Guidelines for Psycho-Educational Assessment of Emotional Disturbance in Children and Adolescents, Revised

W04 / CASP

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W-04: Psycho-Educational Assessment of Complex Cases of Emotional Disturbance: A Case Study Approach

CASP / 2017

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Interviewing Children and Adolescents: Questions for Establishing Rapport, Obtaining Information, and Conducting a Mental Status Examination (MSE)

The following questions should be asked in a friendly and relaxed, yet professional manner. They should be adjusted to the child's or adolescent's level of development and maturity and may be shortened, simplified, or expanded upon as needed. Vary open and closed ended questions. Carefully observe their appearance, receptive and expressive language, verbal and nonverbal communication styles, affect and mood, maturity, levels of attention, eye contact, trust, cognitive and developmental level, memory, thought content and process, motor activity, judgment and insight as appropriate, and ease or difficulty in establishing and maintaining rapport.

Not all of these questions need to be asked of every child, but the general areas should be noted and comparisons made between statements made by the child, their parents and teachers, and the information contained in the school records or cum. Discrepancies need to be clarified. The preceding general areas for observation and mental status assessment continue throughout the testing process and usually only require 15-30 minutes for most typical children, although those with more severe disturbances will take much longer.

Pay careful attention to how you, the interviewer/examiner, feel during and after the interview as well (counter-transference). Your own reactions may provide powerful clues that may lead to valuable insights to be later explored during therapeutic interventions, or during more formal diagnostic assessment and testing.

1. Hello, my name is _____, what's your name? (kneel to their level if necessary)
2. Nice to meet you. I'm the school psychologist / counselor / therapist. Do you know why you are here?
3. Well, I work with children who are having some problems in school like having trouble in subjects or in classes like reading, writing, or math, or who are having problems getting along with others, or in just feeling ok about things. Your (parent, teacher) asked me to talk with you to see if I could help you (learn better, or feel better, or do better in _____, improve _____). Would you like to do better in _____ or in school?
4. Ok, I'll do everything I can to help you. First though, I'd like to find out a little more about you. How old are you? What grade are you in?
5. Who do you live with? (Depending on answer) Do you live with both of your parents?
6. What language do your parents speak? What language do you speak at home? Do you speak any other languages besides English? What was the first language you learned to speak? What language do you think you speak or understand the best?
7. If appropriate: Where were you born? When did you come to this country? Or, how long have you lived here? How was it when you lived in _____? Did you like it there? Here?
8. What does your (mother, father, other caregiver) do during the day? Do they work outside of the home? If one parent does not live at home: Where is your mother/father?
9. How do you get along with your mother/father/other caregiver? How would you describe your mother and father, tell me little bit about them. Which parent do you feel closest to? How are you disciplined at home, and who does the disciplining?
10. Who else lives in your house? Do you have any brothers or sisters? How old are they?

11. How do you get along with your brothers/sisters? What do you like to do with them? Is there anything you really don't like so much about them?
12. How are you doing in school? Which subject(s) do you do well in? Do you like school?
13. What subject do you like best in school? What's hard for you? What's hard about it? What subject(s) don't you like and why? Have you ever attended any other schools? If so how many, which ones, and which grades?
14. How is your attention in school? Is it hard for you to pay attention to the teacher? How about your memory? Are you better at remembering what you hear or what you see?
15. How is your reading, how about your writing, spelling, and math? What do you know how to do in math, what are you learning now? What kinds of things do you like to read? Do you have homework to do after school? How hard is it for you to do? Who helps you with your homework?
16. What do you think would help you do better in school? Has anything ever helped you do better? When you don't understand something do you ask for help?
17. When you're not in school, what do you like to do for fun? Any hobbies, sports, games or other activities you really like to do? Are you in any clubs? Play music or do art?
18. How do you get along with the other kids at school? Ever get teased or bullied?
19. Do you have any friends at school? Who are your friends? What do you like to do with your friends? Do you have any friends outside of school, like near where you live? Any old friends from where you lived before (if applicable)? Do you have any other relatives who you see or who live near you? How often do you see them?
20. How do you feel most of the time? Do you ever feel scared, angry (mad), lonely, or sad? How often and how much? On a scale of 1 to 10 with 10 being the worst you can imagine feeling, how do you feel most of the time (SUDS: Subjective Units of Disturbance Scales)? Do you feel this way at school, at home, or at both places? (*NOTE: if significant depressive states are reported conduct a suicide assessment)*
21. What do you like the most about yourself? What do you like the least, or what would you change about yourself if you could? Anything else that bothers or upsets you? If you could have three wishes come true, what would they be (Three Wishes Scale)?
22. Do you ever get in trouble at school? Ever sent to the office, suspended? Do you ever get into fights? If appropriate, have you ever been arrested? Circumstances?
23. How's your attendance in school? Are you absent a lot? If so, why?
24. How's your health? Are you sick often, why? What diseases have you had and when? Any accidents, head injuries, allergies, medications? Have to see the doctor often, any history of hospitalizations, if so when and for what conditions? Ever seen a counselor or psychologist? If so when, for what, outcome?
25. How is vision and hearing? Do you wear glasses or are you supposed to wear them?
26. How is your appetite, do you like to eat? Do you eat breakfast, lunch, dinner?

