

UNIVERSITY OF CALIFORNIA, BERKELEY

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SANTA BARBARA • SANTA CRUZ

SCHOOL OF PUBLIC HEALTH
MATERNAL & CHILD HEALTH

EARL WARREN HALL
BERKELEY, CALIFORNIA 94720

415: 642-6482



October 31, 1984

Helen Gofman, M.D.
1045 Clayton Street
San Francisco, California 94117

Dear Helen

Thank you so very much for the seminar you gave to my Human Growth and Development students, who gave laudatory reviews to say the least.

I hope we can reserve you again for Fall Semester 1985!

Yours very sincerely,

A handwritten signature in blue ink, which appears to be "Frank Falkner".

Frank Falkner, M.D., F.R.C.P.
Professor and Chairman
Maternal and Child Health Program

→ February 6, 1985

TO: Michael Boyle, M.A. Lane Tanner, M.D.
Pam High, M.D. Abby Alkon, P.N.P.
Helen Gofman, M.D. ✓ Carl Baum, M.D.
Howard Gillis, Ph.D. Benci Franklin, M.D.
Alice Whitsell, B.A. Donya Harvin, M.A.
Margie Kaplan, M.A. Lucy Crain, M.D.
Rochelle Wolk, Ph.D. Sylvia Nagulko, R.N., M.A.
Marty Glasser, M.D.

FROM: Pam Kaiser, PNP

TOPIC: March-April schedule of the Behavioral/Developmental Core
Curriculum for Pediatric Residents in CSU

Attached is the March-April schedule. Please let me know ASAP if there is a conflict with your scheduled time.

The resident's evaluations are attached. Weren't Jon, Vicki, Mary, and Paul a breath of fresh air!!!!?

The trainees for the March-April cycle include two UCSF pediatric residents and one Kaiser-S.F. pediatric resident.

I hope you've had a chance to look over the pre/post test key. I'd appreciate any feedback.

Once again, thank you for your continued participation.

/sl

CHILD STUDY UNIT --- UCSF
BEHAVIORAL/DEVELOPMENTAL CORE CURRICULUM
FOR PEDIATRIC RESIDENTS

<u>TOPIC</u>	<u>FACULTY</u>	<u>DATE</u>	<u>ROOM</u>
*Speech & Language I: Normal Devel. & Assess. Strategies	M. Boyle, M.A.	Fri 3/1 10:30-12	CSU A240
*Overview of Growth and Development	P. Kaiser, MN, PNP	Mon 3/4 9-11	Adol. Med. A270
*Infancy: Observable Phenomena	P. Kigh, MD	Mon 3/4 1-3	CSU A244
*Infancy: <u>Amazing Newborn</u> & <u>Brazelton Neonatal Assess.</u> <u>Scale</u> videotapes	P. Kaiser, MN, PNP	Mon 3/4 3-4:30	CSU A244
*Temperament	H. Gofman, MD	Tues 3/5 1-3	CSU A240
*Speech & Language II: Observation of Speech & Language Therapy	M. Boyle, MA	Thurs 3/7 10:30-12	CSU A244
*Developmental Screening	H. Gillis, Ph.D.	Fri 3/8 10:30-12	CSU A240
*DDST: Videotape & Readings		Fri 3/15 9-12	CSU A240
Community Experience: Visit to Infant Daycare Center	P. Kaiser, MN, PNP	Mon 3/18 8:30-12	YWCA Infant Center
*Infancy: Attachment	P. High, MD	Mon 3/18 1-3	CSU A244
*Learning Disabilities	A. Whitsell, BA M. Kaplan, MS	Tues 3/19 1-3	Reading Clinic 1350 7th Av.
*Developmental Theory I: Erikson & Freud	R. Wolk, Ph.D.	Thurs 3/21 10-12	CSU A244
*Psychiatric Nosology for the Pediatrician	M. Glasser, MD	Thurs 3/21 1-3	CSU A281
*Developmental Theory II: Piaget	L. Tanner, MD A. Alkon, PNP	Fri 3/22 8:30-10:30	CSU A240

TOPIC	FACULTY	DATE	ROOM
Community Experience: Visit to a Preschool	P. Kaiser, MN, PNP	Mon 3/25 8:30-12	SF JCC Preschool
Child & Family Interview in the CEP	C. Baum, MD	Tues 3/26 1-3	CSU A240
*Hyperactivity	C. Baum, MD	Wed 3/27 8:30-10	CSU A244
Community Experience: Visit to a Preschool/Daycare	P. Kaiser, MN, PNP	Thurs 3/28 8:30-12	Gateway Montessori
*Preschool: Common Clinical Issues	H. Gillis, Ph.D. B. Franklin, MD	Thurs 3/28 1-3	CSU A240
*Hospitalization	P. Kaiser, MN, PNP	Mon 4/1 9-11	Adol, Med. A270
*Adolescence	M. Glasser, MD	Wed 4/3 8:30-10	CSU A281
*School Age Child	L. Tanner, MD D. Harvin, MA	Fri 4/5 8:30-10:30	CSU A244
*Developmental Screening II	H. Gillis, Ph.D.	Fri 4/5 10:30-12	CSU A240
Community Experience: Visit to Infant Development Program	P. Kaiser, MN, PNP D. Cook-Clampett, Dir./Spec. Educator	Mon 4/8 9:30-12	SF Easter Seals
*Daycare Options & Devel. Effects of Maternal Employment	P. Kaiser, MN, PNP	Mon 4/8 1-2	CSU A244
Community Experience: Visit to Daycare Center	P. Kaiser, MN, PNP	Mon 4/8 2-5	Child Care Study Center
Community Experience: Teaching Tour of Sonoma State Hospital	L. Crain, MD	Wed 4/10 8-6	Sonoma State Hospital
Community Experience: Visit to a Grade School	S. Nagulko, RN, MA	Thurs 4/11 8:30-10	Commodore Sloat School

*These seminars are open for other trainees (i.e. residents, graduate nursing students) to attend.

DEVELOPMENTAL/BEHAVIOR DIDACTICS --- EVALUATION

TOPIC: Temperament

SPEAKER: _____

DATE: 1/15/85

CHECK ONE: ☒ RESIDENT ☐ FELLOW ☐ OTHER

CIRCLE APPROPRIATE NUMBER: NOT APPLICABLE POOR FAIR GOOD VERY GOOD EXCELLENT COMMENTS:

LECTURE/SEMINAR

Lecturer (Name): Helen Gofman MD

Content: 1 2 3 4 5 6

Presentation: 1 2 3 4 5 6

Relevance to Clinical Practice 1 2 3 4 5 6

READING(s) Have not yet been assigned

Pertinence 1 2 3 4 5 6

Stimulation 1 2 3 4 5 6

Depth/Breadth 1 2 3 4 5 6

RECOMMENDATIONS/SUGGESTIONS:

DEVELOPMENTAL/BEHAVIOR DIDACTICS --- EVALUATION

TOPIC: Temperament

SPEAKER: Helen Popman

DATE: 1-15-85

CHECK ONE: ☐ RESIDENT ☐ FELLOW ☐ OTHER

CIRCLE APPROPRIATE NUMBER: NOT APPLICABLE POOR FAIR GOOD VERY GOOD EXCELLENT

COMMENTS:

LECTURE/SEMINAR

Lecturer (Name): _____

Content: 1 2 3 4 (5) 6

Presentation: 1 2 3 4 (5) 6

Relevance to Clinical Practice 1 2 3 4 (5) 6

Very much enjoyed the participation from Dr Popman gave us. She is an interesting speaker who knows her subject well.

READING(s)

COMMENTS:

Pertinence 1 2 3 4 5 6

Stimulation 1 2 3 4 5 6

Depth/Breadth 1 2 3 4 5 6

RECOMMENDATIONS/SUGGESTIONS:

AMERICAN ACADEMY OF PEDIATRICS
1988 ANNUAL MEETING-SAN FRANCISCO, CA
MEETING SERVICES
PO BOX 927
FLK GROVE VILLAGE, IL 60009-0927

09/22/88

BATCH# 68480
REG. ID: 03699
RECVD DATE: 09/21/88
AAP ID: 102151
PREP ID
CODES: 00-00-00-00-00

REGISTRATION CONFIRMATION

Helen Gofman MD
1045 Clayton St
San Francisco, CA 94117

REGISTRATION FEE (NON-MEMBER)			\$185.00
S104	1 BEHAVIOR & DEVELOPMENT	10/15/88 09:00AM	95.00
S408	1 LEARNING DISORDERS IN CHILDREN & ADOLE	10/18/88 09:00AM	55.00
S803	1 FAMILIES AND SCHOOLS: THE PROBLEMS OF	10/20/88 09:00AM	55.00
TOTAL FEES.....			\$390.00
TYPE OF PAYMENT CK			AMOUNT PAID TO DATE 390.00
BALANCE.....			\$0.00

Your registration packets (including your tickets) can be picked up at the AAP registration center in the SAN FRANCISCO MOSCONE CENTER beginning FRIDAY, OCTOBER 14 AT 3:00 PM.

Additional registration hours are listed in the official program.

All cancellations must be in letter form and postmarked no later than OCTOBER 7, 1988

A negative balance indicates that a refund is due the registrant. This will occur if a seminar or workshop that was requested is now SOLD OUT. The check will be mailed under separate cover.

TICKETS FOR: 03699

BATCH: 68480

Helen Gofman MD

IMPORTANT!

These tickets are transferable to another person only through the registrar in charge of ticket sales at the registration desk to ensure CME credit. These tickets must be returned to the ticket collector at the end of the session for category 1 Physicians Recognition Award credits.

A meeting transcript will be sent to every registrant approximately 10 weeks after the meeting. Workshop and Seminar credit hours will be listed. Plenary Session hours must be added by each registrant.
PLEASE KEEP TRACK OF YOUR OWN PLENARY SESSION HOURS.

JUDITH S. WALLERSTEIN, PH.D.

OUTLINE OF PRESENTATION

AMERICAN ACADEMY OF PEDIATRICS

Monday, October 17, 1988 - 4 PM

Post Helms "retirement"

- I. Initial responses of children
 - A. Age related responses
 - B. Sex related responses
 - C. Expectable changes in the parent-child relationship

- II. New research findings on long term effects of divorce
 - A. Factors in good outcome
 - B. Factors in poor outcome

- III. New research findings on joint custody
 - A. Voluntary joint custody
 - B. Court imposed or mediated joint custody

Reading List for Judith Wallerstein's Presentation

Wallerstein, J., and Blakeslee, S., Second Chances: Men, Women, and Children a Decade After Divorce, Ticknor & Fields, New York, scheduled for publication January, 1989

Wallerstein, J., Children of Divorce: Preliminary Report of a Ten-Year Follow-up of Young Children, American Journal of Orthopsychiatry, 54 (3), July 1984.

Wallerstein, J., Children of Divorce: Preliminary Report of a Ten-Year Follow-up of Older Children and Adolescents, Journal of the American Academy of Child Psychiatry, 24 (5), 1985.

Wallerstein, J., Separation, Divorce, and Remarriage, in M. Levine, W. Carey, A. Crocker, & R. Gross (Eds.), Developmental Behavioral Pediatrics, pp. 241-255, W. B. Saunders, Philadelphia, 1983.

Johnston, J., Campbell, L., & Mayes, Latency Children in Post Separation and Divorce Disputes, Journal of the American Academy of Child Psychiatry, 24 (5), 1985.

Kalter, N., Riemer, B., Brickman, A., & Chen, J., Implications of Parental Divorce for Female Development, Journal of the American Academy of Child Psychiatry, 24 (5), 1985.

Hetherington, M., Cox, M., & Cox, R., Long-Term Effects of Divorce and Remarriage on the Adjustment of Children, Journal of the American Academy of Child Psychiatry, 24 (5), 1985.



1-7 saw parent happy remained
 1/2 2nd divorce
 1/2 - anger continued between parents
 2/5 drop in SES
 few were helped to go to college
 by fathers even tho had
 in SES.

all mother custody
 segn. of visitation to father increased
 with both $\bar{f}$ & $\bar{m}$
 40% spent more time with
 father. (1/2 disillusions
 1/2 stayed with f.

not at risk
 young adolescent when ^{parents} divorced

Custody
 joint physical custody - child spends
 substantial time with both
 not supported by research
 100% more frequent the access - more
 disrupted the child $\bar{f}$ & $\bar{m}$ court ordered
 physical symptoms over objection
 during diff of 1-parent

when voluntary -
 no diff

those who did well - in both groups
 good relations to both
 parents + less anger between parents

131 Middle Class. (1971)
 during
 1 yr later
 5 yr "
 10 yr "
 now - 15 yr "
 90% orig. sample
 any symptoms lasted 1-2 yr
 to not predict long term
 outcome
 poor child's ability
 to express feelings
 preschool - abandoned
 adolescence -
 would fail in relationship
 because parent failed

1 1/2 yr gender diff $\bar{m} > \bar{f}$
 girls recovered quickly

5 yr. mother sex or age
 sign. relationship to custodial
 - m. + visiting father
 when anger
 more harmony in divorced
 family

10 yr - no diff $\bar{m}$ & $\bar{f}$
 effect cumulative
 to a "sleeper" effect
 crescendo effect at 18-23 yr. olds
 will be betrayed or find love
 when child had seen violence
 as preschoolers 26% did - preschool
 very late
 1/2 were involved in violence as
 adolescents in their $\bar{f}$ & $\bar{m}$ relationships



Oct 25 SF Chron
Oct 25, 96

Dealing With Learning Disabilities

By Kathleen Sullivan Alioto

MARIE APPEARED to be lucky. Of 36 students in my truancy class in Harlem, she was one of three with two caring parents. Everyone agreed she was the prettiest student at PS 113, and the most popular. When she was not teasing, laughing, or demonstrating the latest dance steps, she was listening to other kids' problems.

But Marie wasn't as successful in the classroom. She read slowly, was disorganized and often sleepy. Like most of my students, she performed best when working on her own stories and journal, with a partner, or doing group projects and oral reports. She finally progressed well enough to be grouped near the top of the class. When her parents asked how to help her future, I urged them to sign off on her homework each night and try to keep her focused.

I continued teaching, went to graduate school and earned a doctorate at Harvard University, without learning what I should have done differently with Marie.

I did learn that she had a learning disability, defined as "a severe discrepancy between intellectual ability and achievement in listening, thinking, speaking, reading, writing, spelling, or mathematics," in the Disabilities Education Act. She is not alone. Around 15 percent of Americans, or 39 million people, suffer from minimal brain dysfunctions that cause them to underachieve in certain areas.

I saw the cost of not addressing learning disabilities correctly when, as a mem-



May 84

ber and president of Boston's elected school board, and later, as a parent and as educational liaison of Mayor Art Agnos in San Francisco, I visited the schools. Students appeared restless and bored. Many dropped into apathy, depression, substance abuse, gangs and out of school.

That's why I felt a surge of hope when I heard Dr. Mel Levine, the pediatrician who has helped thousands of students whose needs had defeated the efforts of experienced teachers and loving parents. Levine's research on the brain highlights the fact that "each one of us thinks and learns differently. Each is disabled in attention, memory, language ability, motor output, organization or social skills, which causes each of us to underachieve in certain areas."

Levine doesn't label anyone. He helps teachers pinpoint the specific breakdown points and strengths of students,

and identify strategies to help them learn. "The good management of a student with learning problems is called superb teaching. This teacher knows how to present the same material in a variety of different ways," says Levine.

Had I heard Levine when I was teaching Marie, I could have worked with her and her parents to pinpoint precisely where and when her learning broke down. I would have told them the obvious: She had social leadership and listening skills; she was bright; she would have to work harder than her friends to remain attentive. I would have given her a written outline each week of the materials she needed to master; taught her to take notes to stay awake; asked her to pass in a short list of the important facts after each lesson; tested her orally; allowed her to take untimed tests; and investigated her sleep patterns. To help Marie understand her unique strengths, I would have asked her to teach the class and me how to dance.

Kathleen Sullivan Alioto is the wife of former San Francisco Mayor Joseph Alioto. Dr. Levine will train teachers on October 28 (no charge, seats still available) parents of children with learning differences this Saturday at the Masonic Auditorium, 1111 California Street, from 8:30 a.m. till noon (\$25, scholarships available); and clinicians, doctors and psychologists today. All funds raised will help pay for future training of Bay Area teachers. For information, call the Charles and Helen Schwab Foundations (PERC) at (415) 655-2418. For the All Kinds of Minds Institute, call (919) 933-8082.

2 copies

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2 copies

Praise — influence
also mentions
Lore Tanner
as a Helen
disciple

MAILED AT
NEW YORK, NY
DROP SHIPMENT
AUTHORIZATION # 1
PRESORTED
FIRST - CLASS

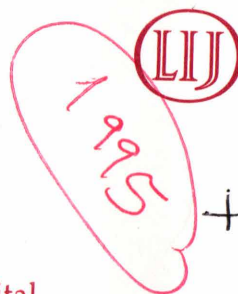


U.S. POSTAGE

03.00:

H METER 606219

Schneider
Children's Hospital
K. Miller, MD
Division of Developmental &
Behavioral Pediatrics
New Hyde Park, NY 11042



Helen Gofman MD
1045 Clayton St
San Francisco CA
94117

KAREN MILLER, M.D.

DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS

Schneider Children's Hospital
Long Island Jewish Medical Center

The Long Island Campus for the Albert Einstein College of Medicine

New Hyde Park, NY 11042
(718) 470-3540

=====

Dear Dr. Gofman

Fall 1995

Thank you for your wonderful letter and booklets. Ironically, I received them the day after I returned from presenting a workshop at the AAP annual meeting in San Francisco. I would have loved to meet you while I was there! I will be speaking in Palm Springs CME in March. I'd love to meet you if you're up to it.

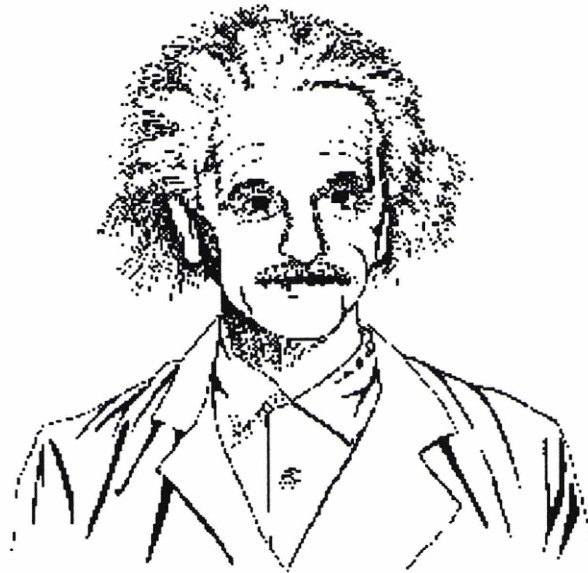
I recognized some of your materials and concepts as I had the

privilege of attending
one of your proteges',
Hane Tanner, lecture on
~~the~~ teaching residents
about learning problems.
This is an area of strong
interest to me.

