet or squirmy in his seat. He talks excessively and will interrupt or intrude on others. He sometimes has difficulty waiting his turn.

Dominic is described by his parents as frequently losing his temper, often arguing with adults, and actively defying or refusing adult requests or rules. He deliberately does things to annoy other people, will blame others for his own mistakes, and is touchy or easily annoyed. He tends to be angry and resentful at times. He will lie in order to obtain favors or avoid obligations.

Dominic's parents note that he sometimes seems to have marked mood swings. He can be irritable and irritating to others. Although he acts as though he is happy most days, if asked, he would likely say that nothing seems to make him happy. It should be noted that when he was about 4 or 5 years old he had made some suicidal sounding comments. At the time, he was upset because his baby-sitter had made him play "school." When he was in kindergarten, his teacher noted that he seemed somewhat depressed. This has been noticed by other teachers since then. Last year, when he was feeling very angry and frustrated, he admits that he was having thoughts of suicide as a way out of his predicament.

Dominic is described by his parents as exhibiting excessive anxiety or worry. He worries about homework being due and whether he has completed it well. He will sometimes look back at his work to make sure that he did it correctly or accurately. He has had some anxiety about changing schools. His parents describe him as having persistent fears of social or performance situations. He seems to have recurrent or persistent thoughts, impulses or images that are sometimes experienced as intrusive. For example, he sometimes feels driven to collect things such as Legos, technology, or Pokémon cards. Particularly when he was younger, he had to line things up, such as his books next to his bed. He reports that he has ten organizers for his three different gaming systems because he likes to keep all the components organized. He has his own shelves in the family room on which to arrange his collections and a table there on which he keeps his Legos (He is currently organizing his Legos by color.) He also has a certain part of his bedroom to himself (even though he shares it with his brother), and he becomes very upset if anyone touches his things. His mother recalls that when he was younger he tended to do more of this lining up of objects, but it is not so prevalent now. He goes through his Pokémon cards every so often to keep them organized. Dominic is described as being very particular about almost everything. He wants his clothing to fit just so. He does not like tight clothing or to feel the zipper on his neck. His shorts need to be above his knee. Otherwise he does not appear to have other sensory issues.

Dominic's parents describe him as having had some rather odd behaviors in the past. He would periodically shake his head back and forth, when he was younger. Dominic claims that he did this purposely because he liked the feeling and thought it was fun. Now he does not do it because it hurts his head. His parents also report that he had tics when he was younger. Sometimes he would make noises which his parents thought were involuntary and not within his awareness. Dominic says he was purposely making noises in order to get someone's attention or to irritate others. These have decreased and are now rather rare. He does not make such noises at school or in church.

Dominic has started the seventh grade at Sauk Rapids Middle School. Previously, he attended St. Katharine Drexel. He felt that peers were critical of his appearance and interests. He is finding the peers at Sauk Rapids Middle School to be much more accepting. He reports that he is making friends there although has typically seemed to perceive himself as having difficulty making friends. His parents do not think that this is especially difficult for him. He prefers to keep the same friends he has always had, even though some have moved away or now attend different schools. Dominic reports that he is doing a better job this year of completing work and staying organized. Last year he was more interested in playing video games or with his Legos. He found the schoolwork boring. His grades suffered. Admittedly, Dominic sometimes has difficulty staying focused at school. This has been an issue since kindergarten. He has historically been an average student. Last year, his grades ranged from Ds to Bs. He has had trouble with organization and work completion.

BEHAVIORAL OBSERVATIONS:
Dominic is a 12-year-old boy of average height and weight. His parents accompanied him to the initial clinical intake for this evaluation. He appeared comfortable with his parents, and engaged in the evaluation process freely. He was friendly

MHlth Assessments signed by Wallinga, Gary, PHD,LP at 10/15/2014 7:37 AM (continued)

and quite talkative. His eye-contact was good. He exhibited an ability to reflect on the feelings of others and to look inward at his own feelings and motivations. He was able to discuss his friendships and relationships with peers in general. He appeared to be of at least average intellectual ability. His concentration and attention during the interview were good. During cognitive testing, though, there were lapses in focus. His memory for recent and remote events appeared to be intact. He did not exhibit any signs of a thought disorder. He did not exhibit any obsessions or compulsive behaviors during this evaluation. No tics or unusual motor mannerisms were noted. His fine and gross motor coordination appeared to be within normal limits. It was noted that he walks slightly "pigeon-toed." Dominic's mood was euthymic and his affect consistent with this. He did not appear to be particularly anxious during testing. He did seem to grow somewhat bored with the process, however. He stated that he trouble staying awake during the administration of the IVA.

EVALUATION RESULTS:

Wechsler Intelligence Scale for Children - Fourth Edition (WISC-IV)

Scale	Standard Score	Percentile
Verbal Comprehension	119	90
Perceptual Reasoning	125	95
Working Memory Index	94	34
Processing Speed Index	94	34
Full Scale IQ	114	75

Verbal Comprehension	Scaled Score
Similarities	15
Vocabulary	14
Comprehension	11

Perceptual Reasoning	
Block Design	13
Picture Concepts	13
Matrix Reasoning	16

Working Memory	
Digit Span	7
Letter-Number Sequencing	11

Processing Speed	
Coding	9
Symbol Search	9

Integrated Visual and Auditory Continuous Performance Test (IVA)