27. How is your sleeping at night? What time do you go to bed, what time do you get up? When you sleep at night, do you sleep all night, how long does it take you to get to sleep, do you wake up at night? Any dreams, nightmares? Any problems with bedwetting? (For younger children, ask their parents these questions)
28. What do you want to do when you are out of school, or when you grow up? What kind of job or career would you like to have? Do you know anyone who does _____ (that kind of work)?
29. Is there anything thing else you would like to talk about, or ask me questions about, or is there anything else you think I should know about you?

30. ***Do you like to draw? At this point, I generally begin the formal testing by presenting the child or adolescent with a piece of paper and a pencil (with an eraser) and present the child with the Bender Visual-Motor Gestalt Test-II (Bender Gestalt), first direct copy, followed by immediate recall. Any of the previous questions or areas which seem potentially problematic may lead to additional interviewing or follow up, at a later date.***

Additional Points

1. Allowing the child to play with games or toys either alone or with you is also often revealing of patterns of interaction, play, socialization, behaviors, affect, and more.

2. Follow-up and/or precede the above interview with parent(s) interviews, and a parent-child interview together to be able to observe parent-child and family dynamics. Attempt to resolve any inconsistencies between the information obtained during the parent(s) interview and the child interview. Be sure to check available school, clinic, hospital, court, and probation, medical or other records as well. Synthesize all available information in arriving at a tentative diagnostic formulation, understanding that this may be subject to further changes and modification as more information becomes available.

3. Remember: Not all of the above questions need to be asked of every child, and not all within the same session. Follow the child's leads and your own intuition and observations. Maintain a stance of respectful curiosity towards the child or adolescent and word your inquiries in a developmentally appropriate manner.

4. Pay attention to matters of socio-cultural sensitivity and seek assistance or consultation when necessary.

5. Observation of the child in multiple environments is crucial, paying attention to systemic and relational factors with peers, adults, and family members.

MENTAL STATUS EXAMINATION: CHILDREN

1. Physical Appearance

Size, stature, head size, bruising, nutritional state, level of anxiety, attention span, gait, dress, grooming, mannerism, mania or psychomotor retardation, disheveled.

2. Separation

Ease of separation from parent: too much ease, difficulty with separation, degree of dependency

3. Manner of Relating

Cautious, indiscriminate friendliness, shallow relating, degree of eye contact, level of cooperation or opposition, trust

4. Orientation: Time, Place, Person

Impairment in these areas may indicate organic brain factors, low intelligence, severe anxiety, or a thought disorder.

5. Language & Speech

Articulation, expressive and receptive vocabulary, speech volume, pressured speech, mutism, slowness, or speech or long pauses, echolalia, preservation, clanging, neologism, or general incoherence

6. Intellectual Level

General vocabulary appropriateness, responsiveness, level of comprehension and curiosity, Orientation to person, time, place, purpose; memory (recent & remote), general information; if older, what is their capacity for abstract thought vs. concrete thinking?

7. Memory

By age 8, normal children can repeat 5 digits forward and at least 2 or 3 backward. By age 10, most can repeat 6 forward and 4 backward. Minor difficulties may reflect anxiety; very poor performance may indicate learning disabilities in auditory processing, intellectual disability, or other neurological disorders.

8. Though Content and Process; Perceptual Disturbances

- **Process:** concentration, attention, loosening of association, flight or ideas, circumstantiality, tangential, obsessions, thought blocking, distractibility
- **Content:** delusions (grandiose, persecution/paranoia, somatic nihilistic, religious, of being controlled), ideas of reference, thought insertion, thought broadcast, thought withdrawal
- **Hallucinations:** auditory, visual, olfactory, tactile, magical thinking, depersonalization, de-realization

9. Emotional Expression

- **Mood:** cheerful, sad, anxious, depressed, euphoric, apathetic, somber, irritable, guilty, angry, ambivalent
- **Affect:** appropriate, broad, labile, expansive, inappropriate, constricted, blunted, flat, mood swings

10. Judgment and Insight

- **Intact or Impaired:** minimal, moderate, severe

- **Judgment:** awareness of the consequences of intended behavior
- **Insight:** self-understanding
  To what degree does the child understand themselves, and their problems?
  What do they think might help?

11. <u>Behavioral Disturbances (present or absent)</u>

- **Aggressive:** violent, destructive, poor impulse control, easily frustrated, inappropriate anger, antisocial, demanding, manipulative, oppositional, fights, detention, suspension history.
- **Passive:** unmotivated, isolated, withdrawn, avoidant
- **Maturity:** mature, immature, inappropriately childish, regressed
- **Self-esteem:** appropriate, inappropriate, high, low ("I can't do that", "I'm no good at that", "I can't do anything right", etc.)

12. <u>Health, Sleep, and Appetite</u>

- **Health:** appearance, history, of illness, & frequency, allergies, medications, accidents, head injuries, hospitalizations, energy level, vision, hearing, wears glasses/contacts, concerns
- **Sleep:** how much, sleep disturbance, nightmares, night terrors, sleep walking, insomnia
- **Appetite:** normal, over or under eating, eating disorders, anorexia, bulimia, weight/appetite change. Any history of enuresis or encopresis? Outcome?

