



McCray Psychological Services, Inc.

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Lic. # PSY 17068

PSYCHOLOGICAL ASSESSMENT

Client Photo

Client Name: Smith, John

DOB: 3-28-2007

Date of Assessment: 3-29-2013

Chronological Age: 6 years 0 months

Examiner: James McCray, Psy.D.



Reason for Referral

Mrs. Smith requested a psychological evaluation to clarify whether her son has any type of Autism Spectrum Disorder (ASD) or any other type of learning/psychological disorder. John's pediatrician and schoolteacher also recommended this evaluation.

Brief Summary of Findings (Please read full report for details.)

Intellectual findings: Average nonverbal IQ

Psychological diagnosis: Autism spectrum disorder and language disorder

Other issues: Sensory issues

Some of the psychological disorders seriously considered and ruled out: Social delays explained by language delays alone

Recommendations: Share report with IEP team, consider ASD intervention services, continue speech therapy as appropriate and reassess current diagnosis as warranted

Procedures

Review of prior records

Collection and review of relevant history

Behavioral observation/mental status exam

Clinical Interview with John and Mrs. Smith

School observation of John

Wechsler Preschool and Primary Scale of Intelligence-Fourth Edition (WPPSI-IV)

Adaptive Behavior Assessment System-Second Edition (ABAS-II)

Childhood Autism Rating Scale-2 (CARS-2)

Autism Diagnostic Observation Schedule-2 (ADOS-2)

Review of DSM-5 Criteria for an Autism Spectrum Disorder (ASD)

Background Information:

<i>History form completed by</i>	Mrs. Sarah Smith, mother of John.
<i>Persons attending the current assessment</i>	Mrs. Sarah Smith (mother of client). John Smith (client)
<i>Parents and living situation</i>	John and both parents live together full time. Biological father: Mr. Jim Smith, 33 years old. Biological mother: Mrs. Sarah Smith, 31 years old.
<i>Languages spoken within the home</i>	English.
<i>Moves within John's lifetime</i>	John's family has moved twice in his life, with the most recent move occurring when he was 4 years old, which he adjusted to with great difficulty.

Birth:

<i>Maternal age at birth</i>	25 years old.
<i>Prenatal care</i>	John's mother began receiving prenatal care within the second trimester.
<i>Exposure to illicit or toxic substances while pregnant</i>	Mrs. Smith reported, "I might have had a beer and sushi before I realized I was pregnant, but neither in excess."
<i>Difficulties with pregnancy</i>	None reported by Mrs. Smith.
<i>Amniocentesis completed</i>	Not completed.
<i>Gestation</i>	40 weeks (full term).
<i>Delivery</i>	Mrs. Smith reported that John was born by emergency cesarean section and complications included: "the labor failed to progress and fetal distress was detected and they decided to do a C-section."
<i>Birth weight and length</i>	7 lb 5 oz and 19 inches long.
<i>APGAR scores</i>	Unknown by Mrs. Smith.
<i>Significant postnatal issues</i>	None reported by Mrs. Smith.

Medical:

<i>Overall health</i>	John's overall health is good although he has mild allergies, asthma, and a mild astigmatism.
<i>Significant illnesses</i>	Mrs. Smith reported, "John has had three episodes of significant vomiting. We didn't know what caused it and took him to the emergency room each time. Doctors gave him fluids through an IV and he recovered quickly."
<i>Significant injuries</i>	None reported by Mrs. Smith.
<i>Hospitalizations</i>	None reported by Mrs. Smith.
<i>Surgeries</i>	None reported by Mrs. Smith.
<i>Signs of seizures</i>	None reported by Mrs. Smith.
<i>Chronic ear infections</i>	John has never had an ear infection.
<i>Allergies to environment, food,</i>	Mrs. Smith reported John is allergic to the following: "whole