As you'll see from the
enclosed handouts, we
share a similar orientation.
Please critique freely
as I would value your
input highly.

Respectfully yours
Karen Miller

LATE TALKERS



PRESENTED TO
AMERICAN ACADEMY OF PEDIATRICS
CALIFORNIA CHAPTERS 1,2,3 & 4
LAS VEGAS, NV
NOVEMBER 1995

KAREN J. MILLER, M.D., F.A.A.P.
DIVISION OF DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS
SCHNEIDER CHILDREN'S HOSPITAL
NEW HYDE PARK, NY 11040

1 ☐ **Late Talkers**

Karen J. Miller, M.D., F.A.A.P.
Division of Developmental and Behavioral Pediatrics
Schneider Children's Hospital
New Hyde Park, NY 11040

2 ☐ **Late Talkers and the Pediatrician**

- Most common developmental disability
- Pediatrician often first person consulted
- Part of process from first suspicion to diagnosis to treatment and adaptation
- Pediatricians often uncomfortable with this role

3 ☐ **Language Disorders**

- Language refers to the symbol system
- Speech refers to the production of sounds
- "Speech delay" often used incorrectly
- 5-10 % of children will have speech or language disorder
- Language disorder increases risk of other problems
- 2 males : 1 female

4 ☐ **Language Disorders Vocabulary**

- Auditory Reception
- Receptive Language
- Expressive language
- Articulation (phonology)
- Voice
- Social Pragmatics

5 ☐ **Patterns of Disordered Development**

- Normal variation
- Delay
- Deviance
- Dissociation
- Regression

6 ☐ **Receptive Language Milestones**

- First stage - Sounds have meaning
 - Alerts 1 month
 - Orients to voice 4 months
 - Orients to bell 6 months
 - Understands "no" 9 months

7 ☐ **Receptive Language Milestones**

- Second Stage - Words have meaning
 - One step command w/ gesture 12 months
 - One step w/o gesture 16 months
 - Points to 1 picture / body part 18 months
 - Two step command 24 months
 - Prepositional commands 36 months

- 8 ☐ Expressive Language Milestones
- First Stage- Saying Sounds
 - Coos 3 months
 - Laughs 4 months
 - Razzes 5 months
 - Babbles 6 months
 - Dada/Mama
 - Non-specific 8 months
- 9 ☐ Expressive Language Milestones
- Second Stage- Saying Words
 - Dada/ Mama
 - Specific 10 months
 - 1 - 2 words 12 months
 - 4 - 6 words 16 months
 - 8-18 words 18 months
 - 48 + words 24 months
 - 200 + 30 months
- 10 ☐ Expressive Language Milestones
- Third Stage - Combining Words
 - Jargon 15 months
 - 2 word phrases 20 months
 - 2 word sentences 2 years
 - 3 word sentences 3 years
 - 4 word sentences 4 years
- 11 ☐ Expressive Language Milestones
- P's of Preschool
 - Pronouns
 - Incorrect 2 1/2 years
 - Correct 3 years
 - Plurals 3 years
 - Prepositions 3 years
 - Personal Info 4 years
- 12 ☐ Articulation Milestones
- Rule of Quarters
 - 2 / 4 at 2 years
 - 3 / 4 at 3 years
 - 4 / 4 at 4 years
 - Intelligibility to strangers
- 13 ☐ Social Language Milestones
- Reciprocal social regard 2 months
 - Reciprocal vocalizations 6 months
 - Reciprocal gestures 12 months
 - Reciprocal words 18 months
 - Reciprocal requests 24 months
 - Reciprocal conversation 36 months

- 14 ☐ Differential Diagnosis
- Normal Variation
 - Hearing Impairment
 - Mental Retardation
 - Autistic Spectrum Disorders
 - Communication Disorder
 - Expressive Language Delay
 - Profound deprivation
 - Selective mutism
- 15 ☒ Differential Diagnosis Chart
- 16 ☐ Normal Language Variation
- Large degree of variability
 - Be wary of language delay “excuses”
 - Be wary of saying “He’ll outgrow it”
 - Parents usually right about language
 - 72% positive when evaluated (Glascoe, 1991)
- 17 ☐ Hearing Impairment
- Sensorineural hearing loss less common than mental retardation
 - Lack of language is a late sign in HI
 - Normal language development until 6-9 months
 - Hearing at or better than 35 db sufficient
 - Otitis media does not cause true language delay
 - Minor variations can occur at 15 dB loss
- 18 ☐ Mental Retardation
- 3% of children
 - Commonly present with delayed speech
 - Delays in multiple areas
 - May be well coordinated
 - May be non-dysmorphic
 - Delayed language is best screen to detect MR
- 19 ☐ Autistic Disorders
- Spectrum of disorders
 - Autism - Pervasive Developmental Disorders - Asperger’s
 - Deviant language development
 - Dissociated language : visual motor skills
 - May have regression of language skills
 - Deficits in receptive, expressive and social skills
 - Not frustrated by inability to communicate
 - Frustrated when interfered with
- 20 ☐ Communication Disorder
- Developmental Language Disorder with both Receptive and expressive delays
 - Frustrated by problem communicating
 - Behavior problems common
 - Majority have learning disabilities at school age

- 21 ☐ Expressive Language Delay
 - Developmental Language Disorder with only expressive language deficit
 - Receptive language within normal limits
 - Other areas of development are normal
 - Fine motor skills may be impaired
 - Increased incidence of behavior problems or syndromes (ADHD)
- 22 ☐ Rare Causes of Language Disorder
 - Profound deprivation
 - Selective mutism
 - Landau- Kleffner Syndrome
 - Degenerative neurological disorders
- 23 ☐ Speech Disorders
 - Dysarthria
 - Oromotor dyspraxia
 - Phonological disorder (articulation)
- 24 ☐ Pediatric Exam
 - Physical Examination
 - Oro-motor Examination
 - Neurological Examination
 - Laboratory Tests
 - Hearing test
 - CBC, lead level
 - Chromosomes, metabolic studies
 - EEG, neuroimaging
- 25 ☐ Hearing Testing
 - Brainstem Auditory Evoked Response (BAER)
 - Otoacoustic emission (OAE)
 - Behavioral Soundfield
 - Standard Audiological
 - Handheld Auditory Screener
- 26 ☐ Management
 - Reassurance with monitoring
 - Normal variation, tongue tie, bilingual
 - Monitor and re-evaluate in 3 - 4 months
 - Isolated expressive delay
 - Referral for assessment
 - Delay > 25% or more than 2 areas
 - Regression
 - Suspected neurological disorder
 - Mental health concerns
- 27 ☐ CAT/CLAMS
 - Kennedy Krieger Institute, Johns Hopkins University
 - Pediatric tool, minimal time and equipment
 - Items from standardized tests (Gesell, Catell)
 - Correlates well with Bayley scales

- Evaluated in normative populations, premature, motor delay and developmentally delayed populations
- Yields quantitative Developmental Quotients (DQ)
- 28 ☐ Referral resources
 - Early intervention services PL 99-457
 - Local school or Department of Health
 - AAP
 - University Affiliated Programs
- 29 ☐ Parent Education
 - Improve language environment
 - Increase relevant and reciprocal language
 - Extend child's utterances rather than correct
 - "Sportscasting" technique
 - Rhyming
 - Behavior management
- 30 ☐ Treatment
 - Early intervention
 - Speech / Language therapy
 - Psychosocial intervention
 - Special education services
 - Regular education modifications
 - FM amplification
- 31 ☐ Outcome
 - S/L disorders have substantial impact
 - Isolated expressive delays tend to "wash out" by 8 years
 - Majority with DLD go on to have LD
 - Increased incidence of behavioral and psychiatric disorders
 - Most important intervention-educating the child and the adults
- 32 ☐ KEY POINTS
 - Pediatricians are ideally situated to detect developmental delays.
 - Language delays can be identified by pediatricians.
 - Delays in detection and intervention have long term consequences.
- 33 ☐ Case 1- Mary
 - Age 27 months
 - Chief complaint: Not talking like the others. Has few words.
 - History: Non-contributory except maternal uncle was "slow". Pleasant, attractive, well coordinated child. Older siblings "talk for her" and do a lot for her. Does not dress herself.
 - Development: Language: 4-6 words other than family names. Immature jargon. No phrases. Can point to 2 body parts. Follows one step command without a gesture. Visual-motor: Can put 10 cubes in cup. Not 3 cube tower. Can put circle in formboard. Scribbles.
- 34 ☐ Case 2-Mary's CAT/CLAMS
 - Level in months/Age x 100 = DQ
 - Chronologic age = 23 months
 - Language age = 16.5 months

- Visual-motor age = 17 months
 - CLAMS LANGUAGE DQ = 61
 - CAT VISUAL-MOTOR DQ = 63
- 35 ☐ Case 2- John
- Age 23 months
 - Chief complaint: Unclear speech. Temper tantrums.
 - History: 28 week gestation. Benign neonatal course. History of recurrent otitis media. Currently resolving SOM. Hearing test within normal limits. "Difficult" temperament profile. "Messy" Enjoys social interaction but rough. Likes to be independent.
 - Development: Language-Maybe 3 words but other words inconsistent. Uses gestures a lot. Frustrated when not understood. Can point to 4 pictures and more than 2 body parts. "Understands everything". Mild drooling that is decreasing. Unclear sounds. Can imitate pencil stroke. Builds 4 block train. Completes formboard. Slightly clumsy on fine motor tasks.
- 36 ☐ Case 2- John's CAT/CLAMS
- Developmental age in months/Age x 100=DQ
 - Chronologic age= 23 months
 - Adjusted age=20 months
 - LANGUAGE AGE= 16.5 months
 - CLAMS LANGUAGE DQ (Chronologic Age)= 72
 - CLAMS LANGUAGE DQ(Adjusted Age)= **83**
 - Receptive Language Age=21 months
 - Receptive Language DQ (Chronologic Age)= 91
 - Receptive Language DQ (Adjusted Age)= **105**
 - Expressive Language Age=14 months
 - Expressive Language DQ (Chronologic Age)= 60
 - Expressive Language DQ (Adjusted Age)=**70**
 - VISUAL- MOTOR AGE= 23.1 months
 - CAT VISUAL-MOTOR DQ(Chronologic Age)= 100
 - CAT VISUAL-MOTOR DQ (Adjusted Age)=**115**

Differential Diagnosis Chart

	Expres.	Recep.	Social	Visual Motor	Gross Motor
Hearing Impairment	↓	↓	N	N	N
Mental Retardation	↓	↓	↓N	↓	N
Autistic Disorders	↓	↓	↓	↓N	N
Commun. Disorder	↓	↓	N	N	N
Expressive Delay	↓	N	N	N	N

↓ = Delayed

N = Normal

EXPRESSIVE LANGUAGE DEVELOPMENT

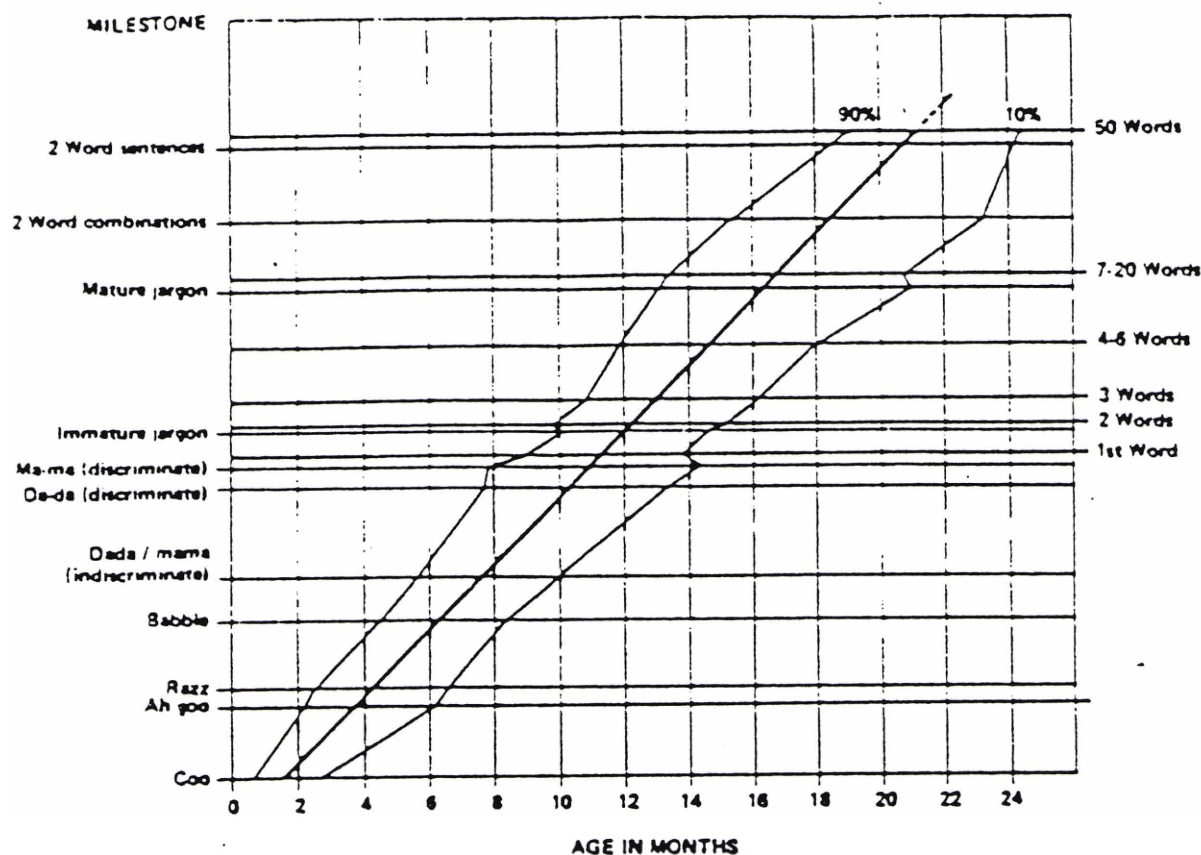


Fig. 1. Expressive language milestones; 90th and 10th percentile for normative population. Infants whose attainment of milestones is consistently later than 10th percentile are at risk of language and cognitive delay. Slope of line through median of each milestone is 1.0 and corresponds to developmental quotient of 100. Milestone attainment can be plotted on this Figure to depict rate of development, as well as plateau or degeneration patterns.

RECEPTIVE LANGUAGE DEVELOPMENT

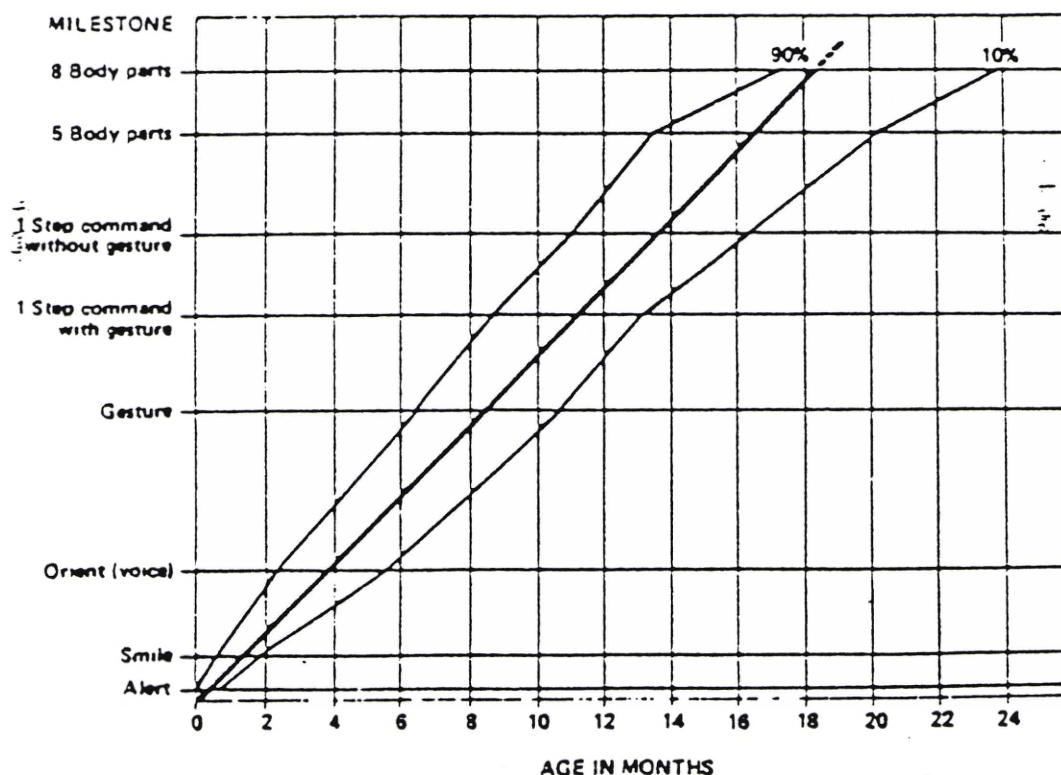


Fig. 2. Receptive language milestones; 90th and 10th percentiles for normative population (see legend for Fig. 1).

