ASSESSMENT OF STUDENTS WITH CO-MORBID DISORDERS AND MULTIPLE ELIGIBILITIES UNDER IDEIA/ADA (1.0)

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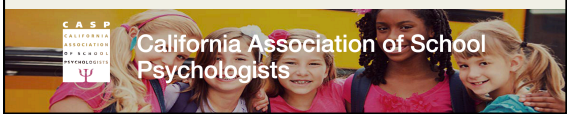


Disclosure

- My expenses for this talk are supported by Multi-Health Systems.
- I have developed tests marketed by Multi- Health Systems, Pro-Ed and Western Psychological Services.
- I have authored books marketed by Springer, Wiley, Guilford, Double Day, McGraw Hill, Brookes, Kluwer and Specialty Press.
- I am Editor in Chief of the Journal of Attention Disorders (Sage) and Co-Editor of the Encyclopedia of Child Development (Springer)

Preschool Graduation Part I

Preschool Graduation Part II

Goals for This Session

- Place our role as evaluators in context.
- Provide an overview of development, behavior diagnosis and eligibility.
- Discuss role of impairment in assessment.
- Discuss critical variables influencing assessment.
- Provide a framework for a comprehensive assessment.
- Review tools and methods.

I Had a Revelation in St. Augustine

The World Operates Along a Normal Curve!

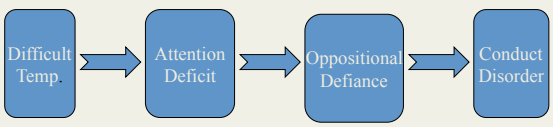
Not surprisingly all but two things we do as school psychologists are dimensional!

Diagnosis

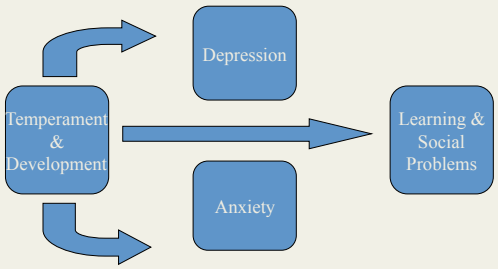
Eligibility Determination

Does diagnosis equal eligibility?

The Disruptive Continuum of Behavior



The Non-disruptive Continuum of Behavior



How distinct are these disorders from each other?

Much less so than makes me comfortable!

Attention Deficit Hyperactivity Disorder

- 44.3% of children with ADHD were also diagnosed with ODD (Cuffe et al., 2015); Kessler et al. (2014) found a lifetime prevalence of 47% for ODD.
- 13.5% of children with ADHD were also diagnosed with CD (Cuffe et al., 2015); Kessler et al. (2014) found a lifetime prevalence of 22% for CD.
- In a recent study by the CDC, 59% of children with ASD were also diagnosed with ADHD (Stevens, Peng, & Barnard-Brak, 2016)
- 2% of children with ADHD were also diagnosed with Major Depressive Disorder (Cuffe et al., 2015); Kessler et al. (2014) found a lifetime prevalence of 41% for MDD/Dysthymia. For youth with MDD, researchers have found an odds ratio for an ADHD diagnosis of *2.58 (Avenevoli, Swendsen, He, Burstein, & Merikangas, 2015).

ADHD

- In a review of the literature, researchers found prevalence estimates of LD in youth with ADHD between 8% and 76%, with a median of 47% and a mean of 45.1% across studies (DuPaul, Gormley & Laracy, 2013). In a sample of youth with SLD, Margari et al. (2013) found that 33% had comorbid ADHD.
- 6.4% of children with ADHD were also diagnosed with Generalized Anxiety Disorder, 10.2% with Separation Anxiety Disorder, and 7.6% with Social Phobia (Cuffe et al., 2015); Kessler et al. (2014) found a lifetime prevalence of 35% for any anxiety disorder

*An odds ratio (OR) is a measure of association between an exposure and an outcome. The OR represents the odds that an outcome will occur given a particular exposure, compared to the odds of the outcome occurring in the absence of that exposure.

Oppositional Defiant Disorder

- For individuals with ODD, researchers have found a lifetime prevalance of 42% for Conduct Disorder (Nock, Kazdin, Hiripi, & Kessler, 2007)
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- For youth with ASD, a systematic review revealed prevalence estimates for ODD from 4% to 37% (Kaat & Lecavalier, 2013).

ODD

- For individuals with ODD, researchers have found a lifetime prevalance of 39% for Major Depressive Disorder
- (Nock, Kazdin, Hiripi, & Kessler, 2007) In a study of Finnish adolescents with ODD/CD, researchers found that 55% of girls and 65% of boys had either a reading or math disorder (Lehto-Salo, Närhi, Ahonen & Marttunen, 2009).
- For individuals with ODD, researchers have found a lifetime prevelance of 62% for any anxiety disorder (Nock, Kazdin, Hiripi, & Kessler, 2007)

Conduct Disorder

- 13.5% of children with ADHD were also diagnosed with CD (Cuffe et al., 2015); Kessler et al. (2014) found a lifetime prevalence of 22% for CD.
- For individuals with ODD, researchers have found a lifetime prevalance of 42% for Conduct Disorder (Nock, Kazdin, Hiripi, & Kessler, 2007)
- For youth with ASD prevalence estimates for CD range from 1% to 10% (Kaat & Lecavalier, 2013).

CD

- For youth with MDD, researchers have found an odds ratio for a behavior disorder (ODD or CD) diagnosis of 4.20 (Avenevoli, Swendsen, He, Burstein, & Merikangas, 2015).
- In a study of Finnish adolescents with ODD/CD, researchers found that 55% of girls and 65% of boys had either a reading or math disorder (Lehto-Salo, Närhi, Ahonen & Marttunen, 2009).
- Youth with CD are at elevated risk for anxiety disorders, with odds ratios of 3.54 for phobias, 3.27 for social anxiety, and 3.46 for generalized anxiety disorder (Marmorstein, 2007).