<i>or medications</i>	eggs, but [he] can tolerate products with eggs in it."
<i>Asthma difficulties</i>	Mrs. Smith indicated John has "mild" asthma and he utilized an "Albuterol inhaler, which he only uses a few times a year."
<i>Currently or previously prescribed psychotropic medications</i>	None reported by Mrs. Smith.
<i>Hearing</i>	Mrs. Smith reported John's hearing was tested by a specialist when he was 4 years old, which indicated normal auditory functioning, and she does not have concerns about John's hearing at this time.
<i>Vision</i>	Mrs. Smith reported John's vision was tested by a specialist when he was 5 years old, which indicated vision difficulties, including "he was found to have a mild astigmatism, but not to the point of requiring corrective lenses," and she does not have concerns about John's vision at this time.
<i>Eating patterns</i>	John prefers to snack throughout the day rather than eat solid meals.
<i>Sleeping patterns</i>	Mrs. Smith reported John often resists or has difficulties falling asleep, which takes approximately 30 to 45 minutes. He does not have nightmares or night terrors regularly. John typically sleeps nine hours per night without waking. He usually does not take naps.
<i>Pica (consuming nonnutritive substances)</i>	Mrs. Smith indicated John will sometimes try to eat/swallow inappropriate items, such as "a little bit of play dough sometimes, but not enough to upset his stomach."
<i>Diarrhea or constipation issues</i>	None reported by Mrs. Smith.
<i>Advanced medical tests completed in past</i>	None reported by Mrs. Smith.
<i>Other medical issues not addressed above</i>	None reported by Mrs. Smith.

Development:

<i>Infant temperament</i>	Mrs. Smith reported John was "great and quiet."
<i>Sat up without support</i>	4 months of age.
<i>Crawled</i>	9 months of age.
<i>Walked</i>	13 months of age.
<i>Current motor skills</i>	Mrs. Smith does not have concerns about John's motor skills at this time.
<i>First functional words</i>	12 months of age.
<i>Began combining words</i>	After 36 months of age.
<i>Current language skills</i>	Mrs. Smith reported John has 50 to 100 words in his expressive vocabulary at this time. He typically communicates in two- to three-word phrases.
<i>Age toilet trained</i>	At 4 to 4½ years of age.

<i>Periods of significant regression</i>	None reported by Mrs. Smith.
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Sensory Processing Issues and Activity Level: Description: Sensory Processing Disorder is a neurological disorder causing difficulties with processing information from the five classic senses (vision, auditory, touch, olfaction, and taste), the sense of movement (vestibular system), and/or the positional sense (proprioception).

<i>Auditory (sounds) issues</i>	Mrs. Smith reported, "He is not bothered by loud noises unless they are sudden.
<i>Visual (light) issues</i>	None reported by Mrs. Smith.
<i>Olfactory (smell) issues</i>	Mrs. Smith reported John smells items excessively/too often.
<i>Oral/Food issues</i>	Mrs. Smith indicated John dislikes soft food and mixed textures.
<i>Tactile (touch) issues</i>	Mrs. Smith reported, "he hates touching gooey textures like Gak."
<i>Unusual clothes texture or fit issues</i>	None reported by Mrs. Smith.
<i>Vestibular (movement) issues (e.g., enjoyment of swinging, spinning, slides)</i>	None reported by Mrs. Smith
<i>Proprioceptive (pressure) issues</i>	Mrs. Smith reported John likes wedging himself between objects and leaning or pressing heavily on other people or objects.
<i>High/low pain tolerance</i>	Mrs. Smith reported John has an unusually high pain tolerance (he does not feel pain easily).
<i>Over- or underactive</i>	Mrs. Smith believes John has an unusually high activity level on a regular basis.
<i>Focus or attention span</i>	Mrs. Smith reported John's attention span is very short when others are trying to get him to focus, but it is excessively strong on objects of interest to him.

Education History:

<i>Early intervention services (services before 3 years of age)</i>	Mrs. Smith reported John did not receive special services prior to 3 years of age.
<i>Day care</i>	According to Mrs. Smith, John started day care at 3 years of age, attending three days a week for an average of four hours per day. John stopped attending day care at 4 years of age.
<i>Services/programs between 3 and 5 years of age</i>	According to Mrs. Smith, John started preschool at 4 years of age, attending four days a week for an average of 4 hours per day at Eric Jones Elementary. John stopped attending preschool when he was 5 years of age.
<i>Kindergarten</i>	John began attending kindergarten at Eric Jones Elementary at 5 years of age.
<i>Current grade & school</i>	According to Mrs. Smith, John currently attends first grade at Eric Jones Elementary in a mainstream/regular classroom full