CAT/CLAMS-r Developmental Assessment

Name: _____

Date of Birth: _____

Chronological Age: _____ months

Date of Visit: _____

Adjusted Age: _____ months

CLAMS

CAT

Yes No

Yes No

One Month:

1. Alerts to Sound (0.5) _____
2. Soothes when picked up (0.5) _____

One Month:

1. Visually fixates momentarily upon red ring (0.5) _____
2. Chin off table in prone (0.5) _____

Two Months:

1. Social Smile (1.0) _____

Two Months:

1. Visually follows ring horizontally & vertically (0.5) _____
2. Chest off table in prone (0.5) _____

Three Months:

1. Cooing (1.0) _____

Three Months:

1. Visually follows ring in circle (0.3) _____
2. Supports on forearms in prone (0.3) _____
3. Visual threat (0.3) _____

Four Months:

1. Orients to voice (0.5) _____
2. Laughs Aloud (0.5) _____

Four Months:

1. Unfisted (0.3) _____
2. Manipulates fingers (0.3) _____
3. Supports on wrists in prone (0.3) _____

Five Months:

1. Orients toward bell laterally (0.3)* _____
2. Ah-goo (0.3) _____
3. Razzing (0.3) _____

Five Months:

1. Pulls down rings (0.3) _____
2. Transfers ring (0.3) _____
3. Regards pellet (0.3) _____

Six Months:

1. Babbling (1.0) _____

Six Months:

1. Obtains cube (0.3) _____
2. Lifts cup (0.3) _____
3. Radial rake with cube (0.3) _____

Seven Months:

1. Orients toward bell (1.0) upwardly indirectly *(90°) _____

Seven Months:

1. Attempts pellet (0.3) _____
2. Pulls out peg (0.3) _____
3. Inspects ring (0.3) _____

Eight Months:

1. "Dada" inappropriately (0.5) _____
2. "Mama" inappropriately (0.5) _____

Eight Months:

1. Pulls ring by string (0.3) _____
2. Secures pellet (0.3) _____
3. Inspects clapper of bell (0.3) _____

Nine Months:

1. Orients toward bell upward directly (180°) (0.5) _____
2. Gesture language (0.5) _____

Nine Months:

1. 3 finger scissor grasp - pellet (0.3) _____
2. Rings bell by handle (0.3) _____
3. Over the edge for toy (0.3) _____

Ten Months:

1. Understands "no" (0.3) _____
2. Uses "Dada" appropriately (0.3) _____
3. Uses "Mama" appropriately (0.3) _____

Ten Months:

1. Bangs cube-cup (0.3) _____
2. Uncovers bell from handkerchief (0.3) _____
3. Fingers pegboard (0.3) _____

Eleven Months:

1. One word (other than "mama" & "dada") (1.0) _____

Eleven Months:

1. Mature pincer grasp-pellet (0.5) _____
2. Solves cube under cup (0.5) _____

Twelve Months:

1. One step command with gesture (0.5) — —
2. Two word vocabulary (0.5) — —

Fourteen Months:

1. Three word vocabulary (1.0) — —
2. Immature jargoning (1.0) — —

Sixteen Months:

1. Four-six word vocabulary (1.0) — —
2. One step command without gesture (1.0) — —

Eighteen Months:

1. Mature jargoning (0.5) — —
2. 7-10 word vocabulary (0.5) — —
3. Points to one picture* (0.5) — —
4. Body parts (2 or more) (0.5) — —

Twenty-One Months:

1. 20 word vocabulary (1.0) — —
2. Two word phrases (1.0) — —
3. Points to two pictures* (1.0) — —

Twenty-Four Months:

1. 50 word vocabulary (1.0) — —
2. Two step command (1.0) — —
3. Two word sentences (noun+verb) (1.0) — —

Thirty Months:

1. Uses pronouns appropriately (2 or more) (1.5) — —
2. Concept of one* (1.5) — —
3. Points to 7 pictures* (1.5) — —
4. Two digits forward* (1.5) (2/3 passes 1-6, 4-7, 8-2) — —

Thirty-Six Months:

1. 250 Word Vocabulary (1.5) — —
2. Three word sentence (1.5) — —
3. Three digits forward* (1.5) (2/3 passes: 3-1-6, 2-9-5, 4-7-1) — —
4. Follows two prepositional commands* (1.5) — —

Twelve Months:

1. Release one cube in cup (0.5) — —
2. Crayon mark (0.5) — —

Fourteen Months:

1. Unwraps cube (0.5) — —
2. Out-in peg (0.5) — —
3. Solves pellet-bottle with demonstration. (0.5) — —

Sixteen Months:

1. Pellet-bottle spontaneously (0.6) — —
2. Round block in formboard (0.5) — —
3. Scribbles in imitation (0.5) — —

Eighteen Months:

1. Ten cubes in cup (0.5) — —
2. Round hole/formboard reversed (0.5) — —
3. Spontaneous scribbling/crayon (0.5) — —
4. Pegboard completed spontaneously (0.5) — —

Twenty-One Months:

1. Obtains object with stick (1.0) — —
2. Solves square in formboard (1.0) — —
3. Tower of three cubes (1.0) — —

Twenty-Four Months:

1. Attempts to fold paper (0.7) — —
2. Horizontal four cube train (0.7) — —
3. Imitates stroke with pencil (0.7) — —
4. Completes formboard (0.7) — —

Thirty Months:

1. Horizontal-vertical stroke with pencil (1.5) — —
2. Formboard reversed (1.5) — —
3. Fold paper w/definite crease (1.5) — —
4. Train with chimney (1.5) — —

Thirty-Six Months:

1. 3 cube bridge (1.5) — —
2. Draws circle (1.5) — —
3. Names one color (1.5) — —
4. Draw-a-Person with head plus one other body part (1.5) — —

NOTE: *Items are performed by the examiner

Reliability of Informant

0 = unreliable

1 = reliable

Are scores an accurate estimate of subject's cognitive functioning
If No, please explain reasons (hyperactive, poorly related etc.)

Yes / No

Completed by _____

SCORING

Chronologic Age: _____ months

Adjusted Age: _____ months

CLAMS Language Age (LA)		CAT Visual-Motor Age (VMA)	
CLAMS DO = LA/CA x 100		CAT DO = VMA/CA x 100	
CAT/CLAMS DO =			
CLAMS DO + CAT DO / 2			

Twelve Months:

yes no

1. One step command with gesture (0.5) ☒ —
2. Two word vocabulary (0.5) ☒ —

Fourteen Months:

1. Three word vocabulary (1.0) ☒ —
2. Immature jargoning (1.0) ☒ —

Sixteen Months:

1. Four-six word vocabulary (1.0) ☒ —
2. One step command without gesture (1.0) ☒ —

Eighteen Months:

1. Mature jargoning (0.5) — ☒
2. 7-10 word vocabulary (0.5) — ☒
3. Points to one picture* (0.5) — ☒
4. Body parts (2 or more) (0.5) ☒ —

Twenty-One Months:

1. 20 word vocabulary (1.0) — ☒
2. Two word phrases (1.0) — ☒
3. Points to two pictures* (1.0) — ☒

Twenty-Four Months:

1. 50 word vocabulary (1.0) — —
2. Two step command (1.0) — —
3. Two word sentences (noun-verb) (1.0) — —

Thirty Months:

1. Uses pronouns appropriately (2 or more) (1.5) — —
2. Concept of one* (1.5) — —
3. Points to 7 pictures* (1.5) — —
4. Two digits forward* (1.5) (2/3 passes 1-6, 4-7, 8-2) — —

Thirty-Six Months:

1. 250 Word Vocabulary (1.5) — —
2. Three word sentence (1.5) — —
3. Three digits forward* (1.5) (2/3 passes: 3-1-6, 2-9-5, 4-7-1) — —
4. Follows two prepositional commands* (1.5) — —

Twelve Months:

yes no

1. Release one cube in cup (0.5) ☒ —
2. Crayon mark (0.5) ☒ —

Fourteen Months:

1. Unwraps cube (0.5) ☒ —
2. Out-in peg (0.5) ☒ —
3. Solves pellet-bottle with demonstration. (0.5) ☒ —

Sixteen Months:

1. Pellet-bottle spontaneously (0.6) ☒ —
2. Round block in formboard (0.5) ☒ —
3. Scribbles in imitation (0.5) ☒ —

Eighteen Months:

1. Ten cubes in cup (0.5) ☒ —
2. Round hole/formboard reversed (0.5) ☒ ☒
3. Spontaneous scribbling/crayon (0.5) ☒ ☒
4. Pegboard completed spontaneously (0.5) ☒ ☒

Twenty-One Months:

1. Obtains object with stick (1.0) — ☒
2. Solves square in formboard (1.0) — ☒
3. Tower of three cubes (1.0) — ☒

Twenty-Four Months:

1. Attempts to fold paper (0.7) — —
2. Horizontal four cube train (0.7) — —
3. Imitates stroke with pencil (0.7) — —
4. Completes formboard (0.7) — —

Thirty Months:

1. Horizontal-vertical stroke with with pencil (1.5) — —
2. Formboard reversed (1.5) — —
3. Fold paper w/definite crease (1.5) — —
4. Train with chimney (1.5) — —

Thirty-Six Months:

1. 3 cube bridge (1.5) — —
2. Draws circle (1.5) — —
3. Names one color (1.5) — —
4. Draw-a-Person with head plus one other body part (1.5) — —

NOTE: *Items are performed by the examiner

Reliability of Informant

0 = unreliable
1 = reliable

☒

Are scores an accurate estimate of subject's cognitive functioning
If No, please explain reasons (hyperactive, poorly related etc.)

(yes) / No

Completed by KJM

SCORING

Chronologic Age: 27 months

Adjusted Age: _____ months

CLAMS Language Age (LA)	16.5	CAT Visual-Motor Age (VMA)	17
CLAMS DG = LA/CA x 100	61	CAT DG = VMA/CA x 100	63
CAT/CLAMS DG = CLAMS DG - CAT DG / 2	62		

Case 1 Mary L. Age 27 months

CAT: 16.0
16.5
17.0
CLAM: 16.0
16.5

Twelve Months:

yes no

1. One step command with gesture (0.5) — —
2. Two word vocabulary (0.5) — —

Fourteen Months:

1. Three word vocabulary (1.0) ✓ —
2. Immature jargoning (1.0) ✓ —

Sixteen Months:

1. Four-six word vocabulary (1.0) — ✓
2. One step command without gesture (1.0) ✓ —

Eighteen Months:

1. Mature jargoning (0.5) — ✓
2. 7-10 word vocabulary (0.5) — ✓
3. Points to one picture* (0.5) — ✓
4. Body parts (2 or more) (0.5) — ✓

Twenty-One Months:

1. 20 word vocabulary (1.0) — ✓
2. Two word phrases (1.0) — ✓
3. Points to two pictures* (1.0) — ✓

Twenty-Four Months:

1. 50 word vocabulary (1.0) — ✓
2. Two step command (1.0) — ✓
3. Two word sentences (noun-verb) (1.0) — ✓

Thirty Months:

1. Uses pronouns appropriately (2 or more) (1.5) — —
2. Concept of one* (1.5) — —
3. Points to 7 pictures* (1.5) — —
4. Two digits forward* (1.5) (2/3 passes 1-6, 4-7, 8-2) — —

Thirty-Six Months:

1. 250 Word Vocabulary (1.5) — —
2. Three word sentence (1.5) — —
3. Three digits forward* (1.5) (2/3 passes 3-1-6, 2-9-5, 4-7-1) — —
4. Follows two prepositional commands* (1.5) — —

Twelve Months:

yes no

1. Release one cube in cup (0.5) — —
2. Crayon mark (0.5) — —

Fourteen Months:

1. Unwraps cube (0.5) — —
2. Out-in peg (0.5) — —
3. Solves pellet-bottle with demonstration. (0.5) — —

Sixteen Months:

1. Pellet-bottle spontaneously (0.6) — —
2. Round block in formboard (0.5) — —
3. Scribbles in imitation (0.5) — —

Eighteen Months:

1. Ten cubes in cup (0.5) — ✓
2. Round hole/formboard reversed (0.5) — ✓
3. Spontaneous scribbling/crayon (0.5) — ✓
4. Pegboard completed spontaneously (0.5) — ✓

Twenty-One Months:

1. Obtains object with stick (1.0) — ✓
2. Solves square in formboard (1.0) — ✓
3. Tower of three cubes (1.0) — ✓

Twenty-Four Months:

1. Attempts to fold paper (0.7) — ✓
2. Horizontal four cube train (0.7) — ✓
3. Imitates stroke with pencil (0.7) — ✓
4. Completes formboard (0.7) — ✓

Thirty Months:

1. Horizontal-vertical stroke with pencil (1.5) — ✓
2. Formboard reversed (1.5) — ✓
3. Fold paper w/definite crease (1.5) — ✓
4. Train with chimney (1.5) — ✓

Thirty-Six Months:

1. 3 cube bridge (1.5) — —
2. Draws circle (1.5) — —
3. Names one color (1.5) — —
4. Draw-a-Person with head plus one other body part (1.5) — —

CASE 2

John J

Chronologic age: 23 months
Adjusted age: 20 months

NOTE: *Items are performed by the examiner

Reliability of Informant

0 = unreliable
1 = reliable

1

CAT:

21.0

CLAM

14.0

Are scores an accurate estimate of subject's cognitive functioning
If No, please explain reasons (hyperactive, poorly related etc.)

Yes No

Completed by KJM

.7
.7
.7
23.1

1.0
.5
.5
.5
16.5
R=21
E=14

SCORING

Chronologic Age: 23 months

Adjusted Age: 20 months

CLAMS Language Age (LA)	16.5	CAT Visual-Motor Age (VMA)	23.1
CLAMS DO = LA/CA x 100	CA=72, AA=93	CAT DO = VMA/CA x 100	CA=100, AA=116
CAT/CLAMS DO =			
CLAMS DO = CAT DO / 2			

Resources

Training:

1. Caring for Infants and Toddlers: New Roles for Physicians. Continuing medical education project developed by Child Development Resources, Inc. sponsored by University of Virginia School of Medicine. Contact Fran Gallagher, M.Ed. (800) 525-0961.

Organizations:

1. American Association of University Affiliated Programs for Developmental Disabilities. (301) 588-8252. Coordinates a network of regional training and service programs.
2. American Speech-Language-Hearing Association. 10801 Rockville Pike, Rockville, MD 20852. (800) 638-6868.
3. Autism Society of America. (301) 565-0433.
4. National Information Center for Children and Youth with Disabilities (NICHCY) P.O. Box 1492, Washington, DC 20013. Excellent resource for free informational handouts on a variety of disabilities.

Assessment instruments:

1. Coplan J. (1987) *Early Language Milestone Scale*. Pro-ED, Inc. Austin, TX. (512) 451-3246.
2. Ireton H, Thwing E. *Child Development Inventories (formerly Minnesota Preschool Inventory)* Behavior Science Systems, Inc. Minneapolis, MN.
3. Hoon AH, Pulsifer MB, Gopalan R, Palmer FB, Capute AJ. (1993) Clinical Adaptive Test/ Clinical Linguistic Auditory Milestone Scale in early cognitive assessment. *J of Peds* 123:S1-S8.
4. CAT/CLAMS items available as replacement parts for the Catell Infant Intelligence Scale. Psychological Corporation (800) 228-0752.

Books:

1. Parker S, Zuckerman B. ed. (1995) *Behavioral and Developmental Pediatrics: A Handbook for Primary Care* \$39. Little, Brown and Co., NY.
2. Powers MD. (1989) *Children with Autism: A Parents Guide*. Woodbine House, Rockville, MD.
3. Aylward GP. (1994) *Practitioner's Guide to Developmental and Psychological Testing*. Plenum Publishing, NY

References:

1. Adesman AR, Altshuler LA, Liplin PH, Walco GA. (1990) Otitis media in children with learning disabilities and in children with attention deficit disorder with hyperactivity. 85:442-446.
2. Aram DM, Elkelman BL, Nation JE (1984) Preschoolers with language disorders: 10 years later. *J. Speech Hearing Res.* 27:232-244.
3. Coplan J, Gleason JR (1988) Unclear speech: Recognition and significance of unintelligible speech in preschool children *Pediatrics* 82:447-452.
4. Glascoe FP. (1991) Can clinical judgment detect children with speech-language problems? *Pediatrics* 67:32-37.
5. Montgomery TR (1994) When "not talking" is the chief complaint. *Contemporary Pediatrics* 11:49-70.



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GENERAL RESOURCE

- ☐ GR1 Brochure *
- ☐ GR2 National Resources
- ☐ GR3 General Information about Disabilities *
- ☐ GR4 Public Agencies Fact Sheet
- ☐ GR5 National Toll Free Numbers
- ☐ GR6 State Resource Sheet: State
- ☐ GR8 Publications List

- ☐ FS6 Epilepsy *
- ☐ FS7 Learning Disabilities *
- ☐ FS8 Mental Retardation *
- ☐ FS10 Severe and/or Multiple Disabilities
- ☐ FS11 Speech and Language Impairments
- ☐ FS12 Spina Bifida *
- ☐ FS13 Visual Impairments *
- ☐ FS14 Attention Deficit Disorder (Briefing Paper)
- ☐ FS17 Reading and Learning Disabilities Resource Guide
- ☐ FS18 Traumatic Brain Injury *

NEWS DIGEST

- ☐ ND11 Children with Disabilities: Understanding Sibling Issues
- ☐ ND12 Respite Care: A Gift of Time
- ☐ ND13 Assistive Technology: Becoming an Informed Consumer
- ☐ ND14 Having a Daughter with a Disability: Is it Different for Girls?
- ☐ ND15 Education of Children & Youth With Special Needs: What Do the Laws Say? (Vol. I, No. 1, 1991)
- ☐ ND16 Related Services for School-aged Children with Disabilities (Vol. I, No. 2, 1991)
- ☐ ND17 Sexuality Education for Children and Youth with Disabilities (Vol. I, No. 3, 1992)
- ☐ ND18 Estate Planning (Vol. II, No. 1, 1992)
- ☐ ND19 Promising Practices & Future Trends for Special Education (Vol. II, No. 2, 1993)
- ☐ ND20 Parenting a Child with Special Needs: Guide to Readings and Resources (Vol. III, No. 1, 1993)
- ☐ ND21 Questions & Answers about the Individuals with Disabilities Education Act (Vol. III, No. 2, 1993)*
- ☐ ND22 Directory of Organizations (Vol. III, No. 3, 1993)
- ☐ ND23 Assessing Children for the Presence of a Disability (Vol. IV, No. 1, 1994)

TRANSITION SUMMARY

- ☐ TS8 Transition Services in the IEP

DISABILITY INFORMATION

- ☐ FS1 Autism *
- ☐ FS2 Cerebral Palsy *
- ☐ FS3 Deafness *
- ☐ FS4 Down Syndrome *
- ☐ FS5 Emotional Disturbance *

MATERIALS FOR PARENTS

- ☐ PA2 Parent's Guide to Accessing Programs for Infants, Toddlers, Preschoolers w/Disabilities (ages 0-5) *
- ☐ PA6 Parent's Guide: Accessing the ERIC Resource Collection
- ☐ PA7 Parent's Guide to Doctors, Disabilities, and the Family
- ☐ PA8 Parent's Guide: Planning a Move, Mapping Your Strategy
- ☐ PA9 Parent's Guide: Special Education and Related Services: Communicating Through Letter Writing (Vol. II, No. 1, Sept. 1991)*
- ☐ PA10 Parent's Guide: Accessing Parent Groups*

BIBLIOGRAPHIES

- ☐ B1 Assessing Children for the Presence of a Disability: Schools
- ☐ B2 Assessing Children for the Presence of a Disability: Families
- ☐ B3 Behavior Management: Schools
- ☐ B4 Behavior Management: Families
- ☐ B5 Children's Literature
- ☐ B6 Mental Health/Mental Illness: Schools
- ☐ B7 Mental Health/Mental Illness: Families

OTHER

- ☐ PAY Paying the Medical Bills
- ☐ ADT Resources for Adults with Disabilities
- ☐ LG1 Questions Often Asked About Special Education Services (ages 3-21) *
- ☐ LG2 Individualized Education Programs (IEPs)
- ☐ TA1 Technical Assistance Guide: Operating a Local Information and Referral Center

Please complete the following:

What age ranges are you interested in? (Please circle all ages that apply)

0-2 3-5 6-12 13-18

19-22 23-over All ages

Have you contacted NICHCY before?

