

The Tale of Tommy's Testing

Facilitator's Guide

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Topic: Learning Disorders

Abstract:

Primary care clinicians are commonly consulted when children are having difficulty at school. In addition to academic failure, teachers and parents may report that a child is misbehaving or not paying attention. Very often, the presenting question is “*Does this child have Attention Deficit Disorder (ADD)?*” Clinicians should know how to evaluate a child with school failure and recommend appropriate interventions. Proper management can have an enormous effect on a child's life. This case presents the story of Tommy Taylor, who is seen as an academic underachiever in third grade. Tommy is described as being inattentive and acting-up in class.

Goal: To provide learners with a basic understanding of school failure.

Objectives:

By the end of this session, learners will be able to:

1. List an appropriate differential diagnosis for school failure and inattention.
2. Interpret school evaluation results including educational and psychological testing reports.
3. Recognize the signs and symptoms of a learning disorder (LD).
4. Describe the pediatric management of school failure.

Prerequisite Case:

“Jesse and the School Quandary: Ready, Set, Go!” (School Readiness)

Related Case:

“The Restless Pupil” (Attention-Deficit/Hyperactivity Disorder)

Themes:

Child Development and Behavior

Key Words:

School failure, learning disorder, learning disability

Bright Futures Core Concepts:

While all of the Core Concepts are included in each case, this particular case can be used to highlight communication, partnership, advocacy, and prevention/health promotion.



Materials Provided:

- Facilitator’s Guide
- 3-part Case Narrative: Part I, Part II, Epilogue
- Handout #1: Tommy’s growth chart
- Handout #2: WISC-III
- Handout #3: WIAT
- Handout #4: Teacher Evaluation and Comments
- Handout #5: Psychological Evaluation
- Bibliography

Facilitator Preparation:

Facilitators should thoroughly review this guide and the other materials provided. Become familiar with the national *Individuals with Disabilities Education Act* (IDEA), and obtain a copy of the special education law of your own state. What rights do students and parents have in getting an assessment and access to special services?

At the end of the guide we have included a section entitled, “**Independent Learning/Prevention Exercises,**” that will further stimulate group and individual education on this topic.

Suggested Format for a One Hour Session:

We anticipate that case facilitators will modify implementation of the case session to best fit their educational setting and learners. For detailed recommendations on case facilitation, please see the chapter entitled, “A Brief Guide to Facilitating Case-Discussion,” found in *The Case Teaching Method; and Growth in Children and Adolescents* (book 1 of this series).

Introduction: School performance is determined by a complex interaction of variables, including those intrinsic to the child (e.g., cognitive ability, vision, hearing, etc.), family factors, community setting, and school-related matters. These variables are not mutually exclusive, but co-exist and co-determine etiology, management, and outcome. Specific Learning Disabilities are, however, the most prevalent and perplexing cause of school failure. In the early twentieth century, physicians first recognized a group of children who had the unexpected pattern of normal intelligence, but specific weakness in learning. This pattern was similar to that seen in patients who had suffered focal brain damage of some sort. Various diagnostic terms have been used over the years to describe this pattern, including “dyslexia” (specific inability to learn to read). Today, Learning Disability or Learning Disorder (LD) is the preferred term. Our understanding of these problems is constantly evolving. In general, LDs are a heterogeneous group of disorders that may affect reading (most common), writing, mathematics, or other specific academic areas. They often co-occur with social skills deficits, emotional problems, misbehavior, or inattention. Prevalence data vary, depending on definition, but about 5% of children in the United States are affected. Almost 2 million children in the U.S. are enrolled in some type of special education. Biomedical, genetic and environmental factors are implicated in both etiology and manifestation of LD. There are four criteria that should be present for a diagnosis:

1. A major difficulty in learning, or deficiency in acquisition of new skills in a particular academic area (e.g., reading, writing, mathematics, organization, or social skills).
2. A significant discrepancy between academic achievement and potential considering the child’s age, intelligence, and appropriate education.

