Psychological Evaluation

Name: D
Date of Birth: XX/XX/1994
Examiners: Jyoti Kolodziej, M.Ed.
Dates of Evaluation: 07/05/2012, 7/11/2012

Admission Screening Summary

Reason for Referral: D was seen as a treatment team request for an additional evaluation for differential diagnosis purposes. Specifically, D's treatment team wants clarification of symptoms of his Mood Disorder, NOS. His treatment team would also like to Rule Out Borderline Personality Disorder, which was noted in treatment records.

Assessment Procedures:
Cumulative File Review
Student Interview
Adaptive Behaviors Assessment System, 2nd Edition (ABAS-II)
    Parent (Dorm Supervisor & Mother) Rating Scales
    Teacher Rating Scales
Behavior Assessment System for Children – 2nd Edition (BASC-2)
    Parent (Dorm Supervisor & Mother) Rating Scales (PRS-A)
    Teacher Rating Scales (TRS-A)
    Student Rating Scales (SRP-A)
Millon Adolescent Clinical Inventory (MACI)
Minnesota Multiphasic Personality Inventory, 2nd Edition, Adolescent (MMPI-2-A)
Revised Children's Manifest Anxiety Scale, 2nd Edition (RCMAS-2)
Children's Depression Inventory, 2nd Edition (CDI-2)

Background Information:

Records indicate that D is in the 10th grade. He previously attended Sample High School in Bloomington, Indiana. According to his Individualized Education Program (IEP) at Sample School Corporation in Bloomington, Indiana dated November 1, 2011, D was eligible for special education services due to an Autism Spectrum Disorder and a Language Impairment. According to his IEP, D presented problems with social communication deficits, significant deficits in nonverbal gestures, lacking reciprocal social or emotional reciprocity, stereotyped behavior or mannerisms, and inattention. According to D's IEP, he will continue academics with inclusion support, daily resource, and speech services. According to a Behavior Intervention Plan (BIP) created on November 8, 2011, two target behaviors were identified for D including: beginning all tasks requested of him within 1 minute of adult prompt and then appropriately ask/wait for adult assistance when needed and making safe and positive choices when frustrated and upset. His re-evaluation is due 11/1/14.

D was evaluated by R. Sample, Ph.D., in Bloomington, Indiana on October 9, 2009 for a clinical evaluation to determine if he met the criteria for an Autism Spectrum Disorder. The clinical evaluation indicated that his cognitive ability was assessed in 2009 with multiple cognitive assessments with the following varying standard scores: Verbal Comprehension: 97-121; Perceptual Reasoning: 86-93; Working Memory: 88-100-105; Processing Speed: 70-89; and FSIQ: 89-96. Because of the discrepancy and differences in D's abilities, Dr. Sample's clinical evaluation indicated that he was administered parts of the Clinical Evaluation of Language Fundamentals-IV (CELF-IV) with the following scaled scores: Recalling Sentences, 9; Word Classes-Receptive, 9; Word Classes-Expressive, 12; Word Classes-Total, 10; Understanding Spoken Paragraphs, 9; and Familiar Sequences, 9. The clinical evaluation indicated that his achievement was assessed in 2002 through 2009 with multiple academic achievement assessments with the following varying standard scores: Letter-Word Identification: 82-106; Word Attack: 90-104; Reading-Fluency: 87; Spelling: 90; -94; Reading/Passage Comprehension: 75-106; Calculation: 83-93; Math Fluency: 70-77; Applied Problems: 85-97; Quantitative Reasoning: 87-97; Writing Samples: 92-112; Writing Fluency: 90; Oral Expression: 113; and Listening Comprehension: 100-120. D's language ability was assessed with the Test of Language Competence-Expanded, level 2 (TLC-E) for the aforementioned clinical evaluation with the following scaled scores: Ambiguous Sentences, 6; Listening Comprehension, 8; Oral Expression, 4; and Figurative Language, 4. D's ability to understand social situations was also assessed with the Test of Problem Solving-2 (TOPS-2) for the aforementioned clinical evaluation with the following standard scores: Making Inferences, 68; Determining Solutions, 87; Problem Solving; Interpreting Perspectives, 73; and Transferring Insights, 69.