☐ Yes ☐ No

Check the one that best describes you:

- ☐ Parent/Family Member
- ☐ Educational Professional
- ☐ Other Professional
- ☐ Advocate
- ☐ Adult with Disabilities
- ☐ Student with Disabilities
- ☐ Student without Disabilities
- ☐ Parent Organization/Group
- ☐ Library/Information Center
- ☐ Other (Please specify _____)

PLEASE TYPE OR PRINT CLEARLY.

First Name

Last Name

Organization (for mailing list purposes only)

Address

City

State

Zip Code

Daytime Telephone
(Area Code + Number)

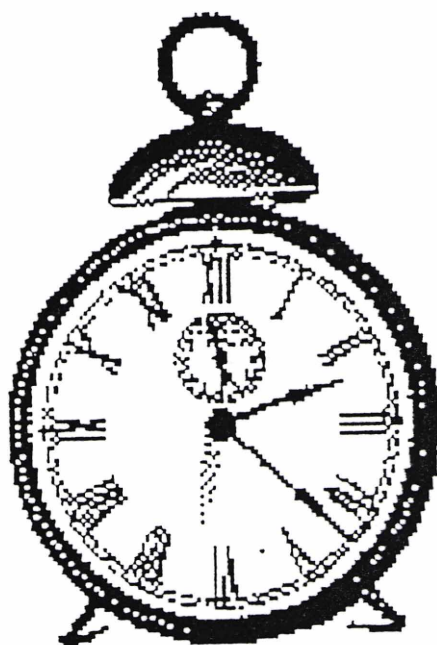
The National Information Center for Children and Youth with Disabilities (NICHCY) is a national information and referral clearinghouse. We operate through the Clearinghouse Program authorized by Section 633 of Part D of the Individuals with Disabilities Education Act (20 U.S.C. 1433), as amended by Public Law 101-476.



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The One - Minute Behavior Manager



Presented to
American Academy of Pediatrics
California Chapters 1,2,3 & 4
Las Vegas, NV
November 1995

Karen J. Miller, M.D., F.A.A.P.
Division of Developmental and Behavioral Pediatrics
Schneider Children's Hospital
New Hyde Park, NY 11040

The One-Minute Behavior Manager

Karen Miller, M.D., F.A.A.P.

Managing Problems and People

- Physicians are parent managers.
- Parents are child managers.
- The person is not the problem,
the problem is the problem.
- Teach parents and children to be problem - solvers.

Basic Principles of Behavior

- **Behavior is a solution to a problem**
If it works, that behavior will continue.
If it works all the time, that behavior gets established.
If it never works, that behavior gets eliminated.
If it works sometimes, that behavior is maintained.
- **Attention is powerful**
Positive is better than negative.
Negative is better than none.
Parents often end up paying attention to the wrong thing.
- **People would rather be right than wrong**
Assume that it seemed like a good idea at the time
Set things up for success next time
Teach to the skill - more effective than punish the error

Assessing the Chief Complaint

- **Ask the "W"right questions**
Who has the problem?
What specifically is the problem?
Where is the problem occurring?
When does the problem happen?
How big a problem is it?
Why now?
What else could it be?
What else is there?

- **Know the Behavior "ABC's"**
 - Antecedent
 - Behavior
 - Consequence
- **Refer, Confer, Defer or Prefer to treat?**
 - Mental health professional referral
 - Consult with a colleague/literature
 - Give advice if convenient and appropriate
 - Give handouts
 - Collect data-ABC log
 - Schedule a special appointment

One Minute Managing

1. One Minute Goals
 2. One Minute Praising
 3. One Minute Reprimand
- **Goals**
 - What do you want them to do
 - Goals should be stated in positive terms
 - Goals should be observable
 - Goals have deadlines
 - Check to see if goal is achieved
 - **Praising**
 - Let them know when they've done it right
 - "Catch 'em being good"
 - Notice when they have achieved a goal or part of one
 - When training a new skill, monitor closely and praise frequently
 - Praise the specific behavior, not the person
 - Praise immediately
 - Praise publicly if possible
 - Decrease the frequency once the skill is established to maintain the skill

- **Reprimand**
 - Reprimands have two parts
 - State what is wrong with the behavior
 - State what is right with the person
 - Frame the misbehavior as atypical for the person
 - Reprimand the specific behavior, not the person
 - Brief description of problem behavior
 - Cite applicable rule
 - Describe preferred behavior
 - Determine remedy
 - Reprimand immediately
 - Reprimand privately
- **Monitor your progress - Check your Goals**
 - Are we there yet?
 - Where do we go next?

Guidelines for effective advice giving

- **Principles**
 - You don't cure behavior
 - Beware the behavioral void
 - Look for the hook and go for the gold
 - Input increases Output
 - B. Caloraso's "That's a problem, what's your plan?"
 - Instill competence.
- **The 5 R's Procedure**
 1. **Reflect** the concerns as stated
 - Verifies your understanding of problem
 2. **Reframe** into a positively worded goal (**Goal**)
 - Brief specific positive goal -What to do, not what not to do
 - Use positive labeling of behaviors
 3. **Reinforce** the right behaviors (**Praise**)
 - How are they going to let the child know they are doing it right?
 - How are they going to remind themselves to notice it consistently?
 - Types of reinforcers

4. Reduce the wrong behaviors (**Reprimand**)

Prevention procedures:

- How to prevent the wrong behaviors from occurring

Reprimand procedures:

- How to let child know what is wrong

Punishment procedures:

- How to deal with rule violations

5. Review the plan

State the plan, numbering the steps

Write key steps on prescription pad

Request verbal feedback "Does that make sense to you? Can you do that?"

Agree on monitoring procedures

Determine fall back position

Always end the interaction with an optimistic, positive statement for the parent and the child

Resources:

Organizations:

1. National Society for Behavioral Pediatrics. 241 East Gravers Lane, Philadelphia, PA 19118. (215) 248-9168.
2. American Register of Health Service Providers in Psychology. Washington, DC. (202) 833-2377.
3. Family Connection. National referral service for families with children with behavior problems. (800) 854-4938.
4. Association for Advancement of Behavior Therapy. (212) 279-7970.

Patient Handouts/Software:

1. Christophersen ER. *Pediatric Compliance: A Guide for the Primary Care Physician* (1994) Plenum Press, NY. (800) 782-5476. A must-have complete with sample handouts to copy.
2. Schmitt B. *Instructions for Pediatric Patients*. (1992) WB Saunders, Philadelphia. (800) 545-2522.
3. Schmitt B, ed. *Pediatric Advisor*. (\$395) Clinical Reference Systems, Greenwood Village, CO (800) 237-8401. Informational handouts on medical, developmental and behavioral topics that can be edited and printed out. Available in Spanish

Behavior Management Videos/Programs

1. Clark L. *SOS: Help for Parents*. Parents Press, PO Box 2180, Bowling Green, KY 42102-2180. \$9.95 book. Easy to read book on handling everyday behavior problems, good discussion of time-out procedures. Also available is a kit for parent training, audiotapes and videotapes for parent counseling in the office.
2. Phelan TW *1-2-3 Magic: Training Your Preschooler and Preteens to do what you Want*" (90 min)"\$40 video, \$10 Book. Useful for office lending library. Easy to watch and use. Useful with multiple care givers.

Books:

1. Blanchard K, Johnson S. *The One-Minute Manager*. (1977) William Morrow & Co., NY. (212) 261-6500.
2. Levine MD, Carey WB, Crocker AC. *Developmental-Behavioral Pediatrics*. 2nd Ed., (1992) WB Saunders Co, Philadelphia. (800) 545-2522.
3. Parker S, Zuckerman B. ed. *Behavioral and Developmental Pediatrics: A Handbook for Primary Care* (1995) \$39. Little, Brown and Co., NY. (212) 522-8700. Excellent, concise and practical. Outline format. Sample questionnaires included.

Books for Parents, Teachers and Children:

1. Kurcinka MS. *Raising your spirited child: A guide for parents whose child is more intense, sensitive, perceptive, energetic*. (1991). HarperCollins Publishers, NY. (1-800-742-7831). \$20.
2. Faber A, Mazlish E. *How to Talk so Kids will Listen and Listen so Kids will Talk*, \$10 Avon Books, (212) 481-5653. This a very readable, practical book on parenting.

3. Garber SW, Garber MD, Spizman RF *If Your Child is Hyperactive, Impulsive, Distractible...* \$20. Available through ADD warehouse (800)233-9273. A step by step guide for behavior management for parents and teachers. Also social skills.
4. Turecki S. *The Difficult Child*, Bantam Books. NY. Parents whose young children are particularly hard to manage find this to be a helpful book.
5. Phelan TW, *Surviving Your Adolescents*. "\$15, Child Management Inc. (1-800-442-4453). Good management program for parents of ADD children and "normal" children.

References:

1. Blum NJ, Williams GE, Friman PC, Christophersen ER. Disciplining young children: The role of verbal instructions and reasoning. *Pediatrics* (1995) 96:336-341.
2. Green M. The 10 minute visit: Anything but routine. *Contemporary Pediatrics*. August 1992. 53-61.
3. Triggs EG, Perrin EC. Improving communication about behavior and development. *Clinical Pediatrics*. (1989) 28:185-192.

Basic Home Behavior Management

Sharon K. Weiss, M.Ed.
Karen J. Miller, M.D.

STATE THE RULES.

All children need and want boundaries and limits. Rules exist, even though they may not be spoken or written. Try to state your rules in positive terms-"Keep your hands and feet to yourself". Keep rules short and to the point. Have a few, reasonable rules. Be consistent in using and enforcing rules. It is important to call attention to rules when the child is following them. Don't wait until the child has violated them.

- K.I.S.S. (Keep It Short and Simple)

MAKE THE WORLD PREDICTABLE.

Develop routines and write out a daily schedule. Homework, TV, school, play, baths and meals should all be written in. Scheduling helps children (and adults) to gauge time, organize activities and prioritize in terms of importance. Schedules provide a visual cue of when things will happen and imply an agreement of when it is time to stop one activity and move on to another. This decreases arguing. Reinforce adherence to the schedule. Use calendars, lists and timers to help structure time and activities. Timers help decrease parental nagging and reminding.

- Set the stage for success

WHEN BEHAVIOR IS APPROPRIATE, PRAISE IT.

Focus on the many small, positive behaviors that your child exhibits. When you enter a room, ask yourself, "What is going right?" Make specific positive comments. For example, notice when your child responds to a direction the first time you say it. Even if the child does it because it's something they want to do, it still merits special attention. This will help the child to notice the exact behavior(s) that you want her to demonstrate. If a task has been partially completed, comment positively on the completed part first. When you notice things that a child does right, it breaks the cycle of negative redirection (nagging) and makes them feel better about themselves and about you. Increase the amount of non-verbal praise. Give lots of warm smiles, pats and thumbs up. Your attention is something your child needs, use it at the right time. Provide extra praise for behaviors you want to increase.

- Catch the child being good

WHEN THE BEHAVIOR IS INAPPROPRIATE, IGNORE IT.

For a child, negative attention is better than no attention at all. Attention reinforces behavior. Before you look at, speak to, or touch the child ask yourself "Do I want the behavior my child is now engaging in to increase?" If not, ignore it! Turn your attention to other matters or other children (siblings) who are behaving appropriately. If the behavior is not dangerous or destructive and you can ignore it, you should do so. When you refuse to give attention to undesirable behavior, a child must do something else to get your attention. Quickly give positive attention to more appropriate behaviors. Be aware that when you begin to ignore a problem behavior, it may increase rather than decrease at first. Be firm and consistent.

- If there is no audience, the show will close

WHEN DIRECTIONS ARE GIVEN, STATE THEM CLEARLY.

Do not phrase directions as questions when you mean them as directions. For example, don't ask "Are you ready for bed?" when it's bedtime. Instead say, "John, it is bedtime". Get the child's attention, give the direction, reinforce compliance. Some children need help stopping and shifting activities. Use timers to structure transitions. "Five more minutes then cleanup time". Whenever possible, give a choice between two acceptable options but your child should know when he has a choice and when he has no option. State expectations clearly. "Straighten up the den" leaves room for debate.

- **Say what you mean**

NEVER GIVE A DIRECTION UNLESS YOU ARE READY TO ENFORCE IT.

Reserve directions for important situations when you are prepared to follow through. If you don't feel like getting up to check, don't direct them to put away their toys. When you are concerned about inconsistency, ask yourself exactly what message you want to convey - that it is okay to leave the toys out or it's okay not to listen to your directions.

- **Mean what you say**

FOCUS ON ONE OR TWO BEHAVIORS AND BE CONSISTENT.

Pick one or two behaviors to work on and respond consistently. This way your child will learn what to expect and in turn, will behave more consistently. Try to discuss specific behaviors with your spouse and agree on specific responses/consequences. Consensus improves consistency. Writing it down is helpful. Try to have others provide the same structure. This increases the rate of learning, there is less testing behavior and it decreases the likelihood that the new skill will be person specific.

- **Pick your battles to win the war**

UNDERSTAND THE LIMITATIONS OF PUNISHMENT.

Punishment procedures, such as time-out, only interrupt behavior but do not teach to an alternative behavior. If punishment procedure is used, to sure to deliver the punishment in a matter-of-fact manner, deliver it immediately, and every time the behavior occurs. An effective punishment entails a warning and has a set beginning and end. Reinforce incompatible behaviors and positive alternative behaviors. In a pinch, ask the child what the punishment should be.

- **Teach them what to do as well as what not to do**

ASK A QUESTION.

When all else fails and re-direction is necessary, ask your child a question such as what is the guideline that applies to that situation. Reinforce his/her ability to repeat the rule. This is less judgmental, provides an opportunity for the child to be reinforced and re-directs a negative interaction into an exchange of information. Be calm. Try writing down the child's responses. Build on what was said. Encourage problem-solving.

- **A statement provokes a defense, a question evokes a response**

MODEL APPROPRIATE BEHAVIOR.

Demonstrate the behaviors you want your child to display. Model the target behavior then encourage the child to imitate you. Pretend to do it wrong and let the child correct you! It is easier to remember new behavior if there is a visual image and a chance for supervised positive practice.

- **A picture is worth...**

OUT

Week

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Family Member	Goal Of The Week	Chores Of The Week

Family Goal:

Remember!
Coming Up!

Using the "Our Week" Calendar

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Mom - business dinner 6 pm	Dad-trip to Detroit 7am Steve-math test	Jane-Doctors appt 11am Steve-Baseball practice 5 pm	Shopping in am Do homework early Pick up Dad at airport- 7 pm	Spelling tests Grandma arrives 4 pm	Steve-Baseball 8:30 Jane-Soccer 9:00 Needs ride home M&D-7pm Movies with L&T	Jane-game 2pm Steve-game 3:30

Family Member	Goal Of The Week	Chores Of The Week
Dad	Run/walk daily	Laundry
Mom	Run/walk daily	Wash dinner dishes
Jane	Start Homework by 4 pm.	Clean rabbit cage
Steve	Eat a new food every day	Empty dishwasher

Remember!
Schedule dentist
Order theater tickets
Coming Up!
Report on whale due

Family Goal: Put back what you take out.
--

Family meeting:

On Sunday night, the whole family gets together to talk about the coming week. This allows everyone to plan together, divide up the chores, problem solve and set new goals.

Days of the Week:

Family fills in all the activities, appointments and deadlines for the week. This keeps everyone informed and helps identify possible conflicts.

Individual Goals:

Each family member sets a specific, achievable personal goal for the week-something that they are working on improving. This could be health related, such as "eat three fruits each day", or academic, such as "practice times table each night", or social, such as "make at least one positive comment to sister each day". This reinforces the concept of setting and achieving goals and that self-improvement is a life-long process.

Family Goal:

Select a goal that everyone in the family can work on this week. It can be social, such as "knocking before entering", a chore "pick up family room daily, etc.

Individual Chores:

Discuss what needs to be done over the coming week including routine tasks (e.g. fixing meals, laundry) and special projects (e.g. raking leaves). Every family member above the age of three should have specific tasks with specific deadlines. Make lots of positive comments about tasks attempted and reinforce any helpful behaviors with special praise and public recognition.

Remember:

Use this section to list things that need to be done or purchased sometime this week.

Coming Up:

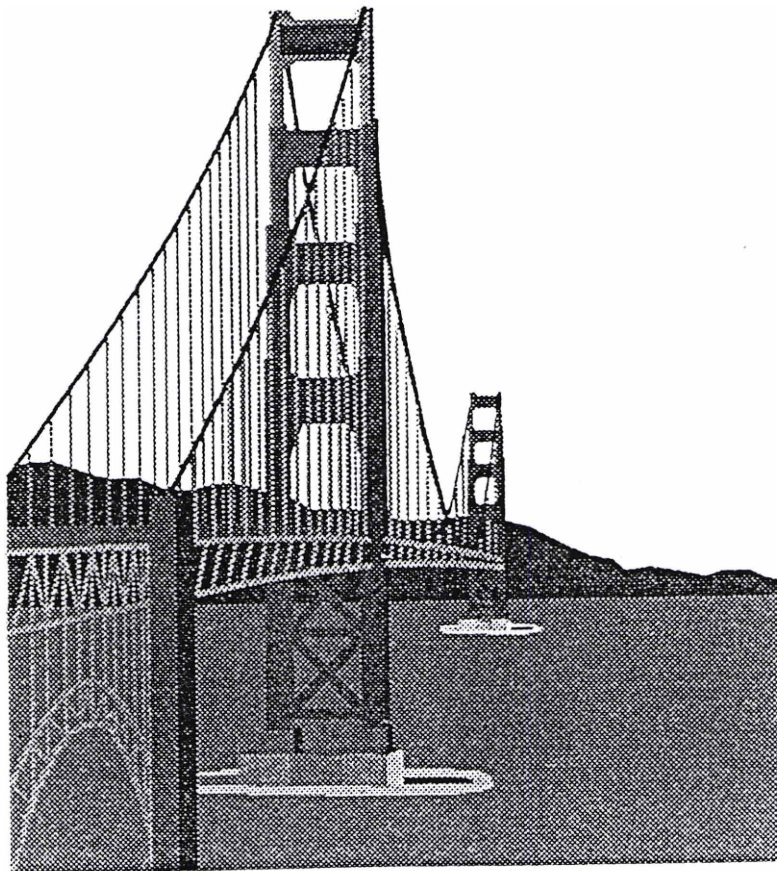
Very important section which encourages long range planning. Use this section for upcoming reports or special events that need preparation.