	time.
<i>Special education services</i>	Mrs. Smith indicated John first qualified for special education services at 4 years of age under the primary category of Speech or Language Impaired (SLI).
<i>Behavioral difficulties</i>	Mrs. Smith reported, "he sometimes gets into trouble for not listening or following directions."
<i>Speech therapy</i>	Mrs. Smith reported John has attended this service since approximately 4 years of age, which occurs four times a month for 50 minutes per session.
<i>Occupational therapy</i>	Mrs. Smith reported John attended this service from approximately 4 years of age until 5 years of age, four times a month for 50 minutes per session.
<i>Physical therapy</i>	John has never been evaluated for physical therapy, according to Mrs. Smith.
<i>Autism Intervention Services</i>	None reported by Mrs. Smith.
<i>Developmental therapy</i>	John has never been evaluated for developmental therapy, according to Mrs. Smith.
<i>Other therapy programs</i>	None reported by Mrs. Smith.
<i>Extracurricular activities</i>	Mrs. Smith reported John "attended karate from 4 to 5 years of age. He has attended swimming classes every summer since 18 months of age."

Behavioral & Psychological Issues:

<i>Visual or auditory hallucinations</i>	Mrs. Smith does not believe John has hallucinations.
<i>Psychiatric hospitalizations</i>	None reported by Mrs. Smith.
<i>Suicidal/homicidal ideation</i>	None reported by Mrs. Smith.
<i>History of abuse or trauma</i>	None reported by Mrs. Smith.
<i>Family history of learning and/or psychological disorders within the last two generations</i>	Mrs. Smith reported the following issues in relation to John: Depression: paternal grandmother Anxiety: paternal grandmother Other disorders/issues: Mrs. Smith indicated she "was adopted and thus little is know about her family history."
<i>Attempts to hurt himself</i>	No significant issues reported.
<i>Attempts to hurt others</i>	No significant issues reported.
<i>Behavioral difficulties (e.g., tantrums)</i>	John typically tantrums four times a day, during which he will "throws himself on the ground, yell and kick things," which typically occurs when "not getting what he wants."
<i>Mental health services</i>	Never received, according to Mrs. Smith.
<i>Signs of depression</i>	None reported by Mrs. Smith.
<i>Signs of anxiety</i>	None reported by Mrs. Smith.

Antecedent to Evaluation:

<i>Current and prior diagnosis by other professionals</i>	Mrs. Smith reported John has never previously been evaluated for, or diagnosed with, a psychological disorder.
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<i>What led to the current assessment</i>	Mrs. Smith reported, "John doesn't seem to want to play with other children and he has significant language delays."
<i>Family's impressions</i>	Mrs. Smith reportedly is unclear about John's diagnosis and was primarily concerned with finding appropriate therapies to address his current struggles.

Prior Assessments

(The following summaries are based on reports provided by the family and/or regional center. There may be other assessments of John that this examiner is unaware of, were not provided, or that were not summarized for this report as the examiner felt they were not fully relevant. Also, the examiner is providing only a summary of the following assessments, and the reader is encouraged to review the actual reports for more details.)

Sydney Friedman, M.S., School Psychologist, completed a Multidisciplinary Team Report on 7-29-10, when John was 3 years-4 months old. During the assessment, he was reported to be "very impulsive" and "sometimes needed extra time to respond to requests." John was administered the Differential Abilities Scales-II (DAS-II), on which he received a Nonverbal score of 95. On the McCarthy Scales of Children's Abilities, he received a Motor Scale of 86. On the Social/Emotional test, John received a Social score of 52 and a Problem Behavior score of 50, suggesting he had significant difficulties with self-control. The examiner suggested he qualify for special education services due to his language delays.

A Speech and Language Report was completed on 3-16-12, when John was 4 years-11 months old. On the Preschool Language Scale-4 (PLS-4), he received an Auditory Comprehension score of 109 and an Expressive Communication score of 64. He was reported to have made tremendous improvement in his overall language development, and the examiner concluded John is an "entertaining young man who qualifies for speech or language services at this time."

Behavioral Observations During Evaluation

At the beginning of the evaluation, the examiner let Mrs. Smith know he would be asking questions about John's history and behaviors as well as openly discussing the examiner's clinical impressions. She was asked to let the examiner know, in advance or during the interview, if he asked a question or was discussing a topic she did not want John to overhear. At no point did she indicate she was uncomfortable with the discussion or that she did not want to discuss an issue in front of John.