3. Presumed etiology of central nervous system dysfunction, evidenced by abnormal neurodevelopmental function (e.g., perception, linguistic ability, processing, memory).
4. An absence of another cause (i.e., sensory impairment, mental retardation, emotional disorder, or educational deprivation) which can *completely* explain the problem. LDs may coexist with these problems, but difficulty with learning must be out of proportion to that expected on the basis of the other impairment alone.

Teachers and school officials may misunderstand children with LDs. Their parents often turn to the pediatric clinician for help. As knowledge and awareness of learning problems increase, all clinicians must be prepared to answer questions, work with school professionals, and guide parents in understanding and advocating for their children.

Open the Discussion: Introduce the case title and the session goal. Explain that this will be an interactive case discussion and not a lecture. Distribute Part I of the case and ask one or more of the participants to read it aloud.

Part I

Tommy, a 10-year-old boy, is repeating the 3rd grade in the public school system. His mother asks you to complete a physical exam form as part of an evaluation being done by the school. Mrs. Taylor states that Tommy has always been a “*good boy*” well liked by both teachers and classmates. His first grade teacher found he had difficulty learning to read, and he was given some extra help throughout the second grade. At that point, his teachers felt he had “*outgrown*” the problem, and the special help was discontinued. In third grade, he failed reading and spelling but did well in math. During the repeat (current) year, his teachers complain that he seems to lack motivation, doesn’t turn in homework, and doesn’t pay attention in class. Where he used to be well behaved, he now acts up in class and distracts other children.

Tommy’s medical history is unremarkable. He was a full term baby and achieved all his early developmental milestones on time. His father is a real estate agent who left college after a year and a half; his mother has a college degree and works as the town accountant. They have been married 15 years. When asked about stresses in the home, Mrs. Taylor says “*we sometimes have our arguments, but overall our marriage is strong.*” Tommy has a 12 year old sister who “*gets all A’s*” and has no medical problems. Extended family history is positive for “*slow learners*” on the father’s side of the family. Tommy’s mother’s brother was “*hyperactive*” as a child and never has held a steady job. Tommy’s mother wonders if her son “*also has attention deficit disorder.*”

Tommy tells you that school is “*stupid and boring*” and that he knows he could do better if he wanted to. He says he just doesn’t care. He states that he has many friends outside of school, and he enjoys bicycling, in-line roller skating, and basketball.

Physical examination reveals a well-developed and well-nourished white male. He is left-handed. He also has some soft neurological signs (hand posturing when asked to heel and toe walk, tongue protrusion while finger-nose pointing, some mild left-right confusion). The remainder of his exam is unremarkable. Hearing and vision screens are normal.

Distribute Handout #1: Tommy’s Growth Chart. Following this reading, ask all participants “So what do you think about this case? What would you like to focus on during our discussion today?” List agenda items on a blackboard or flipchart. Then use the questions below to guide the discussion. Remember that the key to successfully leading a small group is facilitation of the discussion rather than lecture. Draw as many participants as possible into the discussion. Allow silences while group members think about questions. Present material from the discussion guide only when needed to complement or redirect the group discussion.

Guiding Questions for Discussion:

What questions should primary care providers routinely ask about school? According to the Bright Futures Guidelines, primary care clinicians should routinely ask about school performance as part of developmental surveillance. For the 10-year visit, those questions include:

- Do you have any specific concerns about Tommy’s grades?
- How is his attendance?
- Is he reading at grade level?
- Doing math at grade level?
- Is he in any special classes?
- Does Tommy follow the rules at school?
- Is he proud of his achievements at school?
- What did the teacher say about him during your last parent-teacher conference?
- Is Tommy ready for middle school?

Based on the history and physical examination, what is the differential diagnosis for Tommy’s school problem? For children having trouble with either behavior or learning, the clinician should consider impairment of vision or hearing, epilepsy, attention deficit with hyperactivity disorder (ADHD), mental retardation, depression and other psychiatric problems. Medical conditions that may interfere with learning (e.g., poorly controlled diabetes, chronic pain or fatigue) should also be considered. Psychological traumas, such as a recent divorce or death in the family, may cause secondary inattention in school and decreased motivation to succeed. Therefore, any child with school failure should have a comprehensive medical, developmental, and psychosocial history. In this case, Tommy should have a complete physical examination, including a thorough neurological exam. Vision and hearing should be tested. An evaluation by the school is already underway. If it weren’t, the clinician’s first step would be to advise Mrs. Taylor that she should request one. By law, a child has a legal right to an evaluation (including educational and psychological testing) by the school at no charge. If parents are not satisfied with the result, they can usually request a second opinion from a specialty clinic or other referral center.

Distribute Part II of the case and have participant(s) read it aloud.

Part II

Tommy and his mother return to the office several weeks later. As you requested, Mrs. Taylor has brought the reports from the school evaluation (See Handouts). She asks, “*What does all of this mean? Shouldn’t Tommy be started on Ritalin? Is he going to grow up to be a failure like his uncle?*”

Distribute Handouts #2-5 (reports from the school evaluation). Give learners several minutes to review them. Then continue the discussion with the following guide questions:

What are the important findings in the reports from the school? School evaluation reports are often lengthy and detailed, and may be confusing to untrained clinicians.

- a) In reviewing the reports, scan first for cognitive (i.e., IQ) testing. In the handouts provided, this is found at the top of the “Psychological Evaluation” sheet, and on the “WISC-III” report form. While Tommy’s IQ testing is in the normal range, there is a discrepancy between his performance (108) and verbal (91) scores. A difference of more than 15 points is significant. In Tommy’s case, a performance score greater than verbal (PIQ>VIQ) suggests a language-based learning

problem. In support of this, the psychologist also found Tommy's writing sample to be poorly done, with spelling errors and reversals. This may signify weakness in sequencing, visual perception and visual-motor integration; findings often associated with "dyslexia" or language-based learning disorders. Less commonly, a child might have a VIQ significantly greater than PIQ. This finding suggests a nonverbal learning problem, e.g., perceptual problem, motor impairment, slow processing speed, or dyscalculia (specific LD in math). In those children that have no significant discrepancy between VIQ and PIQ, an LD is still possible (e.g., broad based learning disorder).

- b) The next area to review is the achievement testing. Tommy's school used the Wechsler Individual Achievement Test (WIAT). The easiest way to understand the results is to look at *Percentile* ratings for specific academic abilities, included in the "Composites" box at the bottom of the "WIAT" report page. Tommy is at the 3rd percentile for reading and writing, while at the 61st for language and 84th for math. This uneven profile is again suggestive of a specific Learning Disorder rather than a primary disorder of attention or cognition. Clinicians should also review the *Grade Equivalent* column within the WIAT Subtests box (Second from the bottom). Here we see that Tommy's understanding of written passages improves when they are *read to him* (Listening Comprehension = Grade 3.9 vs. Reading Comprehension = Grade 2.0). This indicates that he has more difficulty with decoding (the mechanics of reading) than with actual comprehension (language processing, intelligence). The high math scores (Grade=4.3/4.0) indicate strong thinking and reasoning abilities.
- c) Now go back to the "Psychological Evaluation." On the ADHD rating scales, Tommy was scored in the borderline range by his language arts teacher, but not by his math teacher or his parents. This discrepancy in viewpoint is highlighted in the "Teacher Evaluation and Comments form". Because Tommy had one test score in the "B" range, his language arts teacher is convinced he could do better if he wanted to. She blames his academic failure on poor attention, lack of motivation, and misbehavior. Her last comment, suggesting "*he could use some Ritalin,*" is not an uncommon response from teachers or from parents. In this era of larger class size and limited resources, stimulant medication can be seen as a quick fix. Pediatric clinicians must resist the impulse to reflexively accommodate this kind of request. They should rather review all the data, and be sure there is not an underlying problem which can explain the child's inattention. Most children with LD's are described as inattentive - this, however, does not necessarily mean they have ADHD. Tommy is inattentive and acting up because the work is too hard for him; he has a secondary attentional problem. In contrast, Tommy's math teacher has a very positive view of him. He is giving Tommy some advanced work and having him assist other students.

What is the most likely cause of Tommy's problems? Tommy meets the criteria for a diagnosis of learning disorder. He has a major difficulty in acquisition of new skills (reading). He has a discrepancy between potential (normal IQ) and achievement (below grade level on achievement testing). His profile is uneven, with math abilities being higher than reading and spelling. There is no physical or emotional impairment that can explain the magnitude of his learning problem. He does have some "soft" neurological signs on physical exam. These are relatively non-specific findings that may be found in association with ADHD or LD. Soft neurological signs are non-focal and developmentally inappropriate, i.e., findings that would be considered normal in a younger child. Putting all this information together, Tommy has a "Language-based learning disorder." Learning to read is a complex process which involves symbol recognition, sound association, sequencing, sound blending, comprehension, and articulation. There are at least two ways in which the brain can recognize a written word: phonetically (letter by letter sounding out) or visually (whole word recognition). Children with reading LD may have deficits in either area or both. We cannot completely exclude the possibility that Tommy may also have ADHD. Forty percent of children with

LD also have ADHD, and 15% of children with ADHD also have an LD. At this time, however, it appears that Tommy's inattention is specific to difficulty with language tasks. There is no evidence for a broad-based attentional problem, i.e., all subjects in school, at home, and at play. His attention should be monitored over time, however, as mild cases of ADHD may not be apparent until a child is challenged with more difficult work in the upper grades. Clinicians should use structured rating scales and established DSM-IV diagnostic criteria (for further information on ADHD, see "*The Restless Pupil*."

What recommendations will you make? Clinicians should exercise diplomacy in communicating a diagnosis of LD to school officials. Testing results should be reviewed and discussed with the school psychologist, guidance counselor, learning specialist, and teachers. Remember that they are professional educators and have more expertise and experience in specific educational strategies than most pediatric clinicians. That notwithstanding, clinicians may remind parents that every child with special needs is entitled by law (federal IDEA, state regulations) to an individualized educational plan (IEP). The IEP should provide an appropriate educational approach, geared to individual needs, in the least restrictive environment possible. The clinician can attend school conferences and IEP planning sessions, or simply elect to review the testing reports and make recommendations. Tommy will require a special educational approach designed for children who have language-based learning problems. A formal speech and language evaluation may be helpful in clarifying his specific learning needs. Special education may be given within the regular classroom or in a "resource room" (i.e., specialized smaller classroom), depending on the services available at the school and the individual child's needs. The clinician can advocate for additional "bypass strategies" such as books-on-tape, a "reading buddy" (someone to read *to* him), allowing Tommy to dictate reports and/or take oral exams, use of a computer or word-processor, extra time for tests and assignments, and limits on the amount of homework. Tommy may also benefit from short-term psychological counseling with someone trained to deal with learning disabled children. Tommy's self-esteem may be further lowered by comparison with his sister who is a high achiever. His parents should be advised to help him choose social and recreational activities in which he can be successful. They should value his unique strengths and abilities and praise him for his accomplishments.

What would you like to tell Tommy? How can you improve his feeling of competence and attitude towards schoolwork? During the late middle-childhood period, it is necessary to promote independence by involving the child directly in health care discussions. Developmentally, the tasks of this period involve assuming more responsibility for life management, including school performance and achievement. Tommy's statement about "I could do better if I want to - I just don't care" and his "class clown" behaviors are probably defenses. Children do not like to be seen as different from their peers. His responses to the pictures (TED cards) during the psychological testing indicate the he is actually quite distressed about his academic difficulties. You should explain to him that all kids have "strengths" and "weaknesses." Begin by describing his strengths (intelligence, math ability). Then realistically present his areas of weakness (reading, writing) while explaining that there are strategies which will help him overcome them. His opinions and desires should be respectfully considered in developing the educational plan. You should work with Tommy and his parents to identify potential areas for success. Help him choose a group hobby, team sport, or other activity that will enhance peer acceptance and self-esteem.

****Optional Exercise: Facilitator may wish to have learners role play this conversation, with one participant playing the clinician and another playing Tommy.** The following is an example opening to this dialogue, taken from the "Tommy's Testing" web-based, interactive case video clip. (See bibliography page for internet address.)

Doctor: “Tommy, I’ve read over all aspects of the reports from your school and I think I know why you’ve been having so much trouble. You see, everybody’s brain works differently. We all have both strengths and weaknesses, but some people have a really big difference between the strong and weak areas. When we see this kind of pattern in a smart boy like you, it usually means that you have a Learning Disorder, or LD. That means that the part of your brain that does reading doesn’t work as well as the part that does math. Having an LD doesn’t mean that you can’t learn, it just means that you learn differently and some things will always be harder for you. But the good news is that there are lots of things we can do through your school to make things better for you. I also want you to meet with a counselor who can help you learn new ways of dealing with your weak areas. Anyway, we will work together on this. I can’t promise you it will be easy, but if we all work together, I know you can be successful.

Distribute the Bibliography page and Epilogue. Ask someone to read the Epilogue aloud.

Epilogue

Based on your recommendations, Tommy receives special education services. He goes to the “Learning Center” at his school for all his language arts classes (reading, spelling, etc.), and has math and other subjects (science, art, music) in mainstream classes. He also sees the school psychologist weekly to work on understanding his LD, social skills, and self-esteem. His behavior improves, as do his grades. In 5th grade, he begins to do more and more of his work on a computer, which he enjoys immensely.

Refer back to group’s learning agenda and summarize the key teaching points that were made. This will give the group a sense of accomplishment, and emphasize the important messages. Suggest further sources of reading or other information if there are agenda items that were not covered in the discussion.

Independent Learning/Prevention Exercises: Facilitators may wish to assign “Independent Learning/Prevention Exercises” to the group, particularly if time constraints hinder the completion of the case. The following list includes suggestions to explore the available community resources that focus on Learning Disorders, as well as other areas of pertinent interest that can be integrated during or after the session. If the exercise is done in the absence of the facilitator, learners should take notes on their experience, then discuss with a faculty member for feedback.

1. Invite a school psychologist or special education director to come and speak on school evaluations and services available within the local school system.
2. Talk with a special education teacher about the implementation and practicalities of an Individual Education Plan (IEP).

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Part I

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Tommy and his mother return to the office several weeks later. As you requested, Mrs. Taylor has brought the reports from the school evaluation (See Handouts). She asks, "*What does all of this mean? Shouldn't Tommy be started on Ritalin? Is he going to grow up to be a failure like his uncle?*"

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Epilogue

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Handout #2: WISC-III

WISC-III[®]

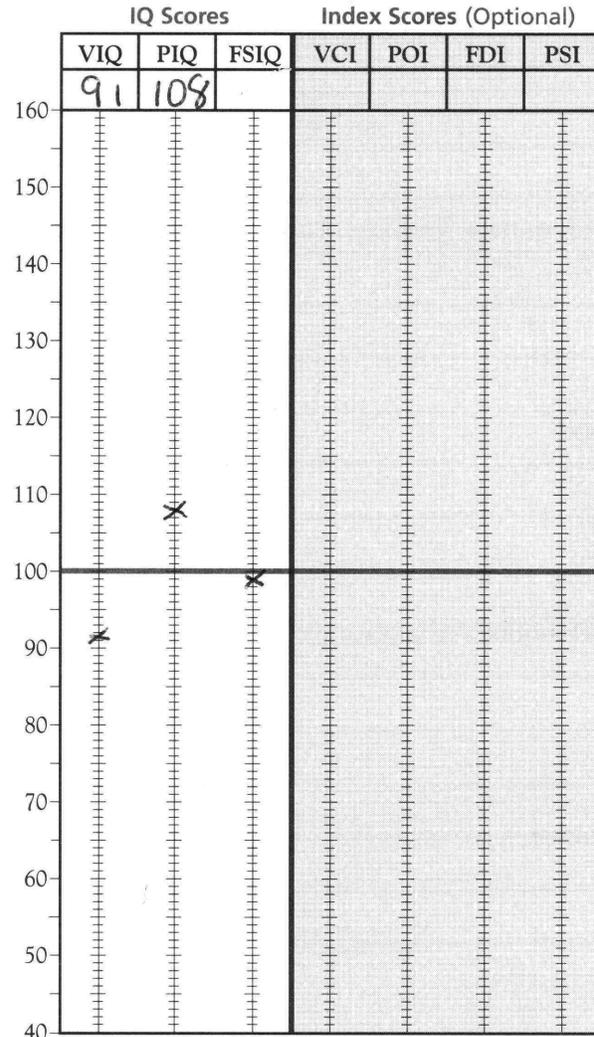
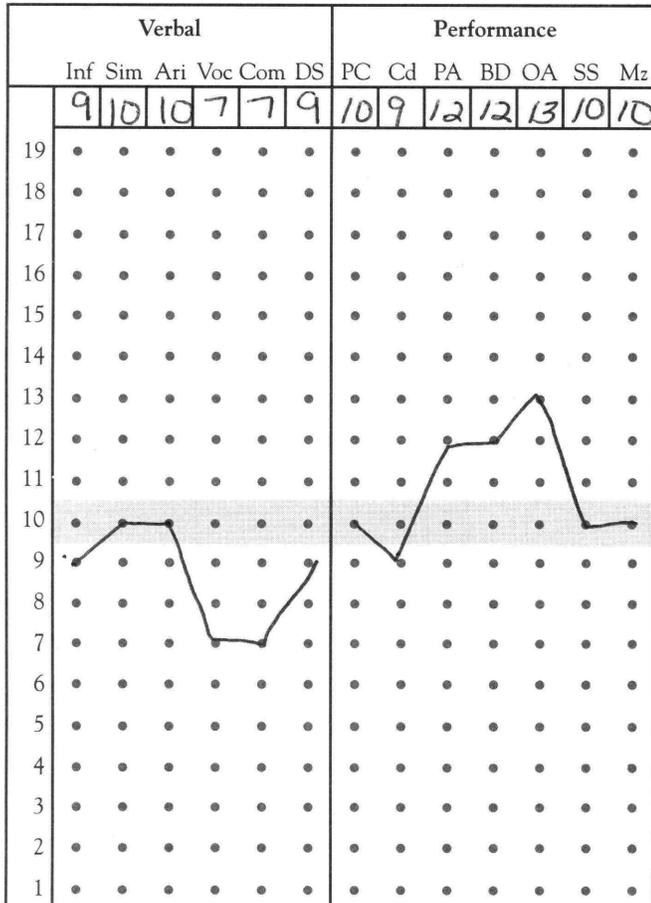
Wechsler Intelligence Scale for Children[®] - Third Edition

Subtests	Raw Scores	Scaled Scores					
		Verbal	Perfor.	VC	PO	FD	PS
Picture Completion			10				
Information	9						
Coding		9					
Similarities	10						
Picture Arrangement		12					
Arithmetic	10						
Block Design		12					
Vocabulary	7						
Object Assembly		13					
Comprehension	7						
(Symbol Search)		(40)					
(Digit Span)	(9)						
(Mazes)		(10)					
Sum of Scaled Scores	42	56					
	Verbal	Perfor.	VC	PO	FD	PS	
	Full Scale Score		OPTIONAL				
	98						

	Year	Month	Day
Date Tested	97	01	03
Date of Birth	86	10	12
Age	10	02	21

	Score	IQ/ Index	%ile	% Confidence Interval
Verbal	42	91		-
Performance	56	108		-
Full Scale	98			-
VC				-
PO				-
FD				-
PS				-

Subtest Scores



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Handout #3: WIAT



Record Form

Summary

Child's Name Tommy Taylor Sex M
 School Maple Street Elementary Grade 3
 Teacher Mrs. Jones Examiner Bill Blum, MA
 Referral Source Mrs. Jones
 Reason for Referral Poor performance, misbehavior

	Year	Month	Day
Date Tested	97	01	06
Date of Birth	86	10	12
Age	10	02	24

Behavioral Observations Attention and persistence were poor on reading and spelling sections. He focused better on listening comprehension and seemed really motivated on math.

WIAT Subtests	<input type="checkbox"/> Age <input checked="" type="checkbox"/> Grade	Raw Scores			Standard Score	Confidence Interval <u>90%</u>	Percentile	Other ^{Grade} <input checked="" type="checkbox"/> Equivalent <input type="checkbox"/> NCE
	Basic Reading		17			78	-	7
Mathematics Reasoning			28		114	-	82	4.3
Spelling				11	71	-	3	1.4
Reading Comprehension		11			83	-	13	2.0
Numerical Operations			21		115	-	84	4.0
Listening Comprehension				21	106	-	66	3.9
Oral Expression				19	101	-	53	3.7
Written Expression				9	89	-	23	1.2

Composites	<input type="checkbox"/> Age <input checked="" type="checkbox"/> Grade	Reading	Mathematics	Language	Writing	Total Composite
	Sum of Raw Scores		18	49	40	20
Standard Score		71	115	104	71	83
Confidence Interval <u>90%</u>		-	-	-	-	-
Percentile		3	84	61	3	13
Other <input type="checkbox"/> Equivalent <input type="checkbox"/> NCE						

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Handout #4: Teacher Evaluation and Comments

Name: Thomas Taylor
Grade: 3
School: Maple Street Elementary
Age: 10 years, 2 months

Teacher Name: Mrs. Jones Subject: Language Arts
Student Performance: Tommy needs to put more effort into his work! His papers are messy with very careless spelling. He often does not complete work. He is missing 5 homework papers so far this term. His spelling quiz scores are 48, 67, (82), 55. I know he could do better if he wanted to!

Comments: Tommy likes to be the class clown. He disrupts the class, and sometimes throws things. I have real concerns about him advancing to the 4th grade. I think he could use some Ritalin!

Teacher Name: Miss Johnson Subject: Math
Student Performance: Tommy's enthusiasm adds a lot to our class. He knows his math facts well, but written work tends to be messy. His last test was a 95 though.

Comments: During the early part of this year, his behavior was a bit of a problem. I think this was due to boredom as he is repeating. Now, I occasionally give him 4th grade work or have him help a classmate.

The Tale of Tommy's Testing Handout #5: Psychological Evaluation

Name: Thomas Taylor **Date of TEAM Meeting:** January 24, 1997
Grade: 3 **Date of Evaluation:** January 3, 1997
School: Maple Street Elem. **Evaluator:** Sheila Smith PhD

Background: Tommy is a 10 year old boy in Mrs. Jones' 3rd grade class. He is currently repeating the year. He was referred for low achievement in reading and misbehavior in class.

Assessments: WISC-III, Writing Assessment, ADHD Rating Scale, ADDES, and TED cards.

WISC-III results were as follows:

Verbal:		Performance:	
Information	9	Picture Completion	10
Similarities	10	Coding	9
Arithmetic	10	Picture arrangement	12
Vocabulary	7	Block Design	12
Comprehension	7	Object Assembly	13
Digit Span	9	(Symbol Search)	10
		(Mazes)	10
Verbal I.Q.	91	Performance I.Q.	108

Tommy's verbal and performance abilities fall within the average range. There is a 17 point discrepancy between these scores, with VIQ<PIQ. This makes calculation of a full scale I.Q. inappropriate. There is not a significant scatter within subtests, but comprehension is an area of relative weakness for him.

His **Writing Assessment** was poorly formed, slowly done, and contained both misspellings and reversals. He wrote "si" for "is", and "The big dog was sab" (instead of sad). These may have been careless errors as writing was clearly not a favored task for him. During this assessment, Tommy began to fidget in his seat and asked "How much longer is this going to take?"

Since ADHD has been considered a possibility for Tommy, additional rating scales were administered which address this concern. His reading teacher completed the **ADHD Rating Scale** and the **School Version ADDES**, both of which described him as inattentive, distractible, and hyperactive; but not at the 95th %ile (the usual cut-off for ADHD). However, his math teacher and his parents rated him as within normal limits.

Tasks of Emotional Development (TED) cards were administered to assess his emotional adjustment. Tommy was shown a series of pictures and asked to compose stories about them.. He had recurring themes of sadness, anger, and low self-esteem related to academic performance. For example, when shown a picture of a child looking in the mirror, Tommy said "He wishes he were smarter". When shown a picture of a child sitting at a desk, he said "He hates school and his stupid teacher told him he has to stay after again".