An Office Based Approach to Attention Deficit Hyperactivity Disorders

American Academy of Pediatrics
San Francisco, California
October 14, 1995

Karen J. Miller, M.D., F.A.A.P.
Schneider Children's Hospital
New Hyde Park, NY

Sharon Korman Weiss, M.Ed.
McLean, VA



1 ☒ An Office Based Approach to
Attention Deficit Hyperactivity Disorders

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Sharon K. Weiss, M.Ed.

2 ☐ Primary Care and the New Morbidity

3 ☐ Inattention and Overactivity are Symptoms, Not Diagnoses

4 ☐ Asking the "W"right Questions

- Who says there is a problem?
- What is the main problem?
- When did the problem start?
- Where is the problem occurring?
- How big a problem is it?
- Why are they seeking help now?
- What else could it be?
- What else is there?

5 ☒ Differential Diagnosis of Inattention / Hyperactivity

6 ☒ Primary Causes of Inattention or Activity Problems

Directly impairs CNS's capacity to regulate attention, inhibition or activity level.

- Neurochemical
- Genetic
- Neurological
- Toxicological

7 ☒ Secondary Causes of Inattention or Activity Problems

Intrinsic factors that affect capacity to meet expectations

- Processing Deficits
- Psychosocial Distracters
- Medical Disorders

8 ☐ Secondary Causes - Processing Deficits

- Sensory Impairments
- Mental Retardation
- Autistic Spectrum Disorders
- Language Processing Disorders
- Learning Disabilities

9 ☐ Secondary Causes - Psychosocial Distracters

- Behavior Disorders
- Emotional Problems
- Psychiatric Illness
- Family Stress
- Abuse

10 ☐ Secondary Causes - Medical Disorders

- Neurological Disorders
 - Endocrine Disorders
 - Allergic Disorders
 - Sleep Disorders
 - Chronic Illness
 - Nutritional Problems
 - Substance Abuse
 - Medication Side Effects
- 11 ☒ Tertiary Causes of Inattention or Activity Problems
Extrinsic factors that affect capacity to meet expectations
- Parenting Issues
 - Situational Mismatch
 - Adverse Environment
 - Cultural Factors
- 12 ☐ Office Procedures - Be Prepared
- Ask about behavioral concerns
 - Flag chart to alert MD
 - Screening questionnaires
 - Special appointment slots
- 13 ☐ Office Procedures - Stay on Top
- Monitor "at risk" children
 - Request report cards for well visit
 - Problem monitoring face sheets
 - Highlight ADHD visits in one color
- 14 ☐ Office Staff
- Establish protocols
 - In-service for office staff
 - Physician extenders
 - Office "ADHD Expert"
 - Behavioral Binder
- 15 ☐ Parent Education
- Handouts
 - Lending library
 - Office lecture series
 - Parent support groups
- 16 ☐ Networking
- 17 ☐ Screening Questionnaires
- Child Development Inventories (Ireton)
 - Pediatric Symptom Checklist (Jellinek)
 - Screening Checklists (in Parker and Zuckerman)
- 18 ☐ Making Referrals - B.E.A.M.
- Behavioral
 - Emotional

Office Based Approach to ADHD

- Academic
- Motor or Medical
- 19 ☐ Triage- Patients for Referral
 - Conduct Disorders
 - Severe oppositional behaviors
 - Depression
 - Tics or family history of tics
 - Significant learning problems
 - Significant family dysfunction
- 20 ☐ Attention Deficit Hyperactivity Disorders
- 21 ☐ A Brief History
- 22 ☐ Prevalence
- 23 ☐ Gender and Genetics
- 24 ☐ Pathophysiology
- 25 ☐ ADHD - Working Definition (see Slides attached)
- 26 ☐ ADHD - Deficit Descriptions (see Slides attached)
- 27 ☐ ADHD Co-morbidity - Behavior Disorders
 - Social Skills Deficits
 - Simple Oppositional Behavior
 - Oppositional Defiant Disorder
 - Conduct Disorder
 - Antisocial Personality Disorder
- 28 ☐ ADHD Co-morbidity - Emotional Disorders
 - Demoralization
 - Mood Disorders
 - Anxiety
- 29 ☐ ADHD Co-morbidity - Academic Disorders
 - Underachievement
 - Specific Learning Disabilities
 - Speech / Language Disorders
 - Memory Disorders
 - Developmental Disorders
- 30 ☐ ADHD Co-morbidity - Motor Disorders
 - Developmental Coordination Disorder
 - Minor Neurological Dysfunction
 - Handwriting Disorders (Dysgraphia)
- 31 ☐ ADHD Co-morbidity - Medical Disorders
 - Enuresis and Encopresis
 - Tics and Tourette Syndrome
 - Sleep disorders
 - Genetic disorders
 - Neurological disorders
 - Thyroid Disorders (very rare)

- 32 ☐ Evaluation Process-Data Collection
- Obtain information before diagnostic exam
 - Questionnaires / rating scales
 - Report cards
 - Standardized test scores
 - Special education reports
 - Previous evaluations
 - Ask or you will not receive
- 33 ☐ Rating Scales-Broad Band Measures
- Comprehensive Behavior Rating Scale for Children (CBRSC)
 - Stony Brook Child Symptom Inventory (SB-CSI)
 - Child Behavior Checklist (CBCL)
 - ANSER Questionnaire System
- 34 ☐ Rating Scales-Narrow Band Measures
- Conners Rating Scales - Parent and Teacher (CPRS, CTRS)
 - ADDH Comprehensive Teacher Rating Scale (ACTeRS)
 - Attention Deficit Disorders Rating Scale (ADDES)
 - Brown Activation -Attention Disorders Scale (BAADS)
- 35 ☐ Rating Scales-Functional Measures
- School Situations Questionnaire (SSQ)
 - Home Situations Questionnaire (HSQ)
 - Academic Performance Rating Scale (APRS)
 - Vineland Adaptive Behavior Scales
 - Normative Adaptive Behavior Checklist
 - Child Depression Inventory
- 36 ☐ Selection of Rating Scales for a Primary Care Setting
- Evaluation phase - elementary school age
 - Conners parent and teacher (quickscore form)
 - CBRSC - teacher
 - Stony Brook CSI parent and teacher
 - Management phase
 - HSQ, SSQ
 - Childhood Attention Profile (CAP)
- 37 ☐ Data Collection - Interviewing the Parents
- 38 ☐ Data Evaluation - What to Look For
- Level of intellectual functioning (e.g. IQ)
 - Discrepancies between areas of functioning
 - Academic and / or behavioral concerns ?
 - When do they function best? Worst?
 - Pervasiveness
 - Chronicity
- 39 ☐ Medical Evaluation - Observing the Child
- 40 ☐ Medical Evaluation - Physical Examination

- 41 ☐ Medical Evaluation - Neurological Examination
- 42 ☐ "Soft Signs" Exam - Selected Items
- Toe and heel walk
 - Tandem or one foot balance
 - Sustained motor stance
 - Repetitive finger tapping
 - Rapid alternating movements
 - Presence of overflow or mirroring
 - Quality of movements
- 43 ☐ Neurodevelopmental Sampling - Fine Motor
- Visual Motor Tasks
 - Draw a Person Test
 - Design copying
 - Graphomotor Tasks
 - Alphabet
 - Writing sample
- 44 ☐ Neurodevelopmental Sampling - Language Tasks
- Receptive skills
 - Expressive skills
 - Social Pragmatic skills
 - Articulation skills
- 45 ☐ Neurodevelopmental Sampling - Reading Tasks
- Single Words
 - Reading Sample
- 46 ☐ Medical Evaluation - Laboratory Measures
- CBC with platelets
 - Lead level
 - Thyroid if indicated
 - Liver functions if using pemoline
 - EKG if using tricyclic
 - Neurological tests (EEG, etc.)
 - not indicated without symptoms
 - Computerized Performance Tests
- 47 ☐ Making the Diagnosis of ADHD
- 48 ☐ DSM IV - Inattention Criteria
- often makes careless mistakes
 - difficulty sustaining attention in tasks
 - often does not seem to listen
 - often does not follow through on instructions (not oppositional)
 - often has difficulty organizing
- 49 ☐ DSM IV - Inattention Criteria (continued)
- often avoids or strongly dislikes tasks requiring sustained mental effort
 - often loses things necessary for task or activities

- often easily distracted by extraneous stimuli
- often forgetful in daily activities
- 50 ☐ DSM IV - Hyperactivity / Impulsivity Criteria
 - often fidgets or squirms in seat
 - often unable to stay seated
 - often runs about or climbs excessively
 - often has difficulty playing quietly
- 51 ☐ DSM IV - Hyperactivity / Impulsivity (continued)
 - often "on the go" or acts as if "driven by a motor"
 - often talks excessively
 - often blurts out answers before the question is finished
 - often has difficulty awaiting turn
 - often interrupts or intrudes on others
- 52 ☐ DSM IV - ADHD Subtypes
 - Predominantly Inattentive (314.00)
 - Predominantly Hyperactive - Impulsive (314.01)
 - Combined (314.01)
 - In Partial Remission (314.01)
 - Not Otherwise Specified (314.9)
- 53 ☐ DSM IV - Additional Criteria
 - 6 criteria in subtype for 6 months
 - Clinically significant impairment
 - Some impairment in two or more settings
 - Some impairment before age 7
 - Not better explained by another disorder
- 54 ☐ DSM PC - DSM Primary Care, Child Version
- 55 ☐ Profile of Child Functioning
 - Strengths and weaknesses of
 - Child
 - Family
 - Environment
 - Prioritize problems
 - Identify resources
 - Plan intervention
- 56 ☐ Treatments Not Recommended for ADHD
 - EEG biofeedback
 - Diet therapy
 - Megavitamins
 - Chiropractic manipulation
 - Sensory integration therapy
 - Anti-motion sickness medicine
 - See Ingersoll, Goldstein 1993 for review of controversial treatments
- 57 ☐ Multi - Modal Management - B.E.A.M.

- Behavior management
 - Emotional management
 - Academic management
 - Medical management
- 58 ☐ Behavioral Counseling in the Pediatrician's Office (see handout)
- Sharon Korman Weiss, M.Ed.
- 59 ☐ Emotional Management
- Social and emotional problems are common
 - "Demystification" is therapeutic
 - Family therapy
 - Social skills groups
 - Individual psychotherapy
 - Not effective for ADHD symptoms
 - May be indicated for complications
- 60 ☐ Academic Management - Federal Laws - Special Education
- PL 94 -142 - Education for Handicapped Act (EHA) 1975
Reauthorized as Individuals with Disabilities Education Act (IDEA)
- 61 ☐ Academic Management - Federal Laws - Civil Rights Legislation
- Section 504 of Rehabilitation Act of 1973
 - American with Disabilities Act
- 62 ☐ Academic Management - Local School System
- 63 ☐ Medical Management - Use of Medication in ADHD
- 64 ☒ Medical Management - Key Points
- Medication is effective but does not cure ADHD -
anymore than eyeglasses cure nearsightedness.
 - Medication is a medical support -
It enables a child do what they want to.
It will not make a child do anything that they don't want to do.
- 65 ☒ Stimulant Medications (Also see Medications Chart)
- Methylphenidate
 - Dextroamphetamine
 - Pemoline
- 66 ☒ DOSE CURVE (see Slides attached)
- 67 ☐ Stimulants - Effects on Attention
- Improves alertness
 - Improves selective attention
 - Improves focus of attention
 - Improves sustained attention (on task)
- 68 ☐ Stimulants - Effects on Cognition
- Improves ability to sustain mental effort
 - Improves short - term memory
 - Improves accuracy
 - Improves comprehension

Office Based Approach to ADHD

- Improves academic performance
 - Does not decrease creative thinking
- 69 ☐ Stimulants - Effects on Impulsivity
- Improves ability to wait
 - Improves self-control
 - Improves ability to delay gratification
 - Increases use of rules
 - Increases self-monitoring
 - Decreases disruptive behaviors
- 70 ☐ Stimulants - Effects on Activity
- Improves regulation of activity
 - Decreases extraneous activity
 - Increases goal-directed activity
 - Improves quality of motor output
- 71 ☐ Stimulants - Effects on Social-Emotional Control
- Decreases interference with others
 - Decreases aggression
 - Decreases emotional lability
 - Improves compliance
 - Improves social behaviors
 - Improves frustration tolerance
- 72 ☐ Stimulants - Indirect Effects
- Decreases negative adult behaviors
 - Improves peer interactions
 - Improves social and family relationships
 - Improves self-esteem
- 73 ☐ Stimulants - ADHD Inattentive Type
- Increases arousal and activation
 - Increases task initiation
 - Improves recall
 - Increases rate of production
 - Increases participation
- 74 ☐ Stimulants - Side Effects
- Decreases appetite
 - Insomnia
 - Headaches and stomachaches
 - Increases pulse and BP (minor)
 - "Rebound"
- 75 ☐ Stimulants - Adverse Effects
- Tics
 - Growth
 - Personality / mood change
 - Anxiety

Office Based Approach to ADHD

- Idiosyncratic
 - Liver dysfunction (pemoline only)
 - Risk of seizures not increased
- 76 ☐ Stimulants - Over-medication
- Over - focused
 - Lethargic
 - Social withdrawal
 - Agitation
- 77 ☐ Side Effects -Assess T.I.R.E.
- Timing
 - Intensity
 - Regularity
 - External factors
- 78 ☐ DOSE CURVE - Side Effects - (see Slides attached)
- 79 ☐ Medication Trial - Practical Matters
- Trial of medication is not a test of diagnosis
 - Provide information to parents, teachers and child
 - Agree on procedure for monitoring response
 - Select two teachers in secondary school
 - Conduct the trial when everything else is stable
 - Try open trial of medication first
 - Consider placebo trial if necessary
- 80 ☐ Medication Trial - People Issues
- Use the word "MEDICATION", not drug
 - Everyone is biased
 - Home is different from school
 - People notice "noisy" issues, need prompts to notice quiet improvement
 - Children are poor reporters, feel "normal"
- 81 ☐ Medication Trial - Protocol
- Establish a routine
 - Consensus between doctors in group
 - Put it in writing and keep in binder
 - Get baseline rating scale and side effects
 - Protocol for follow-up calls and visits
 - Document discussion with parents
 - Provide written handouts
- 82 ☐ Rating Scales - Monitoring
- Child Attention Profile (CAP)
 - ADDH Comprehensive Teacher Rating Scale (ACTeRS)
 - Conners Abbreviated Symptom Questionnaire (ABSQ)
 - Stimulant Drug Side Effects Rating Scale - Barkley
- 83 ☐ Medication Trial - First Stage
- Start low dose in AM

Office Based Approach to ADHD

- Start on weekend
 - Give daily during trial period
 - Adjust on weekly basis
 - Determine onset and duration
 - Assess side effect profile
- 84 ☒ Medication Trial -Types of Responses
- Dramatic
 - Helpful
 - Equivocal
 - Adverse
- 85 ☐ Medication Trial - Second Stage
- Correct single dose is known
 - Add lunch dose or try long - acting
 - Consider afternoon dose
 - Home vs school dose schedules
 - Vacation issues
 - Requirements are highly individual
- 86 ☒ DOSE CURVE (see Slides attached)
Sample Methylphenidate Schedule
- 87 ☒ DOSE CURVE (see Slides attached)
Sample Dextroamphetamine Schedule
- 88 ☐ Antidepressants
- Imipramine
 - Desipramine
 - Nortriptyline
 - Bupropion
- 89 ☐ Antidepressants - Indications
- Unable to tolerate stimulants
 - ADHD with anxiety
 - ADHD with mood disorder
 - More effective for ADHD and enuresis than depression
- 90 ☐ Antidepressants - Benefits
- Decreases impulsivity
 - Decreases hyperactivity
 - Limited effect on attention
 - Decreases emotional lability
 - Improves mood / anxiety
 - Improves sleep and awakening
- 91 ☐ Antidepressants - Side Effects
- Dry mouth / constipation
 - Sedation
 - Dizziness / confusion
 - Changes in cardiac conduction

Office Based Approach to ADHD

- Overdose very dangerous
- 92 ☐ Antidepressants - Monitoring
 - Rule out syncope, sudden death in family history
 - Baseline EKG, repeat with each increased dose
 - Blood levels monitor metabolism of med not response
- 93 ☐ Antihypertensives
 - Clonidine
 - Guanfacine
- 94 ☐ Antihypertensives - Benefits
 - Decreases over-arousal
 - Decreases hyperactivity / impulsivity
 - Decreases aggression / opposition
 - Increases socialization
 - Improves sleep
 - Limited effect on attention
 - Skin patch available
- 95 ☐ Antihypertensives - Disadvantages
 - Sedation common
 - TID dose with pills often needed
 - Contact dermatitis with patch
 - Must be taken daily
 - Increase and decrease slowly
- 96 ☐ Chronic Medication
 - Prescription refill protocols
 - Follow-up visits every 3 - 6 months
 - Many benefit year-round
 - Different schedules may be needed for different situations
- 97 ☐ Troubleshooting
- 98 ☐ Trial Off Medication
 - Most need medication for years
 - If they finish school year on medication, start the new school year on medication.
 - When situation is stable (4 - 6 weeks)
 - Parent informs teachers of med change
 - Obtain baseline and weekly ratings
 - Off for 2 weeks then on for 1 week
 - Follow-up visit in 3 months
- 99 ☐ Adult Outcome
 - 10 - 15 % Severe problems
 - 50 - 70 % Symptomatic
 - 30 - 40 % Asymptomatic
- 100 ☐ Outcome - Subject's Views
- 101 ☐ Long Term Management

Behavioral Counseling in the Pediatrician's Office

Sharon Korman Weiss, M.Ed.

Premise # 1 :

Children would rather be right than wrong.

♦ Behavioral Definitions of ADHD

1. Inability to delay responding
2. Inability to do what you know
rather than not knowing what to do.
3. Inability to organize time and space.

What Works:

Structure and Predictability
Routinize their lives

Premise # 2 :

Treating the non-ADHD child as if he is ADHD can be beneficial. BUT treating the ADHD child as if he is not can lead to disaster.

♦ Three Types of Behavioral Change

1. Decreasing/eliminating inappropriate behavior
 - *When you eliminate a behavior, teach to a new behavior or you leave a behavioral void.*
2. Teaching to a new behavior.
3. Increasing low frequency appropriate behavior-
the behavior you want to see more often.
 - *Ask yourself "What do I want the child to do instead of what he/she is doing?"*

♦ THE A,B,C's of Behavior.