13. <u>Suicidal or Homicidal Ideation</u>

- **Suicidal:** degree/length of depression, suicidal ideation, plan, method, opportunity, prior attempts or gestures, any self-mutilations, family history of suicide, current stressors, coping ability, presence of hallucinations especially auditory command hallucinations. **NOTE:** If the combination of suicidal ideation, depression, a thought disorder and poor impulse control is present especially if drugs or alcohol are involved, consider immediate hospitalization.

- **Homicidal:** assess ideation, plan, means, intensity, history of violence, coping skills, anger management

  NOTE: If there is an active threat towards a specific person, Tarasoff decision requires notification of intended victim(s) and appropriate authorities.

Suicide Assessment for Children & Adolescents

The Suicide Assessment is one component of the **Mental Status Examination (MSE).** At times during the MSE, you may notice some combination of the following in response to your questions and observations of the student.

1. The student appears to be or states they have been depressed.
2. The student has described a number of stressful events in their life.
3. The student appears to lack adaptive coping skills and appears to be easily frustrated or overwhelmed.
4. The student has a history of substance use or abuse.
5. Combinations of the above.

If some of the above are present, especially if the student appears to be sad and depressed, then ask the following questions in an empathic voice using soothing, concerned tones and attentive non-verbal body positioning:

A. Exploration (adjust for age & developmental level, paying attention to diversity and social-cultural variables)

1. "I'm so sorry to hear that you've been feeling so (sad, depressed, stressed out, overwhelmed, etc.)
2. I know that **some** students when they feel that way also start to feel other things too. Sometimes they feel so bad they even begin to think about hurting or even killing themselves. Have you ever thought about that?"
3. If they say yes, but that they'd never actually do anything like that, it's a good sign and you can go on to discuss ways to help them with better coping mechanisms, family and peer support systems, stress reduction and stress management skills, and offer some counseling resources.
4. If they just say yes, then gently begin to explore the degree and nature of their suicidal ideation as follows:
   a. "Oh, I'm sorry you've been feeling that way and thinking those thoughts, but I'm happy that you told me and I'm going to try my best to help you feel better."
   b. "How long have you been having these thoughts?" Find out if their depression is situational or chronic. If chronic is it related to stressors in their life, or does it just seem to have come out of nowhere? Is there a family history of depression?
   c. "When you have these thoughts, what have you thought about doing to yourself?"
   d. "Have you ever begun to actually plan to hurt or kill yourself? If so when and how often do you get these thoughts?" Also, "Have you ever cut or carved on your skin?"
   e. "Do you have the (pills, gun, rope, knife, etc) now to do this? If so, where are they?"

   f. "Right now or lately, on a scale of 1 to 10 with 10 being the worst, how strong are your negative feelings or thoughts?" (This is the **SUDS** or **Subjective Units of Disturbance Scale**). Also determine if they have symptoms of mania at times and might have bipolar disorder.
   g. "What has kept you from trying to hurt or kill yourself? (explore internal/external strengths and resources)
   h. Or if they have had an attempt: "When was the last time you tried? What did you do? What was the result? Did you tell anyone else? (Note: sometimes they've told another dysfunctional youth and you may pick up another possible case here!). Other times you'll identify a good resource person as part of their support network.
   i. Explore whether or not they've been using drugs or alcohol to self-medicate.

j. Say, especially if their depression has been especially severe: "I'm so sorry you've been feeling so stressed (or sad, or overwhelmed, etc). You know, **some** students when they feel that bad have some other things start to happen to them. They start to hear voices talking to them in their head or sounds that other people can't hear. Has this ever happened to you?"
k. If so, explore when, how often, under what circumstances, what exactly the voices are saying, and how they feel about these voices (scared, excited, angry, weaker, etc).
l. Explore if they have any kind of social supports system (friends, parents, relatives, therapists, mentors, etc.)
m. Explore if they have a family history of suicidal ideation, attempts, or actual deaths.
n. Finally, let them know that you appreciate their disclosure of this sensitive information to you and that you are going to help them. Now you have some decisions to make.

B. Actions to Take

1. Notify their parents (no matter what the student says, this is not information you can ever keep secret!); notify your supervisor, school administrators, school or district mental health team, etc as needed. Find out in advance your school district's policies and procedures to be followed in these cases.

2. If the threat is just mild ideation, but without a plan, means, prior attempts, etc., refer the student to counseling resources with you or another school or community professional. They may have a family health care plan that provides for mental health services or you might be able to provide them with community referrals. Get a release so you can communicate with their therapist and follow-up with the student and their family.

3. If the threat is moderate with more severe stressors, poorer coping skills, or they have means available or a plan, more serious action is required. After discussion with the parents (and your supervisor or colleagues), get them immediate counseling or psychotherapeutic help, have the parents remove all potential weapons from the home, and make sure the student has someone with them all of the time. Follow up on a frequent basis to remain informed and to provide suggestions as needed. Get a release so you can communicate with their therapist. Consider a psychiatric referral for a medication evaluation.

4. If the threat is severe (high SUDS, has immediate plans for self-harm, weapons or means available, long or severe history of depression, family history of mental illness or depression or suicide attempts, use of drugs or alcohol, auditory hallucinations, high levels of impulsivity with poor coping skills and low frustration tolerance) then consider immediate hospitalization. Definitely refer for a psychiatric and medication evaluation. Actions you might consider include the following:

    a. Call the parents and see if they can transport to a hospital with a child or adolescent psychiatric unit.
    b. Call the local or county Psychiatric Emergency Team (PET) for an evaluation for a possible 5150 involuntary hospitalization.
    c. Or call the police for a 5150 involuntary hospitalization. Find out which hospital they are taking the student to. Be sure to inform the parents if they have not been located and informed yet.
    d. Get a release so you can communicate with their therapist.
    e. For any of these, be sure to discuss with your supervisor, obtain consultation or supervision as needed, and be attentive to your own self-care as these events are highly stressful and you may well need to debrief and obtain some emotional supports yourself. If you are triggered due to some unresolved issues in your life or past, seek psychotherapeutic help for yourself.

f. Obtain referrals for the family so they can obtain any needed therapeutic supports as well.
g. Follow up on a frequent basis to remain informed and to provide suggestions as needed.
h. If at all possible, go visit the child while in the hospital to maintain contact and support, and to begin to help coordinate after-care with the hospital team and parents.

5. Continue to educate yourself about depression, suicide prevention, and crisis intervention to sharpen your skills in assessment, diagnosis, treatment, and referral resources in the community. Be familiar with the diagnostic guidelines in the DSM-5 (APA, 2013).

6. Be sure to monitor your own feelings and counter-transference while interacting with the child. You may often gain valuable insights form how your interaction with the child makes you feel and derive clues from this dynamic interaction.

7. For all levels of assessment and intervention, be sure to **document** everything you considered and did, with clinical justification clearly explained. Remember, in court, the best defense is always good documentation!

Adult Mental Status Examination (MSE)

LA County DMH

(Circle Responses and Elaborate Significant Issues)

GENERAL DESCRIPTION OF PATIENT:

Hygiene/Grooming: Well Groomed; Dirty, Disheveled, Odorous, Bizarre:
Specify_____
Eye Contact: Appropriate; Little, Erratic, None,
Other_____
Motor Activity: Calm; Catatonic, Intellectual Disability, Rigid; Hyperactive, Agitated;
Tremors/Tics, Muscle Spasms. Other Abnormal
Movements; Posturing, E.P.S.,
Specify_____
Speech: Normal; Incoherent; Mute, Soft, Delayed, Slowed; Excessive, Pressured, Loud, Slurred.
Stuttering: Perseverating, Poverty of Content:
Specify_____

SENSORIUM AND INTELLECTUAL FUNCTIONING:

Orientation: Oriented; Disoriented: Time, Place, Person Purpose:
Specify_____
Memory: Unimpaired; Impaired: (immediate, recent, remote, amnesia)
Specify_____
Intellectual: Vocabulary Poor, Paucity of Knowledge;
Other/Specify_____

MOOD AND AFFECT:

Mood: Euthymic, Depressed (hopeless, worthless), Anxious: Unknown stressor, known
Stressor; Euphoric, Irritable,
Other/Specify_____
Affect: Appropriate; Labile, Expansive, Constricted, Blunted, Flat:
Specify_____

PERCEPTUAL DISTURBANCES: None apparent

Hallucinations: Auditory (command), Visual, tactile
Other_____Describe_____
Illusions:
Specify_____
Self-Perceptions: Depersonalization/Derealization,
Comment_____

THOUGHT PROCESS DISTURBANCES

Associations: Goal Directed; Loose, Circumstantial, Tangential, Confabulations, Flight of Ideas
Concentration: Intact; Impaired: (Minimal, Moderate, Severe), Rumination, Thought Blocking, Fragmented, Abstraction: Intact; Concrete
Judgment: Intact; Impaired: (minimal, moderate, severe)
Comments_____
_____

THOUGHT CONTENT DISTURBANCES: None apparent

Delusions: Grandiose, Persecutory/Paranoid, Somatic, Religious, Nihilistic
Other/Specify_____
_____

Ideations: Bizarre, Phobic, Suspicious, Persecuted, Irrational & Excessive Worry, Excessive/Inappropriate Religiosity, Excessive/Inappropriate Guilt.
Specify_____
_____

BEHAVIORAL DISTURBANCES

Aggressive: Violent/destructive, Self-Destructive, Poor Impulse Control, Manipulative, Excessive/Inappropriate, Anger/Hostility, Antisocial, Uncooperative, Demanding, Demeaning,
Suicidal/Homicidal: Denies, Ideation only, Threatening, Plan, Past attempts
Specify_____
_____

Passive: A-motivational, Isolated/Withdrawn, Avoidance, Evasive,
Other_____
Disorganized/Bizarre, Compulsive/Ritualistic, Silly, Excessive/Inappropriate Crying,
Specify_____
_____

PHYSICAL MANIFESTATIONS OF PSYCHIATRIC ILLNESSES: None apparent

Frequent Somatic Complaints, Sleep Dysfunction, Sexual Dysfunction, Weight/Appetite Change,
Other/Specify_____
_____

SIGNATURE_____

DISCIPLINE_____

DATE_____

EMOTIONAL DISTURBANCE CRITERIA (IDEIA)

I. **Note that the descriptions include, but are not limited to the typical behaviors indicative of the condition and that a student may display behaviors typical of one or more of the five basic characteristics. In addition to the five categories named in the Education Criteria, Schizophrenia is a specific named disorder, which also qualifies. All of the categories must also meet the following set of three limiting criteria:**

A. <u>An Inability to Learn Which Cannot be Explained by Intellectual, Sensory or Health Factors</u>

An inability to learn may be attributed to a severe emotional disturbance in the learning process affecting reasoning, memory and the awareness of reality. The student may evidence (1) hallucinations, or delusions, (2) incoherence or lack of the ability to make logical associations, and (3) conversation and/or response not logically related to the context of the discussion.

B. <u>An Inability to Build or Maintain Satisfactory Interpersonal Relationships with Peers and Teachers</u>

An inability to build or maintain satisfactory interpersonal relationships with peers and teachers and other adults may be evidenced by either (1) social isolation or (2) aggressive behaviors.

Behavior indicative of social isolation may include (1) lack of friends at home, at school, or in the community, (2) no observable voluntary play socializing or engaging in recreational activities with others, (3) lack of acceptance by peers in spite of attempts to relate, and (4) communication avoidance and/or extreme fear when with adults and peers.

Aggressive behaviors may be evidenced by (1) impulsive and uncontrollable verbal and/or property, and (2) over-reactive explosive temper tantrums or rage, especially in unprovoked situations.

C. <u>Inappropriate Types of Behavior and Feelings Under Normal Circumstances</u>

Inappropriate types of behavior, feelings and affect under normal circumstances may include (1) catastrophic reactions to everyday occurrences, (2) lack of appropriate fear reactions, (3) flat, blunted, distorted or excessive affect, (4) bizarre behaviors, (5) extreme mood lability, and (6) denial of reality.

D. <u>A General Pervasive Mood of Unhappiness or Depression</u>

Behaviors indicates of a general pervasive mood or unhappiness or depression for a significant period of time may include (1) significant change in the appetite or weight, (2) insomnia or hypersomnia, (3) psychomotor agitation or lethargy, (4) feelings of worthlessness, self-reproach and a threat of suicide, and/or (5) recurrent thoughts of death and/or suicide attempts. A threat of suicide or an attempt at suicide may or may not, in and of itself, be evidence of a serious emotionally disturbed condition.

E. <u>A Tendency to Develop Physical Symptoms or Fears Associated With Personal or School Problems</u>

Physical symptoms may include (1) physical disorder with no demonstrative organic findings and (2) symptoms with positive evidence or a strong presumption of a relation to psychological factors.

Fears may be evidenced by resistance or refusal to become socially involved and may include (1) persistent and irrational fear of a specific object, activity or situation that results in compulsive avoidance, (2) intense, disabling anxiety often reaching panic proportions, and (3) extreme separation anxiety.

II. Differentiation between socially maladjusted and seriously emotionally disturbed.

When it is appropriate to differentiate between the socially maladjusted and the emotionally disturbed, the following guidelines are provided to assist the IEP team in making the differentiation. The IEP team shall note that IDEIA states that a socially maladjusted student is not an individual with exceptional needs unless **also** identified as emotionally disturbed. **(NOTE: Yes, they can be both!)**

A. The socially maladjusted student typically exhibits a voluntary pattern of actions and an ability to control his/her behavior. In contrast, the behavior of the emotionally disturbed student appears involuntary and lacks apparent self-control.

B. The socially maladjusted student typically is in conflict with established value systems whereas the seriously emotionally disturbed student gives evidence of inner tensions and anxieties, i.e., intrapsychic disturbances.

C. The socially maladjusted student usually can adapt his/her behavior, and the behavior provides a source of personal reinforcement.

C. In the education setting, the socially maladjusted student does not value academic achievement and is frequently truant and/or rebellious; however he/she usually demonstrates the ability to function in the school and/or community although not according to the generally accepted standards.

E. Indicative behaviors of social maladjustment may include:

1. Reactions characterized by an appropriate affect and positive response to environmental change.
2. Disruptive behavior demonstrated only in certain circumstances, at certain times and only in relation to certain individuals. The disruptive behavior is often acceptable by some standards. There appears to be a more voluntary component to their behaviors.
3. New DSM-5 Descriptors for Disruptive, Impulse Control, and Conduct Disorders for ODD (Oppositional Defiant Disorder) with three symptom clusters:
    - Angry/Irritable
    - Argumentative /Defiant
    - Vindictiveness

4. Conduct Disorder

- Can be a developmental outcome of ODD

5. **Intermittent Explosive Disorder**: Broaden criteria, impact issues, impulse and anger based; Impulsive aggressiveness, grossly out of proportion to any precipitating psychosocial stressor

6. Evidence-Based Treatments for Disruptive Behavior:

- Parent Training
- Social Skills Training
- Cognitive Behavior Therapy
- Assertiveness Training
- Communication Skills
- Anger Management
- Relaxation Training

EDUCATION CRITERIA FOR ED ELIGIBILITY

In addition to the five categories named in the Education Criteria, Schizophrenia is a specific named disorder, which also qualifies. All of the categories must also meet the following set of three limiting criteria:

1. Over a long period of time

This is generally considered to be at least six months in length. During this period of time, there should be behavioral, educational or other types of interventions to determine if the behavior or emotional condition can be improved without more restrictive measures.

2. To a marked degree

Both of the components of this criterion must be met.

A. Pervasiveness: The child should exhibit the behavior in question in virtually all settings: home, school and community.

B. Intensity: The behaviors in question should be overt, acute, and observable. The behaviors must be severe enough to produce significant distress.

3. Adversely affects education performance

The behaviors in question must be demonstrated to occur in the school setting and result in a disruption of the pupils' ability to benefit from academic instruction.

BEHAVIORAL CHARACTERISTICS OF SED

The following behavioral characteristics were identified by LEAs participating in the DSNHC-SC survey project as comprising evidence of serious emotional disturbances. In most cases, these characteristics were not broken down by legal category. The list below arbitrarily places LEA-identified behaviors into the five SED categories, which appeared most appropriate to DSNHC-SC staff when reviewing the data.

It should, of course, be kept in mind that the child could be validly classified as SED. It should be remembered that only "clusters" of behaviors, taken into consideration with other assessment variables and sources of information, can provide valid information in this regard.

The California Association of School Psychologists (1984) undertook a more limited selection of behavioral characteristics from 24 LEAs. Using only descriptors that fell above a certain criterion score (number of LEAs who identified that descriptor), the CASP project was able to identify a number of specific descriptors that they felt validly operationalized five SED legal categories. The descriptors identified by the CASP project are identified by an asterisk (*) next to the descriptors listed below.

No claim is made as to the validly of the behaviors listed below, and it should be noted that there is often unclear discrimination among listed behaviors. However, no descriptor was listed unless at least five LEAs identified the same or similar descriptors as comprising evidence of a serious emotional disturbance.

1. An Inability to Learn That Cannot Be Explained by Intellectual, Sensory or Health Factors Include:

- Failure on classroom tests or quizzes
- May appear intellectually impaired (IQ variable)
- May have superior skills in some areas but no apparent application
- May be at any level of achievement
- Performs daily academic tasks or homework at a failing level
- Academic achievement lover than the instructional range for students appropriate age and grade
- Failure to (or refusal to) complete class assignments or homework
- Demonstrates difficulty (or reluctance) in beginning academic tasks
- Tends to refuse any activity that appears difficult
- Reduced productivity across all academic tasks
- Variable academic success- may do poorly in one area but perform well in another

2. An Inability To Build or Maintain Satisfactory Relationships With Peers and Teachers.

***** Has no friends in home, school or community settings
***** Is extremely fearful of teachers and peers
***** Avoids communicating with teachers and peers
***** Does not play, socialize, initiate or engage in recreation with others
***** Avoidance of others or severely withdrawn behaviors

- Incapable of maintaining interactive behaviors with others
- Avoids interactions with students or teachers
- Views others as objects
- Fails to participate verbally or physically in groups situations
- Unresponsive to and unrelated to people

- Pervasive social problems in home and school settings
- Peer relationships short-lived, anxiety-provoking and even chaotic
- Has difficulty in establishing and/or maintaining group membership
- Peers often alienated by intensity of child's need for attention
- Conflict and tension in almost all social relationships
- Forms rapid, intense, engulfing relationships

3. Inappropriate Feelings or Behaviors under Normal Circumstances

***** Catastrophic reactions to everyday occurrences
***** Extreme mood lability
***** Lack of appropriate fear reactions
***** Unexplained rage reactions or explosive, unpredictable behavior
***** Flat, blunted, distorted or excessive affect
***** Manic behavior
***** Inappropriate affect, (e.g., laughing, crying or displaying anger or fear in inappropriate ways)
***** Peculiar posturing
***** Bizarre ideas or statement
***** Belief that other are conspiring against the student
***** Hallucinations (auditory or visual)
***** Delusional thinking (e.g., feelings of being controlled, thought broadcasting, persecutory ideas, etc.)

- Demonstrates sudden or dramatic mood changes
- Demonstrates behaviors not related to immediate situations (e.g., laughs or cries without provocation)
- Has unrealistic plans for self
- Excessive or inappropriate feelings of doubt or guilt
- Repetitive, ritualistic, stereotyped motions
- Distorted use of body or bodily parts
- Marked illogical thinking, incoherence, loosening of associations or magical thinking
- Disorientation in time and place
- Lack of contact with reality
- Excessive or unnecessary body movements
- Involuntary physical reactions
- Self-stimulatory behaviors
- Non-human quality to actions or behaviors
- Habitual confusion
- Reality sense is distorted without regard to self-interest
- Inability to adapt or to modify behaviors to different situations

4. General Pervasive Mood of Unhappiness or Depression

***** Fails to demonstrate an interest in special event or interesting activities
***** Loss of interest in usual activities
***** Prominent and persistent feelings of depression, hopelessness, sadness or irritability'
***** Insomnia or hypersomnia
***** Excessive fatigue or loss of energy
***** Poor appetite or significant weight loss
***** Feelings of poor self-worth

***** Exhibits unwarranted self-blame or self-criticism
***** Inadequate self-concept (e.g., blames self for inadequacies, real or imagined)
***** Engages in self-destructive behavior
***** Recurrent thoughts of death or suicide
- Fails to demonstrate a sense of humor when appropriate
- Makes verbal statements of unhappiness or depression
- Lack of capacity for pleasure
- Rarely experiences truly satisfied feelings
- Has trouble giving or receiving affection
- Outbursts of over-activity

5. Tendency to Develop Physical Symptoms or Fears Associated With Personal or School Problems

***** Physical symptoms without organic findings
***** Persistent irrational fears resulting in avoidance of a specific object
- Panic reactions
- Complains of physical discomfort
- Child is intensely and generally anxious and fearful

Participating LEAs also identified the following behaviors (which appeared more indicative of behavioral disturbance than serious emotional disturbance) as characteristic of a serious emotional disturbance. However, it should be remembered that such behavioral indicators may be reflective of internal distress, and further evaluation and assessment should be undertaken to determine whether a serious emotional disturbance is in fact present.

Emotional Disturbance and the DSM

ED/IDEIA	DSM Mental Disorders
Category 1: An inability to learn which cannot be explained by intellectual, sensory or, health factors.	1. Schizophrenia 2. Schizotypal 3. Dissociative Disorders: - Fugue - Dissociative Identity Disorder 4. Schizoaffective Disorder
Category 2: An inability to maintain satisfactory interpersonal relationships with peers and teachers.	1. Schizophrenia 2. Schizotypal Personality Disorder (or traits) 3. Major Affective Disorders 4. Dissociative Identity Disorder - (Previously Multiple Personality Disorder) 5. Anxiety Disorders: - Phobias 6. Anxiety Disorder of Childhood or Adolescence: - Avoidant Disorder or traits 7. Reactive Attachment Disorder
Category 3: Inappropriate types of behavior or feelings under normal circumstances.	1. Schizophrenia 2. Reactive Attachment Disorder 3. Schizotypal Personality Disorder or traits 4. Schizoaffective Disorder 5. Major Affective Disorders 6. Paranoid Disorders or traits 7. Reactive Attachment Disorder 8. Intermittent Explosive Disorder
Category 4: A general pervasive mood of unhappiness or depression.	1. Major Depressive Disorder 2. Somatic Disorders with depressed mood
Category 5: A tendency to develop physical symptoms or fears associated with personal or school problems.	1. Anxiety Disorders of Childhood or Adolescence 2. Somatic Disorders 3. Feeding and Eating Disorders
Non-categorical: Socially Maladjusted Other Behavioral/Emotional Disorders	1. Conduct Disorder 2. Oppositional Defiant Disorder 3. Adjustment Disorders 4. Personality Disorder – Antisocial

NOTE: Since the medical and educational teams use different languages, help them translate!

APPENDIX:
PSYCHO-EDUCATIONAL PROCEDURES FOR ED ASSESSMENT

A. Procedures

Cum record reviews, health, attendance, & discipline record reviews, work samples, student study team (SST)

Interview with teacher(s), including former teachers, administrators, nurse

Interview with parent, family members

Interview with pupil

Review of medical history, including past family psychiatric history, developmental milestones

Observations of pupil in classroom (direct teaching, independent learning, peer learning group, transitions, on yard, at lunch or recess, possibly at home

Consultation with relevant professionals: physician, MFT, social worker, psychologist (clinical)

Refer for additional assessments as necessary: speech and language, adaptive physical education (APE), occupational therapy (OT), health/medical, etc.

B. Psycho-Diagnostic Testing

Cognitive: Wechsler Scales: (WPPSI-IV, WISC-V, WAIS-IV, WNV), K-ABC-II, Woodcock-Johnson Test of Cognition-IV (W-J-IV/C), Stanford Binet Intelligence Scales-5 (SB-5), Differential Ability Scales-II (DAS-II), Cognitive Assessment System-2 (CAS-2), Comprehensive Test of Nonverbal Intelligence-2, (C-TONI-2), Leiter International Performance Scale-3, Universal Nonverbal Intelligence Test (UNIT), Raven's Progressive Matrices etc. Southern California Ordinal Scale of Development, Developmental Scale of Cognition (SCOSD), Piagetian Tasks, etc.

Adaptive Behavior: Vineland-II (Interview & Classroom Eds.), Adaptive Behv. Inventory for Children (ABIC), Adaptive Behavior Assessment Scales-3 (ABAS-3), Scales of Independent Behavior-R (SIB-R), Woodcock-Johnson Battery, Part IV, etc.

Psychological Processing: Bender Visual-Motor Gestalt Test-II (copy & recall), Beery-Buktenica Test of Visual-Motor Integration-6 (VMI-6), Test of Auditory Processing Skills-3 (TAPS-3), Test of Visual-Perceptual Skills-3, (TVPS-3), Children's Auditory Verbal Learning Test-2 (CAVLT-2), Children's Memory Scale (CMS), Wide Range Assessment of Memory and Learning-2 (WRAML-2), California Verbal learning Test, Children's Version (CVLT-C), Motor-Free Visual perception Test-3 (MVPT-3), Rey Complex Figure Test (CFT), etc.

Neuropsychological Processing and Executive Functioning: Stroop Color and Word Test for Children, Children's Colored Trails (CCT), Behavior Rating Inventory of Executive Function (Parent, Teacher, Self-Report, Adult versions), NEPSY-II, Delis-Kaplan Executive Function System (D-KEFS), WISC-V Integrated, Extended Complex Figure Test (ECFT), etc.

Speech/Language: PPVT-4, Woodcock Language Proficiency-Revised (English & Spanish), Boehm Test of Basic Concepts-3, Clinical Evaluation Language Functioning-Screening (CELF-4 Screening), ROWPVT, EOWPVT, etc.