Autism Spectrum Disorder

- In a recent study by the CDC, 59% of children with ASD were also diagnosed with ADHD (Stevens, Peng, & Barnard-Brak, 2016)
- For youth with ASD, a systematic review revealed prevalence estimates for ODD from 4% to 37% (Kaat & Lecavalier, 2013).
- For youth with ASD prevalence estimates for CD range from 1% to 10% (Kaat & Lecavalier, 2013).

ASD

- A review of the literature revealed wide variation in the estimated rates of depression in children with ASD, ranging from 1.4% to 38% (Magnuson & Constantino, 2011).
- In a sample of children with ASD, Stacy et al., (2014) found that 75% of girls and 72% of boys had a current co-morbid learning disorder.
- Simonoff et al. (2008) found that, among children with ASD, 13% had co-morbid generalized anxiety disorder and 42% had any type of anxiety disorder.

Depression

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Depression

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- In a sample of youth with SLD, Margari et al. (2013) found that 9% had a co-morbid mood disorder.
- For youth with MDD, researchers have found an odds ratio for an anxiety disorder diagnosis of 3.96 (Avenevoli, Swendsen, He, Burstein, & Merikangas, 2015). A review indicated that 25% to 50% of youth with depression have a co-morbid anxiety disorder and 10% to 15% of youth who have an anxiety disorder have co-morbid depression (Garber & Weersing, 2010)

Learning Disorders

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- In a sample of youth with SLD, Margari et al. (2013) found that 29% had a co-morbid anxiety disorder.

Anxiety

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Anxiety

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Special Education Legislative History

- 1975 — The Education for All Handicapped Children Act (EAHCA) became law. It was renamed the Individuals with Disabilities Education Act (IDEA) in 1990.
- 1990— IDEA first came into being on October 30, 1990 when the "Education of All Handicapped Children Act" (itself having been introduced in 1975) was renamed "Individuals with Disabilities Education Act." (Pub. L. No. 101-476, 104 Stat. 1142). IDEA received minor amendments in October 1991 (Pub. L. No. 102-119, 105 Stat. 587).
- 1997— IDEA received significant amendments. The definition of disabled children expanded to include developmentally delayed children between three and nine years of age. It also required parents to attempt to resolve disputes with schools and Local Educational Agencies (LEAs) through mediation, and provided a process for doing so. The amendments authorized additional grants for technology, disabled infants and toddlers, parent training, and professional development. (Pub. L. No. 105-17, 111 Stat. 37).

Special Education Legislative History

- 2004— On December 3, 2004, IDEA was amended by the Individuals With Disabilities Education Improvement Act of 2004, now known as IDEIA. Several provisions aligned IDEA with the No Child Left Behind Act of 2001, signed by President George W. Bush. It authorized fifteen states to implement 3-year IEPs on a trial basis when parents continually agree. Drawing on the report of the President's Commission on Excellence in Special Education,[46] the law revised the requirements for evaluating children with learning disabilities. More concrete provisions relating to discipline of special education students was also added. (Pub. L. No. 108-446, 118 Stat. 2647).
- 2009— Following a campaign promise for "funding the Individuals with Disabilities Education Act",[47] President Barack Obama signed the American Recovery and Reinvestment Act of 2009 (ARRA) on February 17, 2009, including $12.2 billion in additional funds.
- 2009— Americans with Disabilities Amendments Act was signed into law in September 2008 and became effective on January 1, 2009

Six Foundations of IDEA

- Individualized Education Program
- Free Appropriate Public Education
- Least Restrictive Environment
- Appropriate Evaluation
- Parent and Teacher Participation
- Procedural Safeguards

IDEA

Children are placed in special education services through an evaluation process. If the evaluation is not appropriately conducted, or does not monitor the information that is needed to determine placement it is not appropriate.

The goal of IDEA's regulations for evaluation is to help minimize the number of misidentifications, to provide a variety of assessment tools and strategies, to prohibit the use of any single evaluation as the sole criterion of which a student is placed in special education services, and to provide protections against evaluation measures that are racially or culturally discriminatory.

Overall, the goal of appropriate evaluation is to get students who need help, extra help that is appropriate for the student and helps that specific student to reach his or her goals set by the IEP team

Eligible

adjective
having the right to do or obtain something; satisfying the appropriate conditions.
"customers who are eligible for discounts"

synonyms: entitled, permitted, allowed, qualified, able
"those people eligible to vote"
(of a person) desirable or suitable as a partner in marriage.
"the world's most eligible bachelor"

synonyms: desirable, suitable;

Diagnosis

Medicine/Medical.
the process of determining by examination the nature and circumstances of a diseased condition.

the decision reached from such an examination.

Eligibilities Under The School Psychologist's Direct Consideration

- Emotional Disturbance (depression/anxiety related conditions, social impairments, schizophrenia)
- Autism
- Language
- Intellectual
- Specific Learning Disorder
- Other Health Impairment (ADHD)

Eligibilities Under The School Psychologist's Indirect Consideration

- Other Health Impairment (e.g. diabetes)
- Orthopedics
- Hearing
- Vision

California

§ 3030. Eligibility Criteria.

5 CA ADC § 3030BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
Title 5. Education
Division 1. California Department of Education
Chapter 3. Individuals with Exceptional Needs
Subchapter 1. Special Education
Article 3.1. Individuals with Exceptional Needs

(7) Multiple disabilities means concomitant impairments, such as intellectual disability-blindness or intellectual disability-orthopedic impairment, the combination of which causes such severe educational needs that they cannot be accommodated in special education programs solely for one of the impairments. "Multiple disabilities" does not include deaf-blindness.

(6) Intellectual disability means significantly subaverage general intellectual functioning, existing concurrently with deficits in adaptive behavior and manifested during the developmental period that adversely affects a child's educational performance.

Colorado

A child with Multiple Disabilities shall have two or more areas of significant impairment, one of which shall be an intellectual disability. The other areas of impairment include: Orthopedic Impairment; Visual Impairment, Including Blindness; Hearing Impairment, Including Deafness; Speech or Language Impairment; Serious Emotional Disability; Autism Spectrum Disorders; Traumatic Brain Injury; or Other Health Impaired. The combination of such impairments creates a unique condition that is evidenced through a multiplicity of severe educational needs which prevent the child from receiving reasonable educational benefit from general education

New Jersey

Multiply disabled" corresponds to "multiply handicapped" and “multiple disabilities,” and means the presence of two or more disabling conditions, the combination of which causes such severe educational needs that they cannot be accommodated in a program designed solely to address one of the impairments. Multiple disabilities includes cognitively impaired-blindness, cognitively impaired-orthopedic impairment, etc. The existence of two disabling conditions alone shall not serve as a basis for a classification of multiply disabled. Eligibility for speech-language services as defined in this section shall not be one of the disabling conditions for classification based on the definition of "multiply disabled." Multiply disabled does not include deaf-blindness.

Maryland

"Multiple disabilities" means concomitant impairments, such as intellectual disability-blindness or intellectual disability-orthopedic impairment, the combination of which causes such severe educational problems that the student cannot be accommodated in special education programs solely for one of the impairments. (b) "Multiple disabilities" does not include students with deaf-blindness.

Determining eligibility is an outcome best understood and obtained by a thorough assessment.

How Shall We Understand, Define and Categorize Mental Illness?

- By etiology or cause?
- By emotions, behaviors and thoughts?
- By impaired function in activities of life?

What is the Goal of a Comprehensive Evaluation?

- Identify and define symptoms?
- Identify and define strengths and weaknesses?
- Appreciate the relationship of a set of symptoms to a unitary condition?
- Meet eligibility criteria?
- Define limits of functional impairment to set a baseline for intervention?

Components of a Thorough Assessment

- History
- Broad Spectrum Questionnaires (Parent and Teacher)
- Narrow Spectrum Questionnaires (Parent and Teacher
- Self report Questionnaires
- Ability Assessment
- Achievement Assessment
- Clinical Assessment (e.g ASD, personality, etc.)
- Interview with student

Ability
Knowledge
Skill

General Guidelines for a Comprehensive School Psychology Evaluation

- A distinction should be made between acute vs. chronic problems.
- Assessment should be strength focused.
- Test results should be presented in ways that are useful to consumers (e.g. family, school, etc.).
- The least amount of assessment needed to answer referral questions should be completed.

Person Attributes Associated With Successful Coping*

- Affectionate, engaging temperament.
- Sociable.
- Autonomous.
- Above average IQ.
- Good reading skills.
- High achievement motivation.
- Positive self-concept.
- Impulse control.
- Internal locus of control.
- Planning skills.
- Faith.
- Humorous.
- Helpfulness.

* Replicated in 2 or more studies

Environmental Factors Associated With Successful Coping*

- Smaller family size.
- Maternal competence and mental health.
- Close bond with primary caregiver.
- Supportive siblings.
- Extended family involvement.
- Living above the poverty level.
- Friendships.
- Supportive teachers.
- Successful school experiences.
- Involvement in pro-social organizations.

*Replicated in 2 or more studies.

The pathways that lead to positive adaptation despite high risk and adversity are complex and greatly influenced by context therefore it is not likely that we will discover a magic (generic) bullet.

Critical Issues

- Demographics
- Symptoms vs. consequences
- Categories vs. dimensions
- Eligibility vs. diagnosis
- Developmental pathways: accept a moment in time
- There are no shortcuts
- Assess the environment

Critical Issues

- Assess for intervention
- Understand positive and negative predictive power
- Understand sensitivity vs. specificity
- Begin with the disruptive/non-disruptive continuum
- Keep low incidence problems in mind
- Consider resilience (protective) factors
- Measure impairment

Why is the assessment of impairment critical to a comprehensive evaluation?

An exhaustive review of the literature demonstrates that the relationship between symptoms and functioning remains unexpectedly weak and often bidirectional (McKnight and Kashdan, 2009).

Need

- Clinicians are required to demonstrate the impact psychological and psychiatric diagnoses have on children and adults.
- There is a clear need to measure "impairment" when using the IDEIA, Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) or the International Classification of Diseases (ICD) as a guide to eligibility determination and/or diagnosis.
- The need to measure impairment is increasing.

Impairment is the reduced ability to meet the demands of life because of a psychological, physical, or cognitive condition.

SYMPTOMS VS. IMPAIRMENT

Impairment is not the same as symptoms

- Symptoms are physical, cognitive or behavioral **manifestations** of a disorder.
- Impairments are the functional **consequences of these symptoms.**

Inattention

Difficulty completing homework

SYMPTOMS VS. IMPAIRMENT

Impairment can exist absent of formal diagnosis.
(Balazs et al., 2013; Wille et al., 2008)

In one study 14.2% of a sample of children were significantly impaired without a formal diagnosis.
(Angold et al., 1999)

IMPAIRMENT VS. ADAPTIVE BEHAVIOR

A skill deficit occurs when a person does not know how to perform an everyday task, whereas a deficit in performance occurs when an individual has acquired a skill, yet does not seem to use it when needed.

(Ditterline & Oakland, 2009)

IMPAIRMENT VS. ADAPTIVE BEHAVIOR

Thus, while measures of adaptive behavior emphasize the presence of adaptive skills in daily functioning, measures of functional impairment tend to emphasize the outcome of a behavior or the performance of an individual rather than the presence or absence of the skill.

Ditterline & Oakland (2009);
Dumas et al. 2010);
Gleason & Coster (2012)

Adaptive Behavior vs. Impairment

Skill **vs.** **Performance**

Adaptive Behavior vs. Impairment

vs.

Using utensils

Not using utensils to eat

Child with a Disability

IDEIA defines this term as follows:

- (a) ***General***. (1) Child with a disability means a child evaluated in accordance with §§300.304 through 300.311 as having an intellectual disability**, a hearing impairment (including deafness), a speech or language impairment, a visual impairment (including blindness), a serious emotional disturbance (referred to in this part as ''emotional disturbance''), an orthopedic impairment, autism, traumatic brain injury, an other health impairment, a specific learning disability, deaf-blindness, or multiple disabilities, and who, by reason thereof, needs special education and related services.

Child with a Disability

IDEIA defines this term as follows:

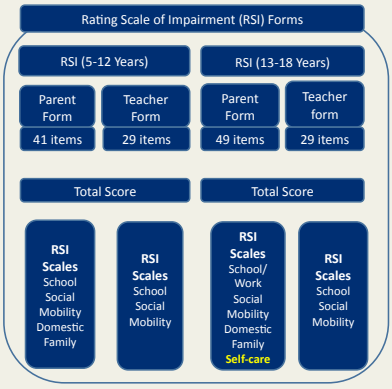
- (2)(i) Subject to paragraph (a)(2)(ii) of this section, if it is determined, through an appropriate evaluation under §§300.304 through 300.311, that a child has one of the disabilities identified in paragraph (a)(1) of this section, but only needs a related service and not special education, the child is not a child with a disability under this part.

Symptoms vs. Impairment

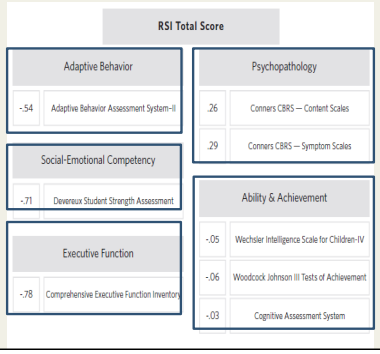
vs.

Inattention

Difficulty completing homework

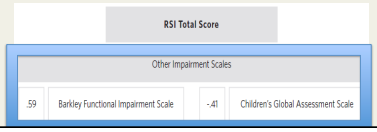


Relationship Between The RSI And Other Measures

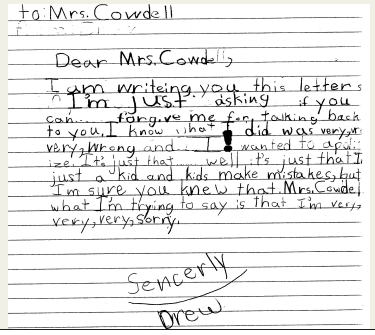


Relationship Between The RSI And Other Impairment Measures

- RSI and the Barkley Functional Impairment Scale (BFIS–CA)
  - Child Sample corrected r = .55 to .67
  - Youth Sample corrected *r* = .63 to .71
- RSI and the Children's Global Assessment Scale (CGAS)
  - Corrected r = -.34 to -.51



Do Children Care What We Think? Part I


to Mrs. Cowdell

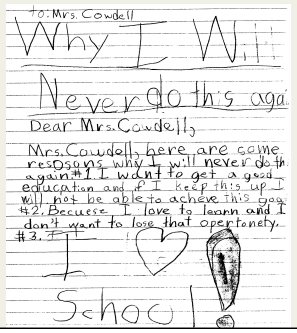
Dear Mrs. Cowdell,

I am writeing you this letter I'm just asking if you can... forgive me for talking back to you, I know that I did was very very wrong and... I wanted to apologize. It's just that... well it's just that I just a kid and kids make mistakes but I'm sure you knew that. Mrs. Cowdell what I'm trying to say is that I'm very very, very sorry.

Sencerly

Drew

Do Children Care What We Think? Part II



Begin with history, impairment measure and a broad spectrum rating like the Conners Behavior Rating Scale

Content: Scales & Subscales

- **Emotional Distress** → *Upsetting Thoughts*[1]*; Worrying*[1]*; Upsetting Thoughts/Physical Symptoms*[2]*; Social Anxiety*[2]
- **Defiant/Aggressive Behaviors**
- **Academic Difficulties**
- **Social Problems**[1]
- **Separation Fears**[2]
- **Hyperactivity**[5]**/Impulsivity**
- **Perfectionist & Compulsive Behaviors**[4]
- **Physical Symptoms**

[1] Within Emotional Distress scale on Conners CBRS-P; [2] Within Emotional Distress scale on Conners CBRS-T; [3] Subscale of Academic Difficulties scale; [4]Scale on Conners CBRS-P & CBRS-T forms only; [5]Scale on Conners CBRS-T form only.

DSM Scales

- ADHD Inattentive
- ADHD Hyperactive-Impulsive
- ADHD Combined
- Conduct Disorder
- Oppositional Defiant Disorder
- Major Depressive Disorder
- Manic Episode
- Mixed Episode
- Autism Spectrum Disorder
- Generalized Anxiety Disorder
- Separation Anxiety Disorder
- Social Phobia
- Obsessive-Compulsive Disorder

[1]Scale on Conners CBRS-P & CBRS-T forms only.

Other Clinical Indicators

- Bullying Perpetration
- Bullying Victimization
- Enuresis/Encopresis[1]
- Panic Attack
- Pervasive Developmental Disorder[3]
- Pica[2]
- Post-Traumatic Stress Disorder
- Specific Phobia
- Tics
- Trichotillomania

[1] Scale Conners CBRS-P & CBRS-T forms only; [2] Scales on Conners CBRS-P & CBRS-SR forms only; [3] Scales on Conners CBRS-SR form only.

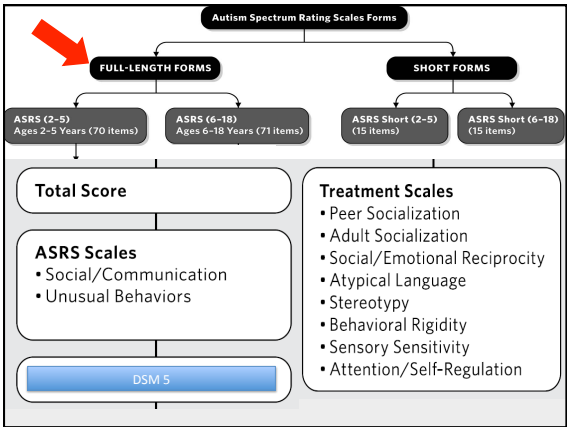
Obtain a Thorough History

- Immediate and extended family risks.
- Pregnancy and delivery
- Infancy and toddlerhood (temperament)
- Preschool and school history
- Socialization
- Family relations
- Sleep, appetite and hygiene
- Past treatments or educational services
- Discipline
- Situational problems

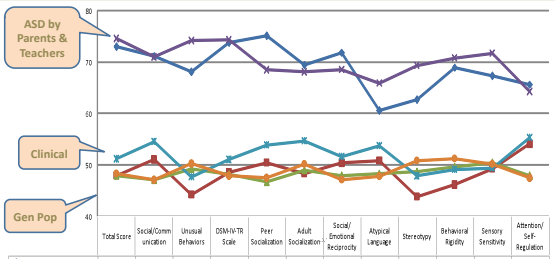
Decide on Narrow Spectrum Questionnaires

- Anxiety
- Depression
- Autism Spectrum
- Resilience
- Executive Functioning
- Personality

Autism Spectrum

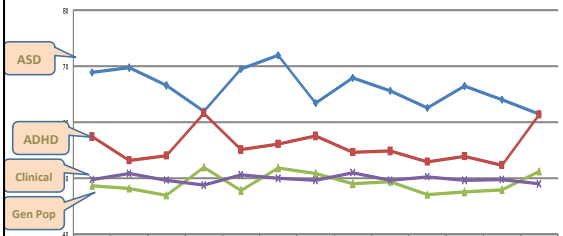


ASRS Validity for ages 2-5 Parents



	Total Score	Social/Communication	Unusual Behaviors	DSM-IV-TR Scale	Peer Socialization	Adult Socialization	Social/Emotional Reciprocity	Atypical Language	Stereotypy	Behavioral Rigidity	Sensory Sensitivity	Attention/Self-Regulation
Parent ASD	73.0	71.2	68.1	73.8	75.1	69.5	71.9	60.6	62.7	69.0	67.3	65.7
Parent Other Clinical	48.0	51.1	44.3	48.6	50.5	48.4	50.4	50.9	43.9	46.2	49.3	54.1
Parent General Population	48.0	47.1	49.3	48.2	46.7	49.0	47.9	48.4	48.8	49.7	50.4	47.9
Teacher ASD	74.6	71.0	74.2	74.3	68.5	68.1	68.6	65.9	69.4	70.8	71.7	64.3
Teacher Other Clinical	51.2	54.6	47.7	51.1	53.9	54.7	51.7	53.8	47.9	49.2	49.4	55.4
Teacher General Population	48.4	47.1	50.3	47.9	47.5	50.2	47.2	47.8	50.9	51.3	50.2	47.5

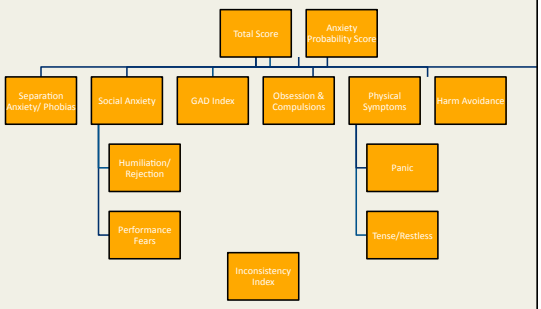
ASRS Validity: Ages 6-18 Parents



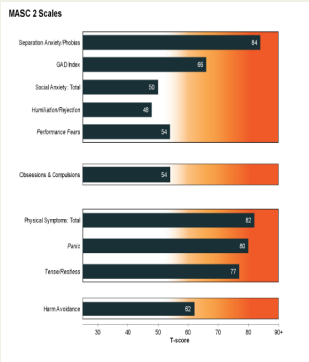
	Total Score	Social/Communication	Unusual Behaviors	Self-Regulation	DSM-IV-TR Scale	Peer Socialization	Adult Socialization	Social/Emotional Reciprocity	Atypical Language	Stereotypy	Behavioral Rigidity	Sensory Sensitivity	Attention
ASD	68.9	69.7	66.6	62.0	69.6	72.8	63.5	67.9	65.6	62.8	66.5	64.0	61.5
ADHD	57.4	53.2	54.1	61.7	55.1	56.1	57.5	54.6	54.8	53.8	53.9	52.9	61.4
Other Clinical	48.7	48.2	47.8	52.0	47.7	51.8	51.8	49.0	49.4	47.8	47.5	47.9	51.2
General Population	49.7	50.8	49.7	48.7	50.6	50.8	49.6	51.0	49.6	50.3	49.6	49.8	49.0