1. Antecedents. Conditions existing just prior to behavior
 - *Sometimes the easiest way to change a behavior is to alter the antecedents-structure for success.*
2. Behavior. Must be observable and/or countable.
 - *If you can't see, hear or feel it, it's not a behavior.*
3. Consequences. Conditions that immediately follow behavior.
 - When you follow a behavior with a positive consequence the behavior will increase, but only in that situation.
 - When you follow a behavior with a negative consequence the behavior will decrease, but only in that situation.
 - Positive consequences (reinforcers/rewards) are far more powerful in teaching to new behaviors than is punishment (negative consequences).

What Doesn't Work*Punishment (in isolation)*

*Punishment can only interrupt a behavior,
it doesn't teach to an alternative behavior.*

♦ **Punishment Procedures**

If punishment procedure is used, know how to increase effectiveness.

- Effective punishment entails a warning and has a set beginning and an end.
- Delivered immediately in a matter-of-fact manner every time the behavior occurs.
- Reinforce incompatible behavior.

♦ **How to Structure**

1. Checklists
2. Timers
3. Schedules

♦ **Reinforcement:** How to strengthen the right behaviors

1. What will make the behavior change worth his/her while?
2. What will capture his/her attention and hold it long enough to enable him/her to remember and practice the desired behavior.
 - *Remember, the child is already doing what originally seemed like a good idea.*
3. To be effective the reinforcement needs to be:
 - a. Feasible to the parent in terms of time, interest or expense.
 - b. Desirable to the child
 - c. Delivered immediately
 - d. Contingent on a specific behavior
 - e. Given every time the behavior occurs when teaching to new behavior or first strengthening behavior that occurs less frequently.
 - f. Given intermittently to keep behavior going
 - *Reinforce improvement. Do not expect perfect performance on the first try*
 - *Premack Principle: Use a high frequency behavior to reinforce a low frequency behavior.*

♦ **Narrow the Focus:** Concentrate on 1 - 3 behaviors at a time♦ **Understand the Learning Curve:** Expect a decline in performance, so be consistent.* **Success breeds success.**

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 American Academy of Child and Adolescent Psychiatry. (800) 333-7636.
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 CHADD. Support group for children and adults with Attention Deficit Disorders. National Office: 499 NW 70th Ave, Plantation, FL, 33317. (305) 587-3700.
 Family Connection. National referral service for families with children with behavior problems. (800) 854-4938.
 Learning Disabilities Association. 4156 Library Road, Pittsburgh, PA 15234. (412) 341-1515.
 NADDA. Parent support group. PO Box 488, W. Newbury, MA 01985. (800) 487-2282.
 National Center for Learning Disabilities. 99 Park Avenue, 6th floor, New York, NY 10016. (212) 687-7211.
 National Information Center for Children and Youth with Disabilities (NICHCY) P.O. Box 1492, Washington, DC 20013.
 National Register of Health Service Providers in Psychology. Washington, DC. (202) 833-2377.
 Society for Behavioral Pediatrics. 241 East Gravers Lane, Philadelphia, PA 19118. (215) 248-9168.

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Patient Education Software

Pediatric Advisor Schmitt B. ed. (\$395) Clinical Reference Systems, Greenwood Village, CO (800) 237-8401. Informational handouts on medical, developmental and behavioral topics that can be edited and printed out. Available in Spanish.

Books for Parents, Children and Adults:

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11. *SOS: Help for Parents*. Clark L. \$9.95 Parents Press, PO Box 2180, Bowling Green, KY 42102-2180. Easy to read book on handling everyday behavior problems, good discussion of time-out procedures. Also available is a kit for parent training, audiotapes and videotapes for parent counseling in the office.

Video Tapes:

1. Barkley RA.. *ADHD-What Do We Know?* 1992 (35 min), *ADHD-What Can We Do?* 1992 (45 min), *ADHD in the Classroom* 1994 (35 min), *ADHD in Adults* 1994(35 min). about \$95 each. Guilford Publications (800) 365-7006.
2. Phelan TW *"1-2-3 Magic: Training Your Preschooler and Preteens to do what you Want"* (90 min) \$40 video. \$10 Book. *Medication for ADD: An up to date Practical Resource for parents, adults and professionals*. 1994 (80 min) \$40. *All About Attention Deficit Disorder* (Part I-100 min, Part 2-80 min) \$40 for set. *Adults with Attention Deficit Disorder* (80 min) \$40. Child Management Inc. (1-800-442-4453).

Basic Home Behavior Management

Sharon K. Weiss, M.Ed., Behavioral Consultant
McLean, Virginia

STATE THE RULES.

All children need and want boundaries and limits. Rules exist, even though they may not be spoken or written. Try to state your rules in positive terms-"Keep your hands and feet to yourself". Keep rules short and to the point. Have a few, reasonable rules. Be consistent in using and enforcing rules. It is important to call attention to rules when the child is following them. Don't wait until the child has violated them.

- K.I.S.S. (Keep It Short and Simple)

MAKE THE WORLD PREDICTABLE.

Develop routines and write out a daily schedule. Homework, TV, school, play, baths and meals should all be written in. Scheduling helps children (and adults) to gauge time, organize activities and prioritize in terms of importance. Schedules provide a visual cue of when things will happen and imply an agreement of when it is time to stop one activity and move on to another. This decreases arguing. Reinforce adherence to the schedule. Use calendars, lists and timers to help structure time and activities. Timers help decrease parental nagging and reminding.

- Set the stage for success

WHEN BEHAVIOR IS APPROPRIATE, PRAISE IT.

Focus on the many small, positive behaviors that your child exhibits. When you enter a room, ask yourself, "What is going right?" Make specific positive comments. For example, notice when she responds to a direction the first time you say it. Even if she's doing it because it's something she wants to do, it still merits special attention. This will help her notice the exact behavior(s) that you want her to demonstrate. If a task has been partially completed, comment positively on the completed part first. When you notice things that a child does right, it breaks the cycle of negative redirection (nagging) and makes her feel better about herself and about you. Increase the amount of non-verbal praise. Give lots of warm smiles, pats and thumbs up. Your attention is something your child needs. Use it at the right time. Provide extra praise for behaviors you want to increase.

- Catch the child being good

WHEN THE BEHAVIOR IS INAPPROPRIATE, IGNORE IT.

For a child, negative attention is better than no attention at all. Attention reinforces behavior. Before you look at, speak to, or touch the child ask yourself "Do I want the behavior my child is now engaging in to increase?" If not, ignore it! Turn your attention to other matters or other children (siblings) who are behaving appropriately. If the behavior is not dangerous or destructive and you can ignore it, you should do so. When you refuse to give attention to undesirable behavior, a child must do something else to get your attention. Quickly give positive attention to more appropriate behaviors. Be aware that when you begin to ignore a problem behavior, it may increase rather than decrease at first. Be firm and consistent.

- If there is no audience, the show will close

WHEN DIRECTIONS ARE GIVEN, STATE THEM CLEARLY.

Do not phrase directions as questions when you mean them as directions. For example, don't ask "Are you ready for bed?" when it's bedtime. Instead say, "it's time for you to go to bed" as a direction, not a request. Get the child's attention, give the direction, reinforce compliance. Whenever possible, give a choice between two acceptable options but your child should know when he has a choice and when he has no option. State expectations clearly. "Straighten up" leaves room for debate.

- Say what you mean

NEVER GIVE A DIRECTION UNLESS YOU ARE READY TO ENFORCE IT.

Reserve directions for important situations where you are prepared to follow through. If you don't feel like getting up to check, don't direct them to put away their toys. When you are concerned about inconsistency, ask yourself exactly what message you want to convey-that it is okay to leave the toys out or it's okay not to listen to your directions.

- Mean what you say

FOCUS ON ONE OR TWO BEHAVIORS AND BE CONSISTENT.

Pick one or two behaviors to work on and respond consistently. This way your child will learn what to expect and will, in turn, behave more consistently. Try to discuss specific behaviors with your spouse and agree on specific responses/consequences. Consensus improves consistency. Writing down it down is helpful. Try to have others provide the same structure. This increases rate of learning, there is less testing behavior and it decreases the likelihood that the new skill will be person specific.

- Pick your battles to win the war

UNDERSTAND THE LIMITATIONS OF PUNISHMENT.

Punishment procedures, such as time-out, only interrupt behavior but do not teach to an alternative behavior. If punishment procedure is used, to sure to deliver the punishment in a matter-of-fact manner, deliver it immediately, and every time the behavior occurs. An effective punishment entails a warning and has a set beginning and end. Reinforce incompatible behaviors and positive alternative behaviors. In a pinch, ask the child what the punishment should be.

- Teach them what to do as well as what not to do

ASK A QUESTION.

When all else fails and re-direction is necessary, ask your child a question such as what is the guideline that applies to that situation. Reinforce his/her ability to repeat the rule. This is less judgmental, provides an opportunity for the child to be reinforced and re-directs a negative interaction into an exchange of information. Be calm. Try writing down the child's responses. Build on what was said. Encourage problem-solving.

- A statement provokes a defense, a question evokes a response

MODEL APPROPRIATE BEHAVIOR.

Demonstrate the behaviors you want your child to display. Model the target behavior then encourage the child to imitate you. Pretend to do it wrong and let the child correct you! It is easier to remember new behavior if there is a visual image and a chance for supervised positive practice.

- A picture's worth....•

Medications for Attention-Deficit/Hyperactivity Disorders

Karen J. Miller, MD 8/94

Name	Cost (approximate)	Dose Schedule	Dose Range	Onset/ Duration	Potential Side Effects
Methylphenidate Ritalin ® 5, 10, 20 mg. tablets	\$.35 @ 10 mg tablet (generic) \$.55 @ 10 mg tablet (brand)	Begin with 5 mg in morning daily. Increase by 5 mg weekly as needed. Usually needs two or three doses/day. Generic dose may differ.	5-80 mg/day	Takes effect in 30 minutes Lasts about 3-5 hours	Loss of appetite, weight loss, insomnia, stomachaches, irritability, headaches, social withdrawal, ties, "rebound". Avoid decongestants.
Ritalin SR ® 20 mg sustained release tablets only	\$1.10 @ 20 mg tablet (brand)	Begin with 20 mg in morning daily. Increase by 20 mg. as needed. Often needs short-acting tablet in morning to "jump- start". Usually given as one to two doses/day. Not as potent as regular.	20-80 mg/day	Takes effect in 60-90 minutes Lasts about 6-8 hours	Loss of appetite, weight loss, insomnia, stomachaches, irritability, headaches, social withdrawal, ties. Avoid decongestants. May release unevenly.
Dextroamphetamine Dexedrine® 5 mg. tablets only Dexedrine elixir ® 5 mg/ 5 ml -discontinued	\$.30 @ 5 mg tablet (brand)	Begin with 2.5 mg in morning daily. Increase weekly by 5 mg. as needed. Usually given as two or three doses/day.	2.5-40 mg/day	Takes effect in 30 minutes Lasts about 3-5 hours	Loss of appetite, weight loss, insomnia, stomachaches, irritability, headaches, social withdrawal, ties, "rebound". Avoid decongestants.
Dexedrine Spansules® 5, 10, 15 mg. capsules	\$.50 @ 5 mg tablet (brand)	Begin with 5 mg in morning daily. Increase by 5 mg. as needed. Often needs short-acting tablet in morning to "jump- start". Given as one to two doses/day.	5-40 mg/day	Takes effect in 60 minutes Lasts about 6-10 hours.	Loss of appetite, weight loss, insomnia, stomachaches, irritability, headaches, social withdrawal, ties. Avoid decongestants.
Pemoline Cylert ® 18.75, 37.5, 75 mg tablets 37.5 mg chewable tablets	\$1.10 @ 37.5mg tablet (brand)	Begin with 37.5 mg in morning daily. Increase by 18.25 mg weekly as needed. Usually given in one dose/day. Must be taken every day.	18.75- 112.5 mg/day	Takes 2 weeks to take effect. Tablets then last 12-24 hours.	Insomnia, stomachaches, irritability, headaches. Rarely, abnormal liver function tests. Blood tests needed regularly. Avoid decongestants.
Imipramine Tofranil ® 10, 25, 50 mg tablets	\$.10 @ 25 mg tablet (generic) \$.50 @ 25 mg tablet (brand)	Begin with 25 mg. before bedtime. Increase by 25 mg. weekly as needed. Given as one or two doses/day. Must be taken daily. Stop slowly.	25-200 mg/day	Takes 5-10 days to take effect. Tablets then last 12-24 hours.	Fatigue, stomach upset, dry mouth, blurry vision, constipation, dizziness. May affect cardiac conduction rate. Baseline and monitoring EKG's.
Desipramine Norpramin ® 10, 25, 50, 75 mg tablets	\$.30 @ 25 mg tablet (generic) \$.75 @ 25 mg tablet (brand)	Begin with 25 mg. in morning. Increase by 25 mg. weekly as needed. Given as one or two doses. Must be taken daily. Stop slowly.	25-200 mg/day	Takes 3-5 days to take effect. Tablets then last 12-24 hours.	Fatigue, stomach upset, dry mouth, blurry vision, constipation, dizziness. May affect cardiac conduction rate. Baseline and monitoring EKG's.
Clonidine Catapres ® 0.1, 0.2, 0.3 mg tablets	\$.10 @ 0.1 mg tablet(generic) \$.55 @ 0.1 mg tablet (brand)	Begin with .05 mg (1/2 tablet) before bedtime. Increase by .05 mg weekly as needed. Given as two to four doses/day. Must be taken daily. Stop slowly.	0.1-0.3 mg/day	Takes 2 weeks to take effect. Tablets then last 8-12 hours.	Sleepiness, dizziness, nausea, hypotension.
Catapres TTS 1,2,3 ® (transdermal patches)	\$7 @ TTS patch (brand)	Begin with TTS 1 patch (delivers 0.1 mg/day) may increase slowly after 2 weeks as needed. Stop slowly.	0.1-0.3 mg/day	Takes 2 weeks to take effect. Lasts 5-7 days.	Sleepiness, dizziness, nausea, hypotension. Skin irritation under patch. Not affected by routine bathing.

Attention-Deficit / Hyperactivity Disorders Working Definition

- Family of neurobiological disorders
- Common but complex disorder
- Chronic but variable course
- Strong genetic predisposition
- Not caused by bad parenting or bad schools
- ADHD causes family stress

Attention-Deficit/Hyperactivity Disorders Working Definition (continued)

- Neurotransmitter imbalance
- Under - functioning of specific brain pathways
- Impaired regulation of attention, behavior, activity level and self - management.
- Normal behaviors but inappropriate amounts
- Consistently inconsistent behaviors
- Often accompanied by other problems

Attention / Cognition Control Problems

Hyperactive - Impulsive

Not tuned in to the right thing
Thoughts jump around
Distractible
Scans
Doesn't listen to directions
Skips when reading
Misses important details
Attends superficially

Inattentive

Not tuned in enough
Thoughts drift off
Daydreams
Stares off
Doesn't "get" the direction
Fades when reading
Misses the point of the detail
Attends incompletely

Impulsivity / Behavior Control Problems

Hyperactive - Impulsive

Acts without thinking
Can't wait
Blurts out answer
Rushes thru work
Reacts too quickly
Gives up too soon

Inattentive

Thinks without acting
Can't decide
Off-topic comments
Plods thru work
Reactions "off base"
Gets "stuck"

Activity / Arousal Control Problems

Hyperactive - Impulsive

Over-aroused
Overactive
Fidgets (gross motor)
Seeks stimulation
Gets over-excited
Chatters
Loud
Hard to stop

Inattentive

Under-aroused
Sluggish
Fiddles (fine motor)
Avoids stimulation
Gets over-whelmed
Rambles
Tentative
Hard to start

Social / Emotional Control Problems

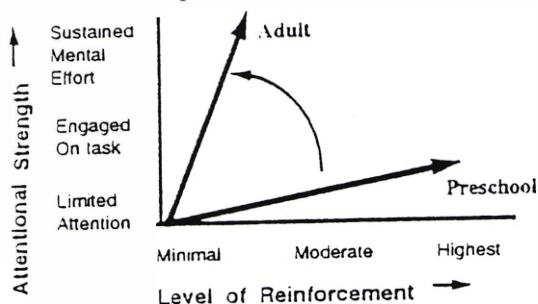
Hyperactive - Impulsive

Misses social cues
"In the middle of it"
Difficulty playing by the rules
Invades other's space
Interferes and annoys
Easily angered
Makes but loses friends fast
Rejected
"Immature"

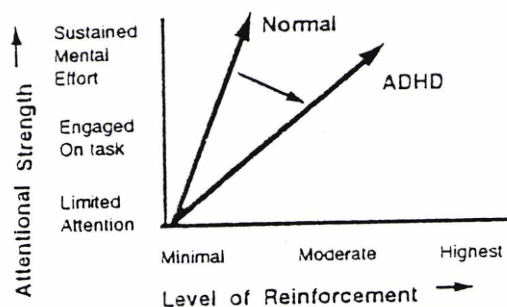
Inattentive

Doesn't "get" social cues
"Out of it"
Difficulty recalling the rules
Oblivious to other's space
Bothers and irritates
Easily hurt
Makes few friends slowly
Tolerated
"Young"

Reinforceability / Satiation Control Developmental Progression



Reinforceability / Satiation Control in ADHD



Reinforceability / Satiation Control Problems

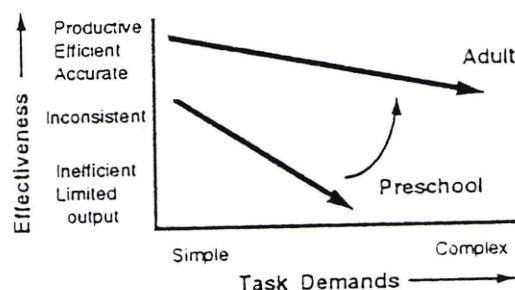
Hyperactive - Impulsive

Works well when interested
Gets bored quickly
Needs immediate feedback
Doesn't learn from mistakes
Insatiable
Prefers novelty
Seeks excitement

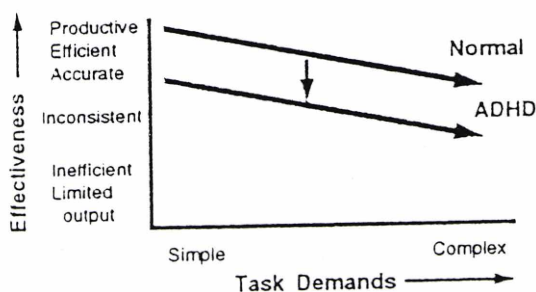
Inattentive

Hard to interest
"Burns out" quickly
Needs constant prodding
Doesn't try
Apathetic
Prefers familiarity
Seeks low demands