Academic: Woodcock-Johnson Achievement-4 WJ-4/A), Kaufman Test of Educational Achievement-3 (K-TEA-3), Wechsler Individual Achievement Test-3 (WIAT-3), Key Math-3, Test of Written Lsanguage-4 (TOWL-4), Brigance Diagnostic Inventory, Woodcock Reading Mastery-3, Wide Range Achievement Test-4 (WRAT-4), etc.

Autism Spectrum: Autism Diagnostic Observation Schedule-2 (ADOS-2), Gilliam Autism Rating Scale-3 (GARS-3), Childhood Autism Rating Scale-2 (CARS-2), etc.

SOCIAL – EMOTIONAL AND BEHAVIORAL FUNCTIONING TESTS

A. Objective Tests

1. Conner's Comprehensive Behavior Rating Scales & Conner's-3
2. Child Behavior Checklist (CBC)
3. Vineland Adaptive Behavior: Maladaptive Behavior subtest
4. Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A)
5. Personality Inventory for Children-2 (PIC-2)
6. Personality Inventory for Youth (PIY)
7. Children Depression Inventory-2 (CDI-2)
8. Beck Depression Inventory-II (BDI-II)
9. Beck Youth Inventories-II (BYI-II)
10. Reynolds Adolescent Depression Scale-2 (RADS-2)
11. Revised Children's Manifest Anxiety Scale-2 (RCMAS-2)
12. Forer Structured Sentence Completion Test
13. Pre-Referral Checklist
14. Burk's Behavior Rating Scales-2 (BBRS-2)
15. Behavior Evaluation Scale-2 (BES-2)
16. Rotter Incomplete Sentences Blank
17. Behavior Assessment System for Children-2 (BASC-2)
18. Wechsler subtest analysis

B. Projective Tests

1. Bender Visual-Motor Gestalt Test-II (Koppitz-2, Emotional Indicators)
2. Draw A Person Test (DAP)
3. Kinetic Family Drawing Test (KFD)
4. House-Tree-Person Test (H-T-P)
5. Three (3) Wishes Survey (3W)
6. Thematic Apperception Test (TAT)
7. Children's Apperception Test-Human Figures (CAT-H)
8. Robert's-2 (Robert's Apperception Test for Children-2)
9. Subjective Units of Disturbance Survey (SUDS)
10. Sandplay, structured and unstructured free play, etc.

Note: Do not rely on projective techniques alone. Use in conjunction with objective tests, behavior rating scales, individual and family mental health history, and behavioral observations, etc. In contentious legal cases, it's probably best to avoid these projectives altogether in spite of their clinical usefulness at times.

About Dr. Carl Allen Totton

Carl Allen Totton, PsyD, NCSP, ABSNP is a Professor in the School Psychology Department at Phillips Graduate University in Chatsworth, CA. He received his BS and MS degrees in Rehabilitation Counseling, and his PPS School Psychology and School Counseling credentials from California State University at Los Angeles, and a PsyD in Clinical Psychology from Pepperdine University in West Los Angeles, California. He is licensed as both a Clinical and Educational Psychologist (LEP) in California.

Dr. Totton has over 35 years of experience across a diverse range of environments including schools (K-12), the Southern California Diagnostic Center, rehabilitation counseling and community mental health agencies, substance abuse treatment programs, general and psychiatric hospital in-patient medical centers, community college psychological and disabled student services, and in private practice. He currently specializes in providing a range of psychological services to adults, adolescents, and children including psychotherapy, counseling, consultation, and psycho-educational and school neuropsychological assessments.

Dr. Totton has been on the faculty of five colleges or universities, including two schools of Oriental Medicine. His doctoral dissertation examined meditation as an altered state of consciousness. He has completed several advanced training programs and is trained and/or certified in psychoanalytic psychotherapy (adults, children & family), Jungian psychology and Sandplay therapy, behavior intervention case management (BICM), EMDR (eye movement desensitization and reprocessing), neuro/biofeedback, and critical incident stress management and debriefing (CISM). He is a co-author of *The Book on Internal Stress Release* (2015).

Dr. Totton was honored by CASP (California Association of School Psychologists) as an Outstanding School Psychologist (2000), and by the California Association of Licensed Educational Psychologists (CALEP) as the Educational Psychologist of the Year (1999). Dr. Totton is a Nationally Certified School Psychologist (NCSP) and a Board Certified Diplomate in School Neuropsychology (ABSNP). He served on the CASP Board of Directors for two years as the LEP Specialist.

Publications

McKinzie, M., Painter, J., Totton, C. (2015). *The book on internal stress release*

Totton, C. (Ed). (2000, 2015). *Best practices in psychoeducational assessment for school psychologists: A guide to test selection*, Revised

Totton, C. (Ed). (2000). *Resource manual for counseling emotionally disturbed college students*. Pasadena, CA: Pasadena City College.

Totton, C. (1999, 2004, 2015). *Psychoeducational assessment and differential diagnosis for emotionally disturbed children and adolescents*, Revised

Professional Activities

Board of Directors, LEP Specialist, California Association of School Psychologist (CASP), 2000-2002
Editorial Advisory Board, the California School Psychologist Journal, 1996-97
Board of Directors, Be Strong Families, Chicago, Ill., 2013 to present
Education Committee, Rancho San Antonio Boys Home, Chatsworth, CA, 2000 to present
Board of Directors, Rancho San Antonio Boys Home, Chatsworth, CA, 2017 to present