Helping the Child or Adolescent with Mental Health Issues Succeed at School

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Jay Berk, Ph.D., is a licensed clinical psychologist and an internationally recognized specialist in the child/adolescent behavioral field. He maintains a well-respected private practice, working with children, adolescents and families. Dr. Berk currently conducts 14 groups and works daily with school professionals, parents, children and adolescents.

A passionate and dedicated educator, his audiences include The Royal Brisbane Hospital in Queensland, Australia, The Royal Children's Hospital in Melbourne Australia, The University of London, The Cleveland Clinic, The Disney Channel, The Screen Actors Guild, and many school districts and universities throughout the United States. As a consultant to the United Nations, he authored a manual for UNICEF that was used by teachers working with children throughout Bosnia during the war.

Dr. Berk is adept at treating children/adolescents in outpatient and residential programs. His experience includes working at several area children's homes and in private practice, in schools and with individual clients and their families. His work includes clients with stress and anxiety, Learning Disabilities, Attention Deficit Disorder, Asperger's and other Pervasive Developmental Disorders, Tourette's Syndrome, and the treatment of individuals who have multiple impairments. Dr. Berk also works with children and adolescents with Oppositional Defiant Disorder, as well as their families.

As a consultant to businesses, schools, and other private organizations, Dr. Berk has advised clients in the areas of employee relations, employee assistance programs, policy development, and reducing burnout. He has instructed paramedics in the field management of behavioral emergencies and has served as a member of, and trainer for, the Greater Cleveland Chapter of the American Red Cross Disaster Mental Health Team.

Dr. Berk has responded to emergencies such as air disasters and fires where there has been loss of life and has provided training in debriefing and trauma response to clinicians and emergency responders. It was in this capacity that he delivered the keynote address at the University of Arkansas-Jonesboro seminar following the highly publicized local school shootings.

Dr, Berk is known for his practical application of knowledge and invites you to both learn from and enjoy your day that will be filled with helpful information.

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BEFORE YOU LEAVE TODAY YOU WILL KNOW THE FOLLOWING INFORMATION!

*Treatment Issues and concerns
- Learn about the biggest mistakes even the most seasoned professionals make
- The Most Left Out Group That You Need to Still Include in Treatment
- What Many Professionals Miss in a Diagnosis
- Axis II Kids: Real or Not
- Important clinical tips for working with children/adolescents exposed to drugs in utero

*Parent Issues
- Reluctant Parents…Understanding Their Unique Perspective

* Electronic Addictions
- Video Games and The Internet…a growing epidemic in our country
- Which kids are most susceptible and why?

* Oppositional Defiant Disorder vs. Conduct Disorder
- Important treatment implications
- What adults should never say but usually do
- Why are they so different?
- Why Monty Python was Right: Pro-Social Punishment;
- Arguments you will never win with Defiant Kids

* Sensory Issues/Behavioral Interventions or both!: Great Sensory Tips

* Anxiety Disorder…
- Recalibration of the scale for a more rapid fix
- The concept of acceptable anxiety

* Tourette's Syndrome
- The terrible triad of accompanying behaviors and how to treat them

* Cutting
- What we really need to treat to intervene effectively?

* Internet Bullying/Bullying in Schools…
- What really helps these clients?
- Will we get rid of all bullying?
- The biggest misconception adults tell kids that fuels this problem

* "Psychological" Munchausen's by Proxy
- Parents who need their kids to have issues

* When School Phobia is Not a Fear Related to **School**

***Disruptive Mood Dysregulation Disorder (DMDD) THE NEW BIPOLAR: NOT REALLY**

*Depression in Children/Adolescents
- The biggest mistakes most clinicians inadvertently make in treatment

*Psychotropic medications for the non-perscriber

TAKE NOTES HERE!!!!!!!!!!!!!!!!!!!!!!!! WE ARE TALKING

-QUESTIONS: PLEASE COMPLETE THIS WHILE YOU ARE WAITING!

IMPORTANT UPDATES

Disruptive Mood Dysregulation Disorder (DMDD) IS THE NEW NAME FOR BIPOLAR(True/False)

EXCESSIVE STREP INFECTIONS MAY CAUSE PANDAS (A RARE FORM OF BEAR) true/false

THE NEW NAME FOR THE ARTIST FORMALLY KNOWN AS ASPERGERS COULD BE Social Communication Disorder (true/false)

THERE ARE THREE TYPES OF CUTTERS..WHAT ARE THEY

_____ _____ _____

THERE IS A DIAGNOSIS CALLED INTERNET GAMING DISORDER (true/false)

MISOPHONIA IS A DISLIKE OF PHONES (true/false)

****

CITE AN IMPORTANT REASON MANY PARENTS STRUGGLE WITH CONTACTING HELP WHEN THERE IS A BEHAVIORAL EMERGENCY IN THE HOME

CITE TWO IMPORTANT REASONS MANY CHILDREN/ADOLESCENTS MAY INADVERTANLY BE MISDIAGNOSED

_____

_____

AN IMPORTANT CONCERN THAT CAN BE COMMONLY OVERLOOKED BY THE MENTAL HEALTH PROFESSIONAL IN TERMS OF DIAGNOSIS

_____

MEDICATION HAS BEEN DETERMINED TO BE THE MOST EFFECTIVE TREATMENT FOR DEPRESSION (True/False)

CHILDREN/ADOLESCENTS WHO HAVE OBSSESSIVE COMPULSIVE DISORDER USUALLY HAVE HAND WASHING AS A PRIMARY PROBLEM (True/False)

OBSESSIVE COMPULSIVE BEHAVIORS ARE FREQUENTLY VERY OBVIOUS IN CHILDREN/ADOLESCENTS (True/False)

CHILDREN/ADOLESCENTS WHO HAVE TOURETTE'S SYNDROME FREQUENTLY ARE SWEARING OUT LOUD (True/False)

THE TWO DIAGNOSES THAT OFTEN OCCOMPANY TOURETTE'S SYNDROME ARE?

_____

_____

CHILDREN/ADOLESCENTS WHO HAVE SCHOOL PHOBIA MOSTLY HAVE A FEAR OF SOME ELEMENT OF THE SCHOOL DAY (True/False)

ONE REASON SCHOOL PHOBIA MAY NOT BE A FEAR OF SCHOOL IS?