Organization / Executive Function Control Developmental Progression



Organization / Executive Function Control in ADHD



Organization / Executive Function Control Problems

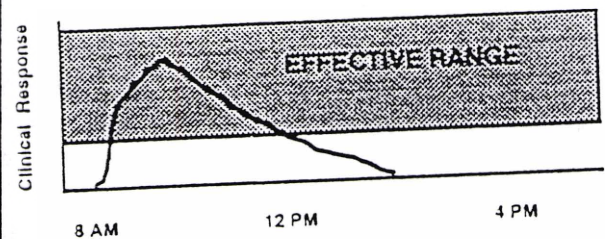
Hyperactive - Impulsive

Inconsistent
Follows their own agenda
Needs supervision
Doesn't follow through
Ineffective activity
Doesn't plan
Careless
"Done is done"

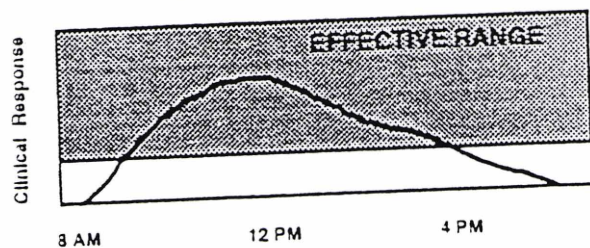
Inattentive

Variable
Forgets the agenda
Needs assistance
Gets side-tracked
Inefficient activity
Disorganized
Forgetful
Doesn't know what's been done"

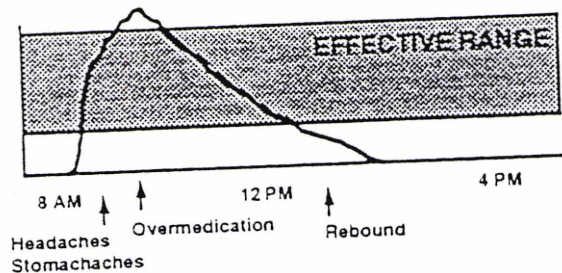
DOSE CURVE Short Acting Stimulants



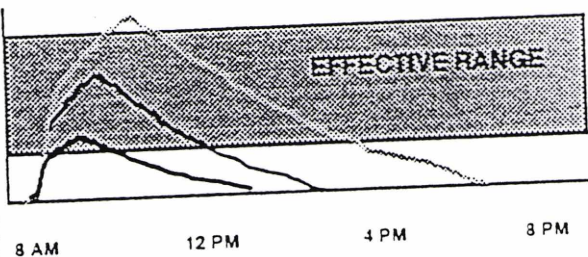
DOSE CURVE Long Acting Stimulants



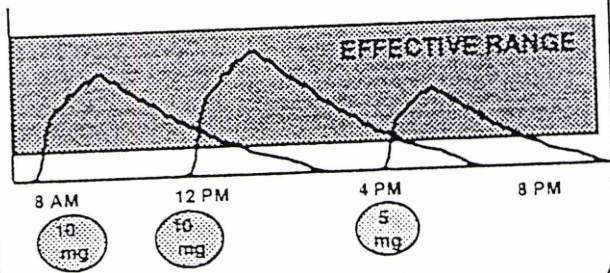
DOSE CURVE Side Effects



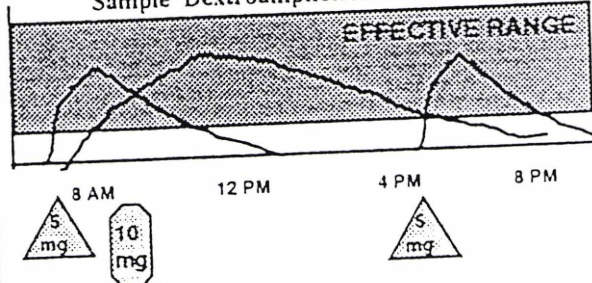
DOSE CURVE Individual Response



DOSE CURVE Sample Methylphenidate Schedule



DOSE CURVE Sample Dextroamphetamine Schedule



EVALUATION AND TREATMENT OF CHILDREN WITH LEARNING PROBLEMS



"NEEDLESS SUFFERING OCCURS WHENEVER CHILDREN GROW UP DISAPPOINTING THEMSELVES AND THE ADULTS WHO CARE ABOUT THEM. OFTEN THEY DO SO BECAUSE THEY PERFORM INADEQUATELY IN SCHOOL...THESE STRUGGLING CHILDREN COMPRISE A VERY LARGE AND HETEROGENEOUS GROUP. THEY DIFFER FROM EACH OTHER IN THEIR STRENGTHS AS WELL AS IN THE REASONS FOR THEIR LEARNING DIFFICULTIES...EVERY ONE OF THEM CONTAINS THE SEEDS FOR MASTERY AND GRATIFICATION IN LIFE; NONE OF THEM NEEDS TO FAIL."

-MELVIN D. LEVINE, M.D., *EDUCATIONAL CARE*

AMERICAN ACADEMY OF PEDIATRICS UPDATE
CALIFORNIA CHAPTERS 1,2,3 & 4
LAS VEGAS, NV
NOVEMBER 1995

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NEW HYDE PARK, N.Y. 11040

1 ☐ **Evaluation and Treatment of the Child with Learning Disabilities**

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Schneider Children's Hospital

New Hyde Park, N.Y. 11040

2 ☐ **Learning Disabilities (LD) - Key Points**

- LD really means Learning Difference
- LD does not mean Lazy and Dumb
- Children with Learning Disabilities also have Learning Abilities.
- Learning Disabilities are also Life Disabilities.
- Learning Disabilities are often Life-long Disabilities.

3 ☐ **What Learning Disabilities Are:**

- LD interfere with ability to store, process or produce information
- Neurological disorder, not emotional disorder
- LD can affect ability to read, write, speak or do math
- LD can affect socialization skills
- Generally average or above intelligence
- Gap between potential and performance
 - Uneven abilities
 - "He's so smart, why can't he ...?"

4 ☐ **What Learning Disabilities Are NOT:**

- Not due to Attention Deficit Hyperactivity Disorder (can co-occur)
- Not due to mental retardation
- Not due to blindness or hearing impairment
- Not due to behavioral disorder
- Not due to lack of educational opportunity
- Not due to environmental deprivation

5 ☐ **Facts about Learning Disabilities**

- 10 - 15 % of US population affected by a learning disability
- 52 % of children in special education had LD in 1992
 - 85-90 % had basic deficits in reading and language
- Learning disabilities run in families
- Girls as likely as boys to have LD
- Boys more likely to be identified

6 ☐ **The Problem of Learning Problems**

- Invisible disabilities with serious consequences
- Secondary emotional, behavioral, social and family problems are common.
- Secondary symptoms more visible, mistaken as primary cause.
- LD not outgrown or overcome but compensated for.

7 ☐ **Learning Disabilities - Early Identification**

- Screening can identify children at risk

- Median age of presentation
 - Developmental delays - 14 months
 - 45% first noted before 1 year
 - Learning disability - 6 1/2 years
 - 45% between 6 - 8 years
 - 16% not detected until secondary school
 - Federal Law mandates that children with suspected disabilities be evaluated.
- 8 ☐ **Learning Disabilities- Early Intervention**
- Disabled children are entitled to a "free and appropriate public education" in the "least restrictive environment"
 - Early appropriate instruction results in substantial gains
 - Delay in intervention has impact on achievement and self-esteem
 - If reading disability not identified by age 9, majority remain reading disabled
- 9 ☐ **The High Cost of Learning Disabilities**
- 60% of adults with severe literacy problems have untreated LD
 - 50% of juvenile delinquents tested had undetected LD
 - 35% of children identified with LD drop out
 - up to 60% of adolescents in treatment for substance abuse have LD
- 10 ☐ **Learning Disability Definition - US Interagency Committee 1988 (Kavanaugh and Truss)**
- "Learning disabilities is a generic term that refers to a heterogeneous group of disorders manifested by significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning or mathematical abilities or of social skills. These disorders are intrinsic to the individual and are presumed to be due to central nervous system dysfunction..." (continued)
- 11 ☐ **Learning Disability Definition - US Interagency Committee 1988 (continued)**
- ... a learning disability may occur concomitantly with other handicapping conditions (e.g., sensory impairment, mental retardation, social and emotional disturbance), with socioenvironmental influences (e.g., cultural differences, insufficient or inappropriate instruction, psychogenic factors), and especially with Attention Deficit Disorder, all of which may cause learning problems. A learning disability is not the direct result of these conditions or influences."
- 12 ☐ **LD and/or ADHD ?**
- LD - Information processing
 - Neuroanatomic differences
 - Orchestra section problem
 - 10 - 15 % of school age children have LD
 - ADHD - Regulation of brain functions
 - Neurochemical imbalance
 - Orchestra conductor problem
 - 3 - 7 % of school age children have ADHD
 - 20 - 40 % of LD have ADHD
 - 35 - 70 % of ADHD have LD
- 13 ☐ **Federal Law 94-142 EHA (now IDEA)**
- Special education law

- LD = Severe discrepancy between achievement and ability
 - No specifics on how to measure this discrepancy
- 14 ☐ **Special Education Terms: Administrative category oriented**
- Preschooler with a Disability
 - Specific Learning Disability
 - Speech/Language Impaired
 - Other Health Impaired
 - Seriously Emotional Disturbed
 - Orthopedically Impaired
 - Autistic Disorder
 - Traumatic Brain Injury
- 15 ☐ **Psychiatrist terms - DSM IV: Outcome oriented**
- Developmental Reading Disorder
 - Developmental Expressive Writing Disorder
 - Developmental Arithmetic Disorder
 - Developmental Language Disorder
 - Developmental Coordination Disorder
- 16 ☐ **Neurologist Terms: Pathology oriented**
- Dyslexia
 - Dysgraphia
 - Dyscalculia
 - Dysphasia
 - Dyspraxia
- 17 ☐ **Psychoeducational diagnostic terms: Process oriented**
- Phonological awareness
 - Visual-motor integration
 - Visual perceptual processing
 - Graphomotor function
 - Auditory figure-ground
 - Central auditory processing
 - Active working memory
 - Oral expressive language
 - Sequential processing
 - Simultaneous processing
 - Higher cognitive functions
- 18 ☐ **Task Component approach**
- Attention
 - Sensory Reception and Perception
 - Memory Storage and Retrieval
 - Information Processing
 - Learned Skills
 - Output
- 19 ☐ **Task Component - Attention**

- Arousal (inferior-brain stem)
- Inhibition (superior-cortical)
- Orienting (phasic-right hemisphere)
- Sustained (tonic-left hemisphere)
- Novel learning (anterior-frontal)
- Multi-tasking (posterior-parietal)
- 20 ☐ **Task Component - Sensory Reception and Perception**
 - Visual
 - Auditory
 - Tactile
- 21 ☐ **Task Component - Memory Storage and Retrieval**
 - Short term
 - Active working memory
 - Long term storage
 - Long term retrieval
- 22 ☐ **Task Component - Information Processing**
 - Language-receptive
 - Language-expressive
 - Visual spatial
 - Temporal sequential
 - Higher cognitive functions
- 23 ☐ **Task Component - Learned Skills**
 - Academic skills
 - Procedural skills
 - Social skills
- 24 ☐ **Task Component - Output**
 - Organization
 - Oral language
 - Written language
 - Motor output
 - Monitoring
- 25 ☐ **Interactive Approach:**
Individual's "goodness of fit" with environment's demands
 - Individual
 - Neurological endowment
 - Temperamental style
 - Sociocultural support
 - Environment
 - Task demand
 - Educational situation
 - Sociocultural expectations
- 26 ☐ **Spectrum of Severity**
 - Episode

- Variation
 - Dysfunction
 - Disability
 - Handicap
- 27 ☐ **Medical Evaluation of School Performance Problems - Key Questions**
- Are there medical issues compromising this child's school functioning?
 - Are there school issues compromising this child's physical functioning?
- 28 ☐ **Medical Evaluation of School Performance Problems - Physician's role**
- Answer the Key Questions
 - Assist parents in obtaining appropriate assessment and services
 - Provide medical treatment when indicated
 - Facilitate balance between acceptance of disability with nurturing of ability.
- 29 ☐ **Presenting Problems: A.B.E.A.M.**
- Academic
 - Behavioral
 - Emotional
 - Attentional
 - Medical or Motor
- 30 ☐ **Presenting Problems: Age related Academic Complaints**
- Preschool - Language / Socialization
 - Early elementary - Reading / Activity
 - Late elementary - Writing / Attention
 - Middle school - Memory / Responsibility
 - High school - Productivity / Attitude
- 31 ☐ **Office Management**
- Proactive protocol
 - Report card review at well visit
 - Scheduling options
 - Patient information handouts
 - Referral list
 - Understanding of local school system
 - Pediatric Problem Checklist (see Appendix)
 - Questionnaires (such as ANSER system)
 - Rating Scales (such as Conners)
- 32 ☐ **History - Presenting Problem: Ask the "W"right questions**
- Who says there is a problem?
 - What exactly are the problems? Strengths?
 - Where is the child having problems?
 - When were problems first noticed?
 - HoW big a problem is it?
 - Why now?
 - What else could it be? (Differential Diagnosis)
 - What else is there? (Comorbidity)

- 33 ☐ **Differential Diagnosis and Comorbidity: A.B.E.A.M.**
- Academic / Cognitive Problem
 - Behavior Problem
 - Emotional Problem
 - Attention Problem
 - Medical / Motor Problem
- 34 ☐ **Differential Diagnosis and Comorbidity: Academic / Cognitive Problem**
- Cognitive Deficit (MR)
 - Learning disorder
 - Skill deficit
 - Productivity deficit
- 35 ☐ **Differential Diagnosis and Comorbidity: Behavior Problem**
- Situational
 - School
 - Home
 - Social
 - Pervasive
 - Compliance problems
 - Antisocial behaviors
- 36 ☐ **Differential Diagnosis and Comorbidity: Emotional Problem**
- Demoralization
 - Performance anxiety
 - Anxiety disorder
 - Depression
 - Adjustment reaction
 - Social relations problem
- 37 ☐ **Differential Diagnosis and Comorbidity: Attention Problem**
- Episodic
 - Situational
 - Task specific
 - School
 - Home
 - Pervasive (ADHD)
- 38 ☐ **Differential Diagnosis and Comorbidity: Medical / Motor Problem**
- Neurological injury
 - Fetal alcohol syndrome
 - Lead poisoning
 - CNS trauma or infection
 - Neurological disorder
 - Seizure disorder
 - Coordination disorder
 - Handwriting problem
 - Medical disorders

- Genetic disorders (Fragile X)
- Chronic illness
- Endocrine disorder

39 ☐ **Assessment for School Performance Problems**

- History
- Physical and neurological
- Neurodevelopmental
- Cognitive/Intellectual level
- Achievement
- School functioning
- Other assessments
- Rating Scales

40 ☐ **History - Medical**

- Birth history
 - Multiple miscarriages, prematurity, small for gestational age, congenital anomalies, maternal substance use, perinatal complications, failure to thrive.
- Medical history
 - Sensory impairments, serious illness or injury especially head injury, chronic illness, recurrent otitis, seizures, anemia, lead poisoning, physical abuse, substance abuse, somatic complaints or tics.

41 ☐ **History - Developmental**

- Global delays or isolated delay
- Uneven language skills
- Loss of milestones, unusual patterns of development
- Delayed self-help skills, problems with elimination
- Sleeping and eating problems
- Key question "How old does your child seem?"

42 ☐ **History - Family**

- Parent's age, educational history and occupation.
- Siblings age, educational history or other problems.
- Family history of school problems especially reading, hyperactivity, psychiatric problems, behavior problems, neurological disorders, developmental disabilities. Males on maternal side (Fragile X).
- Family constellation, support and stability. Child care situation.
- Community factors.

43 ☐ **History - Psychosocial**

- Social - Emotional history
 - Temperament issues. Poor relationships with peers or adults. Attachment issues or emotional abuse. Mood lability, irritability, depression or anxiety. Poor anger control or antisocial acts.
- Behavior history
 - Inattentiveness, situational or pervasive. Impulsivity. Overactivity, large motor, small motor or oral (talkativeness). Disorganization. Forgetfulness. Behavior or compliance problems. Atypical behaviors or repetitive behaviors.

44 ☐ **History - Educational**

- Report cards
 - Pervasive problems or specific subjects
 - Academic vs behavioral issues
 - Poor school attendance
 - Psychoeducational testing
 - IQ measure. Achievement test scores.
 - Group vs individual tests
 - Previous educational interventions
 - Early intervention services
 - Remedial classes
 - Grade retention
 - Special education placement
 - Tutoring
- 45 ☒ **Physical Examination**
- Sensory evaluation
 - Growth parameters
 - General appearance
 - Dysmorphic features
 - Routine physical
 - Neurological Examination
 - Axial or extremity hypotonia
 - Joint hyperextensibility
 - Tics, tremors, balance, incoordination
 - Stance, gait, skipping, hopping in place
- 46 ☐ **Neurodevelopmental Sampling - Minor Neurological Indicators Exam**
- Right/left orientation
 - Sequential finger movements
 - Rapid alternating movements
 - Sustained motor posture
 - Overflow and mirror movements
- 47 ☐ **Neurodevelopmental Sampling - Graphomotor functioning**
- Family drawing (while parent is interviewed)
 - Writing sample (while parent is interviewed)
 - Open ended task
 - Written expression, mechanics, handwriting
 - Written alphabet
 - Pencil grip, letter formation, spacing, memory
 - Figure Copying
 - Task approach, pencil control
- 48 ☐ **Neurodevelopmental Sampling - Language Tasks**
- Rhyming (Phonological awareness)
 - Words that rhyme with “hat”, etc.
 - Category listing (Retrieval memory)

Karen J. Miller, M.D.