Social interactions: John was a very handsome boy who appeared his age. No dysmorphic features or distinguishing marks were noticeable. He had good hygiene and grooming. He appeared very focused on toy cats for the first half hour of the 3-½ hour evaluation. During this time, he focused exclusively on the toy cats and engaged in lots of physical play. The examiner attempted to engage John in a conversation about his actual pets, but without success. In fact, the examiner tried on multiple occasions to engage him in a conversation about several different topics, but John would only answer direct questions and only asked functional questions of the examiner. John often enjoyed creating movie scenarios, such as referring to a certain section of the office as "Pride Rock" (from the movie Lion King), and called each of the cats a different character. While this behavior seemed relatively typical for a six-year-old boy, the extent to

which he perseverated on this topic and dictated how others should act or respond was unusual. At other times, when asked whether what he was describing was a real event or a movie scene, he often insisted it was real when it clearly was not. This reportedly is a frequent issue for John. No self-stimulatory behaviors were observed during the evaluation. The examiner attempted to engage him in direct play, but there was a significant lack of reciprocity in his social interactions.

Verbal interactions: John could express his thoughts and wants in simple sentences with mild articulation difficulties. However, he struggled with spontaneously responding to questions, and it seemed to take him a while to process some questions asked by others and formulate a response. The examiner heard him repeat a few of the examiner's questions or phrases in a rote manner, but more often, he was quoting lines from movies. John tended to speak in a somewhat demanding tone; such as when wanting something, he would say, "Turn this on," in a strong voice, without spontaneously saying "please" or "thank you." However, when prompted by Mrs. Smith, he would then use better manners. John's style of communicating appeared due to a lack of awareness of other people's responses or emotions rather than how a child might behave who is used to getting their way. As previously indicated he demonstrated little desire or ability to engage in a conversation.

Testing interactions: It was extremely difficult to engage John in intellectual testing. This appeared due in part to functional language delays, but even more so because of his lack of desire to perform for or please others. He often became sidetracked by his own thoughts or interests. For part of the testing, he appeared very socially aloof and had an extremely flat affect. Attempts at humor and tickling resulted in little response from John. Later in the assessment, he became more animated, which made testing more difficult as he became more focused on his specific toys rather than completing the testing. During the Matrix Reasoning subtest, he created a very ritualistic routine of making an exaggerated face showing that he was thinking very hard, then a very surprised, excited look before pointing to the correct answer. He did exactly the same set of reactions a dozen times and did not direct these expressions towards the examiner, and the examiner's response to what he was doing had little influence on this behavior. At another time, John only wanted to give silly answers, which, again, is somewhat age-appropriate; yet, his inability to become refocused despite frequent attempts from the examiner was unusual. For example, when asked what has wheels, he would laugh and say anything he say such as "a banana," and then looked around the room and found a different item when the question was asked again. During the ADOS-2, a play based assessment for an ASD, John appeared uncomfortable engaging in imaginary play that was not part of his preset script or incorporating the examiner into his play. John could only demonstrate a routine task when asked for each specific step. He could identify items within a picture but greatly struggled with telling a story based on pictures within a book. John did not seem to want to engage the examiner in a conversation, or talk about his emotions and relationships with others. This appeared largely due to John's lack of awareness of typical social interactions rather than a reluctance to address personal issues with Dr. McCray. John could not identify any friends, why people would want to marry one another, and said he never felt lonely.

Behavioral Observations at School

With the family's permission, the examiner observed John at school for approximately one hour. The examiner discussed the best time for this to be conducted and chose a time period that included classroom time when the teacher was giving a lesson, a group activity time within the classroom, and part of his recess.

While many of the other children in the classroom appeared interested in the examiner and were mildly distracted by his presence, John showed little interest in the examiner. Instead, he appeared content with drawing on his paper while the teacher was talking. He followed her directions well but did need a few extra reminders to focus. John's social struggles became much more evident during the group activity time. The teacher told the children to find a partner for the next activity. While most children were excited about this and quickly tried to find their friends, John seemed to wander aimlessly about the classroom. He did not appear nervous or shy about approaching peers as much as he did not have a strong interest in interacting with them. The teacher eventually realized John did not have a partner and helped him find another child to work with. John had difficulty engaging in cooperative tasks with his partner, which was clearly frustrating for the other child. John often chose to complete parts of a task without first consulting the other child and was never seen sharing pride in his accomplishments with his partner or the teacher.

John excitedly ran out of the classroom when the recess bell rang. He quickly found a basketball and enjoyed throwing it at a hoop, but did not try to engage peers in a game of basketball. In fact, when another child approached John to try to join him, John turned his back to him and walked away. John was fairly active during recess and often ran about, like many of the other children, but, unlike his peers, he did not try to engage others. The examiner talked to one of the recess monitors, who said this was fairly typical behavior for John. Mrs. Smith later said she had heard the same from teachers and said that he often chose to play by himself when she took him to social areas like Chuck-E-Cheese.