Scale	Standard Score
Full Scale Attention Quotient	87
Auditory Attention Quotient	78
Visual Attention Quotient	99
Full Scale Response Control Quotient	90
Auditory Response Control Quotient	91
Visual Response Control Quotient	91

Response Control Subscales	Auditory Standard Score	Visual Standard Score
Prudence	86	99
Consistency	97	105
Stamina	100	78

MHlth Assessments signed by Wallinga, Gary, PHD,LP at 10/15/2014 7:37 AM (continued)

Attention Subscales		
Vigilance	57	99
Focus	103	95
Speed	97	105
Validity Subscale		
Comprehension	105	103
Fine Motor Regulation Quotient	101	

Conners' 3 Parent/Teacher Rating Scale

Scale	Mother T-Score	Father T-Score
Inattention	67	67
Hyperactivity/Impulsivity	87	72
Learning Problems/Executive Functioning	--	--
Learning Problems	46	50
Executive Functioning	55	58
Defiance/Aggression	59	65
Peer Relations	53	45

MHlth Assessments signed by Wallinga, Gary, PHD,LP at 10/15/2014 7:37 AM (continued)

Behavior Assessment System for Children - 2 (BASC-2)

PARENT RATING SCALES (PRS)

	Mother T-Score	Father T-Score
Composite Scores		
Externalizing Problems	73	58
Internalizing Problems	68	56
School Problems	--	--
Behavioral Symptoms Index	76	61
Adaptive Skills	37	47
Individual Scale Scores		
Externalizing Scales		
Hyperactivity	75	58
Aggression	68	56
Conduct Problems	71	57
Internalizing Scales		
Anxiety	66	53
Depression	82	63
Somatization	46	49
School Problem Scales		
Attention Problems	66	63
Learning Problems	--	--
Additional Clinical Scales		
Atypicality	60	60
Withdrawal	68	52
Adaptive Scales		
Adaptability	28	35
Social Skills	37	57
Leadership	41	57
Activities of Daily Living	43	43
Study Skills	--	--
Functional Communication	45	48

MHlth Assessments signed by Wallinga, Gary, PHD,LP at 10/15/2014 7:37 AM (continued)

Behavior Rating Inventory of Executive Function (BRIEF)

PARENT FORM

Scale/Index	Mother T-Score
Inhibit	63
Shift	74
Emotional Control	67
Behavioral Regulation Index	70
Initiate	65
Working Memory	67
Plan/Organize	58
Organization of Materials	55
Monitor	63
Meta-Cognition Index	63
Global Executive Composite	67

Short-Sensory Profile

	Score	Classification
Tactile Sensitivity	26/35	Definite difference
Taste/Smell Sensitivity	16/20	Typical performance
Movement Sensitivity	12/15	Probable difference
Under-responsive/Seeks Sensation	20/35	Definite difference
Auditory Filtering	18/30	Definite difference
Low Energy/Weak	30/30	Typical performance
Visual/Auditory Sensitivity	15/25	Definite difference
Total Score	137/190	Definite difference

Social Communication Questionnaire (SCQ):

Total Score = 5

Millon Pre-Adolescent Clinical Inventory (M-PACI)

Scale	
Response Validity Indicators	
Invalidity Raw Score	0
Response Negativity Percentile	18

MHlth Assessments signed by Wallinga, Gary, PHD,LP at 10/15/2014 7:37 AM (continued)

Emerging Personality Patterns	BR Score
Confident	68
Outgoing	60
Conforming	49
Submissive	62
Inhibited	7
Unruly	3
Unstable	20

Current Clinical Signs	
Anxiety/Fears	79
Attention Deficits	53
Obsessions/Compulsions	29
Conduct Problems	15
Disruptive Behaviors	28
Depressive Moods	0
Reality Distortions	44

Children's Yale-Brown Obsessive Compulsive Scale

SELF-REPORT

- Dominic endorsed two "past" compulsion items: "Checking things that did not make sense" and "Having difficulty not throwing things away."
- Dominic endorsed four "current" compulsion items: "Needing to have symmetry/evening up items," "Superstitious behavior" (not stepping on imaginary lines), "Needing to touch, tap, or rub (his electronic game screen much be free of smudges), and Needing to do things" (arrange video game related items so they look "nice and neat", and Pokémon cards so "he knows where to find them.")
- Dominic endorsed only one "past" obsession item: "Fear that harm will come to self" (when around paper shredders).
- Dominic did not endorse any "current" obsessions.
- In terms of how severe these obsessive thoughts or compulsive behaviors are, Dominic rated them as only mildly occupying his thought, and not interfering with his thinking,. He did not report distress associated with such thoughts and noted that he is usually able to stop or divert obsessive thoughts with some effort and concentration.
- Dominic reported that the amount of time he spends on any compulsion is "mild' and that these do not interfere at all with his life. He felt "extreme" distress, though, if prevented from doing these compulsive behaviors. He does not attempt to resist compulsive behaviors, at all and believes that he has "moderate" control over them.

PARENT-REPORT

- Dominic's mother endorsed four "past" compulsion items: "Checking locks, toys, school books/items, etc.," "Checking that did not make mistake," "Need for symmetry/evening up," and "Difficulty throwing things away, saving bits of paper, string, etc."
- Dominic's mother endorsed two "current" compulsion items: "Need for symmetry/evening up" and Superstitious behaviors/excessive games."
- Dominic's mother reported no "past" obsessions and two "current" obsessions: "Fear of losing things" and "Luck/unlucky numbers, colors, words."
- In terms of how severe these obsessive thoughts are, his mother rated them as only mildly occupying his thoughts and not interfering with his thinking. She rated him as being mildly distressed by such thoughts and mildly resistant to them. She thought that he had "much" control over his obsessions.
- Dominic's mother reported that his compulsions took less than an hour a day to perform, did not interfere with his functioning, caused him severe distress if interrupted, were not resisted by him at all and that he had little control over them.

SUMMARY AND CONCLUSIONS: Dominic is a 12-year-old boy referred by Wendi Johnson, MD, his pediatrician, for a psychological evaluation of attention deficit hyperactivity disorder and anxiety.

Dominic was administered the Wechsler Intelligence Scale for Children-Fourth Edition. On this administration, he obtained a Full Scale IQ of 114. This falls within the above average range and at the 75th percentile rank relative to same-aged peers. The chances that his "true" IQ falls between 109 and 119 are approximately 95 out of 100. The results of the WISC-IV yield several composite scores which provide further information about the specific cognitive abilities.

On the Verbal Comprehension Composite of the WISC-IV, Dominic had an index score of 119. This falls within the above average range and at the 90th percentile rank relative to same-aged peers. The Verbal Comprehension Index is a reflection of his verbal reasoning, comprehension, and concept formation. Dominic performed particularly well on this composite, on subtests reflecting his abstract verbal reasoning and concept formation as well as his word knowledge. These were statistically significant strengths for him.

On the Perceptual Reasoning Composite of the WISC-IV, Dominic had an index score of 125. This falls within the superior range and at the 95th percentile rank relative to same-aged peers. The Perceptual Reasoning Index reflects his perceptual reasoning and organizational ability. Dominic performed extremely well on subtests on this composite measuring visual information processing and abstract reasoning skill. This was another statistically significant strength for him.

On the Working Memory Composite of the WISC-IV, Dominic had an index score of 94. This falls within the average range and at the 34th percentile relative to same-aged peers. The Working Memory Composite reflects his short-term auditory memory, attention, and concentration. This composite is made up of two subtests: Digit Span and Letter-Number Sequencing. Dominic performed within the average range on the Letter-Number Sequencing subtest but below average on the Digit Span subtest. This latter score represented a statistically significant weakness for him. Both of these subtests require some transformation of information or mental manipulation, visual-spatial imaging, sequencing, and short-term auditory memory. During the administration of the Digit Span subtest, he seemed to have trouble focusing.

On the Processing Speed Composite of the WISC-IV, Dominic had a score of 94. This falls within the average range and at the 34th percentile rank relative to same-aged peers. The Processing Speed Index reflects his speed of mental or grapho-motor processing. The two subtests making up this composite also requires some short-term visual memory, visual motor coordination, visual discrimination or scanning, cognitive flexibility and concentration. On at least one of these timed subtests, he was slowed down because he made mistakes and had to erase and rewrite his response.

Comparing Dominic's performance across the four composite scores of the WISC-IV, there were statistically significant strengths and weaknesses. His Verbal Comprehension and Perceptual Reasoning indices were statistically significantly greater than his Working Memory or Processing Speed indices. The differences were large enough as to be unlikely to have occurred by chance. In this respect, then, his verbal comprehension and perceptual reasoning can generally be considered strengths for him while his working memory and processing speed are weaknesses. Other than working quickly and taking information in quickly, or holding information in working memory, school tasks should be relatively easy for Dominic.

Dominic's performance on the Working Memory subtests of the WISC-IV is pertinent to the referral question regarding possible Attention Deficit Hyperactivity Disorder. Dominic's significantly poor performance on the Digit Span subtest suggests problems maintaining his focus. The WISC-IV was not designed to assess for attentional problems, however. A more valid method of assessing for this would be to use a continuous performance test such as the Integrated Visual and Auditory Continuous Performance Test. This was administered to Dominic as part of this evaluation as well. On the Administration of the IVA, Dominic had a Full Scale Response Control Quotient of 90 and a Full Scale Attention Quotient of 87. Both of these scores are considered to be within the average range for this test. The Full Scale Response Control Quotient reflects his impulse control, while the Full Scale Attention Quotient reflects his attentional capacity. Examining the auditory and visual portions of the response control measures, he performed equally well. Both of his scores were towards the lower end of the average range. Looking at the auditory and visual portions of the Attention quotient, the visual attention score was average but the auditory attention quotient was significantly below average. This was due primarily to an extremely low score for the auditory portion of the Vigilance scale. This particular measure reflects failure to respond to a target during the rare presentation blocks. Individuals that performed poorly in this manner are usually described as having problems with discriminatory attention, staying on task and/or being alert. Overall, then, the results of the IVA are not particularly indicative of an individual with Attention Deficit Hyperactivity Disorder. Yet, there was one significantly low score which could point to some possible lapses in focus when task demands are not high.

MHlth Assessments signed by Wallinga, Gary, PHD,LP at 10/15/2014 7:37 AM (continued)

Another method of assessing for Attention-Deficit Hyperactivity Disorder is parent rating scales. Dominic's mother completed the Behavior Rating Inventory of Executive Functioning. On this instrument, her responses resulted in a significantly elevated score on the Behavior Regulation Index and a moderately elevated score on the Metacognition Index. She described him as having significant problems shifting from one task to another and moderate problems inhibiting behaviors or controlling his emotional response. He has moderate problems initiating behaviors, using working memory, and monitoring his behavior. His overall Global Executive Composite, was also moderately elevated. This would seem to support a diagnosis of Attention-Deficit Hyperactivity Disorder.

Dominic's parents completed the Conners' Rating Scale. Their responses resulted in significantly elevated scores on the Hyperactivity/Impulsivity Scale and moderately elevated scores on the Inattention Scale. On another parent rating scale, the Behavioral Assessment System for Children, the Hyperactivity Scale was again significantly elevated on his mother's questionnaire but was average on his father's. Both had moderately elevated scores on the Attention Problems Scale. Considering the results of these rating scales, it is somewhat confusing in that while on the Conners' his parents are reporting primarily hyperactivity and impulsivity, on the BASC, they seem to more consistently report inattention.

Examining Dominic's parent's responses to the Behavioral Health Clinic Intake Form, they endorsed eight of nine symptoms of inattention as occurring often or very often and three of nine symptoms of hyperactivity/impulsivity. That is, they described him as often failing to give close attention to details and as making careless mistakes in his schoolwork. He had difficulty sustaining attention on tasks or activities and is easily distracted by extraneous stimuli. He is described further as not seeming to be listening when spoken to directly. He does not follow through on instructions or fails to finish schoolwork, chores or other duties. He has a difficult time organizing tasks or activities, avoids those tasks that require sustained mental effort, and is forgetful in his daily activities. His parents also reported that he tends to fidget with his hands or his feet or squirm in his seat, talk excessively and interrupt or intrude on others. The symptoms endorsed on the Behavioral Health Clinic Intake Form, in combination with the BRIEF, BASC and Conners' would, taken together, be enough to give him a diagnosis of Attention-Deficit Hyperactivity Disorder. The fact that his father reports relatively few symptoms on the BASC and the fact that Dominic's IVA composite scores were essentially average, makes giving this diagnosis a little more difficult, however.

There would appear to be several possible alternative explanations for the test results. First, it could be that Dominic has ADHD but, because he is fairly bright, he is able to often compensate for ADHD symptoms and under most circumstances function fairly well. Secondly, it could be that he does not have ADHD and the test results are just a false positive finding. Thirdly, it could be that there is another factor such as mood or sensory issues, making Dominic appear inattentive and fidgety rather than ADHD. The diagnosis of Attention-Deficit Hyperactivity Disorder, then, should probably remain a provisional diagnosis, until it is clear that his inattention is not being caused by a mood disturbance and/or sensory related issues.

Dominic's mother completed the Short Sensory Profile. Her responses resulted in "definite differences" on several scales: Tactile Sensitivity, Under-Responsive/Seeks Sensation, Auditory Filtering, Visual/Auditory Sensitivity, and the Total Sensory Score. What this would indicate is that relative to others his age, his response to tactile, auditory and some visual sensory input is unusual with him either being hypersensitive or hyposensitive. If this is true, it could contribute to him being distracted by certain sensory stimuli around him, thus making him appear inattentive. The Short Sensory Profile is a screening device and diagnosing sensory integration problems is beyond the scope of this evaluation or the expertise of the examiner. An occupational therapist could accomplish this at a later date.

There were indications on the BASC completed by Dominic's parents that he exhibits moderate to severe symptoms of depression and average to moderate symptoms of anxiety. Regarding depression, his parents described him as complaining about being teased, being negative about things, being moody and saying he does not have friends. On the Anxiety Scale they endorsed items indicating that he often worries about making mistakes, is nervous, says he is not very good at things, and worries about things that cannot be changed. Interestingly, on the Millon Pre-Adolescent Clinical Inventory, Dominic's responses resulted in a very low score on the Depressive Mood Scale, but a high score on the Anxiety/Fear Scale. The profile that he obtained on the M-PACI is usually associated with at least a mild anxiety condition evidenced by an agitated state and several behavioral signs, such as feeling jumpy or ill at ease. Such symptoms may be prompted by a recent failure of things to go his way and a disparity between having things as he is accustomed to having them and the presence of events that precluded his more usual successful manipulations. In the clinical interview, his mother reported that he has excessive anxiety and worry, some recurrent or persistent thoughts or impulses that he

MHlth Assessments signed by Wallinga, Gary, PHD,LP at 10/15/2014 7:37 AM (continued)

experiences as intrusive and inappropriate and recurrent distressing recollections or dreams of traumatic events, such as moving school. She did not note depressed mood so much as irritability and a tendency to irritate others. She further commented that while Dominic often acts happy, if asked directly he would say that nothing makes him happy. The only other symptoms related to depression that she endorsed were related to agitation, lethargy or marked mood swings. These test results seem to support more a diagnosis of anxiety rather than depression. It does not appear that his anxiousness if pervasive enough to warrant a diagnosis of Generalized Anxiety Disorder but he will be given a diagnosis of Unspecified Anxiety Disorder, instead.

Beyond simple worry. Dominic appears to have a number of symptoms that seem to reflect some obsessive-compulsiveness. He and his mother both responded were interviewed using the Children's Yale-Brown Obsessive Compulsive Scale. He does seem to have some repetitive behaviors that he feels driven to perform and are aimed at preventing or reducing anxiety or distress. His mother estimates that these take at least an hour a day, and that he may experience these as intrusive, although this is not entirely clear. He does not seem to attempt to ignore or suppress such thoughts or urges at the present. He would probably be able to receive at least a provisional diagnosis of Obsessive-Compulsive Disorder, based on these test results.