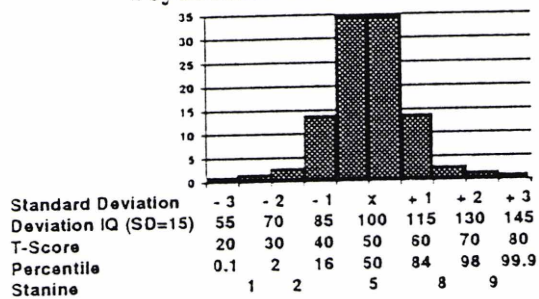
- 9 items by 9 years in 30 seconds
 - Look for patterns, repeats
 - Reading
 - Graded paragraphs. Error pattern. Summarize.
 - Language
 - Spontaneous vs Demand
- 49 ☐ **Child Observation / Interview**
 - Waiting room
 - Examination behavior
 - Language
 - Awareness of issues
 - What is the problem TO THE CHILD.
- 50 ☐ **Rating scales**
 - Comprehensive Behavior Rating Scale for Children (Neeper, Lahey, Frick)
 - Conners Rating Scales (Conners)
 - Stony Brook Child Symptom Inventories (Gadow)
 - School and Home Situations Questionnaires (Barkley)
 - Academic Performance Rating Scale (DuPaul)
 - Brown Activation Attention Disorders Scales (Brown)
- 51 ☐ **Comprehensive Behavior Rating Scale for Children (CBRSC)**
(Neeper, Lahey, Frick)
 - Inattention - Disorganization
 - Reading Problems
 - Cognitive Deficits
 - Oppositional - Conduct Disorders
 - Motor Hyperactivity
 - Anxiety
 - Sluggish Tempo
 - Daydreaming
 - Social Competence
- 52 ☐ **Laboratory - Tests to Consider**
 - Blood count
 - Blood chemistries
 - Lead level
 - Thyroid studies
 - Chromosomes
 - Metabolic Studies
 - EEG
 - Neuroimaging
- 53 ☐ **Psychoeducational Test Vocabulary - 1**
 - Reliability - consistency and accuracy of measurement
 - Validity - does it really test what it says it's testing
 - Age equivalent - Average age for score

- Grade equivalent - Average grade level for score
 - Ratio IQ / DQ - Test score age / Chronologic age.
 - Deviation IQ - Often used. Normal distribution with mean of 100 and standard deviation (SD) of 15 or 16
 - Range - Difference between highest and lowest
- 54 ☐ **Psychoeducational Test Vocabulary - 2**
- Percentile rank - standing within a group
 - Average range = 16 - 84 th percentile
 - Standard deviation (SD)- measure of variability indicating the extent to which scores deviate from the mean.
 - Standard score - how many standard units from the mean
 - T-score - standard score with mean of 50 and SD of 10
 - Z - score - standard score with mean of 0 and SD of 1
 - Scaled score - Standard score with mean of 10 and SD of 3
 - Stanine - single digit system with mean of 5 and SD of 2
 - Average range = 4 - 6 stanine, 1 = percentile 2 or below
- 55 ☐ **Comparison of Psychometric Terms (see slide pages)**
- 56 ☐ **Cognitive/Intellectual Functioning**
- Common Individual Tests
 - Wechsler Preschool and Primary Scale of Intelligence - Revised (WPPSI - R)
 - Wechsler Intelligence Scale for Children - Third Edition (WISC III)
 - Stanford Binet - Fourth Edition (SB - 4)
 - Kaufman Assessment Battery for Children (K - ABC)
 - Wide-Range Assessment of Memory and Learning (WRAML)
- 57 ☐ **WISC - III Subtests - Verbal Scale (see slide pages)**
- 58 ☐ **WISC - III Subtests - Performance Scale (see slide pages)**
- 59 ☐ **Analysis of WISC - III**
- Verbal IQ
 - Performance IQ
 - Full Scale IQ
 - Verbal Comprehension Factor
 - Perceptual Organization Factor
 - Freedom from Distractibility Factor
 - Processing Speech Factor
- 60 ☐ **IQ Classification (on WISC III) (see slide pages)**
- 61 ☐ **Group Achievement Tests**
- Common standardized group achievement tests
 - California Achievement Test
 - Iowa Tests of Basic Skills
 - Metropolitan Achievement Tests
 - Stanford Achievement Tests
 - Group measures are screening tests
 - Indicate which students need evaluation

- Never make a placement decision based on a group test
 - Individual test scores may differ significantly
- 62 ☒ Jennifer's Stanford Achievement Test (see slide pages)
- 63 ☐ Individual Achievement Tests
 - Screening
 - Wide Range Achievement Test
 - Peabody Individual Achievement Test
 - Comprehensive
 - Woodcock-Johnson Psychoeducational Battery
 - Kaufman Test of Educational Achievement (KTEA)
 - Wechsler Individual Achievement Test (WIAT)
- 64 ☒ Erik's Test Scores (selected) (see slide pages)
- 65 ☐ Multi - Modal Management: A.B.E.A.M.
 - Academic management
 - Behavior management
 - Emotional management
 - Attention Deficit management
 - Medical management
- 66 ☒ Academic Management: Continuum of Support
 - Demystification
 - Collaborative problem - solving
 - Tutoring
 - Remedial Education
 - Related Services
 - Resource Room
 - Self - contained
 - Center - based
 - Residential
- 67 ☐ Academic Management: Special Education Law
 - PL 94 - 142
 - 1975-Education for the Handicapped Act (EHA)
 - reauthorized in 1990 as Individuals with Disabilities Education Act (IDEA)
 - PL 99 - 457
 - Section 504 of Rehabilitation Act of 1973
 - Americans with Disabilities Act (ADA)
- 68 ☐ Academic Management: Special Education Buzz Words
 - Child Find
 - FAPE - Free Appropriate Public Education
 - IEP - Individualized Educational plan
 - LRE - Least restrictive environment
 - Continuum of Services
 - Due process
 - Independent Evaluation

- 69 ☐ **Behavior Management**
- Appropriate adaptation of the environment by adults
 - Behavior modification techniques
 - Set child up for success
 - Teaching to new skills
 - Collaboration between home and school with frequent feedback
- 70 ☐ **Emotional Management**
- Social and emotional problems common
 - "Demystification" is therapeutic
 - Family therapy
 - Group therapy with other LD
 - Individual counseling
 - May be indicated for improving adaptation or for complications
 - Not effective for ADHD symptoms
- 71 ☐ **Attention Deficit Management**
- Manage secondary attentional problems by addressing the primary cause
 - Attention Deficit Hyperactivity Disorder
 - Inattentive type - increased LD, language and memory problems
 - Hyperactive-Impulsive - Increased conduct, social and motor problems.
 - Medication can be effective for ADHD but does not treat LD.
- 72 ☐ **Medical Management**
- Treat acute and chronic illnesses
 - Advocate for accommodations due to physical limitations as appropriate
 - Consider occupational therapy if significant fine motor deficit present
 - Insist on specific skill coaching
 - Teaching handwriting and keyboarding
 - Advise on appropriate sports activity
 - SSI eligibility?
- 73 ☐ **Treatments Not Recommended for LD**
- Developmental Optometry
 - Sensory integration therapy
 - Chiropractic manipulation
 - Megavitamins
 - Anti-motion sickness medicine
- See Ingersoll, Goldstein 1993 for review of controversial treatments
- 74 ☐ **Management: Referral and Advocacy**
- Locate educational diagnosticians, academic therapists, educational advocates and parent support groups
 - Support parental expertise and advocacy
 - Support patient expertise and advocacy
 - Support pro - active advocacy
 - Avoid reactive excuse - making
 - Long-term outcome determined by level of support and self - esteem, not severity

Comparison of Psychometric Terms



WISC - III Subtests Verbal Scale

Subtest	Task	Measures
Information	Factual questions	Fund of general information
Similarities	How are a magazine and a book alike?	Abstract concept-formation skills
Arithmetic	Math problems and some word problems	Ability to do mental computation
Vocabulary	Defines various words	Vocabulary and verbal fluency
Comprehension	What would you do if...?	Verbal practical reasoning
(Digit Span)	Repeat series of digits	Short term auditory memory and attention

WISC - III Subtests Performance Scale

Subtest	Task	Measures
Picture Completion	Indicate the missing part	Detect visual detail
Picture Arrangement	Arrange pictures series in order	Non-verbal practical reasoning
Block Design	Copy design with colored blocks	Nonverbal abstract reasoning
Object Assembly	Jigsaw puzzle assembly	Part to whole
Coding	Timed copying of symbols	Learning, attention and visual-motor
(Mazes)	Path through mazes	Visual planning and visual-motor skills
(Symbol Search)	Compares target group to search group	Visual memory, attention

IQ Classification (on WISC III)

IQ Scores	Description
Above 130	Very Superior
120 - 129	Superior
110 - 119	High Average
90 - 109	Average
80 - 89	Low Average
70 - 79	Borderline
55 - 69	Mild Mental Retardation
40 - 54	Moderate MR
25 - 39	Severe MR
Less than 25	Profound MR

Jennifer's Stanford Achievement Test

Grade: 6	Age: 11-10						
	GE	NS	NP				
Word Study Skills	4.0	4	23	x	x	x	x
Reading Comprehension	8.6	6	64			x	x
Vocabulary	PHS	8	95				x
Total Reading	6.0	5	41			x	x
Total Listening	11.7	7	85				x
Total Language	8.7	6	74			x	x
Total Math	10.7	7	86				x
Percentile Confidence Bands 2 10 30 50 70 90 98							

Erik's Test Scores (selected)

Test	Subscale	Grade: 6	
		Standard Score	Percentile
WISC-III	Verbal IQ	73	3
	Performance IQ	78	7
WIAT	Basic Reading	79	8
	Spelling	70	2
	Math Composite	74	4
	Writing Composite	67	1

Resources

Organizations:

1. American Academy of Pediatrics. Section on Developmental and Behavioral Pediatrics. Section on School Health.
2. Council for Exceptional Children. 1920 Association Drive, Reston, VA, 22091. (703) 620-3360.
3. Learning Disabilities Association. 4156 Library Road, Pittsburgh, PA 15234. (412) 341-1515. \$25 dues. Helpful newsletter.
4. National Center for Learning Disabilities. 99 Park Avenue, 6th floor, New York, NY 10016. (212) 687-7211.
5. National Information Center for Children and Youth with Disabilities (NICHCY) P.O. Box 1492, Washington, DC 20013. Excellent resource for free informational handouts on a variety of disabilities from learning disabilities, special education law, attention deficit disorder, developmental disabilities, etc.
6. National Register of Health Service Providers in Psychology. Washington, DC. (202) 833-2377.
7. Society for Behavioral Pediatrics. 241 East Gravers Lane, Philadelphia, PA 19118. (215) 248-9168.

Training:

1. Videotapes: Lavoie R. *How Difficult Can This Be?* (Learning disabilities simulation) (1990), Also *Learning Disabilities and Social Skills: Last one Picked, First One Picked On.* (1994) PBS video (703) 739-5380.
2. Videotape: National Center for Learning Disabilities. *We Can Learn: Understanding and helping children with learning disabilities.* (1991). NCLD (212) 687-7211. For professionals and parents providing basic information on LD, assessment process and legal rights.
3. Clinical Center for Learning and Development. University of North Carolina, Chapel Hill, NC., Melvin D. Levine, M.D., Director. (919) 929-1020. Courses available for health care professionals in primary care, mental health professionals and educators.
4. Meetings of AAP, CHADD, LDA, Society for Behavioral Pediatrics, Society for Developmental Pediatrics, Orton Dyslexia Society, American Psychological Association often have helpful lectures appropriate for primary care professionals.

Rating Scales and Questionnaires:

1. *ANSER* questionnaires and neurodevelopmental examination systems (PEET, *PEER*, *PEEX*, *PEERAMID*). Levine MD. Educators Publishing Service, Cambridge, MA (800) 225-5750.
2. *BAADS rating scale*. Brown TE. Dept. of Psychology, Yale University, PO Box 6694, Hamden, CT 06517.
3. *Childhood Attention Profile (CAP)* Edelbrock CS, *Home Situations Questionnaire (HSQ)*, *School Situations Questionnaire (SSQ)*, *Academic Performance Rating Scale (APRS)* DuPaul GJ. Forms and scoring with permission for reproduction contained in

Barkley RA. *Attention Deficit Hyperactivity Disorder: A Clinical Workbook*. New York, NY. Guilford Press:1991.

4. *Comprehensive Behavior Rating Scale for Children* (CBRSC) Neeper R, Lahey BB, Frick PJ. Psychological Corp. (800) 228-0752.
5. *Conner's Rating Scales*. Conners CK. Multi-Health Systems, 908 Niagara Falls Boulevard, North Tonawanda, NY 14120 (800) 456-3003
6. *Stony Brook Child Symptom Inventories: Parent and Teacher Checklist*. Screening instruments for childhood emotional and behavioral disorder. Gadow KD, Sprafkin J. Checkmate Plus, LTD., PO Box 696, Stony Brook, NY 11790

Texts:

1. Aylward GP. *Practitioner's Guide to Developmental and Psychological Testing*. (1994) Plenum Press, NY. (800) 782-5476.
2. Johnson, DD. *Physician-School Collaboration for the Student with Attention Difficulties: Handbook for Intervention*. (1991) Kids' Consults, TDS, 5070 Santa Fe Street, San Diego, CA 92108 (800) 642-1144.
3. Levine MD. *Developmental Variation and Learning Disorders*. (1987) Educators Publishing Service, Cambridge Mass. (800) 225-5750.
4. Levine MD. *Educational Care: A System for Understanding and Helping Children with Learning Problems at Home and in School*. 1994. Educators Publishing Service, Cambridge Mass. (800) 225-5750.
5. Wender, E, ed. *School Dysfunction in Children and Youth: The Role of the Primary Health Provider for Children Who Struggle in School*. Report of the 24th Ross Roundtable on Critical Approaches to Common Pediatric Problems. 1993. Ross Laboratories, Columbus, OH.

Booklets for Office:

1. American Academy of Pediatrics. *Learning Disabilities and Children: What Parents Need to Know*. (1989) Division of Publications, 141 Northwest Point Blvd, Elk Grove Village, IL, 60009. (800) 433-9016. \$25/100 (members)
2. American Academy of Pediatrics. *Understanding the ADHD Child: Information for Parents about Attention Deficit Hyperactivity Disorder*. (1994) 141 Northwest Point Blvd, Elk Grove Village, IL, 60009. (800) 433-9016. \$25/100 (members)

Books for Parents, Teachers and Children:

1. Anderson W, Chitwood S, Hayden D. *Negotiating the Special Education Maze, 2nd Ed*. Woodbine House, 1991, \$15. MD(1-800-843-7323). Step-by-step guide for parents with children with special needs.
2. Ingersoll, BF and Goldstein, S. *Attention Deficit Disorder and Learning Disabilities: Realities, Myths and Controversial Treatments*. 1994. \$13. Dell Reader Service, (800-223-6834).
3. Learning Disabilities Association. *Learning Disability Association Advocacy Manual*, 4156 Library Road, Pittsburgh, PA 15234, (412) 341-1515, \$5 + 10% shipping. Essential guide to LD and Special Ed. law.

4. Levine MD. *Keeping A Head in School: A Student's Book about Learning Abilities and Learning Disorders*. 1990. \$25 Educators Publishing Service, Cambridge Mass. (800) 225-5750. Easily understood explanation of learning and attention problems recommended for physicians, parents, teachers and secondary school students. Practical self-management tips.
5. McCarney SB, Bauer AM. *The Parent's Guide to Learning Disabilities: Helping your LD child succeed at home and school*. Hawthorne Educational Services, PO Box 7570, Columbia, Missouri 65205. (800) 874-1710. \$13. 1991. An good resource for families with specific, problem based interventions.
6. Tuttle CG, Paquette P. *Parenting a Child with A Learning Disability*. Doubleday Books.

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3. Dworkin PH. "School Failure". *Pediatr Rev* 10:301-312. 1989.
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8. Silver LB. "Introduction and overview to the clinical concepts of learning disabilities". *Child. Adoles. Psych. Clin. North Am.* 2:181-192. 1993.
9. *Journal of Child Neurology*, Vol 10, Supplement 1. January 1995. Entire supplement on learning disability issues.

Pediatric Problem Checklist

Karen J. Miller, M.D.

There are many reasons for a child to be having problems at home or at school. This questionnaire will help us understand your child's problems better and how we can help you and your child. Our staff will be happy to answer any questions. Thank you.

Child's name: _____ Age: _____ Sex: M / F Date: _____

Person completing form: _____ Relationship: _____

Home phone: _____ Work phone: _____

Briefly describe child's main problem: _____

What have you tried to do about this problem? _____

Please answer the following questions regarding your child:

Medical or Physical Problems	No	Yes
1. Any current health concerns or chronic medical problems?		
2. History of serious illness or injury? Many ear infections?		
3. Frequent complaints (headaches, stomachaches, etc.)?		
4. Any medications taken regularly?		
5. Any concerns about vision or hearing?		
6. Concerns about eating, sleeping or growth?		
7. Seems listless, hard to get going or easily tired?		
8. Overactive, restless, fidgety? Talks constantly?		
9. Wets bed or pants? Has accidents with bowel movements?		
10. Concerns about tobacco, drug or alcohol use?		
11. Concerns about physical or sexual abuse?		
12. Concerns about sexual activity?		
13. Any seizures or staring spells?		
14. Tics, nervous twitches or unusual movements?		
15. Clumsiness or poor coordination?		

Comments: _____

Speech or Language Problems	No	Yes
1. Mispronounces words, doesn't speak clearly or stutters?		
2. Concerns about voice (loud, hoarse, unusual quality)?		
3. Trouble understanding directions or needs repetition?		
4. Poor vocabulary or difficulty expressing ideas?		

Comments: _____

Academic or Task-Related Problems	No	Yes
1. Is in a special education class or has repeated a grade?		
2. Often absent, truant or avoids school?		
3. School grades poor, slipping or very inconsistent?		
4. Difficulty learning in school?		
5. Problems with remembering information consistently?		
6. Problems following directions?		
7. Is inattentive, easily distracted or daydreams often?		
8. Difficulty staying on task, completing homework or chores?		
9. Works too quickly or makes careless mistakes?		
10. Problems with handwriting or messy work?		
11. Works too slowly or has difficulty changing activities?		
12. Disorganized or forgetful?		
13. Easily frustrated or gives up too easily?		

Comments: _____

Behavioral or Emotional Problems	No	Yes
1. Problems getting along with other children?		
2. Acts like younger child, seems "immature"?		
3. Withdrawn, fearful or anxious?		
4. Moody, unhappy or has low self-esteem?		
5. Impulsive, acts without thinking, has poor self-control?		
6. Over-reacts, irritable or easily upset?		
7. Gets angry easily or has temper tantrums?		
8. Defiant, disrespectful or often argues with adults?		
9. Lies or takes things that do not belong to them?		
10. Is mean to others or is aggressive?		
11. Had a very upsetting experience (e.g. witnessed violence)?		
12. Family problems that may be bothering child?		

Comments: _____

Any other concerns about your child or his/her situation? _____

FOR OFFICE USE: Reviewed by: _____ Date: _____

Disposition: _____

A.B.E.A.M. Problem Solving Grid

DOMAIN		CASE 1	CASE 2	CASE 3
ATTENTIONAL:	Situational			
	Pervasive			
BEHAVIORAL:	School			
	Home			
EMOTIONAL:	Feelings			
	Relationships			
ACADEMIC:	IQ			
	Memory			
	Processing			
	Skills			
	Productivity			
MEDICAL:	Health			
	Motor			

Case 1

Diagnosis:

Management:

Case 2

Diagnosis:

Management:

Case 3

Diagnosis:

Management: