

OHIO DDD GUIDELINES ON CHILD CONSULTATIVE EXAMINATIONS

When the claim filed on behalf of a child lacks evidence needed to reach the disability determination, DDD may purchase consultative examination of the child. The *Ohio DDD Guidelines on Child Consultative Examinations* supplement SSA's publication, *Pediatric Mental Disorders*, which is available at <https://www.socialsecurity.gov/disability/professionals/greenbook/ce-pediatric.htm>. The consultative child examination requires knowledge of developmental psychology, child psychopathology, and juvenile forensics, as well as knowledge of developmental influences of ethnic heritage, family composition, and socioeconomic factors. Because that knowledge is foundational and available to you elsewhere through peer-reviewed literature, continuing education, and other professional resources, it is not the focus of the *Guidelines*. Instead, the *Guidelines* cover concepts unique to the SSA child consultative examination and report. The consultative examiner is responsible for meeting professional requirements such as those defined by Ohio laws and rules, professional ethical principles and codes of conduct, standards of practice, and other sources of professional requirements. The *Guidelines* do not supplant any professional requirements for psychologists or psychiatrists.

Child Mental Functional Abilities & Limitations

The work of childhood is to learn, grow, play and mature through advancing phases of development. SSA identifies four basic mental functional abilities the typically developing child applies across all childhood phases, though expression of these abilities differs widely with age. At an age-appropriate level, the typically developing child:

1. acquires and uses information;
2. attends to and completes tasks;
3. interacts and relates with others;
4. conducts age-appropriate self-care.

Most children develop normatively, with the four mental abilities advancing on schedule across each developmental phase. Children learn and apply increasingly complex information, conduct increasingly complex tasks, hone increasingly nuanced social abilities, and become increasingly independent in self-care. The SSA disability program recognizes, however, that a DSM disorder can disrupt some children's acquisition or retention of one or more of these four mental abilities.

The SSA disability program is practical. The program considers a child's *mental functional abilities and limitations*. "Functioning" is applying one's mental abilities to the tasks and demands of life. Mental functional *ability* is the mental ability to *do*. Under the disability program, a child's mental functional ability is the child's capacity to apply each of the four mental abilities in meeting age-level tasks and demands. A mental functional *limitation* is the lack, loss, or significant reduction of one or more of the four mental abilities as the result of a DSM disorder. Otherwise stated, mental functional limitation is a psychopathological gap between the child's mental functional ability and the mental functional ability of typically developing children the same age.

Functional abilities and limitations are different from wants and preferences. A 14-year-old may want to do 8th grade academics, but as the result of Intellectual Developmental Disorder, can only do 3rd grade work. An 11-year-old prefers not to do household chores, but has the mental functional abilities to do them. A child's wants or preferences are not the focus of the disability program. The disability program considers what a child is able to do, and unable to do as the result of DSM disorder, compared to the mental abilities of typically developing children the same age.

The Functional Assessment Opinion

Your opinion is not sought on whether a child is disabled. Disability is a legal decision reached by DDD and SSA. Your two-pronged professional opinion is sought, however, on:

- 1) *What, if any, DSM disorder is present?* Use current DSM nomenclature for diagnosis.
- 2) *What are the child's mental abilities and any limitations compared to the functioning of typically developing children the same age?* This is your **Functional Assessment** opinion. Within the disability program, to conclude Functional Assessment limitations, logically you must diagnose a DSM disorder from which the limitations result. Only limitations resulting from a DSM disorder are appropriate to include in the Functional Assessment. The preferred Functional Assessment format is:

FUNCTIONAL ASSESSMENT

What is your assessment of the claimant's abilities and limitations in acquiring and using information compared to the functioning of typically developing children of the same age?

What is your assessment of the claimant's abilities and limitations in attending to and completing tasks compared to the functioning of typically developing children of the same age?

What is your assessment of the claimant's abilities and limitations in interacting with others compared to the functioning of typically developing children of the same age?

What is your assessment of the claimant's abilities and limitations in self-care compared to the functioning of typically developing children of the same age?

Your Functional Assessment opinion needs to flow logically from your report data and interpretations. (Sample Functional Assessments pages 11-17)

The Useful Child Consultative Examination & Report

Your examination and report need to reflect the following concepts to contribute usefully to claim adjudication.

- ***Disability Duration.*** SSA's disability program only covers total disability lasting 12 months or longer. Partial or temporary disability is not covered. Readers need information from you about the duration and course of the child's DSM disorder and any resulting limitation(s).
- ***Limitation: Decreased Ability "To Do."*** The DSM disorder is not a limitation. Autism Spectrum Disorder is not a limitation. Intellectual Developmental Disorder is not a limitation. Limitation is decreased ability to function (to *do*) arising from a DSM disorder. For example, during the interview a 6-year-old with Autism Spectrum Disorder flips the office light switch on and off continuously. He does not speak at any point, but when his parent physically guides his hand away from the light switch, he makes a high-pitched shrieking sound. Throughout the clinical examination, he makes no eye contact with his parent or the examiner. He is unresponsive when either his parent or the examiner calls his name. Fixation on light switches with disinterest in people, nonuse of words, and inability to recognize and reciprocate basic human emotions are *limitations in social ability*. Those limitations result from Autism

Spectrum Disorder. In a different case, a 14-year-old with Intellectual Developmental Disorder cannot identify currency or coins. She cannot walk to school alone because she steps into the street without checking traffic. During the clinical interview, she requires prompting to wash her hands after sneezing into them without a tissue. Her inability to *do* as the result of IDD is the limitation, not IDD.

- *Severity Continuum.* Across children with limitations resulting from DSM disorders, limitations span a severity continuum. At one end, children show slight limitations. An 8-year-old's inattention and impulsivity arising from ADHD are well-controlled with medication. Academic achievement is in the average range with no special education accommodations. He and his parent report he has friends in the neighborhood and at school. He participates on local basketball and soccer teams, responding appropriately to coaching. He takes medication willingly, but occasionally needs reminders. Toward the other end of the continuum, a different 8-year-old already has required two psychiatric hospitalizations for stabilization of uncontrollable rages arising from Bipolar Disorder. Special education accommodations intensified recently after he injured an intervention specialist in school. Now he receives educational instruction in the therapeutic setting of daily partial hospitalization. Every two weeks his parent presents him for a psychiatry appointment. The psychiatrist's records document seven medication changes in the past 18 months with no sustained periods of mood or behavioral stability.
- *Child's Behavior Compared to Behavior of Typically Developing Children.* In your report, the most effective way to convey limitation severity is to compare specific behaviors of the child to the behaviors of typically developing children the same age. A 12-year-old is distracted repeatedly during the clinical interview by counting ceiling tiles in the examiner's office. Based on available treatment records, history reported during the consultative examination, and direct behavioral observations, the consultative examiner diagnoses Obsessive Compulsive Disorder. In the report, the examiner contrasts the child's observed behaviors with the ability of typically developing 12-year-olds to ignore mundane environmental stimuli during one-on-one conversation with an adult. In another case, the examiner notes observing an 8-year-old out of his chair repeatedly, climbing and spinning on a stool. The examiner describes instructing the child seven times to wait until questions are finished before responding. Based on available treatment records, history reported during the examination, and the constellation of behaviors observed directly, the examiner diagnoses ADHD. In the report, the examiner contrasts the child's observed behaviors resulting from ADHD to typically developing 8-year-olds' abilities to stay seated during conversation with an adult, and to listen to entire questions before responding.

In ETRs and IEPs, educators compare the student's observed behavioral abilities to behaviors of typically developing students the same age. This approach transfers well to child consultative examinations.

- *Signs versus Symptoms.* Signs and symptoms are distinct forms of evidence under the disability program. A sign is an observable clinical abnormality manifested in the child's behavior. The clinician directly observes a sign. "Multiple fresh-appearing cuts approximately 2" long were visible across both wrists" is a sign. A symptom is the child's self-report of psychopathological emotion, thought, and/or behavior. "I cut myself to feel something" is a symptom. Symptoms are subjective. Under the disability program, a claimant's statement of symptoms alone cannot be the basis for establishing mental disability. Supporting signs and findings are required. Many children are too young or otherwise psychologically unable to self-report symptoms. A parent's account of abnormal behavior by the child

is neither sign nor symptom, but another form of evidence - the 3rd party statement. Additional forms of evidence include collateral records and psychological test results. In your report, distinguish clearly among different types of evidence by attributing each data point to its source.

- *Cross-compare Different Types of Data.* The child consultative examination is a forensic examination. All types of available data need to be cross-compared for convergence and unexpected divergence. Your direct behavioral observations (positive signs, negative signs, functional observations), examinee self-report (symptoms), the caregiver's account, collateral records, and your test findings are different types of data. Evidence of the child's functioning in everyday settings independent of the disability claim should be factored into diagnostic and Functional Assessment opinions.

What Isn't a Mental Limitation?

Only reduced ability resulting from a DSM disorder is mental limitation, and, therefore, appropriate to include in the Functional Assessment. The following factors are *not* mental limitations.

- *Physical Conditions.* The disability program considers functional limitations resulting from physical conditions. In referring a child for mental examination, whether you are a psychiatrist or psychologist DDD does not seek your opinion or presumptions on physical aspects of the case no matter how compelling you find them. DDD engages licensed physicians to conduct physical examinations of claimants, and to provide medical opinions on physical aspects of claims. Though you are not asked for your opinion on physical matters, it is helpful if you summarize unusual reported physical medical history, and if you mention noteworthy physical *observations* as mental status data. An examiner might mention under mental status that across the examination a 3-year-old never was observed to walk independently.
- *Speech-Language Disorders.* The disability program considers functional limitations resulting from speech-language disorders. Though speech-language disorders appear in DSM, under the disability program consultative psychologist and psychiatrist examiners are not experts on speech-language disorders. Only speech-language pathologists licensed by the Ohio Board of Speech-Language Pathology and Audiology are qualified as speech-language experts. Therefore, you are not asked for your diagnostic or functional opinion on speech-language matters. It is appropriate to note reported SLP services as medical information, and to describe as mental status observations challenges you encountered trying to understand the child's speech. On the other hand, speech signs of psychiatric disturbance are well within the scope of the psychiatric or psychological examination. For example, the concrete speech of Intellectual Developmental Disorder, echolalia of Autism Spectrum Disorder, and vocal tics of Tourette's Disorder are psychiatric signs independent of speech-language disorders.
- *Age-level behaviors.* Typically developing children at times can be impulsive, withdrawn, fidgety, loud, whiny, uncooperative and demanding. When such observed or reported behavior reasonably is expected for the child's age, it is not a mental limitation.
- *Non-pathological variations in skill emergence.* Child development literature defines the normative trajectory of child development based on research analyses of group data. A specific child's development, however, can show numerous non-pathological variations from group-based expectations. Before preschool some children recognize their printed name and can recite the alphabet, but this knowledge is not expected on most kindergarten entrance assessments. Around one-year-old, most toddlers can switch from a bottle to a sippy cup and feed themselves finger foods.

Considerable variation in emergence of these behaviors can be created by parenting practices and the child's preferences, however. Some children look forward to starting school and adapt immediately while others are reluctant and take longer to transition. If it does not result from a DSM disorder, variation from group-based expectations is not a mental limitation.

- *Uncomfortable Biological States.* In general, typically-developing young children have low ability to ignore uncomfortable biological states. While an adult is expected to remain composed despite having skipped lunch or slept poorly, young children who have gone too long without food or sleep are unable to comply with clinical assessment. A 3-year-old's tears and signs of low frustration tolerance throughout the appointment are interpreted differently when the parent mentions the afternoon nap was missed to attend the assessment. Developmentally appropriate child assessment considers the possibility transient non-psychiatric states, such as fatigue, hunger, or mild physical illness, might account for distressed or disruptive behaviors during the examination.
- *Non-pathological Individual Differences in Temperament.* The range of "within normal limits" is vast, and particularly broad in infancy and early childhood. Children, even those within the same family, can show great individual differences in temperament. Sometimes parents interpret non-pathological differences in temperament between a child and her siblings, or between a child and neighborhood peers, as worryingly large. Child temperament is in developmental flux. Unlike adults who have had time to develop skills modifying expression of temperament, children still are learning, developing, and practicing. The shy 5-year-old has not yet developed social skills comparable to those of a more outgoing peer, but his abilities still fall within the broad normal range. A 3-year-old's "No!" when told by her parent "It's time to leave" your office falls in the range of behavior expected of typically developing 3-year-olds. That behavior alone does not reach threshold of Oppositional Defiant Disorder. There is a threshold, however, at which a child's behavioral constellation reaches psychopathology with possible functional limitations. The consultative child examiner is to apply knowledge of developmental psychology, child psychopathology, and juvenile forensics in recognizing when that threshold is reached.

Developmentally Appropriate Child Consultative Examinations

The report needs to be written in a manner illustrating your application of clinical concepts, examination techniques, and functional expectations tailored to the child's age.

Clinical Concepts

SSA points out there are age-group variations in disease manifestations. Explore for disorders emerging in childhood. Some expected facets of examining a 6-year-old include intellectual level, ability to separate from the attachment figure, range of interests, social reciprocity, and concentration, for example. Examination of a 6-year-old is not expected to explore for delusions, hallucinations, and psychotically disorganized speech.

Examination Demands & Techniques

SSA points out there are age-group variations in evaluation methods. The report needs to illustrate evaluative demands and techniques developmentally matched to the child's age. For a 4-year-old, was child-sized furniture available? During the parent interview, were attractive age-appropriate toys made available? Illustrate in the report the age-suited techniques you applied to establish rapport, engage the child's attention, and redirect attention when needed. Copying a circle, cross, and square is not an age-appropriate cognitive task for a 16-year-old, but is appropriate for a preschool-aged child. Gathering clinical and functional data through clinical interview is a reasonable method for examining a 16-year-old. Clinical interview is not an

appropriate method for examining a preschooler, however, because the preschooler's less developed verbal abilities will limit useful information. When examining a preschooler, your account of play-based assessment is expected.

Ability Expectations

The report must illustrate you applied ability expectations developmentally appropriate to the child's age. A typically developing 3-year-old is expected to interrupt the parent interview multiple times with requests for attention to her toys and activities. While two adults converse nearby, a typically developing 3-year-old is not expected to sit quietly in an adult-sized chair for more than a few minutes without wiggling or fidgeting. A typically developing 3-year-old is expected to require multiple reminders from adults conversing nearby not to touch a highly attractive object on the examiner's desk. A typically developing 6-year-old is not expected to know the purpose of the examination, produce a government-issued ID, know the exact date, or name the current US president. Once the examiner establishes rapport, a typically developing 6-year-old is expected to answer personal information questions correctly such as name, age, name of school, and grade in school.

Some behaviors are normative at one age, but of concern at an earlier or later developmental phase. An 18-month-old is expected to be afraid when approached by an unfamiliar adult, and to hide his face and require extended time before making eye contact. The same behavior by a 16-year-old requires considerable description and clinical exploration. A 12-year-old sitting quietly through a parent interview without toys or other entertainment is unremarkable. A two-year-old showing the same behavior warrants detailed description and expanded assessment.

A child claimant's abilities should not be compared to the demands of adult roles and responsibilities.

Parents' Knowledge of Child Development

Sometimes typically developing children engage in unpleasant and annoying behaviors. Children sometimes whine and cry, act silly, refuse to cooperate, or are highly active when parents want them to be quiet and still. Children often are messy, and sometimes destructive. Parents vary in knowledge of child development, and in degree of realistic expectations for their own child's behaviors. Some parents may pathologize normative behavior. Others may normalize pathological behavior. No matter how firm the parent's view, in reaching diagnostic and Functional Assessment opinions the consultative examiner is to apply child development and child psychopathology expertise, and to consider available collaterals, direct behavioral observations, and any test findings in addition to the parent's account. The length of time the reporting caregiver has lived with the child should be noted.

Unrepresentative Behaviors

Sometimes behavior in one setting does not represent the child's characteristic day-to-day functioning. Uncharacteristic behavior can emerge in response to the one-time clinical interview. A shy child may not warm up sufficiently during the clinical interview to speak directly to the consultative examiner, particularly if developmentally appropriate methods for establishing rapport were not applied. The same child in school may routinely speak to teachers and classmates age-appropriately. An 11-year-old removed once from her family by Child Protective Services may misconstrue the clinical examination as prelude to another removal. She may behave as withdrawn or disruptive, though that is not her characteristic behavior. Or during the examination a young child may not show a competence the parent says is mastered, such as reciting the alphabet or naming colors. An 8-year-old with ADHD may remain seated, answer questions without repetition and follow instructions without redirection in the one-on-one interview setting, yet school records document impulsivity and inattention negatively affecting his achievement. A child repeatedly suspended from school for fighting

and aggression may sit calmly in your office with no signs of hostility, and deny any problems getting along with others. Explore with the parent (and the youth, if age appropriate) whether behaviors during examination reflect the child's characteristic behaviors in the home, school and community.