Anxiety

MASC-2 Scales

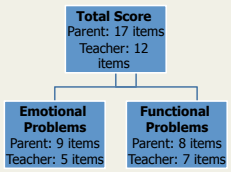


MASC 2 Scales



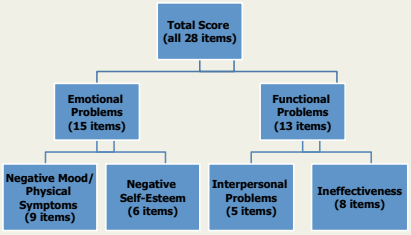
Depression

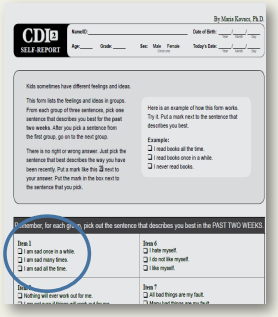
Scale Structure: Parent and Teacher



4-point Likert-type rating: 0="Not at All" ; 3="Much or Most of the Time"

Scale Structure: Self-Report (Full Length)

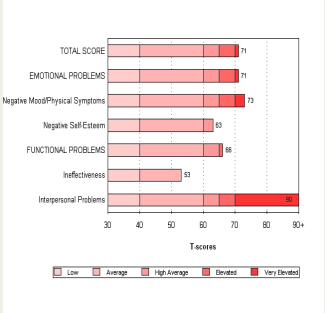




CDI-2 Self-Report

Each sentence is given either 0,1, or 2 points

CDI Profile



Executive Functioning

CEFI Scales

Each form yields a **Full Scale** score and 9 separate content scales which contain items as follows…

Consistency Index
Negative Impression Scale
Positive Impression Scale

Full Scale

CEFI Scales
Attention
Emotion Regulation
Flexibility
Inhibitory Control
Initiation
Organization
Planning
Self-Monitoring
Working Memory

Group Differences: ADHD (Naglieri & Goldstein, 2013)

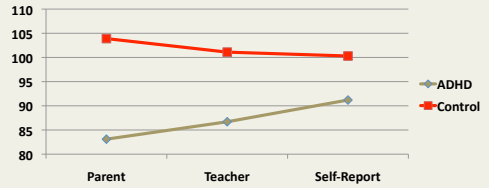


Table 8.19 Differences Between ADHD and Matched General Population Samples: CEFI Full Scale

Form		ADHD	Matched Gen. Pop.	*d*-ratio	*F* (*df*)	*P*
Parent	*M*	83.1	103.9	-1.59	216.56 (1, 340)	< .001
	SD	13.0	13.0			
	N	171	171			
Teacher	*M*	86.7	101.1	-1.07	79.93 (1, 278)	< .001
	SD	13.5	13.5			
	N	138	142			
Self-Report	*M*	91.2	100.8	-0.62	22.21 (1, 232)	< .001
	SD	14.7	14.7			
	N	117	117			

Group Differences: ASD (Naglieri & Goldstein, 2013)

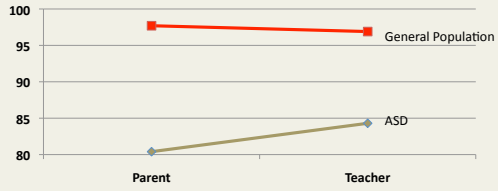


Table 8.20 Differences Between ASD and Matched General Population Samples: CEFI Full Scale

Form		ASD	Matched Gen. Pop.	*d*-ratio	*F* (*df*)	*P*
Parent	*M*	80.4	97.7	-1.41	48.96 (1, 96)	< .001
	SD	12.2	12.2			
	N	48	50			
Teacher	*M*	84.3	96.9	-0.99	23.11 (1, 92)	< .001
	SD	12.7	12.7			
	N	47	47			

Group Differences: Learning Disabilities (Naglieri & Goldstein, 2013)

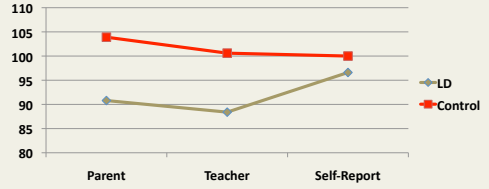


Table 8.22 Differences Between LD and Matched General Population Samples: CEFI Full Scale

Form		LD	Matched Gen. Pop.	*d*-ratio	*F* (*df*)	*p*
Parent	*M*	90.8	103.9	-0.92	19.89 (1, 93)	< .001
	SD	14.4	14.4			
	N	47	48			
Teacher	*M*	88.4	100.6	-0.91	37.29 (1, 178)	< .001
	SD	13.4	13.4			
	N	90	90			
Self-Report	*M*	96.6	100.0	-0.21	1.45 (1, 126)	0.231
	SD	15.9	15.9			
	N	64	64			

Group Differences: Mood Disorders

(Naglieri & Goldstein, 2013)

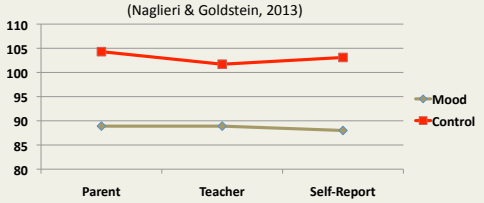


Table 8.21 Differences Between Mood Disorder and Matched General Population Samples: CEFI Full Scale

Form		Mood Disorder	Matched Gen. Pop.	*d*-ratio	*F* (*df*)	*p*
Parent	*M*	88.9	104.3	-1.11	22.66 (1, 71)	< .001
	SD	13.8	13.8			
	N	36	37			
Teacher	*M*	88.9	101.7	-1.01	14.9 (1, 57)	< .001
	SD	12.8	12.8			
	N	29	30			
Self-Report	*M*	88.0	103.1	-1.09	16.34 (1, 53)	< .001
	SD	13.9	13.9			
	N	27	28			

Resilience

Efforts to Measure Resilience in Clinical Practice

- Devereux Elementary Student Strength Assessment (81 item rating scale).
- Devereux Early Childhood Assessment. (45 items).
- Resiliency Scales for Children and Adolescents (60 + item rating scales).
- Psychological Resilience Scale (25 items).