Test Results

It is important to realize that test scores may be interpreted in a number of different ways and that the validity (accuracy) of the results is often dependent upon the person's age and the effort he placed into testing. For example, the validity of IQ tests on a 2-year-old is limited, whereas on a 9-year-old it is much more accurate.

General intellectual testing description: John was administered the Wechsler Preschool and Primary Scale of Intelligence-Fourth Edition (WPPSI-IV), which is a series of tests to evaluate intellectual abilities. It consists of five scales: Verbal Comprehension, Visual Spatial, Fluid Reasoning, Working Memory and Processing Speed. Each of these scales has several subtests. While this test is a good predictor of future learning and academic success, it cannot determine motivation, curiosity, creative talent, work habits, study skills, or achievement in academic subjects.

IQ testing results: John received a Full Scale Composite score of 82, which represents a low-average IQ. However, this total score does not fully or accurately reflect his relative strengths and weaknesses, and thus is not a particularly good way to summarize his overall intelligence.

John received a Visual Spatial composite score of 90, which represents an average perceptual organization and visual-motor proficiency. The examiner suspects his scores may have been a little higher if he had tried harder on certain subtests and had not been so easily distracted. He did not seem to have as much difficulty focusing on the Processing Speed subtests as seen by his score of 93, which falls within the average range. John also received average scores on the Fluid Reasoning and Working Memory composites indicating an average ability to think logically and solve problems as well as an average visual short-term memory. His Verbal Comprehension composite score of 75 falls within the borderline range, which represents a relative weakness in his language skills. John seemed to especially struggle with his expressive language. Scores and their descriptions are as follows:

Wechsler Preschool and Primary Scale of Intelligence-Fourth Edition (WPPSI-IV)

Score	Composites	Attribute Measured
75	Verbal Comprehension	Language expression, comprehension, and listening
90	Visual Spatial	Nonverbal problem-solving, perceptual organization, and visual-motor proficiency
95	Fluid Reasoning	The capacity to think logically and solve problems in novel situations, independent of acquired knowledge
93	Working Memory	Ability to retain information in memory for short periods of time
93	Processing Speed	Visual-motor quickness, concentration, and persistence
82	Full Scale	Combined composite scores
Verbal Comprehension Subtests		
Score	Subtest	Attribute Measured
5	Information	Factual knowledge, long-term memory and recall
6	Similarities	Abstract reasoning, verbal categories and concepts
Visual Spatial Subtests		
Score	Subtest	Attribute Measured
8	Block Design	Spatial analysis and abstract visual problem-solving skills
8	Object Assembly	Visual analysis and construction of objects
Fluid Reasoning Subtests		
Score	Subtest	Attribute Measured
10	Matrix Reasoning	Visual information processing and abstract reasoning skills
9	Picture Concepts	Ability to categorize objects based on similar underlying concepts
Working Memory Subtests		
Score	Subtest	Attribute Measured
9	Picture Memory	Short-term visual memory and concentration
8	Zoo Locations	Visual-spatial short-term memory
Processing Speed Subtests		
Score	Subtest	Attribute Measured

9	Bug Search	Visual-motor coordination, speed, and concentration
8	Cancellation	Visual-perceptual recognition and discrimination

Adaptive skills measure: Mrs. Smith was asked to complete the ABAS-II questionnaire, which addressed John's adaptive behaviors and independent living skills. The examiner reviewed Mrs. Smith's responses and found them to be consistent with prior reports and his experience of John during the evaluation. The focus of this instrument is on the functions an individual actually performs without the assistance of others. John's General Adaptive Composite (GAC) score was 62, which represents very delayed skills and is most likely due to him having an ASD. Scores are as follows:

Adaptive Behavior Assessment System-Second Edition (ABAS-II)

Composite Scores	Standard Score	Adaptive Level
GAC	62	Very Low
Conceptual	65	Very Low
Social	50	Very Low
Practical	58	Very Low
<u>Conceptual Subtests</u>	<u>Standard Score</u>	<u>Adaptive Level</u>
Communication	3	Very Low
Functional Pre-Academics	8	Average
Self-Direction	4	Very Low
<u>Social Subtests</u>	<u>Standard Score</u>	<u>Adaptive Level</u>
Leisure	2	Very Low
Social	1	Very Low
<u>Practical Subtest</u>	<u>Standard Score</u>	<u>Adaptive Level</u>
Community Use	2	Very Low
Home Living	3	Very Low
Health & Safety	6	Borderline
Self-Care	3	Very Low
Motor	9	Average