WHAT IS "PSYCHOLOGICAL MUNCHAUSEN"

_____

CHILDREN/ADOLESCENTS WHO HAVE ADHD HAVE TROUBLE FOCUSING IN SCHOOL AS WELL AS WITH THEIR VIDEO GAMES (True/False)

CHILDREN/ADOLESCENTS WITH AUTSIM (FORMERLY ASPERGER'S SYNDROME) MAY BE MORE SUSCEPTABLE TO ELECTRONIC ADDICTIONS (true/false)

Why/why not?

_____

_____

AS A NON-PHYSICIAN, IS IT STILL IMPORTANT TO KNOW ABOUT PSYCHIATRIC MEDICATIONS (Yes/No..If yes why?)

_____

CHILDREN/ADOLESCENTS WITH LEARNING DISABILITIES MAY HAVE A HIGHTENED STATE OF ANXIETY (True/False)

CHILDREN/ADOLESCENTS WHO ARE BULLIED BY PEERS SHOULD IGNORE THE BULLY (true/false)

ONE WAY IN WHICH POVERTY MAY IMPACT MENTAL HEALTH ISSUES IS

_____

OPPOSITIONAL CHILDREN/ADOLESCENTS NEED A PERSPECTIVE OF CONTROL (True/False)

TRADITIONAL PUNISHMENT WORKS WELL WITH OPPOSITIONAL AND DEFIANT CHILDREN? (true/false)

WHAT IS AN IMPORTANT DIFFERENCE BETWEEN OPPOSTIONAL DEFIANT CHILDREN/ADOLESCENTS AND THOSE WITH CONDUCT DISORDER?

ALWAYS USE IMMEDIATE AND SHORT TERM CONSEQUENCES FOR CHILDREN/ADOLECENTS WITH CONDUCT DISORDER SO THAT ISSUES DO NOT "HOLD OVER THEIR HEAD" FOR LONG PERIODS OF TIME true/false)

DESCRIBE SOME OF THE IMPACTS OF SENSORY ISSUES ON BEHAVIOR

Misophonia is a fear of phones? (true/false) …no googling on your phone!

WHAT IS A VITAL AREA TO CONSIDER WHEN INTERVENING WITH CHILDREN/ADOLESCENTS EXPOSED TO DRUGS/ALCOHOL IN UTERO

AGGRESSION STARTS AT ABOUT _____ AGE IN CHILDREN

WANT ARE THE BIGGEST MENTAL HEALTH ISSUES YOU OBSERVE IN CHILDREN AND ADOLESCENTS?

ELECTRONIC ADDICTION

CUTTING AND TYPES OF CUTTERS

SYSTEM DELIVERY ISSUES

- **RED CROSS**
- **L.D. SCHOOL**
- **CLEVELAND PUBLIC SCHOOLS / AKRON CITY SCHOOLS**
- **RESIDENTIAL TREATMENT**
- **PSYCHIATRIC HOSPITALS**
- **ENGLAND, NORWAY, BOSNIA (UNICEF)**
- **SCREEN ACTORS GUILD (SAG) / THE DISNEY CHANNEL**

WRITE YOUR NOTES HERE FOR SYSTEM DELIVERY TIPS CITED BY DR. BERK

Hospital issues especially!

WHERE WERE ALL THE CHILDREN WITH MENTAL HEALTH ISSUES YEARS AGO?

DIAGNOSIS IS A COLLECTION OF SYMPTOMS

WHAT IS MISSED BY MANY CLINCIAL PROFESSIONALS
WHY IS IT MISSED

LINE UP ACTIVITY

WHAT DOES THE TEACHER DO NOW?

TEACH

GUIDE

MODEL SUPPPORT

TEACH NORMS

PROVIDE MORE SUPERVISION

TEACH MORALITY

GUIDE PARENTS

TUTOR

DEVELOP CURRICULUM

ADVOCATE

SURROGATE PARENT

PROVIDE STRUCTURE

PARTICIPATE IN THE TEAM

MENTOR

COORDINATE ACTIVITIES

GUARD THE HALLS

DISCIPLINE

FIGHT DRUGS

SUPERVISE LUNCH PROGRAMS AND OTHER BASIC SURVIVAL NEEDS

AND DANCE VERY, VERY, FAST

PLUS TAKE CARE OF THEIR OWN LIVES

IN ADDITION….

WORK TO HELP WITH MENTAL HEALTH NEEDS OF THE CHILD/ADOLESCENT

LAWS AND SCHOOL BEHAVIORS

504 VS. IEP

SUSPENSION YES/NO

MANFESTATION DETERMINATION

HERE IS WHERE YOU CAN WRITE YOUR COMMENTS AND ANSWERS

Disruptive Mood Dysregulation Disorder (DMDD) IS THE NEW NAME FOR BIPOLAR(True/False)

Children with DMDD have severe and frequent temper tantrums that interfere with their ability to function at home, in school or with their friends. Some of these children were previously diagnosed with bipolar disorder. Research has also demonstrated that children with DMDD usually do not go on to have bipolar disorder in adulthood. They are more likely to develop problems with depression or anxiety

EXCESSIVE STREP INFECTIONS MAY CAUSE PANDAS (A RARE FORM OF BEAR) true/false

PANDAS: Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections

PANDAS is short for Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections. A child may be diagnosed with PANDAS when:

- Obsessive compulsive disorder (OCD) and/or tic disorders suddenly appear following a strep infection (such as strep throat or scarlet fever); or
- The symptoms of OCD or tic symptoms suddenly become worse following a strep infection.

