

EXAMPLE REPORT



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PECS Example Learning Disorder Report:
John Smith

Strictly Confidential

RATIONALE

This **Example Comprehensive Psychological Report** is provided to act as an example of the breadth and thoroughness of an assessment performed by Psychological & Educational Consultancy Services (PECS).

The assessment components, and reporting, meet the Department of Education (DoE) requirements for a Specific Learning Disorder.

This example report also reflects changes relating to the recent release of the DSM-5 (APA, 2013) and includes the recently released WISC-V and WIAT-III.

BRIEF BIOGRAPHY OF THE AUTHOR

Dr Shane Langsford is a highly qualified and very experienced psychologist who has conducted more than 3000 assessments since opening his private practice in 1999.

Dr Langsford's qualifications include a PhD, Bachelor of Education with First Class Honours, and a Bachelor of Psychology.

Dr Langsford is fully registered with the Psychology Board of Australia (PBA) and the Australian Health Practitioners Regulation Agency (AHPRA).

Dr Langsford is an APS College of Educational & Developmental Psychologists Full Academic Member

Dr Langsford is also a full member of the Australian Psychological Society (APS), Australian Association of Psychologists (AAPi), Australian ADHD Professionals Association (AADPA), and ADHD Australia.

In 2015, Dr Langsford was personally selected from a shortlist by the then Federal Minister of Health (the Hon Sussan Ley) to be part of the 13-member Mental Health Expert Reference Group (MHERG). The group was formed to provide advice to the Commonwealth Department of Health in relation to the government's response to the National Review of Mental Health Programmes and Services. Dr Langsford was the only practising psychologist in Australia appointed to the group, and the only member in the group from Western Australia. (For more information, see www.pecs.net.au/pecs-profile)

With regards to ADHD, Dr Langsford has conducted over 1500 ADHD assessments for various Psychiatrists and Paediatricians, was asked in 2014 to be on the National Shire ADHD Expert Panel for the "A Snapshot of ADHD: A Consumer and Community Discussion", and in April 2018 was the only Psychologist from Australia participating in the ADHD Institute's invite-only "Meeting of the Minds" forum in Madrid (Spain). (For more information, see www.adhd-institute.com)

Dr Langsford's extensive knowledge of a wide range of disorders led to the creation of the award-winning PsychProfiler, which is oriented to the DSM-5 and has been the most widely used Australian global psychiatric/psychological/educational assessment tool since 2004 and is in the top five global screening instruments internationally. (For more information, see www.psychprofiler.com)

WHAT IS A COMPREHENSIVE PSYCHOLOGICAL REPORT?

A Comprehensive Psychological Assessment (CPA) is the systematic collection, analysis developmental, behavioural, socioemotional, cognitive and/or educational for the purpose of making inferences about underlying brain function.

These inferences are achieved by investigating an individual's strengths and weaknesses across the aforementioned areas and identifying any patterns that may exist.

Ultimately, the investigation's aim is to rule out the presence of any clinically significant afflictions, or if indeed present, to facilitate diagnosis of the core underlying problem, identify its aetiology and impact on the individual, and identify any comorbid concerns that may exist.

The large majority of subsequent diagnoses are genetic, hereditary and familial in nature, with a significant minority environmental/experiential in origin.

A Comprehensive Psychological Report (CPR) contains the information garnered from the CPA and is primarily compiled to convey the information to other medical, health, and educational professionals (often the referrer) for the purpose of specialist diagnosis, and/or the implementation of intervention/treatment.

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[For quick interpretation, please read the Summary, Conclusion, and Recommendations sections only.](#)

BIOGRAPHICAL DETAILS

Name:	John Smith
Date of Birth:	14/04/2002
Gender:	Male
Age:	13 years
Grade:	9
School:	Local High School
Address:	123 West Coast Drive, TRIGG WA 6029
Parent's Phone Number:	0444 444 444
Parent's Email Address:	smith@example.net.au

REFERRAL INFORMATION

John was referred to Psychological and Educational Consultancy Services (PECS) by Dr Jane Brown (Consultant Paediatrician) for a *Comprehensive Psychological Assessment* and indication of whether the results are reflective of an individual with a Specific Learning Disorder.