D was evaluated by school psychologist, Ms. Sample, Ed.S., NCSP, School Psychologist, at Sample School Corporation in Bloomington, Indiana on April 22 & 23, 2010, following Dr. Sample's evaluation. A Behavior Assessment System for Children, 2nd Edition (BASC-2) was completed by D, his parent, and teachers to evaluate his behavior in the home and school environments. D's response patterns indicated attention problems. The examiner concluded that D met the eligibility criteria, due to the results from the psychoeducational evaluation and prior evaluations, for a change in eligibility to a student with an Autism Spectrum Disorder, rather than a Specific Learning Disability and an Other Health Impairment (OHI) for an Attention-Deficit Hyperactivity Disorder.

Records indicate that D was treated by Dr. Sample at the Behavioral Care Center of Sample Health, from 12/07/2011 to 12/12/2011 and was found capable of understanding his behavior and should be held responsible for his actions. According to records, D received outpatient treatment with Sample, M.D., LLC from 04/15/2011 to 10/04/2011. Records indicate that D was also treated by M. Sample, Ph.D., HSPP, during four different hospitalizations at Sample Hospital in Bloomington, Indiana. According to records, D also previously received in-patient care at Sample B Hospital. Records indicate that D also previously detained at Sample Home Village. D has reportedly overdosed on his medication and been aggressive towards his adoptive parents in the past.

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

Axis I: 299.80 Asperger's Disorder (by history and current)
296.40 Mood Disorder, NOS (by history)
Axis II: Deferred
Axis III: Elevated Glucose
Axis IV: Problems with primary support group, problems related to social environment, educational
Axis V: GAF= 35 (upon admission) GAF= 40 (current)

D has been treated with a variety of psychotropic medications, most recently Prozac, Concerta ER, Metformin, and Geodon.

Upon his admission to Sample Residential Facility, D was administered a brief measure of academic achievement. On the Kaufman Test of Educational Achievement, 2nd Edition (KTEA-II), D's academic skills were within the Average range for reading and Low Average in writing, but his math was in the Extremely Low range (Brief Reading = 92, Brief Math = 68, Comprehensive Writing = 82). Previous records suggest D functions within the average range of cognitive ability.

Behavioral Observations:

The evaluation was conducted over a period of thirteen days on Sample Residential Facility's campus. D cooperated with the testing process as a whole. He was pleasant, compliant, and generally cooperative throughout the evaluation. He was fully oriented. His mood was generally euthymic with a broad range of affect. His speech was coherent, logical and goal directed. His attention and focus were adequate for task completion.

Evaluation Results and Interpretation:

It is recognized that D was not evaluated in a natural environment. It is noted that results may be influenced by the environment in the setting within which he was evaluated. Results of the evaluation are believed to be a fair representation of his current functioning.

Student Interview

Throughout the course of the interview, D's responses were typical for teenagers his age. D demonstrated abilities to cope with difficult situations. D indicated throughout the interview that when he did not get his way, he was able to adapt or compromise with parents and teachers as necessary. He indicated that he would use coping skills to respond to upset feelings to calm down. Problems are most difficult, uncomfortable, and anxious when D is required to complete an unappealing task, such as cleaning his room; speak publicly; and being late to an event or scheduled outing. D indicated that he fears being late because others may lose their trust in him and his family. Public speaking is reportedly difficult for D because he has not had sufficient practice on a day-to-day basis. To overcome his difficulties with completing a task, he makes lists and labels items. To cope with his feelings of completing an unappealing task, he expressed

that he understands when he must compromise or adjust to a new task. To cope with being late and public speaking, D again expressed that he understood when these uncomfortable tasks or realities occur. D reported that when he refuses to complete a chore or task at home, he receives a consequence. For example, he indicated that if it took him two days to clean his room, he may have his iPod use removed for two days. D reported that he feels sadness when dealing with death in his family, such as losing his uncle or two pets. He indicated that there was nothing that made him sad on a day-to-day basis.

Millon Adolescent Clinical Inventory (MACI)

D was administered the Millon Adolescent Clinical Inventory (MACI). The MACI is a self-report measure designed to assist in understanding psychological issues common among teens seen in clinical settings. Base rate scores less than 60 are considered Average. Scores between 61 and 74 are considered Moderately Elevated and scores 75 and greater are considered Clinically Significant. D's responses yielded a valid profile.

D's responses on the MACI are similar to teenagers that report significant signs of inhibition, submissiveness, anxious feelings, depressive affect, and peer insecurity. When efforts of peer approval are unsuccessful, teenagers like this withdraw and become even more isolated. These teenagers have a tendency to report sadness over being rejected by their peers. D's responses indicated significant problems with identity diffusion. D's responses also specified considerable sexual discomfort. Teenagers with similar responses may present dissatisfaction with their self-image, speaking of their low self-esteem to others. Without intervention, these teenagers may become fearful of unknown calamitous events and sustain a gloomy outlook on life.