The symptoms are usually dramatic, happen "overnight and out of the blue," and can include motor and/or vocal tics, obsessions, and/or compulsions. In addition to these symptoms, children may also become moody, irritable, experience anxiety attacks, or show concerns about separating from parents or loved ones

THE NEW NAME FOR THE ARTIST FORMALLY KNOWN AS ASPERGERS COULD BE Social Communication Disorder (true/false)

Social communication disorders may include problems with social interaction, social cognition, and pragmatics. A social communication disorder may be a distinct diagnosis or may occur within the context of other conditions

THERE ARE THREE TYPES OF CUTTERS..WHAT ARE THEY

_____ _____ _____

Non-suicidal self-injury (NSSI) content has proliferated on the Internet in recent years. Research indicates that many youth who self-injure go online to connect with others who self-injure and view others' NSSI experiences and share their own through electronic platforms

THERE IS A DIAGNOSIS CALLED INTERNET GAMING DISORDER (true/false)

Video game addiction is an excessive or compulsive use of computer games or video games, which interferes with daily living. Video game addiction may present itself as compulsive game-playing; social isolation; mood swings; diminished imagination; and hyper-focus on in-game achievements.

In May 2013, the American Psychiatric Association (APA) proposed criteria for video game addiction in the *Diagnostic and Statistical Manual of Mental Disorders*, concluding that there was insufficient evidence to include it as an official mental disorder

If you feel disgusted to the point of rage when you hear the sound of chewing, swallowing, breathing, throat-clearing and other common "people" noises, you're not alone. You're also not crazy. Misophonia is a sound sensitivity disorder, which makes certain noises intolerable to the sufferer.

Although this condition is primarily neurological, the experience of these sounds can cause psychological distress

MISOPHONIA IS A DISLIKE OF PHONES (true/false)

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DEPRESSION INTERVENTIONS

- PILLS AND SKILLS TOGETHER
- DON'T UNDERESTIMATE CARING AND EMOTIONAL SUPPORT
- DO NOT MINIMIZE
- SENSE OF HELPLESSNESS
- FORESHORTEND SENSE OF FUTURE
- MAY VARY ON A DAILY BASIS
- LIMIT OVERSTIMULATION
- CHANGE CAN CREATE FEAR

- ALLOW THEM TO USE SUPPORTIVE FRIENDS
- ALLOW SUPPORTIVE PERSON AND PLACE AT SCHOOL
- ACCEPT THERE MAY BE LIMITATIONS (TEMPORARY) IN WHAT THEY CAN DO OR ARE WILLING TO DO
- BREAK TASKS DOWN TO SMALL STEPS
- COORDINATE MEDICATION WITH PHYSICIAN
- STUDENT MAY "LOOK" OPPOSITONAL
- LET THEM KNOW YOU CARE
- BIBLIOTHERAPY Book "WHEN NOTHING MATTERS ANYMORE"
- COORDINATE CARE WITH MENTAL HEALTH PROFESSIONALS

- **Disruptive Mood Dysregulation Disorder (DMDD) <u>INTERVENTION IDEAS:</u>**
  - EARLY AWARENEESS/TRAINING FOR STAFF TO KNOW WHAT TO LOOK FOR
  - USUALLY A PARENT HAS BIPOLAR OR SOME "UNIDENTIFIED" MOOD CONDITION
  - SMALL CLASS
  - HOMEWORK REDUCED WHEN NEEDED
  - STUDY BUDDY
  - LATE START ISSUES
  - BATHROOM ACCESS
  - WATER ACCESS
  - EXTRA SET OF BOOKS
    - SUPPORT SESSIONS WITH A COUNSELOR
    - COURT IF NEEDED
  - EASY EXIT FROM CLASS AS NEEDED
  - SOCIAL SKILLS GROUPS
  - CUES (NON-VERBAL)
  - STRONG BEHAVIORAL PLANNING WHEN NEEDED
  - SLEEP SCHEDULE
  - HOSPITAL TUNE UPS
  - LINK TO COMMUNITY SERVICES

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_____

TIPS ON TOURETTE'S SYNDROME

TICS COME AND GO AND CHANGE

STRESS AND EXCITEMENT CAN BRING OUT TICS

CAN CAUSE DIFFICULTY READING AND TRACKING (BOOKS ON TAPE)

NOTE-TAKER

SAFE PLACE TO TIC…

IN-SERVICE FOR PEERS IF NEEDED

MORE PRESSURE CAN CAUSE MORE TICS

TERRIBLE TRIAD CHANGES WITH AGE

OCCUPATIONAL THERAPY HELPS

REDIRECT THEM AS NEEDED

EXTENDED TIME ON TESTS

CHECK IN AND CHECK OUT WORKS WELL

MEDICATIONS TIRE THEM OUT

CHILDREN/ADOLESCENTS WHO HAVE SCHOOL PHOBIA MOSTLY HAVE A FEAR OF SOME ELEMENT OF THE SCHOOL DAY (True/False)

ONE REASON SCHOOL PHOBIA MAY NOT BE A FEAR OF SCHOOL IS?

Notes here for three types of school phobia…

WHAT IS "PSYCHOLOGICAL MUNCHAUSEN"

CHILDREN/ADOLESCENTS WHO HAVE ADHD HAVE TROUBLE FOCUSING IN SCHOOL AS WELL AS WITH THEIR VIDEO GAMES (True/False)

CHILDREN/ADOLESCENTS WITH AUTISM (ASPERGER'S SYNDROME) MAY BE MORE SUSCEPTABLE TO ELECTRONIC ADDICTIONS (true/false)

Why/why not?

AS A NON-PHYSICIAN, IS IT STILL IMPORTANT TO KNOW ABOUT

PSYCHIATRIC MEDICATIONS (Yes/No..If yes why?)

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OPPOSITIONAL CHILDREN/ADOLESCENTS NEED A PERSPECTIVE OF CONTROL (True/False)

TRADITIONAL PUNISHMENT WORKS WELL WITH OPPOSITIONAL AND DEFIANT CHILDREN? (true/false)

Notes here on “pro-social punishment”

WHAT IS AN IMPORTANT DIFFERENCE BETWEEN OPPOSTIONAL DEFIANT CHILDREN/ADOLESCENTS AND THOSE WITH CONDUCT DISORDER?