Assessment of Risk

- Risky Behaviors
- Protective Behaviors
- Risky Behaviors
  - Bullying
  - Delinquency
  - Health
  - Sexual
  - Substance Abuse
  - Suicide

Ability and Achievement

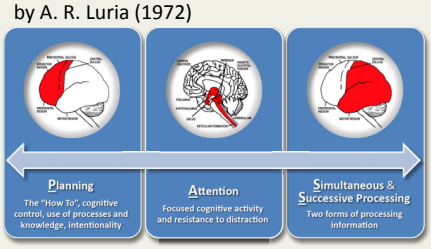
PASS Theory

- **PASS** theory is a way to define functioning based on measuring neuropsychological abilities
- **P**lanning =Getting from point A to Point B
- **A**ttention = Attending to details
- **S**imultaneous = Solving problems
- **S**uccessive = Following a sequence

96

The Brain as PASS

PASS: A neuropsychological approach to the Brain based on three Functional Units described by A. R. Luria (1972)



97

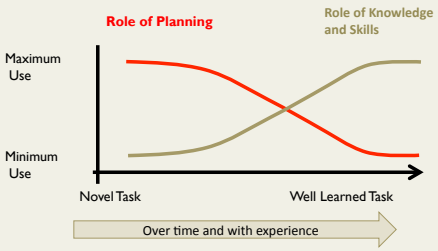
PASS Theory: Planning

- **Planning** is a neurocognitive ability that a person uses to determine, select, and use efficient solutions to problems
  - developing plans and using strategies
  - retrieval of knowledge
  - impulse control and self-control
  - control of processing

98

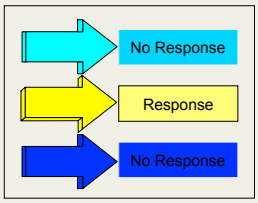
Knowledge and Planning Learning Curves

- Learning depends upon instruction and intelligence (PASS)
- At first, PASS plays a major role in learning
- When a new task is learned and practiced it becomes a skill and execution requires less PASS



PASS Theory

- **Attention** is a basic neurocognitive ability we use to selectively attend to some stimuli and ignores others
  - focused cognitive activity
  - selective attention
  - resistance to distraction



100

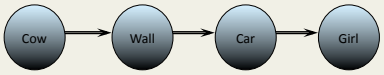
PASS Theory

- **Simultaneous** processing is a basic neurocognitive ability which we use to integrate stimuli into groups and solve problems
-
  - Stimuli are seen as a whole
  - Each piece must be related to the others

101

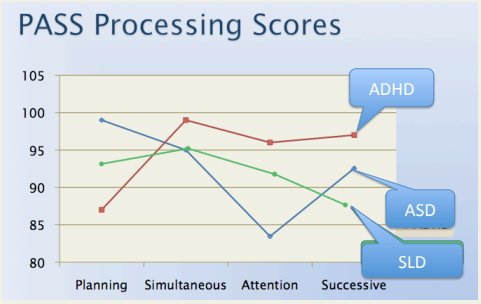
PASS Theory: Successive

- **Successive** processing is a basic neurocognitive ability which we use to manage stimuli in a specific serial order
  - Stimuli form a chain-like progression
  - Stimuli are not inter-related

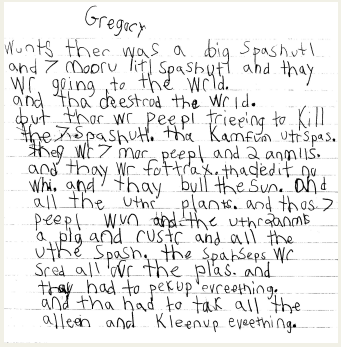


102

Ability Profiles

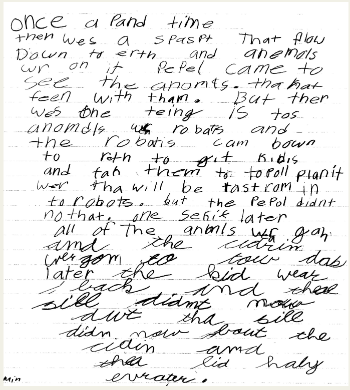


Examples of Planning, Successive and Attention Weaknesses



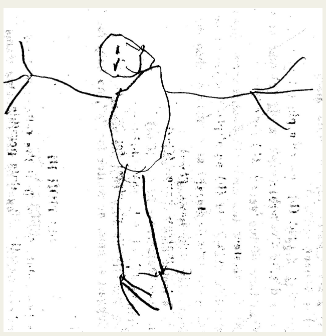
Gregacy

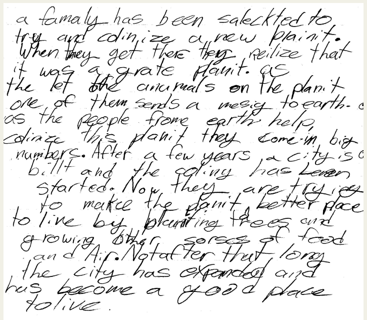
Wants ther was a big Spashutl and 7 moore litl Spashutl and thay Wr going to the Wrld. and tha deestrod the Wrld. but thar wr peepl trieing to Kill the Spashutl. tha Kamfon uthSpas. ther Wr 7 mor peepl and 2 animls. and thay Wr fattrax. thagedit on Wh. and thay bull the Sun. and all the uthr plants. and thos 7 peepl Wun and the uthranmls a pig and rustr and all the uthr Spash. the SpahSeps Wr Sced all Wr the plas. and thay had to pesup eveething. and tha had to tar all the alleen and Kleenup eveething.



once a Pand time
then wes a spaspt That flow
Down to erth and anemols
wr on it Pepel came to
see the anomts. tha hat
feen with tham. But ther
wes the teing is tos
anomdls wr robats and
the robatis cam bown
to roth to git Kidis
and fah them to to Poll planit
wer tha will be tastrom in
to robots. but the Pepol didnt
no that. one sekik later
all of the anmls wr gah
and the cidrin
wer gom to tow dab
later the kid wear
back and thea
sill didmt now
dwt tha sill
didn now bout the
cidin amd
thea lid haly
evrater.