Pertinent Developmental Information

In mental claims, SSA and DDD only request developmental milestones for children up to age 3. For children 3 and older, early developmental milestones like independent sitting and age at first spoken word often are too remote and narrow to be clinically and functionally informative currently. Usual daily activities are expected for children 3 and older. Inquiry into daily activities needs to be age-tailored to the child. Depending on the clinical and functional hypotheses emerging in a case, explore facets of daily activities likely to be most informative. Daily activities inquiry in a case of Autism Spectrum Disorder is expected to take different directions and turns than inquiry in a case of Oppositional Defiant Disorder.

Helpful information on daily activities may include: What chore(s) is the child expected to complete on a daily basis? If the child does not complete chores independently, what form and amount of assistance is needed? Does the child independently complete homework? Does the child have friends from school who visit him/her at home? Is the child part of any regular group activities, such as a playgroup, church school/nursery or sports team? If so, how does he/she get along with the other children? How does the child get along with the adults in that setting? Does the child have friends in the neighborhood? Does the child go outside to play by him/herself? If so, what does he/she do outside and how long does he/she stay out unsupervised? How does the child know when it is time to come home? Does he/she come home on time independently? Does the child independently follow a bedtime routine (such as bathing, putting on pajamas, brushing teeth or something similar)? Does the child independently follow a morning routine? What does it entail? How does the child react to frustration or disappointment? How does the child respond to excitement or positive anticipation? How frequently does the child need the caregiver's help to manage emotions appropriately?

Child development involves transitions. Account of the child's responses to expected and unexpected transitions is informative. For example, what were the child's immediate and long-term responses to starting daycare or preschool, and to advancing from preschool to kindergarten? How did the child respond immediately and long-term when relocated to a different household with different family composition? How did the child respond immediately and long-term to the absence, illness or death of a significant adult? Integrating developmental information with behavioral health information is particularly helpful.

Behavioral Health Information

Readers need sufficient behavioral health information to understand the nature, severity, course, duration, response to any interventions, and impact on the four mental abilities of any DSM disorder(s). Behavioral health information should be construed broadly. Behavioral health information includes account of current and lifetime abnormalities of emotions, thoughts, and/or behaviors reasonably considered psychiatric allegations - whether treated or untreated. A parent's report a child has untreated poor concentration is behavioral health information. A child's report of low mood, tearfulness, and self-loathing - whether treated or untreated - is behavioral health information. A parent's report a child "has depression and gets Zoloft from Dr. Smith our family doctor" is behavioral health information. A child's report "I lived at a treatment place for a while in middle school" is behavioral health information.

The parent's account of when concerns about the child's behavior first emerged can be helpful. What informal strategies were attempted? What were the results? When did concerns rise to the level prompting discussion with the pediatrician or other health care provider? What intervention was recommended? What was the

result? Whether reported treatment is past, current, or both, relay account of who initiated treatment, why treatment was needed, types/intensity of treatment, any medications prescribed, treatment dates, names of treatment providers/facilities, the role of the caregiver in treatment, the child's response to treatment including the extent to which the disorder is/was controlled, and circumstances under which treatment ended. If no past or current treatment is reported, the caregiver's explanation for the lack of treatment is needed.

As part of treatment, children with DSM disorders may be placed in a variety of structured settings outside the home. Such settings include, but are not limited to, psychiatric hospitals, developmental disabilities facilities, residential treatment centers and schools, community-based group homes, and workshop facilities. Structured placements reduce mental demands and may attenuate overt signs of the DSM disorder, giving a falsely high impression of the child's functional abilities. In evaluating severity of a DSM disorder and resulting limitations, consider the child's four mental abilities compared to age-level functioning outside the highly structured setting. When naming a treatment facility in your location, mention for readers the nature of its services. Not all structured placements of children are for psychiatric reasons. Juvenile justice sentencing to Ohio Dept. of Youth Services on an RSP conviction is non-psychiatric placement of the child in a structured setting. Placement in a structured setting for a non-psychiatric reason is not behavioral health information.

Educational Experiences

Name the reported school district. Account is needed of customary marks, and the current or highest grade completed. Mention if a vocational curriculum is reported. If the child left school before completing high school, sufficient information is needed for readers to determine whether departure was for psychiatric or non-psychiatric reasons. Information is needed also on the quality of relations with teachers and peers, extracurricular involvements, and the basis and frequency of any suspensions/expulsions.

A child's or 3rd party's account is needed of the purpose, nature, intensity, and outcome of any specialized educational interventions received. Most children receive education in a regular classroom without accommodations or special education classification. When needed, however, schools provide specialized interventions along a vast continuum. At one end, children with slight learning difficulties receive minimal supports such as flexibility with assignments and homework submission dates. At the other end, intensive resources support children with abilities far below age expectations as they work toward highly modified educational goals. For example, IEP goals of a 13-year-old with IDD include improving her skill choosing between two beverage options. An 80% response rate of picking orange juice or milk with lunch is required to meet her educational goal. A full-time one-on-one assistant supports her throughout the school day. It should be kept in mind that children requiring intensive intervention, such as this 13-year-old, are at particular risk of under-reporting services.

Although grades, accommodations, and special education classification(s) are important information, they are not conclusive. There is too much variability from school district to school district in the expected level of grading and in the criteria for special education placement to rely solely on those factors in reaching diagnostic and Functional Assessment opinions.

Psychological Testing

Testing Requests & Related Issues. DDD lists on the voucher any requested psychological testing. Use the current test edition. SSA requires standardized administration, scoring and interpretation of psychological tests. A testing request from DDD does not supplant testing requirements for psychologists defined by Ohio laws and rules, ethical principles and codes of conduct, standards of practice, or other sources of professional

requirements. If the DDD voucher lists WISC-V testing with language interpreter participation, the examiner is expected to contact Medical Administration and question the request because English-language intelligence testing of non-English-speaking examinees is contraindicated. More generally, if you think a test other than the one requested is more suitable, contact Medical Administration for preauthorization prior to any test substitution.

Supervisees. If you conduct the clinical interview with mental status exam, interpret test results, and write the report, DDD accepts testing administered by a supervisee under your direct supervision as long as supervision meets Ohio Board of Psychology requirements. Disclose supervisee participation to readers.

Test Scores, Testing Interpretation, Validity Opinion. Submit complete WISC-V subtest and composite scores. Equivalent score detail is needed for other testing. In addition to your narrative discussion of scores, provide scores in a table or other format that is easy-to-process visually. Clearly state your validity opinion about the scores produced. Note factors influencing score validity, such as level of cooperation or distraction. Discuss consistency of scores with educational information and evidence of the claimant's customary functioning in everyday settings. SSA requires you compare IDD range scores for consistency with information on the claimant's adaptive level of personal, social, and academic functioning during the developmental period. Test outcomes are incremental data. Diagnosis and Functional Assessment opinions are not to be based solely on psychological test outcomes, such as WISC-V scores.

Mental Status Examination

SSA indicates adult mental status tasks are inappropriate for the child claimant. The child mental status exam needs to be tailored to the child's age, reflecting your expertise in child development, child evaluation techniques and age-appropriate functional expectations. Mental status data need to inform readers about clinical status and functional level. The adjudicative team has no opportunity to observe the child directly. Two types of mental status data need to be well represented in particular:

1. Provide multiple direct behavioral observations keyed to the child's age. Include sufficient detail so readers can compare for themselves behaviors you observed to behaviors of typically developing children the same age. A consultative examiner writes, "3-year-old Justin did not utter any intelligible words during the assessment. He did produce repetitive consonant-vowel babbling (bababa, mamama) while making eye contact and engaging in social turn-taking with me. When I pushed the button on a toy and its door opened to a Sesame Street figure, Justin startled then looked at his father and laughed. He did not try to mimic my actions with the toy, even when I handed it to him saying, 'push this button' while pointing at the button on the toy. Justin appeared to be wearing diapers, consistent with his father's report toilet training has not been achieved." The examiner's behavioral description of 3-year-old Justin conveys limitations consistent with developmental delay. The examiner's observations on nonverbal communication and shared attention helped DDD readers identify program concepts best matching the claim. Developmentally tailored direct behavioral observations are crucial for a useful report.
2. Describe the setting, methods and course of the examination to show readers how you tailored demands to fit the child's developmental level. Readers need sufficient data to appraise for themselves the fit of your methods to the child's age. An examiner's self-appraisal that "developmentally-appropriate interview methods were used" does not suffice. Describing the office environment, actions of various parties, materials you made available to the child, and illustrating your strategies to engage the child give readers a window into the age-match and functional demands of your approach.

Asking a 4-year-old to sit quietly in an adult-sized chair while you interview the parent is a greater functional demand than providing the child with attractive age-appropriate toys for play while the parent is interviewed. A 4-year-old's interruptions of the adults would have different functional implications in these two circumstances.

Your direct observations of positive signs, negative signs, and functionally informative behaviors should comprise the mental status data, not symptoms or parent allegations. One exception is risk assessment which explores for risk-related symptoms in addition to signs and history, and by convention often appears under mental status.

Reliability Estimate

SSA requires your reliability estimate. The reliability estimate is a summary statement on what data you relied on and why, and what data you did not rely on and why not, in reaching your conclusions. Instruction is available through continuing education, professional publications, and other resources on assessing the representativeness of examinee behaviors, 3rd party statements, and other forms of evidence.

Case Formulation

A cut-and-paste restatement of your report data is not a case formulation. The case formulation is an interpretive bridge from your data to your diagnostic conclusions and Functional Assessment. The case formulation needs to reflect developmentally appropriate clinical concepts and functional expectations. This is where you explain the evidence supporting your conclusions, and reconcile contradictory data. This is where you anticipate and address aspects of your exam and conclusions that are particularly open to alternative interpretations. Unreconciled contradictory data and unaddressed obvious alternative interpretations reduce the usefulness of a report and open it to addendum requests.

Diagnostic Formulation

The diagnostic conclusion needs to appear under an easy-to-locate heading. SSA requires use of current DSM nomenclature. SSA points out there are age-group variations in disease manifestations. The diagnostic formulation needs to reflect developmentally appropriate psychiatric concepts. The diagnosis needs to arise logically from the signs (positive and negative), symptoms, and findings in the data available to you, and link logically to your Functional Assessment.

V-Codes & Borderline Intellectual Functioning (BIF). The disability program considers limitations resulting from DSM psychiatric disorders. V-codes are not psychiatric disorders. Borderline Intellectual Functioning is a v-code and, therefore, not a psychiatric disorder. Though not a psychiatric disorder, the disability program formally recognizes mental functional limitations can result from BIF, and considers BIF's functional impact when evaluating claims. When present, include BIF in the diagnostic formulation. BIF is the only v-code considered by the program. V-codes other than BIF have no corresponding disability program concept. Omit v-codes other than BIF. The legal decision maker is a non-clinician who may mistake a v-code for a psychiatric disorder, which introduces problems in adjudication that could have been avoided had the examiner omitted the v-code.

The first pages of these *Guidelines* defined the Functional Assessment. The Functional Assessment can be most effective when located at the end of a report, after readers are familiar with your data and interpretations. The Functional Assessment is to reflect details unique to the child, and not template phrasing. Cite from all types of available evidence including signs (positive and negative), direct functional observations, claimant-reported history and symptoms, 3rd party account, any collateral records, and psychological test results. Citing only WISC-V scores or only mental status data is not a well-supported Functional Assessment. Importantly, *compare specific behaviors illustrating the child's abilities and any limitations to the behavioral abilities of typically developing children the same age.* The following samples illustrate the types of information that can make a Functional Assessment useful to adjudication.

Infant/Toddler (approx. 12 months to age 3)

Functional Assessment Example One: 14-month-old with no diagnosis

What is your assessment of the claimant's abilities and limitations in acquiring and using information compared to the functioning of typically developing children of the same age?

This 14-month-old consistently responded to her name. She followed simple verbal directions. When asked to find a ball she visually scanned office toys, walked to a shelf, picked up a football, and said "Ball!" She put a hat on her head when instructed to do so. She correctly pointed to her feet, belly and head, but did not identify her forehead or elbow. She did not reliably identify colors; she pointed to a green block when asked to find the red one. She did not count or repeat my counting during our interaction. When asked to copy a circle, she tried to put the crayon in her mouth. She engaged in symbolic play with a toy telephone, holding the receiver to her ear and saying "Hello" (pronounced "heyo"). She showed symbolic play with a doll by wrapping it in a blanket, holding it and rocking back and forth. Ability in this area is developmentally appropriate.

What is your assessment of the claimant's abilities and limitations in attending to and completing tasks compared to the functioning of typically developing children of the same age?

This 14-month-old played independently with toys for up to two minutes. Frequently she sought attention from her father and me, interrupting the parent interview. Interruptions increased across the assessment. She fidgeted and moved often during the 45-minute examination, never sitting still for more than a few minutes at a time. She squirmed for release when briefly held on her father's lap. She climbed on and under furniture, and this became more frequent across the assessment. She completed my one-step instructions without need for prompting. Ability in this area is developmentally appropriate.

What is your assessment of the claimant's abilities and limitations in interacting with others compared to the functioning of typically developing children of the same age?

She hid her face on her father's shoulder when I approached initially, but established eye contact with her father and me during the rest of the examination. She vocalized "Look, look!" (pronounced "yook, yook") to get adult attention. Separation from her father was not observed due to her young age. Her father described both separation and stranger apprehension in some settings. He said she has trouble playing cooperatively with her siblings and tends to snatch toys. She showed social referencing, looking to her father for approval when I offered her a small package of goldfish crackers during the interview. She showed joint attention and shared enjoyment when sitting on her father's lap in the waiting room as they read a book together. Ability in this area is developmentally appropriate.

What is your assessment of the claimant's abilities and limitations in self-care compared to the functioning of typically developing children of the same age?

Her father reported she is not toilet trained. He said she refuses to use a cloth to wipe hands/face after eating, and requires full parental assistance for hygiene and grooming. She was observed to feed herself finger foods in the office. He father said "she is very messy" when trying to feed herself with a spoon. He said she is able to take off her socks and some pants, but does not yet put on any clothes independently. He said she has tantrums several times weekly, generally "when she's frustrated." No tantrum behavior was observed here. Ability in this area is age-appropriate.

Functional Assessment Example Two: 2-year-old with Autistic Spectrum Disorder

What is your assessment of the claimant's abilities and limitations in acquiring and using information compared to the functioning of typically developing children of the same age?

This 2-year-old did not respond to my requests that he point to various body parts. He also did not respond to my requests to find a ball on the toy shelf. He chose toys with buttons and spent much of his time pushing the buttons repeatedly with no demonstrated expectation that the button would cause something else to happen. Understanding of simple cause and effect with an object is evident early in normal development via secondary circular reactions seen between 4 and 8 months of age. Mastery of object permanence between 8 and 12 months results in a deeper understanding of cause and effect connections, which is then consistently incorporated into play behaviors. A 2-year-old who does not attend to cause and effect relationships is engaged in exploratory play, which is cognitively less advanced. The child did not spontaneously show symbolic play. He did not attempt to mimic or join in pretend play demonstrated by his father or me. He responded to his name 3 out of 8 times when called by me, and 5 out of 7 times when called by his father. Typically developing two-year-olds consistently respond to their name, are able to answer questions and follow simple instructions, engage in pretend play, and imitate actions of adults. His father said the child's behavior in the office was usual for him.

What is your assessment of the claimant's abilities and limitations in attending to and completing tasks compared to the functioning of typically developing children of the same age?

For the entire 70-minute examination, this 2-year-old concentrated on his play without redirection from adults. He resisted adult attempts to interrupt his play, and resumed a fixed style of play repeatedly pushing buttons as soon as allowed to do so. Typically developing 2-year-olds can independently concentrate for 2-5 minutes. He did not abandon pushing buttons to seek adult attention at any time during the examination. Typically developing 2-year-olds seek frequent, if not constant, attention from an adult.

What is your assessment of the claimant's abilities and limitations in interacting with others compared to the functioning of typically developing children of the same age?

His father said, "He hasn't enjoyed being held since about 3 months old." He added, "He likes to be tickled and wrestled with," but otherwise does not want to be physically close. The child did not make eye contact during the assessment and did not spontaneously look to adults when pretend play was modeled. His father reported, "He doesn't come to his mother or me" for comfort when upset at home. When his father stood and left the interview room briefly (door kept open due to young age), he did not look up or otherwise respond. He inconsistently responded to his name during the assessment. He showed no joint attention or social referencing behavior. Typically developing 2-year-olds generally are aware of the location of their primary caregiver, resist separation from that person, and seek affection/physical proximity when distressed. Children at this age also regularly use eye contact, facial expressions, body posture and gestures to express their thoughts and feelings.

What is your assessment of the claimant’s abilities and limitations in self-care compared to the functioning of typically developing children of the same age?

His father reported the child is not toilet trained. His father said he is uncooperative with changing clothing and taking baths, and frequently has extended tantrums during those activities. His father said, “He has meltdowns 5-6 times a day over ordinary stuff.” His father described severe tantrums, reporting the child has injured himself during outbursts including bruises and one laceration requiring stitches. Here the child showed no interest in snack crackers his father offered during the assessment. His father reported the child is able to feed himself finger food. His father said the child still drinks from a bottle, and refuses to drink from a sippy cup. His father described high sensitivity to food texture and said he eats only a limited number of foods. Typically developing two-year-olds will not persist at painful behaviors, even during a tantrum. 2-year-olds are generally able to drink from a cup or sippy cup. Picky eating, including refusing all but one or two favorite foods, is not unusual for toddlers.

Early Childhood (approx. 3-6 years)

Functional Assessment Example One: 3.5-year-old with no diagnosis

What is your assessment of the claimant’s abilities and limitations in acquiring and using information compared to the functioning of typically developing children of the same age?

This 3.5-year-old sang part of the alphabet song, counted to 4, and reliably identified red, blue, green and purple. He was partially correct with the color yellow, using that word to describe orange items also. He printed an approximation of the first letter of his name, but could not recognize his name among an array of words starting with the same letter. He did not know his address or phone number. His mother said he enjoys preschool which he attends 3 mornings weekly. His mother said he does not have an IEP or receive other early childhood interventions. Ability in this area is developmentally appropriate.

What is your assessment of the claimant’s abilities and limitations in attending to and completing tasks compared to the functioning of typically developing children of the same age?

His mother said, “He’s hyperactive. We have to watch him all the time.” She said, “He’s always getting into things when he knows better.” She said he repeats behaviors he has been punished for in the past. This 3.5-year-old independently maintained play with several toy cars on a racetrack for almost 7 minutes while his mother was interviewed. His play was punctuated by near-constant physical movement (rocking back and forth as he moved the cars, sitting/standing/lying down, jumping as the cars “crashed” off the track) and loud verbal outbursts (“Wow...Uh-oh...Big crash”) that were clearly related to his play. He sought adult attention (“Mom, look at this!”) several times, but returned to play after his mother’s brief acknowledgement. As the interview progressed, he showed increasing difficulty resisting urge to touch items on my desk, and eventually required physical assistance from his mother who picked him up and moved him back to the toy area. He sat and colored at his mother’s suggestion, but after only a few minutes was out of his seat exploring the office again. The frequency of his verbal interruptions and his level of physical activity increased over the course of the parent interview. During the child interview, he and I worked together to build a house out of play-doh. He responded to my questions, complied with one-step directions and remained engaged in the activity for almost 15 minutes. During that time, he alternated between sitting/standing/hopping and climbing on and around the table. His mother said his behavior during the exam represented his usual behavior. His mother said his preschool teachers have not raised concern about his attention or activity level in the school setting. Ability in this area is developmentally appropriate.

What is your assessment of the claimant’s abilities and limitations in interacting with others compared to the functioning of typically developing children of the same age?

His mother said, "I don't like to say it, but he can be mean and aggressive." She said, "They're older, but he's always hitting, wrestling, and pulling his sister's and brother's hair." In this setting, he presented bright affect and was generally compliant with parental instructions, although he did need physical assistance to move away from some attractive items on my desk after about 30 minutes in the office. His play with cars included some loud outbursts and toys pushed off the table, but his tone of voice remained pleasant and there was no indication of a negative affective state. He showed multiple incidents of social referencing and frequently attempted to engage his mother in his play. He was responsive and open to interacting with me, an unfamiliar adult, and complied with all my directions while playing together. He tolerated a 5-minute separation from his mother when I asked her to leave the office briefly. Abilities in this area are developmentally appropriate.

What is your assessment of the claimant's abilities and limitations in self-care compared to the functioning of typically developing children of the same age?

His mother reported he can put on his own clothes, but needs assistance with buttoning and zipping. She said he is toilet trained during the day, but described frequent nocturnal enuresis. "He wears pull-ups to bed." The child did not appear to be wearing diapers today, did not ask to use the restroom and showed no signs of toileting accidents during the clinical interview. She said he drinks from a cup and can feed himself, though resists using spoons/forks, instead eating with his fingers. She said he needs ongoing reminders to wipe his mouth. His mother said the child requires adult assistance to use soap and bathe properly. The child and his clothing appeared clean at today's appointment. She reported he is easily annoyed by his siblings, often making an angry face, hitting or crying. In my office, the child played happily with toys and did not show undue frustration or agitation when his mother helped him move away from interesting objects on my desk. She said she has not heard any feedback from preschool teachers about problems with tantruming at school. Abilities in this area are developmentally appropriate.

Functional Assessment Example Two: 5-year-old with Intellectual Developmental Disorder

What is your assessment of the claimant's abilities and limitations in acquiring and using information compared to the functioning of typically developing children of the same age?

The current IEP provided by DDD reflects 5-year-old Kaylee is enrolled in special education kindergarten for cognitive delays. Kaylee produced WPPSI-IV FSIQ 62 today, consistent with her adaptive level reflected in the IEP and with Intellectual Developmental Disorder. Kaylee's non-test behaviors here included not understanding my verbal instruction to "put the crayon back in the box," though she mimicked my demonstration. When asked her age, she responded "Kaylee." Her language was very simple and her statements short ("Go home now?"). Her father described developmental milestone delays, including taking her first step at 23 months and completing daytime toilet training at 39 months. Her father reported early intervention programming including Help Me Grow, case management through Developmental Disabilities and special needs preschool consistent with FSIQ 62. Typically developing 5-year-olds attend a regular education program without specialized assistance/instruction, produce an average-range FSIQ score (85-115), and can understand and implement simple instructions and questions from adults. Kaylee's FSIQ 62 is consistent with functioning at the 1st percentile for children her age.

What is your assessment of the claimant's abilities and limitations in attending to and completing tasks compared to the functioning of typically developing children of the same age?

Her father described Kaylee as easily distracted and needing excessive redirection to complete simple tasks, such as putting a toy on the shelf or putting on her jacket. WPPSI-IV results included working memory (WMI 58) and processing speed (PSI 71) below age expectations, and at the less than first and 3rd percentiles, respectively. During the parent interview, this 5-year-old sat in a child-sized chair and quietly played with blocks and the doll she brought with her. She was not particularly attentive to the interview process. Nor was

she disruptive. During testing, she sometimes needed multiple prompts to respond to questions, and sometimes appeared to lose track of what she was doing in the middle of a response. Typically developing 5-year-olds achieve testing scores in the average range (SS 85-115) and are able to sustain attention to tasks during one-on-one interactions with an adult.

What is your assessment of the claimant's abilities and limitations in interacting with others compared to the functioning of typically developing children of the same age?

Kaylee smiled and waved to me after prompted by her father. She complied with all instructions from her father and me. She answered questions with one to three word responses, sometimes giving unresponsive answers such as responding with her name when asked her age. She made occasional eye contact, but frequently had a rather blank expression on her face. I did not observe social referencing during the assessment, but she did show turn taking and gesturing. She showed no distress when her father stepped out of the office for a few minutes at my request. Her father said Kaylee enjoys watching children at a park near their home, but rarely joins in their play. The IEP notes Kaylee rarely asks for assistance when not understanding a task, instead sitting and looking at the paper until an adult intervenes. The IEP notes Kaylee needs prompting and ongoing support to interact with classroom peers. Typically developing 5-year-olds enjoy, seek out, and join play with same-age children. Typically developing 5-year-olds generally are able to respond relevantly to age-level questions and directions from adults, and show basic social behaviors independently, such as making eye contact and responding to someone's greeting.

What is your assessment of the claimant's abilities and limitations in self-care compared to the functioning of typically developing children of the same age?

Her father reported Kaylee feeds herself finger foods, and is improving her use of a spoon. He said Kaylee still has difficulty drinking from an open cup without spilling, but can use a sippy cup independently. He reported Kaylee is toilet trained and "only occasionally" has nighttime accidents. During this assessment, I observed the child squirming in her chair, then putting her hand between her legs. When her father asked her if she needed to "go potty", Kaylee nodded. We took a break while he took her to the restroom. According to her father, Kaylee still needs a lot of assistance getting dressed/undressed and is completely dependent for bathing. Her father said Kaylee can brush her own teeth, but needs oversight to ensure thorough cleaning. According to the IEP, Kaylee sometimes needs a prompt to visit the bathroom, always requires assistance unfastening/fastening clothing for restroom breaks, often needs a reminder to put her lunchbox in the basket, but is able to find her cubby independently with a pictorial reference. Children of this age generally are adept at using utensils and open cups, though most require assistance cutting food. Typically developing 5-year-olds can put on and take off most clothing items, and request assistance as needed with difficult fasteners (zippers, buckles, tying shoes).

Middle Childhood (approx. 6-10 years)

Functional Assessment Example – 9-year-old with Specific Learning Disorder with impairment in reading, written language and math

What is your assessment of the claimant's abilities and limitations in acquiring and using information compared to the functioning of typically developing children of the same age?

The available 2014 ETR reflects 9-year-old Brandon receives special education accommodations for Specific Learning Disorder. The 2014 ETR reflects intellectual functioning in the average range (WISC-V FSIQ 102) along with deficits in academic skills (WJIII Reading 72 Written Language 78 Math 74). Testing was not requested for this assessment. In the clinical interview, Brandon showed comprehension of simple questions by responding appropriately. For example, when asked what school he attends, he said "Spring Creek Elementary." When asked his favorite food, he answered "pizza." His mother described Brandon as working "hard and carefully"

on class assignments and homework, but said he has “great difficulty catching on to” the 3rd grade curriculum. Typically developing children show academic achievement levels generally consistent with their intellectual functioning in the average range.

What is your assessment of the claimant’s abilities and limitations in attending to and completing tasks compared to the functioning of typically developing children of the same age?

2014 ETR classroom observations reflect attentive, hard-working behavior during class, while needing individualized, repeated instruction on key concepts in a small group setting. 2014 ETR classroom observations are consistent with mother’s report here of careful attention to his homework. 2014 ETR WISC-V results suggest relative weakness in working memory (WMI 79) and processing speed (PSI 83), though these scores fall in the high BIF and low average ranges respectively. His mother said Brandon often requires reminders, but usually then completes chores quickly. During this assessment, he tracked topics under discussion, and did not need questions or instructions repeated. He did not require redirection to task. Typically developing children are able to carry out academic assignments at grade level in a general classroom setting without specialized intervention.

What is your assessment of the claimant’s abilities and limitations in interacting with others compared to the functioning of typically developing children of the same age?

Nine-year-old Brandon presented as friendly and cooperative. He greeted me politely and showed pleasant and appropriate emotional expression throughout the clinical interview. His mother said he has good relationships with teachers and has never been disciplined for any significant behavior problem at school. No social deficiencies were noted in the ETR. He told me, “I have a bunch of friends” at school and in his neighborhood. He agreed to speak with me independently, and continued to be polite and cooperative in his mother’s 10-minute absence from the interview room. Ability to interact is age appropriate.

What is your assessment of the claimant’s abilities and limitations in self-care compared to the functioning of typically developing children of the same age?

His mother said Brandon needs prompting to complete hygiene tasks, but that he is able to wash his hair/body, brush teeth, comb hair and get dressed independently. The 2014 ETR, Brandon’s mother, and Brandon do not identify problems with emotional outbursts. In the 2014 ETR, school personnel describe Brandon as “easy-going and generally positive.” There is no reported history of behavioral health services. Ability in this area is age appropriate.

Adolescence (approx. 11+ years)

Functional Assessment Example: 16 year-old with Major Depressive Disorder with Mixed Features

What is your assessment of the claimant’s abilities and limitations in acquiring and using information compared to the functioning of typically developing children of the same age?

In this setting, spontaneously she used the words “marginalized” and “immobile” correctly. During the parent portion of the interview, her father reported this 16-year-old formerly had “mostly As with some B grades,” until the past 2 years when “her grades slid seriously.” The available 2016 ETR reflects special education accommodations for “Emotional Disturbance,” including high school classes currently provided within partial hospitalization. School records document average intellectual assessment results, but very low participation and completion of class/homework resulting in her failure of all academic subjects during the last semester. Teacher aide comments in the partial hospitalization records indicate “she appears to understand literary concepts such as tense and tone during instruction, but is unable to restate definitions 5 minutes

later.” Typically developing youth are able to process and encode information presented in a classroom setting and retrieve that information for use on subsequent academic tasks.

What is your assessment of the claimant’s abilities and limitations in attending to and completing tasks compared to the functioning of typically developing children of the same age?

Recent OSU Harding Hospital inpatient psychiatric discharge summary reflects severe depression was unresponsive to a series of four antidepressant medications with antipsychotic augment, and minimally responsive to the therapeutic milieu and talk therapy. Here, her father reported she no longer has interest or motivation “in anything.” He said a few years ago she “couldn’t wait” to get her driving learner’s permit, but in the 6 months since eligibility she has not completed the 1-page application. The youth was interviewed independently for approximately 40 minutes. During that time, her movements here were slow and laborious. She said, “It feels like there are weights on my arms and legs.” She said she has trouble making decisions. When asked for elaboration, she said “I can hardly face showering because I can’t decide the order for washing body parts.” Despite past average range WISC-IV scores, she did not correctly spell a familiar 5 letter word in reverse. Three times she requested repetition of serial 7 instructions before starting to cry and saying “I just can’t do it. I’m sorry.” Typically-developing adolescents have the ability to complete a series of tasks to reach a goal. The ETR reflects she began skipping classes about 2 years ago, and was found several times by school security personnel “cutting” her arms and abdomen in the school bathroom.

What is your assessment of the claimant’s abilities and limitations in interacting with others compared to the functioning of typically developing children of the same age?

This 16-year-old appeared unkempt and lethargic. She moved slowly. Her facial expression was morose. At no point did she return a smile or simple pleasantries. She reported no longer spending time with friends, especially since transferring to a therapeutic setting for school. She said she has turned down invitations to friends’ houses and to activities. “In my head I know I like them (friends), but I can’t feel liking them. I don’t feel anything anymore. Seeing people smile makes it all worse.” Her parent said over the past two years she isolated in her room increasingly until requiring admission to daily partial hospitalization. Typically-developing adolescents are highly motivated to spend time with same-aged peers and tend to rely more heavily on them than parents for guidance and support.

What is your assessment of the claimant’s abilities and limitations in self-care compared to the functioning of typically developing children of the same age?

Recent OSU Harding Hospital records and the school ETR document two psychiatric hospitalizations for severe depression, suicidal thoughts, and cutting prior to Buckeye Ranch partial hospitalization step-down where she has attended 5 days weekly, 9 hours daily, for the past 6 months. The ETR and outpatient psychiatry records of Dr. V. Christopher reflect this youth’s need for near constant adult supervision to ensure safety. Her father told me he and her mother do not trust her alone in any room of the house with the door closed because of her extensive cutting behaviors, though she is allowed to close the bathroom door with time limits. The ETR reflects similar safety measures in place when at partial hospitalization. Here her father said the family tries to restrict her access to sharp objects, “but somehow she gets them.” The claimant said she knows how to address hygiene and grooming on her own, though bathes “maybe once a week” due to trouble facing decisions involved in showering. During this assessment, she presented as unkempt and malodorous wearing a short-sleeved shirt, with multiple cuts in various stages of healing clearly visible on her arms. Typically developing adolescents are able to maintain their personal safety in familiar surroundings and navigate throughout their school setting without constant adult oversight. Despite intensive therapeutic resources and constant adult oversight, she lacks ability to maintain basic personal safety.

APPENDIX

BEHAVIORS/ABILITIES OF TYPICALLY DEVELOPING CHILDREN

The full child development and child psychopathology literatures, available to you elsewhere, are ever expanding and instruct on child assessment. For your conveniences, below is a summary sampling of current research-based findings on the psychological benchmarks of typical child development. To remain informed and current, the child development literature and related continuing education need to be accessed directly. The vast differences between phases of typical child development illustrate the necessity of tailoring examination procedures, expectations, interpretations, and opinions to the child claimant's age.

The following material is broken out on two dimensions:

I. *Childhood phase:*

- approximately 12 months to 3 years
- approximately 3 years to 6 years
- approximately 7 years to 11 years
- approximately 11 years +

II. *Functional Assessment abilities:*

1. acquiring and using information;
2. attending to and completing tasks;
3. interacting and relating with others;
4. conducting age-appropriate self-care.

1. ACQUIRING & USING INFORMATION

Consideration should include the following behaviors:

- Comprehending oral instructions
- Understanding vocabulary
- Learning new material
- Recalling/applying previously learned material
- Applying problem-solving skills
- Understanding/participating in conversation
- Providing organized oral explanations & descriptions

Infants/Toddlers (approx. 12 months to 3 years)

When evaluating the child claimant, to support attention and engagement consider using child-directed speech (slow, higher pitched with fewer simpler words than typical speech).

- Child can understand more words than can produce
- Holophrasis (single word sentences – same word for multiple meanings) expected by 12-18 months
- Telegraphic speech (2-3 word sentences) expected by 18-24 months
- Communication includes gestures & babbling
- Problem-solving
 - One-step solutions with familiar, concrete materials
 - Can seek help (social referencing)
- Math concepts
 - Basic concepts (more/less) by age 2

- Count to 5 by age 3 (counting may not match manipulatives)
- Fund of information
 - Can point to 2-3 body parts by age 12-18 months
 - Can identify (respond to your request to point) 2 primary colors by age 3

Early Childhood (approx. 3-6 years)

When evaluating the child claimant, to support attention and engagement consider using child-directed speech (slow, higher pitched with fewer simpler words than typical speech).

- Increased expressive language makes interviewing easier
- Children consistently show overregulation errors (misapplication of grammar rules to irregular situations such as adding “s” for plural of “foot” or adding “ed” for past tense of “go”)
- Hippocampus development increases storing and processing of memories
- Strong recognition memory, but recall limited to 3-4 familiar concrete items
- Immature use of memory strategies decreases working memory capacity. Prompting needed for recall.
- Memory enhanced by use of “scripts” (generic episodic memory)
 - Accurate organization and sequence
 - Limited details
- Frontal lobe grows, and organizing/planning ability increases. Become better able to coordinate strategies to solve increasingly complex problems. Multiple problem-solving strategies, but inconsistent application
- Emergent literacy
 - Can copy or write name/part of name by age 4
 - Knows alphabet and some phonics by age 4-5
 - Can recognize printed name by age 5
 - Reads one syllable common sight words by age 5
 - Can “sound out” simple words by age 6
- Math concepts
 - Can count to 10 by age 4, understand one-to-one correspondence
 - Understands single digit addition/subtraction (can calculate by age 5-6)

Middle Childhood (approx. 7-11 years)

In evaluating the child, expressive and receptive language should be adequate for developmentally sensitive clinical interview, though some simplification of vocabulary still needed at younger ages in middle childhood.

- Children are able to use logical thought structures that are increasingly objective and reversible by age 7. Use of mental operations is still tied closely to concrete materials, contexts, and situations. Still reason concretely and have difficulty with abstractions
- Can focus on more than one thing at a time, so can follow familiar multi-step directions
- Overregulation errors diminish toward the later end of this age range
- Increased use of memory strategies and real-world experiences increase the available capacity of working memory and result in gradually increasing processing speed
- Recall memory is gradually improving
- Reading skills will gradually increase during middle childhood
- Competence in the concepts of multi-digit addition/subtraction (early) and multiplication/division (later); calculation errors expected

Adolescence (approx. 11+ years)

- More proficient in all aspects of acquiring/using information
- Reasoning highly rule-based
- Consistent application of reasonably efficient problem-solving strategies is expected in familiar situations
- Transition in way think and reason about problems and ideas. Show gradual improvement in ability to classify and order objects, reverse process, think logically about concrete objects, consider more than one perspective at a time and gain greater ability to think and plan about future.

2. ATTENDING AND COMPLETING TASKS

Consideration should include the following behaviors:

- Paying attention when spoken to directly
- Sustaining attention during play
- Focusing long enough to finish activity/tasks
- Refocusing on task when necessary
- Carrying out single or multi-step directions
- Waiting to take turns
- Changing activities without disruption
- Working without distracting self/others
- Working at a reasonable pace

Infants/Toddlers (approx. 12 months to 3 years)

Infants/toddlers have no investment in staying focused on an adult-centered activity, so assessing ability to sit still/quiet in a chair while a parent is interviewed would be developmentally inappropriate.

- By 4 months, infants show anticipatory looking (demonstrating attention)
- Infants able to sustain attention long enough to absorb visual and tactile elements of stimulus
- Attention becomes more efficient and more flexible over time during first 3 years
- Toddlers able to sustain attention long enough to complete self-initiated play (stack 3-4 blocks)
- Cannot sustain attention to complete a multi-step task without reminders (cannot maintain more than one step in working memory without prompting)

Early Childhood (approx. 3-6 years)

Children in this age range still have little to no investment in staying focused on an adult-centered activity. Statements about ability to sit in a chair and remain still/quiet without toys/books or other developmentally appropriate distraction while parent is interviewed are developmentally inappropriate.

- Development of the prefrontal cortex allows for gradually increasing ability to inhibit urges. Will still need considerable support to wait for turns, keep hands off attractive items.
- Attention is improved by suggestions/questions/comments from adults. Without adult support, attention span remains short
- Higher levels of distractibility are associated with tasks too complex for child's ability level
- Thinking is characterized by centration (inability to focus on more than one aspect of task), so multi-step tasks will predictably require prompting at early stages
- Planning – 6-year-old children can plan and carry out 3-4 step sequence for familiar simple tasks but quickly become disorganized if task is too complex
- Private speech (out-loud statements to self) are developmentally appropriate and serve to support sustained attention to task
 - Will decrease with age and with task mastery

- Expected to increase as task difficulty increases
- Also seen in older children attempting to compensate for limits in attention span

Middle Childhood (approx. 7-11 years)

- Increased efficiency in working memory results in longer sustained attention and better ability to avoid distraction intentionally
- Can now focus on more than one thing at a time, so can follow familiar multi-step directions

Adolescence (approx. 11+ years)

- Resurgence of egocentrism results in decreased attention to demands outside of self
 - With motivation, adolescents can focus on demands unrelated to their immediate focus
- Prefrontal cortex and basal ganglia are not fully developed until early 20s, so attention/concentration continues to improve in this period
- Synaptic pruning of excitatory synapses continues at fast rate through age 16, at which time behavioral inhibition is expected to be present at near-adult levels
- Increasing importance of distinguishing between inability to complete tasks and unwillingness to cooperate

3.INTERACTING & RELATING WITH OTHERS

Consideration should include the following behaviors:

- Playing cooperatively with other children
- Making and keeping friends
- Seeking attention appropriately
- Expressing anger appropriately
- Asking permission appropriately
- Following rules (classroom, games, sports)
- Respecting/obeying adults in authority
- Relating experiences verbally
- Using language appropriate to the situation and listener
- Introducing and maintaining relevant and appropriate topics of conversation
- Interpreting verbal/nonverbal cues of others
- Using adequate vocabulary/grammar to express ideas in general, everyday conversation

Infants/Toddlers (approx. 12 months to 3 years)

Infants/toddlers have little to no investment in playing independently to avoid interrupting an adult-centered activity, so frequent attention bids (verbalizing, making loud noises, showing/asking for toys) while adults are talking are developmentally appropriate.

- Toddlers may not warm up easily to examiner. Toddlers actively seek proximity to their favored caregiver(s) – following and clinging to them and often becoming distressed when separated from them, using them as a safe base to explore the environment. Fear of strangers develops
- Toddlers may not engage in much cooperative play. Toddlers choose playmates largely on convenience such as who is available for play and who has the interesting toys/play materials
- After age 1, toddlers seek each other out, follow each other around and add verbal dialogue to their play
- Starting around age 2, toddlers engage in more coordinated imitation, taking turns imitating each other and becoming aware they're being imitated. Toddler interactions evolve as games they repeat

from earlier experiences or create on the spot. These games include taking turns imitating each other playing roles and engaging in numerous repetitions of the game sequences

- Making and keeping friends - most play situations are arranged by caregivers. By age 2, pairs of children begin selecting each other as mutually preferred playmates. Toddlers may identify preferred friends, but are not yet in position to actively seek out friends
- Parents and other adults often need to help toddlers resolve disputes. Lecturing and moralizing aren't effective because toddlers don't have abstract reasoning ability. Distracting with a more attractive activity is the most practical way to resolve a dispute
- Language is in its development stages. Infants learn they can use sounds to communicate needs and control the behavior of others. Between 18-24 months, they begin to produce 2-3 word sentences (telegraphic speech) and can communicate egocentric wants in basic language, but may still engage in grunts, other sounds, gestures, and other behavior to communicate wants on occasion
- The child's sense of self-control and autonomy increases significantly with the development of cognition, language and physical mobility. The child's increased autonomy isn't entirely autonomous with "assured self" (ex. possession, initiative, independence), and "stormy self" (ex. strong will, tantrums, stubbornness, negativeness)
- Can seek help (social referencing)

Early Childhood (approx. 3-6 years)

Young children still have little investment in playing independently to avoid interrupting an adult-centered activity. Frequent attention bids such as asking questions or for assistance, or saying "watch me" are expected while adults are talking.