ALWAYS USE IMMEDIATE AND SHORT TERM CONSEQUENCES FOR CHILDREN/ADOLESCENTS WITH CONDUCT DISORDER SO THAT ISSUES DO NOT "HOLD OVER THEIR HEAD" FOR LONG PERIODS OF TIME true/false)

DESCRIBE SOME OF THE IMPACTS OF SENSORY ISSUES ON BEHAVIOR

WHAT IS A VITAL AREA TO CONSIDER WHEN INTERVENING WITH CHILDREN/ADOLESCENTS EXPOSED TO DRUGS/ALCOHOL IN UTERO

AGGRESSION STARTS AT ABOUT _____ AGE IN CHILDREN

<u>GENERAL THOUGHTS</u>

AGGRESSION ISSUES

EDUCATION IS KEY ("Cheat Sheet")

THE 101 SHEET FOR ALL WHO WORK WITH THEM

STAFF TRAINING IS IMPERATIVE (EVEN IF IT IS SHORT)
GIVE INFORMATION AND FOLLOW UP

- **INCLUDE PARENT AND CHILD**
- **GIVE WEB ADDRESSES**
- **BOOK IDEAS**

THE RELATIONSHIP IS KEY

RECOGNIZE EARLY SIGNS

- **MOOD SWINGS**
- **EXTREME ANXIETY**
- **LONGSTANDING BEHAVIORS**
- **EXTREME DISTRACTION**
- **"STICK OUT" COMPARED TO SAME AGE PEERS**
- **GET ADVICE**

- **BEHAVIORS ARE NOT AGE APPROPRIATE**

ASK STUDENTS WHAT THEY THINK

TRANSITIONAL INFORMATION IS IMPORTANT

COORDINATE GRADE TRANSION

INTERMITTANT ABILITY/BEHAVIOR

IT MAY NOT BE ONE THING

DIAGNOSIS MAY CHANGE AS THE CHILD AGES
MEDICATION MAY CHANGE AS THE CHILD AGES

STUDY BUDDY IS VITAL

SOCIAL SKILL SUPPORTS

COMMON PSYCHIATRIC MEDICATIONS WITH CHILDREN AND ADOLESCENTS

*note discussion on current trend of "off label use and what it means"

STIMULANTS
RITALIN (CONCERTA)
ADDERALL (ADDERALL XR)
CYLERT
DEXADRINE
FOCALIN
VYVANSE
DAYTRANA
Quillivant XR

ADD (non-stimulant)
STRATTERA
INTUNIV

ANTIDEPRESSANTS
ZOLOFT*
LUVOX*
PROZAC*
PAXIL*

WELLBUTRIN
CELEXA
EFFEXOR
(* SELECTIVE SEROTONIN REUPTAKE INHIBITORS)

ANTI-HYPERTENSIVE
TENEX

ANTI-PSYCHOTIC
RISPERDAL
ZYPREXA
SEROQUEL
CLOZARIL
GEODON
ABILIFY

TOURETTE'S SYNDROME
ORAP
HALDOL
RISPERDAL
CLONIDINE

OBSESSIVE COMPULSIVE DISORDER
LUVOX
ZOLOFT
ANAFRANIL

BIPOLAR DISORDER
LITHIUM
DEPAKOTE

Note: Reference Book " Straight Talk About Psychiatric Medications for Kids" P. Wilens

Medications Chart

Stimulant Medications

Brand Name Generic Name Approved Age

Adderall amphetamines 3 and older
Concerta methylphenidate 6 and older
Cylert* pemoline 6 and older
Dexedrine dextroamphetamine 3 and older
Dextrostat dextroamphetamine 3 and older
Ritalin methylphenidate 6 and older
**Because of its potential for serious side effects affecting the liver, Cylert should not ordinarily be considered as first line drug therapy for ADHD.*
Antidepressant and Antianxiety Medications

Brand Name Generic Name Approved Age

Anafranil clomipramine 10 and older (for OCD)
BuSpar buspirone 18 and older
Effexor venlafaxine 18 and older
Luvox (SSRI) fluvoxamine 8 and older (for OCD)
Paxil (SSRI) paroxetine 18 and older
Prozac (SSRI) fluoxetine 18 and older
Serzone (SSRI) nefazodone 18 and older
Sinequan doxepin 12 and older
Tofranil imipramine 6 and older (for bed-wetting)
Wellbutrin bupropion 18 and older
Zoloft (SSRI) sertraline 6 and older (for OCD)
Antipsychotic Medications

Brand Name Generic Name Approved Age

Clozaril(atypical) clozapine 18 and older
Haldol haloperidol 3 and older
Risperdal (atypical) risperidone 18 and older
Seroquel (atypical) quetiapine 18 and older
(generic only) thioridazine 2 and older
Zyprexa (atypical) olanzapine 18 and older
Orap pimozide 12 and older (for Tourette's syndrome).
Data for age 2 and older indicate similar
safety profile.
Mood Stabilizing Medications

Brand Name Generic Name Approved Age

Cibalith-S lithium citrate 12 and older
Depakote divalproex sodium 2 and older (for seizures)
Eskalith lithium carbonate 12 and older
Lithobid lithium carbonate 12 and older
Tegretol carbamazepine any age (for seizures)

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ADDITIONAL NOTES AND THOUGHTS ABOUT MEDICATIONS:

Many children and adolescents stop taking the medications

Watch out for side effect issues that impact them

What else happens with their medications?

ADDITIONAL ISSUES TO CONSIDER

ABUSE OF THE MEDICATIONS

- WWW.CLUBDRUGS.ORG
- **NOT AS EASY TO RECOGNIZE**
- **LATEST DRUGS**
- **THE MOST IMPORTANT THING TO A DRUGGIE CHILD IS THE DRUG !**

IN-UTERO EXPOSURE

Lots of memory aides!

Memory issues!

SENSORY ISSUES IMPACTING BEHAVIORS

Name:
The purpose of a sensory diet for _____ is to assist him to maintain his optimum alert level through out the school day, so that he can participate in and learn from the educational material being presented to him. This sensory diet is an attempt to address the continuum of arousal states seen in _____ during the school day going from low arousal to the over stimulated.

_____ can move from one level to another throughout the day. Staff reports that they cannot identify behaviors associated with underarousal; therefore, levels 1 and 2 will be left blank. If behaviors appropriate for one or both of these levels are observed, the blank spaces will be filled in at the time.

	BEHAVIORS YOU MAY SEE	**WHAT TO DO**
Level 1		
Level 2		
Level 3	_____ is on task, attending to directions and transitioning without difficulty. He is following daily routines and verbal directions. _____ has been observed during this time to take a visual break from the activity in the classroom. This is the level we would like to maintain. This is the level at which _____ can learn the best.	Build heavy work routines into the school day, starting as soon as he gets to school. A social story may be paired with sensory activities to prepare _____ for the school day and for upcoming activities. See attached sheet for suggestions. When _____ is seen to be taking a visual break let him continue this for a short period of time. This seems to be a coping skill he has developed to deal with the activity in the classroom Build into the routine times to stretch. _____ may not know how to do this but staff can help him out by making him reach for objects just out of his reach. Use alternative work positions, such as working on all fours for a short period or doing some work in standing. Build into the routine times to go for a steady paced walk, perhaps to run an errand.
Level 4	_____is beginning to have difficulty with the daily routine and with verbal directions. He runs around and can't focus on materials being presented. He may argue about verbal input or	Decrease verbal interactions and use gestures as much as possible. If possible, dim the lights in the room or at least in the quiet area. If possible decrease the noise level in the room or have him listen to quiet music.

	suggestions. He may perseverate on verbal directions	_____ may need a short break in a quiet area. While in the quiet area, give him a fidget toy to calm himself. A social story may help him to calm himself and anticipate upcoming activities. Have him go for a slow steady paced walk. As he becomes calm, have him do some heavy work to prepare him to refocus his attention on schoolwork.
Level 5	_____ is running around and may beat on lockers. He may throw objects. He may throw himself on the floor and cry. He may beat on himself or pick at his nose.	Rely on visual cues primarily. If possible dim the lights and reduce the noise level. Give him some down time in a quiet area and allow him to use a sensory item to calm himself. He may benefit from being in a bean bag chair or under a weighted or heavy blanket. Silently show him a social story and/or his daily schedule to anticipate upcoming activities. Once calm, have him stretch and/or go for a slow steady paced walk. Have him do a heavy work activity to get ready to rejoin his group for schoolwork.

Functional Behavior Assessment Line of Inquiry Worksheet

Student: School: Grade: Date: Team Members:

Slow Triggers (setting events)	Fast Triggers (Antecedents)	Problem Behavior	Perceived Function	Actual Consequences	Strengths
New to area from Delaware Attended separate facility for students with learning problems Learning disability NeuroFibromytosis Type1 – neurological disorder ADHD symptoms Easily distracted Picky eater IQ scores decreased in latest evaluation Needs glasses, others broken	Transitions When not in proximity of adult When does not perceive adult as in charge When cannot meet academic demand When he feels singled out in front of peers When feels work is too difficult When he is in small group setting (does well 1-1 or in large group, although needs assistance to do academics in large group)	Low frustration level Swears, uses inappropriate language to peers and adults Makes poor choices Non-compliant unless he is interested in activity Refuses academic work at times Breaks glasses and pencils, tears up his papers, throws objects in garbage Negative comments about others Does not tell adults when he needs help	To gain affirmation and approval by peers Lacks social skills, has difficulty verbalizing wants and needs Wants to be accepted by the group Avoids academic challenges	Ignore or downplay negative comments when rest of group is not affected Keep adult emotions on even keel to avoid showing “shock” reactions Other kids may react by laughing or staying away Removal to office Work with resource officer	Outgoing Likes to use hands-on manipulatives such as clay, tools Computer skills Likes to change date on board Likes attention of peers and adults Has been staying after school with _____ to do _____ homework Engaging, comfortable with adults Likes video games Persistent Focuses well on areas of interest and capability Responds well to Resource Office Can de-escalate quickly

Hypotheses:
_____ is a new student at KMS. He has a neurological condition that affects his cognitive and behavior skills. He has symptoms of ADHD. When _____ has academic demands that he perceives as difficult, has to make transitions or doesn’t have immediate reinforcement, he uses inappropriate language or makes negative comments, tears up work papers and becomes non-compliant with directions in order to access one-to-one adult attention and assistance, meet need for peer approval and avoid academic tasks. He lacks some social skills including his ability to use appropriate words to express feelings of frustration and ask for help.

IDEA AND THE LAW

CAN THE CHILD/ADOLESCENT BE SUSPENDED?

WHAT IS A MANIFESTATON HEARING?

IS IT A MANIFESTATION OF THE DISABILITY?

<u>FUNCTIONAL BEHAVIOR ASSESSMENT</u>

SLOW TRIGGERS:

FAST TRIGGERS:

PROBLEM BEHAVIORS:

PERCEIVED FUNCTION:

ACTUAL CONSEQUENCES:

STRENGTHS:

More than a behavior plan

Iceberg!

Diagnosis Social (Pragmatic) Communication Disorder 315.39 (F80.89)

Diagnostic Criteria

A. Persistent difficulties in the social use of verbal and nonverbal communication as manifested by all of the following:

1. Deficits in using communication for social purposes, such as greeting and sharing information, in a manner that is appropriate for the social context.

2. Impairment of the ability to change communication to match context or the needs of the listener, such as speaking differently in a classroom than on the playground, talking differently to a child than to an adult, and avoiding use of overly formal language.

3. Difficulties following rules for conversation and storytelling, such as taking turns in conversation, rephrasing when misunderstood, and knowing how to use verbal and nonverbal signals to regulate interaction.

4. Difficulties understanding what is not explicitly stated (e.g., making inferences) and nonliteral or ambiguous meanings of language (e.g., idioms, humor, metaphors, multiple meanings that depend on the context for interpretation).

B. The deficits result in functional limitations in effective communication, social participation, social relationships, academic achievement, or occupational performance, individually or in combination.

C. The onset of the symptoms is in the early developmental period (but deficits may not become fully manifest until social communication demands exceed limited capacities).

D. The symptoms are not attributable to another medical or neurological condition or to low abilities in the domains or word structure and grammar, and are not better explained by autism spectrum disorder, intellectual disability (intellectual developmental disorder), global developmental delay, or another mental disorder.

Autism Spectrum Disorder 299.00 (F84.0)

Diagnostic Criteria

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive, see text):

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.

2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.

3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

Specify current severity:

Severity is based on social communication impairments and restricted repetitive patterns of behavior (see Table 2).

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).

2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day).

3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g, strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interest).

4. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

Specify current severity:

Severity is based on social communication impairments and restricted, repetitive patterns of behavior (see Table 2).

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

Note: Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not

otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.

Specify if:

With or without accompanying intellectual impairment
With or without accompanying language impairment
Associated with a known medical or genetic condition or environmental factor
(**Coding note:** Use additional code to identify the associated medical or genetic condition.)
Associated with another neurodevelopmental, mental, or behavioral disorder
(**Coding note:** Use additional code[s] to identify the associated neurodevelopmental, mental, or behavioral disorder[s].)
With catatonia (refer to the criteria for catatonia associated with another mental disorder, pp. 119-120, for definition) (**Coding note:** Use additional code 293.89 [F06.1] catatonia associated with autism spectrum disorder to indicate the presence of the comorbid catatonia.)

Table 2 Severity levels for autism spectrum disorder

Severity level	Social communication	Restricted, repetitive behaviors
Level 3 "Requiring very substantial support"	Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches	Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.
Level 2 "Requiring substantial support"	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and how has markedly odd nonverbal communication.	Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.
Level 1 "Requiring support"	Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful response to social overtures of others. May appear to have decreased interest in social interactions. For example, a person who is able to speak in full sentences and engages in communication but whose to- and-fro conversation with others fails, and whose attempts to make friends are odd and typically	Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

unsuccessful.

trained health care providers can diagnose or treat ADHD.

DSM-5 Criteria for ADHD

People with ADHD show a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development:

1. **Inattention: Six or more symptoms of inattention for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of inattention have been present for at least 6 months, and they are inappropriate for developmental level:**
   - Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities.
   - Often has trouble holding attention on tasks or play activities.
   - Often does not seem to listen when spoken to directly.
   - Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side-tracked).
   - Often has trouble organizing tasks and activities.
   - Often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework).
   - Often loses things necessary for tasks and activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
   - Is often easily distracted
   - Is often forgetful in daily activities.
2. **Hyperactivity and Impulsivity: Six or more symptoms of hyperactivity-impulsivity for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of hyperactivity-impulsivity have been present for at least 6 months to an extent that is disruptive and inappropriate for the person's developmental level:**
   - Often fidgets with or taps hands or feet, or squirms in seat.
   - Often leaves seat in situations when remaining seated is expected.
   - Often runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless).
   - Often unable to play or take part in leisure activities quietly.
   - Is often "on the go" acting as if "driven by a motor".
   - Often talks excessively.
   - Often blurts out an answer before a question has been completed.

- Often has trouble waiting his/her turn.
- Often interrupts or intrudes on others (e.g., butts into conversations or games)

In addition, the following conditions must be met:

- Several inattentive or hyperactive-impulsive symptoms were present before age 12 years.
- Several symptoms are present in two or more setting, (such as at home, school or work; with friends or relatives; in other activities).
- There is clear evidence that the symptoms interfere with, or reduce the quality of, social, school, or work functioning.
- The symptoms are not better explained by another mental disorder (such as a mood disorder, anxiety disorder, dissociative disorder, or a personality disorder). The symptoms do not happen only during the course of schizophrenia or another psychotic disorder.

Based on the types of symptoms, three kinds (presentations) of ADHD can occur:

Combined Presentation: if enough symptoms of both criteria inattention and hyperactivity-impulsivity were present for the past 6 months

Predominantly Inattentive Presentation: if enough symptoms of inattention, but not hyperactivity-impulsivity, were present for the past six months

Predominantly Hyperactive-Impulsive Presentation: if enough symptoms of hyperactivity-impulsivity but not inattention were present for the past six months.

Because symptoms can change over time, the presentation may change over time as well.

ADHD in Adults

ADHD often lasts into adulthood. For more information about diagnosis and treatment throughout the lifespan, please visit the websites of the National Resource Center on ADHD and the National Institutes of Mental Health.

Changes in the DSM-5

The fifth edition of the DSM was released in May 2013 and replaces the previous version, the text revision of the fourth edition (DSM-IV-TR). There were some changes in the DSM-5 for the diagnosis of ADHD:

- Symptoms can now occur by age 12 rather than by age 6;

- Several symptoms now need to be present in more than one setting rather than just some impairment in more than one setting;
- New descriptions were added to show what symptoms might look like at older ages; and
- For adults and adolescents age 17 or older, only 5 symptoms are needed instead of the 6 needed for younger children

Among possible causes of ADHD like behavior are the following:

• A sudden change in the child's life—the death of a parent or grandparent; parents' divorce; a parent's job loss

• Undetected seizures, such as in petit mal or temporal lobe seizures

• A middle ear infection that causes intermittent hearing problems

• Medical disorders that may affect brain functioning

• Underachievement caused by learning disability

• Anxiety or depression.

CONDUCT DISORDER

Diagnostic criteria for Conduct Disorder

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least on criterion present in the past 6 months:

Aggression to people and animals:

(1) often bullies, threatens, or intimidates others

(2) often initiates physical fights

(3) has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)

(4) has been physically cruel to people

(5) has been physically cruel to animals

(6) has stolen while confronting a victim (e.g., mugging, purse snatching,

extortion, armed robbery)

(7) has forced someone into sexual activity

Destruction of property

(8) has deliberately engaged in fire setting with the intention of serious damage

(9) has deliberately destroyed others' property (other than by fire setting)

Deceitfulness or theft

(10) has broken into someone else's house, building, or car

(11) often lies to obtain goods or favors or to avoid obligations (e.g., "cons" others)

(12) has stolen items on nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)

Serious violations of rules

(13) often stays out at night despite parental prohibitions, beginning before age 13 years

(14) has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)

(15) is often truant from school, beginning before age 13 years

B. The disturbance on behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. If the individual is age 18 years or older, criteria are note met for Antisocial Personality Disorder.