Conclusions:

Tommy is a 10 year old boy with a history of academic and behavioral difficulties. He has average intellectual ability, with a >1 S.D. discrepancy between verbal and performance scores. While this could indicate language-based problems, his attention on the language section was poor. At least one of his teachers rates him in the borderline range for ADHD. Psychologically, he is distressed by his academic problems. It is unclear how much lack of motivation and/or inattention may be playing into Tommy's present troubles. Further assessment is recommended.

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Bibliography

1. Dworkin PH. School failure. *Pediatrics In Review* 1989;10(10):301-12.
2. Green M, editor. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. Arlington, VA: National Center for Education in Maternal and Child Health; 1994.
3. Green M, Palfrey JS, editors. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Second Edition. Arlington, VA: National Center for Education in Maternal and Child Health; 2000.
4. Johnson DJ. An overview of learning disabilities: Psychoeducational perspectives. *Journal of Child Neurology* 1995;10(suppl 1):S2-5.
5. Keys MP. The pediatrician's role in reading disorders. *Pediatric Clinics of North America* 1993;40(4):869-79.
6. Knight JR, Burr B, Frazer C. Behavior. In: Graef J, editor. *Manual of Pediatric Therapeutics, 6th Edition*. New York: Lippincott-Raven; 1997. p. 539-560.
7. Levy HB, Harper CR, Weinberg WA. A practical approach to children failing in school. *Pediatric Clinics of North America* 1992;39(4):895-928.
8. Lyon GR. Learning disabilities. *The Future of Children* 1996;6(1):54-76.
9. McInerney TK. Children who have difficulty in school: A primary pediatrician's approach. *Pediatrics in Review* 1995;16(9):325-32.
10. Nass R. Advances in learning disabilities. *Current Opinions in Neurology* 1994;7(2):179-86.
11. Nass R. Developmental dyslexia: An update. *Pediatrics In Review* 1992;13(6):231-6.
12. Shapiro BK, Gallico RP. Learning disabilities. *Pediatric Clinics North America* 1993;40(3):491-505.
13. Shaywitz SE, Escobar MD, Shaywitz BA, Fletcher JM, Makuch R. Evidence that dyslexia may represent the lower tail of a normal distribution of reading ability. *New England Journal of Medicine* 1992;326:145-150.

Suggested Readings (Annotated):

Levy HB, Harper CR, Weinberg WA. A practical approach to children failing in school. *Pediatric Clinics of North America* 1992;39(4):895-928. This article provides an extensive discussion of school failure and learning disabilities. There is a detailed guide to history and evaluation tools. Specific strategies are given for problems ranging from specific learning disorder to psychiatric problems, including psychopharmacological management.

McInerney TK. Children who have difficulty in school: A primary pediatrician's approach. *Pediatrics in Review* 1995;16(9):325-32. This article presents a comprehensive overview of management of school failure in primary care office practice. It includes a discussion of the etiologies, a guide to diagnosis, a list of commonly used tests, and clinician's guide to management strategies.

Shapiro BK, Gallico RP. Learning disabilities. *Pediatric Clinics of North America* 1993;40(3):491-505. This article provides a concise guide to the various types of learning disabilities and their etiologies and associated problems. It includes clinical strategies for intervention, including medical, educational, and behavioral therapies. There is a brief discussion of outcome over the lifespan (including adolescence.)

Educational Resources on the World Wide Web

Keys to Successful Learning: A National Summit on Research in Learning Disabilities.

<http://www.nclld.org/summit99/keys99-top.html>

Pediatric Development and Behavior Homepage.

<http://www.dbpeds.org>

American Academy of Child and Adolescent Psychiatry—Facts for Families. This site provides access to the AACAP's award winning "Facts for Families" pamphlet series on various developmental topics. The LD information sheet is #16, and there is one for "Children's Who Can't Pay Attention," #6.

<http://www.aacap.org/publications/factsfam/index.htm>

There is a web-based, interactive version of this case available through a link on the *Bright Futures Center for Pediatric Education in Growth and Development, Behavior and Adolescent Health* web site.

<http://www.pedicases.org>