CURRENT CONCERNS

From a presented list, John's parents identified concerns in the following areas:

- Academic
- Attention
- Learning
- Spelling
- Reading
- Written language
- Schoolwork/homework
- Memory

ACADEMIC AREAS

Presented below are parent estimates of John's achievement in the main academic areas:

Maths:	<input type="checkbox"/> Well Below Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average	<input type="checkbox"/> Well Above Average
Reading:	<input type="checkbox"/> Well Below Average	<input checked="" type="checkbox"/> Below Average	<input type="checkbox"/> Average	<input type="checkbox"/> Above Average	<input type="checkbox"/> Well Above Average
Writing:	<input type="checkbox"/> Well Below Average	<input checked="" type="checkbox"/> Below Average	<input type="checkbox"/> Average	<input type="checkbox"/> Above Average	<input type="checkbox"/> Well Above Average
Spelling:	<input type="checkbox"/> Well Below Average	<input checked="" type="checkbox"/> Below Average	<input type="checkbox"/> Average	<input type="checkbox"/> Above Average	<input type="checkbox"/> Well Above Average
Language:	<input type="checkbox"/> Well Below Average	<input type="checkbox"/> Below Average	<input checked="" type="checkbox"/> Average	<input type="checkbox"/> Above Average	<input type="checkbox"/> Well Above Average

BRIEF BACKGROUND INFORMATION

Relevant information reported during the initial interview session:

- Was born with no apparent complications.
- Reached most of the major developmental milestones (e.g., crawling, walking, toileting) during the expected age ranges; speaking short sentences was achieved late.
- No major medical or neurological conditions.
- Normal visual and auditory acuity reported.
- No prescription medication use.
- Is a mix of right and left-handed/footed; John's older brother is left-handed.
- John's mother reported she was also late to speak, experienced similar academic difficulties during schooling and received English remediation.
- John's older brother has been diagnosed with Dyslexia and ADHD.
- Past assessments and interventions include;
 - Speech Therapy (at age 3 to 6 years) for an articulation error with /th/ sounds (e.g. "fwee" for three, "bofe" for both, and "fing" for thing).
 - Occupational Therapy (at age 7 years) to help with poor coordination and pencil grip.
 - Literacy remediation (Reading Recovery Programme) since Grade 1, however, this has produced little improvement.
- Was retained in Pre-Primary due to; "not being academically ready and having obvious difficulty with speech".
- John's mother reported John;
 - Was a very active 2 to 3-year-old.
 - Is very impulsive, fails to listen to or follow instructions; will not sit within a group.
 - Had problems learning the alphabet; still reverses letters and words.
 - Inaccurate and slow reading; further concerns regarding his reading comprehension.
 - Difficulties with spelling and transferring ideas onto paper (e.g. essay writing).
 - Is better at Maths than English.
 - Runs out of time during timed assessments.
- John's English teacher reported John;
 - Struggles with un-structured activities, both in the classroom and at recess and lunchtime. He fidgets constantly in the classroom, calls out, leaves his seat, and hastily completes work. He is generally interested in what is happening in the classroom and is curious about different subjects.

Past testing:

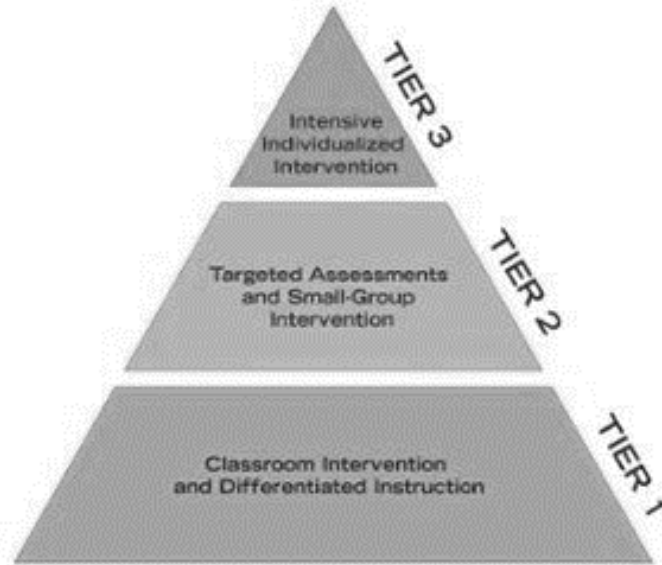
- NAPLAN Year 5:
 - Reading – just below average
 - Writing – well below average
 - Spelling – just below average
 - Grammar & Punctuation – just below average