Specify type based on age at onset:

Childhood-Onset Type: onset of at least one criterion characteristic of Conduct Disorder prior to ate 10 years

Adolescent-Onset Type: absence of any criteria characteristic of Conduct Disorder prior to age 10 years

Specify severity:

Mild: a few if any conduct problems in excess of those required to make the diagnosis **and** conduct problems cause only minor harm to others

Moderate: number of conduct problems and effect on others intermediate between "mild" and "severe"

Severe: many conduct problems in excess of those required to make the diagnosis **or** conduct problems cause considerable harm to others

OPPOSITIONAL DEFIANT DISORDER

Diagnostic criteria for Oppositional Defiant Disorder

A. A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:

(1) often loses temper

(2) often argues with adults

(3) often actively defies or refuses to comply with adults' requests or rules

(4) often deliberately annoys people

(5) often blames others for his or her mistakes or misbehavior

(6) is often touchy or easily annoyed by others

(7) is often angry and resentful

(8) is often spiteful or vindictive

Note: Consider a criterion met only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level.

B. The disturbance in behavior causes clinically significant impairment in the social, academic, or occupational functioning.

C. The behaviors do not occur exclusively during the course of a psychotic or Mood Disorder.

D. Criteria are not met for Conduct Disorder, and, if the individual is age 18 years or older, criteria are note met for Antisocial Personality Disorder.

ANXIETY ISSUES

Diagnostic criteria for Separation Anxiety Disorder

A. Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by three (or more) of the following:

(1) recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated

(2) persistent and excessive worry about losing, or about possible harm befalling, major attachment figures

(3) persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped)

(4) persistent reluctance or refusal to go to school or elsewhere because of fear of separation

(5) persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings

(6) persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home

(7) repeated nightmares involving the theme of separation

(8) repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated.

B. The duration of the disturbance is at least 4 weeks.

C. The onset is before age 18 years.

D. The disturbance causes clinically significant distress or impairment in social, academic, (occupational), or other important areas of functioning.

E. The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and, in adolescents and adults, is not better accounted for by Panic Disorder with

Agoraphobia.

Specify if:

Early Onset: if onset occurs before age 6 years

Diagnostic criteria for Social Phobia

A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing. **Note:** In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults.

B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed Panic Attack. **Note:** In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.

C. The person recognizes that the fear is excessive or unreasonable. **Note:** In children, this feature may be absent.

D. The feared social or performance situations are avoided or else are endured with intense anxiety or distress.

E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.

F. In individuals under the age 18 years, the duration is at lest 6 months.

G. The fear or avoidance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., Panic Disorder With or Without Agoraphobia, Separation Anxiety Disorder, Body Dysmorphic Disorder, a Pervasive Developmental Disorder, or Schizoid Personality Disorder).

H. If a general medical condition or another mental health disorder is present, the fear in Criterion A is unrelated to it, e.g., the fear is not

Stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behavior in Anorexia Nervosa or Bulimia Nervosa.

Diagnostic criteria for Obsessive-Compulsive Disorder

A. Either obsessions or compulsions:
Obsessions as defined by (1), (2), (3), and (4):

(1) recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress

(2) the thoughts, impulses, or images are not simply excessive worries about real-life problems

(3) the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action

(4) the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

Compulsions as defined by (1) and (2):

(1) repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly

(2) the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. **Note:** This does not apply to children.

C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.

D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body

Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of Perihelia; or guilty ruminations in the presence of major Depressive Disorder).

E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.
Specify if:

With poor insight: if, for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable.

Diagnostic criteria for 300.02 Generalized Anxiety Disorder

A. Excessive anxiety and worry (apprehensive, expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance)

B. The person finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). **Note:** Only one item is required in children.

(1) restlessness or feeling keyed up or on edge

(2) being easily fatigued

(3) difficulty concentrating or mind going blank

(4) irritability

(5) muscle tension

(6) sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder, being away from home or close relatives (as in Separation Anxiety Disorder) gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Summarization Disorder), or in having a serious illness (as in Hypochondriasis), and the

anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.

E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.

ANXIETY TIPS

1-10 RULE

DISTRACT

DBT

Diagnostic Criteria for – Expressive Language Disorder

A. The scores obtained from standardized individually administered measures of expressive language development are substantially below those obtained from standardized measures of both nonverbal intellectual capacity and receptive language development. The disturbance may manifest clinically by symptoms that include having a markedly limited vocabulary, making errors in tense, or having difficulty recalling words or producing sentences with developmentally appropriate length or complexity.

B. The difficulties with expressive language interfere with academic or occupational achievement or with social communication.

C. Criteria are not met for Mixed Receptive-Expressive Language Disorder or a Pervasive developmental Disorder.

D. If Mental Retardation, a speech-motor or sensory deficit, or environmental deprivation is present, the language difficulties are in excess of those usually associated with these problems.

Coding note: If a speech-motor or sensory deficit or a neurological condition is present, code the condition on Axis III.

DEPRESSION

Criteria for Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood.

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

(3) significant weight loss when not dieting or weight gain (e.g., a change

of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.

(4) insomnia or hypersonic nearly every day

(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed own)

(6) fatigue or loss of energy nearly every day

(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicidal attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e. after the loss of a loved one, the symptoms persist for longer than 2 months or a re characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Diagnostic criteria for Tourette's Disorder

A. Both multiple motor and one or more vocal tics have been present at some time during the illness, although not necessarily concurrently. (A *tic* is a sudden, rapid, recurrent, no rhythmic, **stereotyped** motor movement or vocalization.)

B. The tics occur many times a day (usually in bouts) nearly every day or intermittently throughout a period of more than 1 year, and during this period there was never a tic-free period of more than 3 consecutive months.

C. The disturbance causes marked distress or significant impairment in social, occupational, or other important areas of functioning.

D. The onset is before age 18 years.

E. The disturbance is not due to the direct physiological effects of a substance (e.g., stimulants) or a general medical condition (e.g., Huntington's disease or post viral encephalitis).

ADDENDDUM 1

This page gives a brief background about . It shows things that have worked well with him in the past and a little of his personal history.

Family
Both parents at home
Brothers

Education
attends Middle School He is primarily in the typical classroom for most subjects except Math and Reading. He gets pulled out of the class for extra help in these areas. In his regular education classes his subjects are modified. For example in Science. . . if his classmates get 30 vocabulary words to learn, will only be given 15.

Things he likes to do
Soccer, Rec Council basketball, horseback riding, computer games, swimming, camping and started jogging in Spring '08

Places he has recently visited
Aruba, Oregon, Vermont, Lake Tahoe, Hilton Head Island

Things He Likes to Talk About
Sports! He loves the Cavs and NHL Hockey. He also is into current pop music.

General Health
is very healthy. He takes a pill every morning to monitor his thyroid and this is basically it. He does have trouble sleeping however, and may need to get to bed extra early on occasion or have a short cat nap in the day to catch up. Also, he can get a little sluggish in very hot weather.

Home Expectations – the Four Rules for :

- Be a gentleman at all times
- Always look an adult in the eye when speaking to them
- Be helpful and respectful to your Mom

- If you can't say anything nice, don't say anything at all

Specific things that work well

- Short, concise instructions – ask to repeat what was just said… this is a good way to determine whether he is comprehending the content
- Be firm and consistent with behavior expectations (similar to home)
- is a visual learner so give him concrete examples
- Speak slowly and clearly
- Keep his "bubble" - should keep his hands and feet to himself and no hugging. is inclined to hug people when he is tired and does not have enough energy to use his words to express himself.

Although can be charming, he is very "street smart" and will test all limits at first. He knows the rules even though others may think he does not. Treat him with the expectation that "society" will not let him get away with things or to cut corners. Being extra easy on him due to his disability and his charming nature seems natural but does not necessarily help him prepare for life.

May, 2008
Prepared by Mom:

ADDENDUM TWO

Functional Behavior Assessment Line of Inquiry Worksheet

Student: School: Grade: Date: Team Members:

Slow Triggers (setting events)	Fast Triggers (Antecedents)	Problem Behavior	Perceived Function	Actual Consequences	Strengths
New to area from Attended separate facility for students with learning problems Learning disability NeuroFibromytosis Type1 – neurological disorder ADHD symptoms Easily distracted Picky eater IQ scores decreased in latest evaluation Needs glasses, others broken	Transitions When not in proximity of adult When does not perceive adult as in charge When cannot meet academic demand When he feels singled out in front of peers When feels work is too difficult When he is in small group setting (does well 1-1 or in large group, although needs assistance to do academics in large group)	Low frustration level Swears, uses inappropriate language to peers and adults Makes poor choices Non-compliant unless he is interested in activity Refuses academic work at times Breaks glasses and pencils, tears up his papers, throws objects in garbage Negative comments about others Does not tell adults when he needs help	To gain affirmation and approval by peers Lacks social skills, has difficulty verbalizing wants and needs Wants to be accepted by the group Avoids academic challenges	Ignore or downplay negative comments when rest of group is not affected Keep adult emotions on even keel to avoid showing “shock” reactions Other kids may react by laughing or staying away Removal to office Work with resource officer	Outgoing Likes to use hands-on manipulatives such as clay, tools Computer skills Likes to change date on board Likes attention of peers and adults Has been staying after school with _____ to do _____ homework Engaging, comfortable with adults Likes video games Persistent Focuses well on areas of interest and capability Responds well to Resource Office Can de-escalate quickly

Hypotheses:
_____ is a new student at KMS. He has a neurological condition that affects his cognitive and behavior skills. He has symptoms of ADHD. When _____ has academic demands that he perceives as difficult, has to make transitions or doesn’t have immediate reinforcement, he uses inappropriate language or makes negative comments, tears up work papers and becomes non-compliant with directions in order to access one-to-one adult attention and assistance, meet need for peer approval and avoid academic tasks. He lacks some social skills including his ability to use appropriate words to express feelings of frustration and ask for help.

ADDENDUM FOUR

A Guide to Asperger's Syndrome (AS)

Asperger's Syndrome is a neurobiological disorder on the autistic spectrum, affecting peer social interaction and communication. Children with AS have rigidity of thinking, much like those with high-functioning autism as well as a heightened sensitivity to noise and crowds, poor understanding of facial expressions, and tendencies toward isolation. There is a range of severity of symptoms within the syndrome, the very mildly affected child often going undiagnosed, appearing only odd or eccentric. Consequently, the issues facing the parents and teachers of students with AS are many, as their communication can be both awkward and challenging.

Academically, students with AS have trouble with auditory instruction and keeping themselves organized. They tend to be reluctant to accept change, and to be inflexible with thought. Not surprisingly, these children frequently have all absorbing narrow areas of interest. AS children typically are good with rote memory skills (facts, figures, dates, times, etc); many excel in math and science. It is not uncommon for these students to have very uneven academic experiences. These children tend to thrive in environments that are structured, patient and supportive; simultaneously, calm and specific.

Amongst their peers, children with AS have difficulty reading social cues. They often use language in a slightly odd way, and take literal meaning form what is read or heard. Making friends is very difficult because an this child does not understand the social nuances necessary to do so, and other children frequently do not understand and accept the odd, and somewhat clumsy, manner this child might have. Lunch room, playground or any situations with unstructured activities can be the most difficult time of the day; conflicts that occur at these times can often drastically affect their concentration in the classroom.

The following is a list of issues which often arise with AS children, along with strategies which have proven effective in supporting them both academically and socially:

❖ Complex, large, fast paced and/or unfamiliar classroom settings create major distractions	❖ Limit group sizes; limit distractions; allow additional time to process and assimilate information; reduce noise levels; reiterate instructions and directions often
❖ Verbal or vague instructions cause confusion	❖ Keep instructions simple; visually supplement and support information; limit options; use clear, literal unambiguous language
❖ Changes in schedule/routine and additions/subtractions to assignments result in late or incomplete work	❖ Pre-warn, when possible, of changes and deadlines; clarify schedules; communicate new expectations; help with re-identifying priorities
❖ Poor time management and disorganized work habits interfere with long term projects, tests, quizzes and lab work	❖ Schedule out assignments; discuss breaking up priorities on larger projects; remind of time constraints; inquire about issues periodically; allow additional time when possible, choose partners carefully
❖ Pace of maturity expected at rate of peers becomes a potential setup for failure	❖ Expect occasional lapses in independence; encourage responsibility for <u>specific</u> behavior
❖ Social conflicts, stressful situations can severely affect engagement and cooperation	❖ Be aware of stress triggers; look for overly rigid behavior; give specific solutions (i.e., count to 10, breathe deeply), remove from environment if necessary