Dominic's responses to the M-PACI resulted in a profile that could be interpreted one of two ways. One possibility is that he is essentially a normal child who has inappropriately taken this clinically oriented inventory. The second possibility is that he is troubled and demonstrates the characteristics described below. The latter seems to be more likely in light of the fact that his parents are so concerned about him. Individuals that responded to the M-PACI as did Dominic tend to report feeling self-assured and confident in their abilities. They often approach activities and interests with a sense of determination and excitement. In their interactions, they are good natured and affable. These aspects of their developing personality, tend to draw others towards them.

This M-PACI profile can also be indicative of a child who has a somewhat inflated sense of worth, an air of imperturbability and a dislike of following social traditions, although they want to be seen as being sociable. Their tendencies to exploit and to be self-centered, while not malicious in intent, may stem from the assumption that rules do not apply to them. Their behavior is often characterized by a persistent seeking of recognition and compliments, usually through self-enhancing or exhibitionistic behaviors. These pre-adolescents have a talent for intriguing but exploiting peers, although this is probably not the result of deliberate or conscious deceit. In fact, these pre-adolescents seem to be unaware that their self-centeredness and undependability is inconsiderate and presumptuous. If these pre-teens are unable to fulfill their narcissistic needs, more extreme forms of coping may become evident.

Pre-adolescents with this M-PACI profile are often seen in mental health settings because of family conflicts or school problems associated with attention deficits or hyperactivity. These children tend to react quickly to others' displeasure or confrontations by projecting blame, acting indifferently or offering up rationalizations. There may be periods of acting out, particularly within the home. They become genuinely upset in the face of unavoidable evidence of their personal and scholastic failures or inadequacies.

Dominic's dislike or disregard for rules in combination with anxious irritability and some impulsivity results in him conflicting with others. He is described as losing his temper, arguing, defying rules and requests, annoying others, blaming others, being touchy and angry. Taken together, these behaviors describe Oppositional Defiant Disorder. This would also be reflected in his parent's responses to the BASC, where the Conduct Problems Scale was significantly elevated, and the Conners', where his father reported moderate defiance and aggression.

With Dominic's parent's reports of him exhibiting involuntary vocal noises and repetitive body movements, his need to put things in order and his severe reaction when others touch his possessions, symptoms of ADHD, sensory processing issues, and behavioral inflexibility, one might consider a diagnosis of Autism Spectrum Disorder. On the other hand, many of these symptoms have spontaneously decreased over time. Also, his mother's responses to the Social Communication Questionnaire resulted in a total score of five which is far below the cutoff of 15 used to indicate Autism. In fact, she did not endorse any of the behaviors on the rating scale that should have been evident at ages four and five if he had the diagnosis. The only symptoms she reported him exhibiting were him having to do things in a very particular way or order, having interests that preoccupied him and that would seem odd to others, being more interesting in parts of objects rather than the object as it was intended to be used, and as having interests that were unusual in their intensity. At this time, then, Dominic would probably not meet diagnostic criteria for Autism Disorder. He meets the criteria for "restricted, repetitive

MHlth Assessments signed by Wallinga, Gary, PHD,LP at 10/15/2014 7:37 AM (continued)

patterns of behavior and interests or activities" but not for "persistent deficits in social communication and social interaction across multiple contexts."

DIAGNOSIS:
Attention Deficit Hyperactivity Disorder - combined type, provisional
Obsessive-Compulsive Disorder - provisional
Unspecified Anxiety Disorder
Oppositional Defiant Disorder
R/O Sensory Processing Disorder

RECOMMENDATIONS:

1. Dominic and his parents should consult with a child psychiatrist regarding medication for Attention Deficit Hyperactivity Disorder and possibly anxiety.
2. Individual therapy is usually recommended for children with ADHD and/or anxiety. This means working with a psychologist who will target certain behaviors, such as correcting automatic negative thoughts. The therapist will function as a coach to help develop "internal supervision skills," teach focused breathing to reduce temper outbursts and anxiety while improving impulse control and clarity of thought, teach problem solving, and work on communication and social skills. Cognitive behavioral therapy is the general term used to describe this approach to treatment. For obsessive-compulsive behaviors, the specific treatment strategy is exposure and response prevention.
3. The therapist working with this family could also provide support and assistance in developing effective family and parenting strategies. Some experts believe that parent training is a primary intervention for children that have inattention, hyperactivity and behavior problems. With children such as this, it is particularly important that the adults or parents be in agreement in terms of expectations and means of delivering negative and positive consequences for behavior. The follow though of consequences must be unwavering.
4. Parents of children with ADHD are encouraged to obtain a good text on this disorder such as those offered by Russell Barkley, Ph.D., Ed Hallowell, M.D., or John F. Taylor, Ph.D. All three of these authors have written texts for the general public that do a good job of reviewing the symptoms of Attention Deficit Hyperactivity Disorder, its origins, and treatment strategies that include both family and school interventions.
5. It is important that children diagnosed with ADHD receive an explanation of this conditions as well, so that they can begin to better understand what this means about them. This would be a first step towards eventually learning helpful coping strategies.
6. There are a number of interventions or strategies recommended for working with children with ADHD, summarized in the appendix of this report.
7. Many children, who have ADHD do not seem to respond to the normal parenting strategies most parents use. These children need an approach that emphasizes intense positive feedback. A good description of such an approach is presented in a book by Howard Glasser: *Transforming the Difficult Child*. This approach emphasizes positive reinforcement of appropriate behaviors using intense verbal praise and a "credit" or point system. Intense negativity in the form of punishment and nagging is discouraged. Time outs given in a matter-of-fact manner are used as a consequence, instead.
8. It is recommended that parents of children with ADHD read *Executive Skills in Children and Adolescents* by Peg Dawson and Richard Guare or *Late, Lost, and Unprepared* by Joyce Cooper-Kahn and Laurie Dietzel.
9. Additionally, a number of good websites are available, such as www.chadd.org and www.help4adhd.org.
10. There are a number of interventions or strategies recommended for working with children with ODD, summarized in the appendix of this report.
11. There is a list of strategies for parents working with anxious children summarized in the appendix to this report.
12. *Freeing Your Child From Anxiety,* by Tamar is a book written for parents about anxiety in children that might be of help. Also, Chansky *Helping Your Anxious Child, A Step-By-Step Guide for Parents* by Ronald M. Rapee, Ph.D., et. al, might be a useful resource.
13. These test results should be shared with the school so that they can use the results in refining their teaching approach to best match this child's needs.
14. Regular and frequent communication between home and school will be vitally important to ensure academic and behavioral success. A means of regularly communicating should be developed, if it has not already been accomplished.

MHlth Assessments signed by Wallinga, Gary, PHD,LP at 10/15/2014 7:37 AM (continued)

15. Searching for this child's areas of social, academic or functional competence and supporting them in getting healthy doses of activities that utilize these strengths will be important in building a sense of mastery and self-esteem and helping to prevent feelings of marginalization.
16. Dominic should be further evaluated for sensory processing issues, by an occupational therapist.

Gary Wallinga, PhD, LP

GW/dcs D: 09/24/2014 10:29 A T: 09/24/2014 11:13 A Doc#: 11394219

cc:

APPENDIX

CLASSROOM STRATEGIES FOR STUDENTS WITH ADHD

Physical Arrangement of the Classroom:

1. Place the student near the teacher but away from windows or the doorway.
2. Give the student an unobstructed view of the chalkboard, movie screen, etc.
3. Minimize distractions (visual and auditory).
4. Require an organized desk/work area.
5. Use desk dividers or offer a study carrel as a quiet place to work. (make this available to all students)
6. Surround the student with positive role models.
7. Avoid seating the student at a table with other students.
8. Use rows for the seating arrangement and provide aisles for easy teacher mobility.
9. Encourage parents to set up an appropriate study space at home with a homework routine outlining when and where homework will be completed and who will help with homework and review completed assignments.

Lesson Presentation:

1. Provide an outline, key concepts, or vocabulary, prior to lesson presentation.
2. Make eye contact.
3. Stand near the student when giving directions or presenting lessons.
4. Use the student's paper as an example, during instruction.
5. Use the student's name during presentations.
6. Keep lessons brief.
7. Use larger type. Keep page formats simple (no extraneous pictures, one activity per page).
8. Use multi-sensory presentations but screen audio-visual aids to prevent unnecessary. distraction.
9. Use colored chalk or markers during presentations.
10. Draw arrows on the text or worksheet to show how ideas are related.
11. Include a variety of activities during each lesson.
12. Actively involve the student during lesson presentation by:
    - -using cooperative learning activities
    - -developing learning stations
    - -providing self-correcting materials
    - -using computer assisted instruction
    - -enabling the student to make frequent responses
    - -employing role playing activities
    - -interacting frequently, either verbally or physically, with the student
13. Provide specific instruction on how to work in groups.
14. Arrange peer tutoring and pair students to check work.

Worksheets and Tests:

1. Give out only one task at a time.
2. Give clear, simple, directions.
3. Provide written backup for verbal directions.
4. Repeat instructions twice.
5. Provide models of expected work.
6. Make certain the student comprehends before beginning a task.
7. Reduce time limit pressures.
8. Do not return homework to be copied over.
9. Clearly group similar items on worksheets.
10. Underline key direction words, vocabulary words, etc.
11. Draw boundaries around the parts of the page you want emphasized.
12. Shorten assignments.
13. Add reminders on worksheets to check work.
14. Allow extra time for tests and assignments.
15. Give frequent short quizzes and avoid longer tests.

MHlth Assessments signed by Wallinga, Gary, PHD,LP at 10/15/2014 7:37 AM (continued)

16. Avoid essay tests and limit choices on matching to five or less.
17. Avoid rote memorization.
18. Allow take-home tests.
19. Provide practice tests.
20. Provide alternative environments for test taking with fewer distractions.
21. Substitute projects for written assignments.

Organization:

1. Use individual assignment charts or books to keep track of what work has to be completed.
2. Provide daily and weekly assignment sheets.
3. Develop a means of communicating regularly with the parents. Keep parents informed.
4. Give the parents a copy of the syllabus at the beginning of the semester.
5. Write the schedule and timelines on the board each day.
6. Establish a daily classroom routine and schedule.
7. Use visual and auditory cues as signals prior to changing a task and to signal a task ending.
8. Allow the student to keep extra books at home for homework assignments.
9. Provide due dates of assignments, each day.
10. Have the student organize notebooks, folders, and backpack daily.
11. Develop a reward system for in-school work and homework completion.
12. Keep the student's desk clear.
13. Divide longer assignments into sections and provide due dates or times for completion of each section.