D's notation of sexual discomfort was further explored during his interview. When asked about this, D referred to his feelings about sex with some discomfort, shown by a change in his facial affect and stiffening of his body. However, D denied discomfort about sexuality. He reported that he would consider sexual activity three to four years after getting married because he wanted to wait to have children. He expressed concern with others that had children when they were too young.

Minnesota Multiphasic Personality Inventory, 2nd Edition, Adolescent (MMPI-2-A)

D's responses on the Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A) indicate that he feels inadequate and tends to view the future with uncertainty and pessimism. He tends to lack confidence in himself, is somewhat moody, is rather sensitive to criticism, and may tend to blame himself for things that go wrong. He seems to worry excessively, has low energy, has a slow personal tempo, and is dissatisfied with his life. His low moods and vulnerability to feelings of inadequacy and despair may make him guilt-prone. There may be reason to suspect sleep disturbances, based on D's responses. Results specified that D's tendency towards depressive episodes and suicidal thoughts be evaluated.

Children's Depression Inventory, 2nd Edition (CDI-2) and Revised Children's Manifest Anxiety Scale, 2nd Edition (RCMAS-2)

CDI-2 and RCMAS-2 scores regarding depressive feelings/attitudes and anxiety indicate that the behaviors that D experiences are within the average range, similar to same-age peers.

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 D's mother, residential supervisor in his living unit, and classroom teacher. They were subsequently returned, scored and interpreted by the examiner.

	Parent Mother		**Parent Dorm Supervisor**		**Teacher**	
	Standard Score	Percentile	Standard Score	Percentile	Standard Score	Percentile
General Adaptive Composite	**66**	**1**	**67**	**1**	**77**	**6**
Conceptual Composite	69	2	75	5	81	10
Social Composite	72	3	72	3	66	1
Practical Composite	68	2	68	2	69	2

	Mother		Dorm Supervisor		Teacher	
Adaptive Skills Area	Scaled Score		Scaled Score		Scaled Score	
Communication	7		7		8	
Community Use	9		6		3	
Functional Academics	5		6		7	
Home/School Living	2		3		2	
Health and Safety	5		7		4	
Leisure	7		5		5	
Self-Care	1		1		8	
Self-Direction	1		3		3	
Social	2		4		2	
Work	-		-		3	

Mrs. Teacher, Ms. Dorm Supervisor, and Ms. Parent rated D's current adaptive behavior as falling within the extremely low, borderline, and below average ranges, indicating that D's adaptive behavior appears to be consistently deficient across home and school settings. There was some variability within rated skill areas. For example, Self-Care was rated average by his teacher and extremely low by both his mother and dorm supervisor. His teacher's responses may reflect the more structured setting of a classroom in placement that D currently works in, with more one-on-one instruction with class sizes of ten or less. Areas of relative weakness for D are Self-Direction, Social, and School Living, according to his teacher. Areas of relative weakness for D are Self-Direction, Social, Self-Care, and Home Living, according to his parent and dorm supervisor. According to his teacher, areas of relative strength for D are Communication, Functional Academics, and Self-Care. According to his parent and dorm supervisor, areas of relative strength for D are Communication, Leisure, and Community Use. Intervention in the other areas (i.e., home/school living, self-direction, social skills, self-care, etc.) is needed to assist D in developing these necessary skills.

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 D's residential supervisor in his living unit as well as his 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. Dorm Supervisor	T-Score TRS – Mrs. Teacher	T-Score PRS – Mrs. Parent
School Problems	NA	66*	NA
Attention Problems	NA	68*	NA
Learning Problems	NA	61*	NA
Internalizing Problems	67*	62*	77**
Anxiety	64*	62*	64*
Depression	71**	60*	83**
Somatization	57	60*	70**
Externalizing Problems	83**	63*	79**
Hyperactivity	83**	75**	83**
Aggression	68*	54	63*
Conduct	88**	56	82**
Behavioral Symptoms Index	77**	75**	84**
Atypicality	66*	63*	76**
Withdrawal	72**	98**	72**
Attention Problems	64*	68*	78**
Adaptive Skills	31*	40*	35*
Adaptability	31*	37*	24**
Social Skills	39*	45	56
Leadership	39*	39*	39*
Study Skills	NA	42	NA
Functional Communication	32*	43	46
Activities of Daily Living	30**	NA	20**

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

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

Mrs. Teacher indicated that D has clinically significant levels of hyperactivity, withdrawal, and a behavioral symptoms index. Mrs. Teacher found the following areas of concern at-risk: school

problems, attention problems, learning problems, internalizing problems, anxiety, depression, somatization, externalizing problems, atypicality, and attention problems.