- Numeracy – average
- NAPLAN Year 7:
 - Reading – well below average
 - Persuasive Writing – well below average
 - Spelling – well below average
 - Grammar & Punctuation – just below average
 - Numeracy – well above average

Please note that only a brief overview was obtained due to John and his parents already having provided more detailed background information to Dr Brown.

See checklists for more behavioural information.

PAST INTERVENTION



There are many different types of intervention utilised to help children who are having difficulty learning. However, please note, for a formal diagnosis of a Specific Learning Disorder, the application of 6 months or more of Tier 3 Intervention is required. Tier 3 intervention is Intensive, Individualised, and must occur outside of the classroom.

PAST INTERVENTION:

John has received extra remediation in the below academic areas:

Reading Intervention:

Reported by Parent:

John has been receiving individualised reading tutoring one hour per week for the past two years from a registered DSF-SPELD tutor.

Writing Intervention:

Reported by Parent:

John has been receiving individualised writing tutoring one hour per week for the past two years from a registered DSF-SPELD tutor.

Spelling Intervention:

Reported by Parent:

John has been receiving individualised spelling tutoring one hour per week for the past two years from a registered DSF-SPELD tutor.

Mathematics Intervention:

Reported by Parent:

John has not required any additional remediation in the academic area.

PAST INTERVENTION SUMMARY:

Based on the above information, six or more months of Intensive, Individualised Tier 3 intervention has been implemented for the following areas: Reading, Writing, and Spelling.

GLOBAL SCREENING ASSESSMENT

Global Screening Test Administered:

Date of Administration

**Child & Adolescent PsychProfiler* (CAPP; Langsford, Houghton, & Douglas, 2014)

11/09/2018

CAPP Outline:

The CAPP comprises 126 items and utilises three separate screening forms; the Self-Report Form (SRF: 126 items), Parent-report Form (PRF: 126 items), and Teacher-report Form (TRF: 126 items) for the simultaneous screening of 14 of the most prevalent disorders in children and adolescents (see next page). The CAPP comprises screening criteria that closely resemble the diagnostic criteria of the *Diagnostic and Statistical Manual of Mental Disorders–Fifth Edition* (DSM-5: American Psychiatric Association: APA, 2013).

Disorders included in the CAPP:

Anxiety Disorders:

- ★ Generalised Anxiety Disorder
- ★ Separation Anxiety Disorder

Attention-Deficit/Hyperactivity Disorder:

- ★ Attention-Deficit/Hyperactivity Disorder

Autism Spectrum Disorder:

- ★ Autism Spectrum Disorder

Communication Disorders:

- ★ Language Disorder
- ★ Speech Sound Disorder

Depressive Disorders:

- ★ Persistent Depressive Disorder

Disruptive, Impulse-Control, & Conduct Disorders:

- ★ Conduct Disorder
- ★ Oppositional Defiant Disorder

Feeding and Eating Disorders:

- ★ Anorexia Nervosa
- ★ Bulimia Nervosa

Obsessive-Compulsive and Related Disorders:

- ★ Obsessive-Compulsive Disorder

Specific Learning Disorders:

- ★ Specific Learning Disorder – Reading, Mathematics, and Written Expression

Trauma and Stressor-Related Disorders:

- ★ Posttraumatic Stress Disorder

Global Behavioural Assessment Results:

In order to provide more conclusive information, John, John's parents, and John's teacher all completed separate CAPP Forms.