Autism screening measure: The examiner completed the Childhood Autism Rating Scale-2 (CARS-2), which is a 15-item behavioral rating scale. It is designed as a screening tool to identify children with an autism spectrum disorder and help identify possible signs of an ASD. The CARS-2 ratings are comprised of behavioral observations, parental reports, and a review of relevant records. Scores are as follows:

Childhood Autism Rating Scale-2 (CARS-2)

Raw Score	T-Score	Interpretation
32	42	Mild-to-moderate symptoms of autism spectrum disorder

Standardized Autism measure: John was administered the Autism Diagnostic Observation Scale-2 (ADOS-2), which is a standardized, semi-structured, observation assessment tool that allows the examiner to observe and gather information regarding an individual's social behavior and communication in a variety of different social communicative situations. Module 3 was utilized based on John's age and language abilities. John's total score exceeded the autism

cutoff point, suggesting a diagnosis of autistic disorder. His Level of Autism score was 9, suggesting he has a high level of autism compared to other children with this disorder. Results are as follows:

Social Affect: John was unable to provide an account of a routine or non-routine event unless asked specific questions. He would answer direct questions asked by the examiner but there was little sense of reciprocal conversation. John had some spontaneous and descriptive gestures, but less than would be expected for his age. He used poorly modulated eye contact to initiate, terminate, or regulate social interactions. John directed some facial expressions towards others, but less than would be expected for his age. He showed little pleasure during interactions unless focusing on a topic of interest to him. The overall quality of his social interactions and responses were mildly unusual. Most of John's communication was in response to direct questions and his overall interactions were one-sided and mildly awkward.

Restricted and Repetitive Behaviors: John's use of words tended to be overly repetitive. He demonstrated some signs of sensory issues, such as not wanting to touch certain soft toys within the examiner's office. He was briefly observed flapping his hands when excited and walking on his tiptoes. John focused on cats regularly to the point of them interfering with his ability to socially engage others.

Autism Diagnostic Observation Scale-2 (ADOS-2)-Module 3

	John's Score	Autism Cutoff	Autism Spectrum Cutoff
Social Affect (SA)	5		
Restricted and Repetitive Behavior (RRB)	10		
Overall Total (SA + RRB)	15	9	7
Level of Autism Spectrum	9 (High)		

DSM-5 criteria for autism spectrum disorder (ASD): Listed below are the Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM-5) criteria for an autism spectrum disorder (ASD) 299.00. To be diagnosed with an autism spectrum disorder, a person must clearly meet all three criteria in section A, at least two criteria within section B, and criteria C, D, and E. Results follow:

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive). [All three criteria must be met within this section.]		
Met	Not Met	
X		(A1) Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions. John will only sometimes show his interests and achievements with others, but not on a frequent basis and much less often than would be expected for his age.

		<p>More often, he is pointing out an object because he wants an adult to buy it for him, which is not a social sharing of his interest. John will sometimes spontaneously hug or kiss his parents, but most of the time they have to encourage this to occur. He does not consistently show a positive reaction to praise from others. John will be curious and ask many questions when seeing someone is upset, but the extent of his empathy is limited. John is unable to carry on a social conversation at a level appropriate for his language development. He will sometimes go into monologues about his interests rather than engage in truly reciprocal conversations. Questions he asks of others are typically fact based, rather than used to socially engage others.</p>
X		<p><i>(A2) Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.</i> John only occasionally seeks social eye contact with others, and when he does, it is typically very brief. He has an expressive face, but often seems to be acting out emotions and does not direct his expressions towards others on a regular basis. John uses a limited number of nonverbal gestures to compensate for his language delays. The family said he did not point to objects with an index finger until approximately 4 years old, and even now uses this skill infrequently.</p>
X		<p><i>(A3) Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.</i> John often plays by himself on the playground. When playing with others, he wants people to do things his way and has difficulty with cooperative play. He has never developed a special friendship and appears content with his limited social interactions. When at home, he also appears content to play on his own and typically only seeks out adults when he needs help with something rather than just for social engagement.</p>
<p><i>B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):</i></p>		
Met	Not Met	<p><i>(B1) Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).</i> John flaps his hands when excited. He likes to walk on his tiptoes, which he does throughout the day. If not recreating movie scenes with his toys, he will line them up in a very specific manner and becomes upset if another person disturbs the line. He will sometimes stare at the wheels of a toy car. John used to engage in lots of immediate echolalia (repeating of words), but does so to a lesser extent now. Currently, he often quotes lines from movies, which are only sometimes relevant to the situation. (This is known as idiosyncratic</p>
X		