Ms. Dorm Supervisor, Mrs. Teacher, and D's mother all agreed that withdrawal and hyperactivity are clinically significant areas of concern for D. While Mrs. Teacher found depression to be an area of concern at-risk, Ms. Dorm Supervisor and D's mother found it to be a clinically significant problem for D. Ms. Dorm Supervisor and D's mother also both agreed that he has clinically significant levels of externalizing problems, conduct problems, behavioral symptoms index, and activities of daily living. Ms. Dorm Supervisor and D's mother's rating slightly differed, but found the following areas of concern at-risk or clinically significant: internalizing problems, anxiety, aggression, atypicality, and attention problems. Ms. Dorm Supervisor, Mrs. Teacher, and D's mother all agree on the following areas of concern at-risk: internalizing problems, anxiety, atypicality, and attention problems.

Ms. Dorm Supervisor, Mrs. Teacher, and D's mother's ratings of adaptive skills slightly differed, but found the following areas of concern at-risk or clinically significant: adaptability and leadership. Ms. Dorm Supervisor also indicated that D's social skills and functional communications were areas of concern at-risk.

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 his or his problematic behavior is focused internally, externally, globally and adaptively. D completed the rating scale on July 11, 2012 on Sample Residential 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	48
Attitude to School	47
Attitude to Teachers	50
Sensation Seeking	49
Internalizing Problems	64*
Atypicality	62*
Locus of Control	55
Social Stress	62*
Anxiety	54
Depression	53
Sense of Inadequacy	68*
Somatization	73**
Inattention/Hyperactivity	70**

Attention Problems	72**
Hyperactivity	63*
Emotional Symptoms Index	65*
Personal Adjustment	39*
Relations with Parents	62
Interpersonal Relations	39*
Self-Esteem	33*
Self-Reliance	35*

D's responses appeared to be valid, consistent, not overly patterned, and in a manner that suggests he answered honestly. D's ratings suggest that he perceives that he experiences unusually more amounts of emotional symptoms in comparison to peers his age, specifying clinically significant problems with somatization, inattention/hyperactivity, and attention problems. Specifically, a reported area at-risk in his self-report includes the following: internalizing problems, atypicality, social stress, sense of inadequacy, hyperactivity, personal adjustment, interpersonal relations, self-esteem, self-reliance, and the emotional symptoms index, which indicates that he believes that he has inordinately more problems with social situations, internalized stress, self-esteem, hyperactivity, and emotional instability.

Summary and Recommendations:

Previous records suggest D functions within the Average range of cognitive ability. Academic achievement is within the Average to Extremely Low range, with strength in reading and weakness in math, according to a previously administered brief measure.

D was seen as a treatment team request for an additional evaluation for differential diagnosis purposes. Specifically, D's treatment team wants clarity regarding symptoms of a Mood Disorder, NOS. His treatment team would also like to Rule Out Borderline Personality Disorder, which was noted in treatment records. The evaluation was completed over a period of thirteen days within a month's time and the following is a summary of the obtained results.

D was administered several objective measures related to mood and personality disorders (i.e., MACI, MMPI-2-A, CDI-2, and RCMAS-2) adaptive behavior (i.e., ABAS-II) and a social-emotional measure to assess his current functioning (i.e., BASC-2). CDI-2 and RCMAS-2 scores indicate that the behaviors that D experiences regarding anxiety and depression were within the average range and similar to same-age peers. According to the rating on the MMPI-A, D expressed the following concerns: pessimism, low self-confidence, excessive worries, guilt-prone, and low energy.

Mrs. Teacher, Ms. Dorm Supervisor, and Mrs. Parent scored D's current adaptive behavior as falling within the extremely low, borderline, and below average ranges, indicating that D's adaptive behavior appears to be consistently deficient across home and school settings. Areas of relative weakness for D are Self-Direction, Social, and School Living, according to his teacher. Areas of relative weakness for D are Self-Direction, Social, Self-care, and Home Living, according to his parent and dorm supervisor. According to his teacher, areas of relative strength for D are Communication, Functional Academics, and Self-Care. According to his parent and

dorm supervisor, areas of relative strength for D are Communication, Leisure, and Community Use. Intervention in the other areas (i.e., home/school living, self-direction, social skills, self-care, etc.) is needed to assist D in developing these necessary skills.