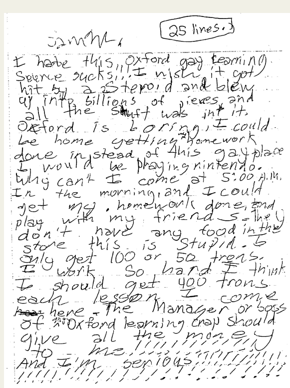
Min





a famaly has been salеckted to
try and colinize a new plainit.
When they get there they reilize that
it was a grate planit. as
the let the animals on the planit
one of them sends a mesig to earth.
as the people frome earth help
colinize this planit they come in big
numbers. After a few years a city is
billt and the coliny has been
started. Now they are trying
to make the planit better place
to live by planting trees and
growing other sorses of food
and Air. Not after that long
the city has expanded and
has become a good place
to live.

Examples of Simultaneous Weaknesses

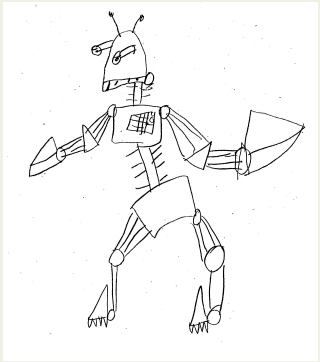


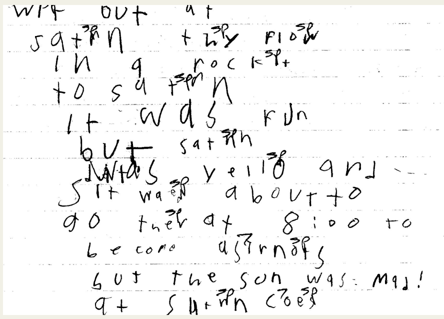
[illegible] 25 lines.

I hate this oxford gay learning
Science sucks!!! I wish it got
hit by a asteroid and blew
up into billions of pieces and
all the stuft was in it.
Oxford is boring, I could
be home getting homework
done instead of this gay place
I would be playing nintendo.
why can't I come at 5:00 A.M.
In the morning, and I could
get my homework done, and
play with my friends. They
don't have any food in the
store this is stupid. I
only get 100 or 50 trons.
I work so hard I think
I should get 400 trons
each lesson I come
here. The Manager or boss
of Oxford learning crap should
give all the money
to me!!!!!!!!!!!
And I'm serious!!!!!!!!!!
!!!!!!!!!!!!!!!!!!!

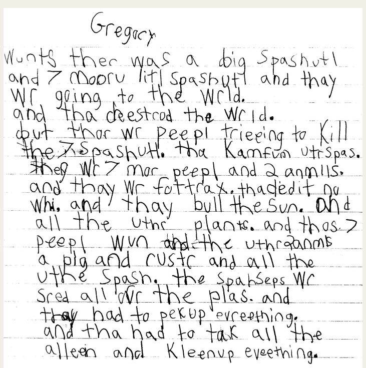
We have lots of pets we live at mars. One day we say "we've never even took one foot off this planet lets go on an trip and that means a long one. so everyone got in there one ship and decited to go to earth. They thought it was so great that they would live there but they still did miss the fact of being able to float.

I got the chance of for 1 week, it was a big change for me. Or diference was that instead of a little puppy for a pet they would have a dog robot! Everything was electrodeck there. I even meet an Alian, ma named Happy Alian. And I made a cool new best friend then, her name was Iasonr I know all of you would love it!





wrt out at
satrn thy flow
in a rockt
to satrn
it was fun
but satrn
was yello and
it was about to
go ther at 8:00 to
become astrnots
but the son was mad!
at satrn coes



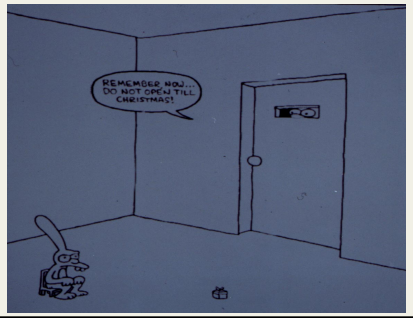
Gregory
Wunts ther was a big Spashutl
and 7 mooru litl spashutl and thay
wr going to the wrld.
and tha deestrod the wrld.
but thor wr peepl trieeing to kill
the 7 Spashutl. tha Kamfun utrspas.
they wr 7 mor peepl and 2 anmlls.
and thay wr fottrax. thadedit no
whi. and thay bull the sun. and
all the uthr plants. and thos 7
peepl wun and the uthr anmls
a pig and custr and all the
uthe spash. the spahseps wr
sred all ovr the plas. and
thay had to pekup evreething.
and tha had to tak all the
alleen and kleenup eveething.

Organizing the Data

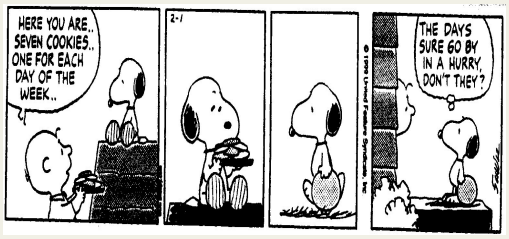
- A day in the life.
- Ability/Knowledge/Skill
- Risk and Protective factors
- Determining eligibility
- Suggesting possible diagnoses
- Recommending needs
- Considering continuum of services

Multiple Handicap or Primary/ Secondary?

Linguistic Competence, Self-control and a Resilient Mindset are the Keys to a Successful Life



Self-control is Important For All Species!



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