- As temporal lobes develop, language development increases significantly. After age 3, children absorb the structure and grammar of the language they hear around them
- Children exercise newfound symbolic thinking ability, using imagination and engaging in fantasy and make-believe play
- Frontal lobe grows, can participate more fully in group settings like preschool/kindergarten. Become better able to control emotions and inhibit first reactions.
- More able/willing to cooperate with others, including cooperative play
- Develop ability to lead as well as follow
- Hippocampus development increases storing and processing of memories. More able to converse about prior events, though content will be basic. Immature use of memory strategies. Prompting needed for recall.
- Begin to practice individual skills and turn-taking skills. Instruction/activities in preschool and school "force" practice and development of these skills
- Can adjust behaviors to changing needs/desires of attachment figures
- Around age 5, can produce 5-7 word sentences, learn how to use past tense (with overregulation errors), tell familiar stories using pictures as cues
- Sense of right and wrong develops
- Events often interpreted in all-or-nothing thinking. Ex. expect others to share their toys while extremely possessive of own favorite toy
- "Fairness" determined by own interests
- Beginning age 5, emerging ability to form peer relationships, show loyalty to peers, develop enduring friendships

- Difficulty taking others' perspective, though beginning at age 5, ability to take perspective of others begins to emerge. Ability emerges to control need for attention while parents/other adults focus on another task. The emotional relationship between child and caregiver becomes more integrated
- Around age 6, typically will want affection and acceptance, but may be embarrassed to show affection

Middle Childhood (approx. 7-11 years)

Ability to take perspective of others and control need for attention while parents/other adults focus on another task develops further

- Form friendships, become best friends with special peers and playmates
- By ages 9-11, show loyalty to peers
- Growing peer orientation, yet strongly influenced by family
- As at end of prior phase, typically children want affection and acceptance, but may be embarrassed to show affection
- Concern over group recognition and approval. Becoming more conscious of self
- Thinking becomes more logical and child's play follows suit
- Progression from free play to play that may be elaborately structured by rules and demand formal teamwork
- Enjoy play activities/games that involve structured rules. Engage in more play involving some physical skill mastery
- Increased efficiency in working memory results in longer sustained attention and better ability to avoid distraction, which improves ability to relate experiences and introduce/maintain relevant and appropriate topics of conversation
- Can engage in small group discussions due to ability to focus on more than one thing at time
- More able to interpret verbal/nonverbal cues of others
- Sufficient vocabulary/grammar to express ideas in general, everyday conversation
- Still primarily consider self first when deciding what should do, but beginning to think about society's laws and conventions.

Adolescence (approx. 11+ years)

- Increased competence in interpersonal/social relationships
- Ability to express ideas in general conversation reaches new level due to increasing logical thought/reasoning
- Gain ability to think/plan about future
- Meta-cognition emerges (ability to think evaluatively about one's own thoughts)
- Try new roles and new ways of thinking and behaving. Explore different ideas and values
- Increased ability to interpret verbal/nonverbal cues of others when motivated to do so
- Often rely on peers for direction on what is normal and accepted. Begin to pull away from family as source of identity and may encounter conflicts between family and peers.
- Resurgence of egocentrism results in decreased attention to demands outside self
 - With motivation, adolescents can focus on demands unrelated to immediate focus

4.SELF-CARE

Consideration should include the following behaviors:

- Handling frustration effectively
- Being patient when necessary to reach goal
- Taking care of personal hygiene

- Caring for other physical needs
- Cooperating with, or being responsible for, taking needed medications
- Making sound personal safety judgments
- Identifying and appropriately asserting emotional needs
- Responding appropriately to changes in own mood (ex. calming self)
- Using effective coping skills to meet demands of environment
- Knowing when to ask for help

Infants/Toddlers (approx. 12 months to 3 years)

Infants/toddlers have no investment in entertaining themselves while adults are talking or otherwise distracted. Frequent interruptions, including escalating emotional expression, are appropriate for this age range.

- This stage is characterized by helplessness and total egocentricity of child
- Before understanding spoken language, infants communicate via crying, cooing, babbling, and paralinguistic behaviors such as turn-taking and gaze
- Infants don't fully understand they are separate from other people and don't see themselves as separate. Consequently their emotions echo the emotional state of caregivers
- Social referencing - Infants and toddlers tend to look for emotional cues from their parents/caregivers and respond accordingly
- At 15 months, toddlers begin comparing their behavior to what is expected of them
- By 15 months, self-conscious emotions begin to emerge. A toddler who spills her juice may look down and feel guilty or embarrassed by this action. She may feel pride if she pours juice successfully
- At 15 months, children begin to show sympathy (concern for others who are distressed/in trouble) and empathy (sharing the same happy, sad emotions others have)
- By age 2, children spontaneously talk about their feelings and the feelings of other people. They also begin to understand their emotions are separate from those of others
- Later in this phase, with increased language and physical mobility, children gain newfound sense of control
- This increased autonomy isn't entirely autonomous with "assured self" (ex. possession, initiative, independence), and "stormy self" (ex. strong will, tantrums, stubbornness, negativity)
- Children in this phase are not focused on or independent in hygiene tasks

Early Childhood (approx. 3-6 years)

Young children have minimal investment in entertaining themselves while adults are talking or otherwise distracted. Frequent interruptions, including escalating emotional expressions, are appropriate for this age range.

- Development of prefrontal cortex supports gradual increase in ability to control emotions, inhibit first reactions, and inhibit urges. Still need considerable support to wait for turns, keep hands off attractive items. And due to high self-focus, coping skills to meet environmental demands and ability to handle frustration still are highly limited
- Children begin to understand the feelings and motives of caregivers and can adjust their behaviors to the changing needs and desires of their attachment figures. They learn that sometimes their caregivers are busy and have other demands that interfere with caregiving
- By age 5, children understand that events confirming/disconfirming their beliefs and expectations can trigger emotions. As they understand their individualized emotions, they tend to report positive emotions more than negative ones

- Children learn emotions represent their own reactions, and can differ from the emotions/reactions of others
- Children begin to distinguish between real and ideal self, and typically believe they are more capable than they actually are. They don't know when to ask for help and have limited personal safety judgments
- Children require direction to attend to hygiene needs. Children begin to learn and practice motor coordination for hygiene skills. May still need assistance with coordination/physical demands of self-care

Middle Childhood (approx. 7-11 years)

- Make judgments about themselves. Self-appraisals on physical appearance consistently show highest correlation with overall self-esteem
- Self-evaluations are becoming more realistic, and scores on self-esteem measures may decline
- Learning to control and regulate emotional reactions and improve abilities to accurately read emotions of others
- Sometimes youth engage in physical mastery skills to impress peers which may include dangerous play for status, popularity, or mastery
- Self-discipline skills increase
- Begin to demonstrate initiative and can be industrious
- Begin to master skills required for independent academic success
- Puberty results in rapid, significant physical body changes. Hygiene does not receive strong attention, though child knows how and is able independently to apply hygiene skills
- Rapid and extreme mood shifts such as between aggressive and sympathetic are typical for this age range

Adolescence (approx. 11+ years)

- By the end of middle school, youth have broadened knowledge, experiences and skills, and become more mature and capable of coping with physical, cognitive, and social challenges
- Hormonal fluctuations/puberty/sexual maturity results in numerous physical and emotional changes. May experience significant difficulty identifying and appropriately asserting emotional needs
- Mood swings typical due to hormones and contending with physical/cognitive changes
- Youth in this phase explore identity and practice aspects of independence
- Some amount of identity diffusion is experienced. May experiment with different roles. May include experimenting with minor delinquency or flourishes of rebellion. Self-doubts flood youths in this phase, including doubts about whether they are normal
- Confront challenge of who they want to become and what is socially desirable
- Evolve self-concept within peer context
- Seek leadership from others. Seek to be inspired by others. Gradually develop set of ideals (socially congruent and desirable)
- Greater ability to think and plan about future
- Ability to reflect on own thoughts
- With sexual maturity, become interested in own body and personality. Increased attention to personal hygiene