Behavioral Interventions:

1. Classroom rules should be clearly stated, posted, and reviewed daily.
2. Remain calm, state the infraction of the rule and don't debate or argue with the student.
3. Enforce classroom rules consistently.
4. Positive and negative consequences should be pre-established and clearly stated.
5. Administer consequences matter-of-factly and immediately.
6. Emphasize positive behavior and de-emphasize negative behavior. Negative behavior should receive no adult intensity and positive behavior should receive increased adult intensity.
7. Reinforce appropriate behavior, following rules and doing classroom chores with intense verbal praise and perhaps even concrete rewards.
8. Be specific in your praise: describe the behavior and name the quality the student was exhibiting, i.e. cooperation, helpfulness, patience, etc.
9. Develop a classroom behavior management system. Use tokens, points or contracts to shape appropriate behavior. Remember to chart progress.
10. Discipline should be quick and short and appropriate to the rule infraction.
11. Avoid ridicule, lecturing, nagging, yelling, embarrassment and criticism.
12. Coordinate the classroom behavior management system with the parent's disciplinary efforts.
13. Teach the student problem solving.
14. Give the student choices.
15. Use cues to refocus the student (hand signal, tap on the shoulder).
16. Provide activities that build self-esteem. Find things that student does well and create opportunities for the student to use these skills regularly. Create ways for the student to make a positive contribution to the school family/community.
17. Find some way to connect with the student on a personal level.
18. Meet with the student regularly to review progress.

PARENT RECOMMENDATIONS FOR ADHD CHILDREN

1. Seek up to date, scientifically supported information about ADHD. Be careful about ads claiming to cure ADHD because currently there is no cure. It is up to parents to become good consumers of information. Go to sources that are reputable: American Psychiatric Association, American Psychological Association. National Alliance for the Mentally Ill, CHADD, etc.
2. Seek professional treatment. When first seeking a professional, ask questions about the diagnosis and treatment of ADHD, how many of their clients have ADHD, what methods of treatment do they use, can they evaluate co-existing conditions common with ADHD. Effective treatment should be multimodal and include an appropriate educational program, behavior modification, parent, child and teacher education, counseling and medication.
3. Become your child's best advocate. You may have to protect and represent your child's best interests in school situations both academically and behaviorally. You should be part of your child's team that determines what services your child will receive according to their Individual Educational Plan (IEP) or Section 504 Plan. You should know your child's rights under the Individuals with Disabilities Act (IDEA) and Section 504 of the Rehabilitation Act.
4. Seek parent training from a qualified mental health professional experienced in treating ADHD. Approaches that work well with your other children may not work well with your ADHD child. Parent training can teach you strategies to change your child's behavior and improve your relationship with your child. It will also help you learn to:
    - Provide clear and consistent expectation, limits and directions. ADHD children do not do well with any ambiguity. They must know exactly what is expected of them.
    - Set up an effective discipline system. Learn proactive discipline methods that teach and reward appropriate behavior and respond to misbehavior with alternatives such as time out or loss of privileges.
    - Create behavior modification plans to change the most problematic behaviors. Behavior charts and other behavior modification techniques will help you focus on and address problems in systematic, effective ways. Use positive behavior modification principles to reinforce positive behaviors and to eliminate negative behaviors.
    - Set aside a daily "special time" for your child. Constant negative feedback can undermine a child's self esteem. Positive attention can build self-esteem and strengthen your relationship with one another.
5. Help your child with social issues. Teach them the necessary skills to make and keep friends and work cooperatively with others.
6. Identify your child's strengths in areas that are not necessarily academic in nature such as art, music, computers, mechanical ability - and build upon these strengths so that your child has a sense of pride and accomplishment. This is very important.
7. Seek out support for yourself. Parents can give each other information as well as support.
8. Have yourself evaluated for ADHD if you or your spouse suspects you have this disorder.
9. Seek up to date, scientifically supported information about ADHD. Be careful about ads claiming to cure ADHD because currently there is no cure. It is up to parents to become good consumers of information. Go to sources that are reputable: American Psychiatric Association, American Psychological Association. National Alliance for the Mentally Ill, CHADD, etc.
10. Seek professional treatment. When first seeking a professional, ask questions about the diagnosis and treatment of ADHD, how many of their clients have ADHD, what methods of treatment do they use, can they evaluate co-existing conditions common with ADHD. Effective treatment should be multimodal and include an appropriate educational program, behavior modification, parent, child and teacher education, counseling and medication.
11. Become your child's best advocate. You may have to protect and represent your child's best interests in school situations both academically and behaviorally. You should be part of your child's team that determines what services your child will receive according to their Individual Educational Plan (IEP) or Section 504 Plan. You should know your child's rights under the Individuals with Disabilities Act (IDEA) and Section 504 of the Rehabilitation Act.
12. Seek out support for yourself. Parents can give each other information as well as support.
13. Have yourself evaluated for ADHD if you or your spouse suspects you have this disorder.

PARENTING STRATEGIES FOR OPPOSITIONAL DEFIANT BEHAVIOR

1. **Learn to pay attention to your child's desirable behavior.**
   A. First, practice the skills of "positive attention" by spending 15-20 minutes each day, for one week, alone with your child describing out loud what your child is doing. Ask no questions and give no commands. Occasionally, provide you child with positive statements of praise, approval, or positive feedback about what you like about his/her play. Be accurate and honest.
   B. Second, use your attending skills to provide approval to your child when he/she follows a command or request. When you give a command, give immediate feedback when your child begins to comply and for how well he/she is doing. Once you have attended to your child's compliance, if you must, you can leave for a few moments, but be sure to return frequently to praise your child's compliance some more. If you find your child has done a job or chore without being specifically told to do so, this is also a time to provide especially positive praise. You should begin to use positive attention to your child for virtually every command you give him/her.
   C. For several weeks, take a few minutes and specifically train compliance in your child. Select a time when your child is not very busy and ask him/her to do very brief favors for you, such as, "Hand me a Kleenex (spoon, towel, magazine etc.)," or, "Can you reach that _____for me?" These are called "fetch commands. Give about five or six of these in a row during these few minutes. Be sure to provide specific praise for your child's compliance. Try to have several of these compliance training periods each day.
2. **Learn to give effective commands**. If parents simply change the way they give commands to their children, they can often see significant improvements in how well their child complies. When giving a command:
   A. Make sure you mean it! Never give a command that you do not intend to see followed up to its completion.
   B. Do not present the command as a question or a favor.
   C. Do not give too many commands at once. Most children can follow only one or two instructions at a time.
   D. Make sure your child is paying attention to you.
   E. Reduce all distractions before giving the command.
   F. Ask you child to repeat the command.
   G. Make up chore cards. Listed on each card are the steps involved in correctly doing the chore. You might also indicate how much time it should take to complete the chore.
3. **Attend to independent play.**
   A. When you are about to become preoccupied with some activity, such as a phone call, cleaning, reading, etc. give you child a direct command. This command should contain two instructions. One part of it tells your child what he/she is to be doing while you are busy, and the second part specifically tells them not to interrupt or bother you.
   B. Then, as you begin your activity, stop what you are doing after a moment, go to your child, and praise the child for staying away and not interrupting. Remind your child to stay with his/her assigned task and not to bother you. Return to what you were doing.
   C. Then wait a few moments longer before returning to your child and again praising him/her for not bothering you. Return to your activity, wait a little longer, and again praise him/her.
   D. Over time, what you are trying to do is gradually reduce how often you praise your child for not bothering you while you increase the length of time you can stay at your own task. Initially, you will have to interrupt what you are doing and go praise the child very frequently, about every 30 seconds to 2 minutes. After a few times like this, wait 3 minutes before praising your child. Then wait 5 minutes before praising your child. Each time you return to what you are working on for a slightly longer period of time before going back to praise your child.
   E. If it sounds like your child is about to leave what he/she is doing and come to bother you, immediately stop what you are doing, go to your child, praise him/her for not interrupting you, and redirect him/her to stay with the task you gave him/her. This task should not be a chore but something interesting and fun.
   F. By gradually decreasing how often you praise your child, you will be able to stay with your task for longer and longer periods of time without being interrupted.
4. **Develop a home point system.**
   A. You can buy poker chips or use play money for this purpose. If your child is under 5, then each child or "dollar" should be worth 1 credit. For children older than 5, you can have different "dollar" amounts or different chips can be worth different values. Post a list somewhere that illustrates how much each chip or "dollar" is worth.
   B. Sit your child down and explain that you feel he/she has not been rewarded enough for doing nice things at home and you want to change that. You want to set up a new reward program so your child can earn nice privileges for behaving properly.
   C. Help you child create or make something to keep his/her chips or "dollars" in.

MHlth Assessments signed by Wallinga, Gary, PHD,LP at 10/15/2014 7:37 AM (continued)

D. Make a list of Rules, Appropriate Behaviors, and Chores. These should include things that are very easy for your child and that he/she does routinely and some that are very infrequently done but that you want your child to do more often. Assign a value to each of these items with the things that are most important receiving the highest value.
E. Make a list of all the privileges you child has. These are all the things they do for fun or things that are special treats or favors that you do for them. Assign a value to each of these items with the things that are most reinforcing or important to your child having the highest value. In other words, the things that he/she wants to do the most will "cost" him/her the most points. As a general guideline, about two thirds of the child's daily points should be spent on his/her typical daily privileges. This allows the child to save about one third of his/her chips every day toward the purchase of some of the very special rewards on the list.
F. Go out of your way to reward your child for doing chores, following rules or acting appropriately. Catch your child being good, in these ways, as often as you can.
G. Do not punish by taking away earned points.

5. **Use time out as a negative consequence for misbehavior.**
   A. This means behavior that you want to **stop** such as acting inappropriately or not following house rules. Time out does not work when you are attempting to get your child to start a behavior.
   B. Time out should be one minute for each year of age of your child.
   C. Use a counting approach as described by Thomas W. Phelan, Ph.D. in the book 1-2-3 Magic.
   D. Always give you first command in a firm but pleasant voice. Never yell or ask it as a favor. Make it a a simple, direct statement in a businesslike tone of voice.
   E. After you have given the command for you child to stop, you say, "That's one." If your child does not comply, you say, "That's two." If your child still has not complied, you say, "That's three, take a five minute timeout."
   F. Do not discuss or talk with your child. Do not act angry.
   G. Reward your child verbally and with points for being compliant with the time out.
   H. Your child will not be able to cash in any of his/her points for privileges until he/she has completed all time outs.
6. **Anticipate Problems - Managing children in public places**.
   Rule 1: Set up the rules before entering the place.
   Rule 2: Set up an incentive for the child's compliance.
   Rule 3: Set up your punishment for noncompliance.
   Rule 4: Give your child an activity to do.

Electronically signed by Wallinga, Gary, PHD,LP at 10/15/2014 7:37 AM