D has some clinically significant and at-risk concerns in the areas of global behavior difficulties (i.e., somatization, inattention/hyperactivity, and attention problems) as well as an expressed need for intervention in at-risk and clinically significant emotional and adaptive concerns (i.e., internalizing problems, atypicality, social stress, sense of inadequacy, hyperactivity, personal adjustment, interpersonal relations, self-esteem, self-reliance, and the emotional symptoms index). D's teacher, Mrs. Teacher, specified a need for support of his at-risk and clinically significant areas including: hyperactivity, withdrawal, behavioral symptoms index, school problems, attention problems, learning problems, internalizing problems, anxiety, depression, somatization, externalizing problems, atypicality, attention problems, adaptive skills, adaptability, and leadership.

Ms. Dorm Supervisor, Mrs. Teacher, and D's mother all agreed that withdrawal and hyperactivity are clinically significant areas of concern for D. While Mrs. Teacher found depression to be an area of concern at-risk, Ms. Dorm Supervisor and D's mother found it to be a clinically significant problem for D. Ms. Dorm Supervisor and D's mother also both agreed that he has clinically significant levels of externalizing problems, conduct problems, behavioral symptoms index, and activities of daily living. Ms. Dorm Supervisor and D's mother's rating also found aggression as an area of concern at-risk. Ms. Dorm Supervisor, Mrs. Teacher, and D's mother all agree on the following areas of concern at-risk: internalizing problems, anxiety, atypicality, and attention problems. Ms. Dorm Supervisor, Mrs. Teacher, and D's mother's ratings of adaptive skills slightly differed, but found the following areas of concern at-risk or clinically significant: adaptability and leadership.

According to his treatment review team, D's prognosis outside of a structured treatment facility is viewed as poor due to his history of defiance at home and at school including: non-compliance and threats to harm self. It was noted that D is currently beginning to identify and recognize his behaviors and the need to change; however, he continues to struggle with directives.

Based on the results of the current evaluation, D does not meet criteria for a Borderline Personality Disorder. D's Mood Disorder, NOS was clarified to Depressive Disorder, NOS based on parents' and teacher's reports of significant adaptive problems, withdrawal, anxiety, and depression. On two of the D's self-report ratings (MMPI-2-A and MACI) suggested the following concerns: pessimism, low self-confidence, excessive worries, guilt-prone, low energy, inhibition, submissiveness, anxious feelings, depressive affect, and peer insecurity. Although some of D's ratings do not suggest symptoms of depression and anxiety, he may have not been forthcoming due to his controlled responses in the structured setting, under prescription of psychotropic medications, and his avoidance of confrontation of his own symptoms. Some of his behaviors also appear to be a manifestation of his Asperger's Disorder according to the *Diagnostic and Statistical Manual* (DSM-IV-TR) criteria.

The following recommendations are suggested:

1. 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, 5 point scale, power cards).

2. Treatment with D 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 D time to adjust whenever a transition takes place (i.e., switching classes, introducing a new schedule, etc.).

3. Continuation of speech and language services is recommended to assist in improved pragmatic skill, social awareness and communication skills.

4. D is encouraged to learn to control his impulsive and disruptive behaviors as well as increase his frustration tolerance. He 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.

5. 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 his low self-esteem, anxiety, depression, anger, aggression, and impulsivity.

6. Skills training in problem solving, emotional and stress management and positive interpersonal relatedness is recommended. A cognitive-behavioral approach is suggested that assists D 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.

7. Individual therapy may help D understand his 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 his to have rational or irrational Beliefs, which can lead to emotional and behavioral defeating Consequences. D can then decrease threats to his self-esteem and replace unhealthy beliefs with effective beliefs with support from his counselor and staff.

8. Regarding the school setting, D is encouraged to identify one or more support persons within the school that he 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 D's family to continue utilizing behavior management and behavior monitoring techniques, with structured visual supports in the home setting. Family therapy is recommended to assist D in generalizing these therapeutic goals and resulting changes to his home community.

10. D should continue to see a psychiatrist to monitor his current medication regimen.

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School Psychology Intern	Licensed School Psychologist
	Licensed Psychologist