		language or delayed echolalia.)
	X	<i>(B2) Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).</i> John is hesitant of new situations, such as going to Disneyland, whereas most children would have been excited. (This issue may be due in part to being overwhelmed by the high level of sensory stimulation at Disneyland.) He has difficulty with changes, but no specific nonfunctional routines.
	X	<i>(B3) Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).</i> John becomes intensely focused on certain topics. For example, after watching a movie, he will sometimes persevere on a certain character by constantly pretending to be that character and will try to get others to be the other characters. When the examiner observed John, he was obsessed with pretending to be like an animal from a popular television show.
	X	<i>(B4) Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).</i> John reportedly often smells objects and dislikes soft foods or foods with mixed textures. He also “hates” touching gooey textures such as “Gak.” Finally, John likes intense proprioceptive feedback.
<i>C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies later in life).</i>		
<i>D. Symptoms cause clinically significant impairment in social, occupation, or other important areas of current functioning.</i>		
<i>E. These disturbances are not better explained by intellectual disability or global developmental delay. Intellectual disability and ASD frequently co-occur; to make comorbid diagnoses of ASD and intellectual disability, social communication should be below that expected for general developmental level.</i>		

Severity level	Social communication
Level 2 “Requiring substantial support”	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal response to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and who has markedly odd nonverbal communication.

Severity level	Restricted, repetitive behaviors
Level 2 “Requiring	Inflexibility of behavior, difficulty coping with change or other restricted/repetitive behaviors appears frequently enough to be obvious to

substantial support”	the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.
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Impressions

Summary of client history: John is a six-year-old boy living with his parents. He was born full term by emergency cesarean section after fetal distress was detected. However, there were no significant post-natal issues and he did not require specialized medical care after his birth. John’s overall health is good, with the exception of mild allergies and asthma. He has passed a hearing test at 4 years of age and vision testing indicates he has a mild astigmatism that does not yet require corrective lenses. John completed his physical developmental milestones in a relatively normal time frame and currently has adequate motor skills. He said his first words in a normal time frame, but his overall language skills were slow to develop, and he currently has a relative weakness in his expressive language skills. John demonstrates some moderate signs of a sensory processing disorder as he is overly upset by sudden noises, often smells objects, dislikes certain food textures, dislikes touching “goeey” textures, but enjoys lots of proprioceptive feedback. John has qualified for speech therapy services since approximately 4 years of age under the category of a speech of language impairment and has received individualized speech therapy since that time. He typically is not self-injurious, nor is he aggressive towards others, but he does throw multiple tantrums a day. John has never previously undergone an evaluation for an Autism Spectrum Disorder (ASD).

Summary of intellectual and adaptive testing: John was administered the WPPSI-IV for the current assessment to help determine his overall cognitive level of functioning. He demonstrated an average nonverbal IQ, as seen by his Visual Spatial composite score of 90 and Fluid Reasoning composite score of 95. (Scores of 85 to 115 are generally considered to fall within the average range.) John’s Verbal Comprehension composite score of 75 fall in the borderline range indicates a relative weakness in his language skills, which will be diagnosed as a language disorder. Prior assessments also indicated John language skills are delayed. John’s processing speed and short term visual memory appears to also function within the average range. Given the disparity between John’s composite scores, his full-scale IQ is not an accurate way to summarize his overall intelligence. John’s adaptive skills, as reported by Mrs. Smith on the ABAS-II, were significantly delayed in most areas, which this examiner also suspects is due to John having an autism spectrum disorder (ASD).

Summary of ASD issues or other psychological issues: John demonstrates many clear signs of having an autism spectrum disorder (ASD). Specially, he demonstrates limited social reciprocity (such as showing items of interest to others, an interest in verbally engaging others or being motivated by praise), delayed nonverbal communication (such as seeking eye contact or directing his facial expressions towards others) and he has little interest to socially engage peers or adults. These difficulties do not appear due to just his language delays or shy personality, because even when comfortable or engaging in nonverbal play, John chooses to be on his own rather than engage others. Other signs of an ASD include his repetitive behaviors (such as engaging in echolalia, flapping his hands and staring at the wheels or a toy car), fixated interests (such as repeating scenes from movies) and sensory issues. When reviewing these behaviors in light of the DSM-5, John clearly met enough criteria for an ASD. Quantitative measures appear to support this diagnosis, as seen by John’s scores on the ADOS-2 and CARS-

2. It is important to realize that approximately 70% of individuals with an ASD also have an intellectual disability, whereas John appears to have at least an average nonverbal intelligence, which most likely explains some of his relative strengths within his ASD diagnosis.

Parent Discussion: The examiner discussed the testing results and his clinical impressions with Mrs. Smith. While she was not particularly surprised by the diagnosis, it was clearly hard to hear. The Smiths appear to have provided a very loving environment for John and have done their best to provide appropriate therapies for him from a young age. It is typical for a parent to question whether they could have done anything to cause the disorder, and the examiner believes it is very important Mr. and Mrs. Smith realize there is nothing they have done to cause this disorder. In fact, during the evaluation, Mrs. Smith showed excellent parenting skills and great patience, which have undoubtedly helped John progress as well as he has.

Diagnosis

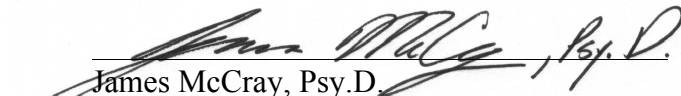
- 299.00 Autism spectrum disorder
- Without accompanying intellectual impairment (average nonverbal IQ)
 - With accompanying language impairment (verbal comprehension score 75 on WPPSI-IV)
 - Associated with a known medical condition: mild astigmatism and hypoglycemia
 - Requiring substantial support or support for deficits in social communication (Level 2) and requiring substantial support for restricted, repetitive behaviors (Level 2)
- 315.39 Language disorder

Recommendations

1. **Autism intervention:** Given John's diagnosis, he would benefit from an evaluation for enrollment in a program for children with an autism spectrum disorder. Such programs typically emphasize social skills training, speech therapy, and structured behavioral interventions. The exact type and nature of this therapy are best determined by the experts who provide this service. Also, while studies may suggest an "ideal" or "optimal" level, the examiner encourages therapists and family members to base their decisions about the extent of any particular therapy on how John responds to that therapy. Given his average nonverbal intelligence, it is important his placement is carefully considered to ensure it is the least restrictive environment.
2. **IEP:** Given John's current diagnosis, the family may want to request a new IEP to determine whether he may better qualify under a different special education category, such as "Autistic-Like."
3. **Speech therapy:** Continued speech therapy is also encouraged given John's relative weakness in his expressive language skills.
4. **Awareness of his disorder:** John appears quite content with his current social interactions and has limited awareness of how he differs from his peers. It is not uncommon for children with an average IQ and an ASD to eventually realize they are different from others, which leads to significant frustration and sometimes depression. Therefore, the examiner encourages the family to be open with John about his differences and help him find skills or hobbies that he is proud of and can help maintain his self-confidence.
5. **Reevaluation:** John's progress should be carefully monitored by his parents and care providers (i.e., teachers, pediatrician, etc.) to determine whether further testing is warranted

in the future. For example, should John show marked improvement in skills or a lack of appropriate development/progress, then a reevaluation of his diagnosis may be warranted. In addition, intellectual testing results tend to become more accurate as a child ages, as does a child's diagnostic presentation.

6. **Other resources:** The Smiths may benefit from becoming involved with organizations that focus on children with special needs, such as WarmLine (www.warmlinefrc.org or 916-922-9276). Such organizations can provide parents with support groups, behavior management techniques, education about ASDs, and other valuable resources that may support a family with a child who has an ASD.
7. **Record tracking:** The Smiths are encouraged to create a system for tracking the numerous reports and paperwork that will most likely accumulate throughout John's life. Bringing these reports to their various meetings will help ensure goals are more reliably tracked and information is provided in the most expedient manner. The examiner has found the best system includes purchasing a 2-inch-thick three-ring binder with at least five divider tabs. Each tab should represent different types of meetings/evaluations such as IEPs, psychological evaluations, speech/language evaluations, occupational therapy evaluations, etc. The Smiths should obtain a copy of each assessment and place it chronologically within its appropriate section. It is important they keep a permanent copy for their records. The examiner also encourages them to put in writing any requests to the agencies from which they are seeking/receiving services.


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