John self-reported positive screens for:

- Speech Sound Disorder
- Specific Learning Disorder – with Impairment in Reading
- Specific Learning Disorder – with Impairment in Written Expression

John's parents reported positive screens for:

- Attention-Deficit/Hyperactivity Disorder: Combined Presentation
- Language Disorder
- Speech Sound Disorder
- Specific Learning Disorder – with Impairment in Reading
- Specific Learning Disorder – with Impairment in Written Expression

John's teacher reported positive screens for:

- Attention-Deficit/Hyperactivity Disorder: Predominantly Hyperactive/Impulsive Presentation
- Language Disorder
- Oppositional Defiant Disorder
- Specific Learning Disorder – with Impairment in Reading
- Specific Learning Disorder – with Impairment in Written Expression

A copy of the CAPP Report is included as an Appendix, as are the completed CAPP Forms.

Please refer to the CAPP Report for the individual behaviours which were responsible for the positive screens elicited.

SOCIO-EMOTIONAL ASSESSMENT

Checklists Administered:

<i>Checklists</i>	<i>Date of Administration</i>
Beck Youth Inventories of Emotional and Social Impairment (Beck: BYI-II: 2005)	23/09/2015

Checklists Results:

Beck Youth Inventories of Emotional and Social Impairment (Beck: BYI-II: 2005)

The BYI is a reliable and valid self-report instrument that contains 5 subscales pertaining to self-concept, anxiety, depression, anger, and disruptive behaviour.

BYI Subscales	Raw Score	T-Score	Interpretive Guidelines
Self-Concept	34	42	Lower than Average
Anxiety	26	62	Moderately Elevated
Depression	40	82	Extremely Elevated
Anger	31	65	Moderately Elevated
Disruptive Behaviour	22	66	Moderately Elevated

The BYI results indicate that the areas of Self-Concept, Anxiety, Depression, Anger, and Disruptive Behaviour **warrant further investigation**.

Psychometric Tests Administered:

Wechsler Intelligence Scale for Children-Fifth Edition (WISC-V, 2016)

11/09/2018

WISC-V Overview:

The Wechsler Intelligence Scale for Children- Fifth Edition (WISC-V) is an individually administered, comprehensive clinical instrument for assessing cognitive ability of children between the ages of 6 years through to 16 years 11 months.

The WISC-V provides primary index scores that represent intellectual functioning in specified cognitive areas (i.e., Verbal Comprehension Index, Visual Spatial Index, Fluid Reasoning Index, Working Memory Index, and Processing Speed Index), a composite score that represents general intellectual ability (i.e., Full Scale IQ), ancillary index scores that represent the cognitive abilities in different groupings based on clinical needs (e.g., Nonverbal Index, General Ability Index) and complementary index scores that measure additional cognitive abilities related to academic achievement and learning-related issues and disorders (e.g., Naming Speed Index).

The WISC-V has Australian norms and Australian language adaptation and takes approximately 60 minutes for the core subtests.

WISC-V Subtests:

Please see Appendix for full subtest descriptions.

WISC-V Primary Indexes:

The **Verbal Comprehension Index (VCI)** measure's the client's ability to access and apply acquired word knowledge. More specifically the VCI is designed to measure the client's ability to verbalise meaningful concepts, think about verbal information, and express themselves using words.

The **Visual Spatial Index (VSI)** measure's the client's ability to evaluate visual details and understand visual spatial relationships in order to construct geometric designs from a model. This skill requires visual spatial reasoning, integration and synthesis of part-whole relationships, attentiveness to visual detail, and visual-motor integration.

The **Fluid Reasoning Index (FRI)** measure's the client's ability to detect the underlying conceptual relationship among visual objects and use reasoning to identify and apply rules. Identification and application of conceptual relationships in the FRI requires inductive and quantitative reasoning, broad visual intelligence, simultaneous processing, and abstract thinking.

The **Working Memory Index (WMI)** measure's the client's ability to register, maintain, and manipulate visual and auditory information in conscious awareness, which requires attention and concentration, as well as visual and auditory discrimination.

The **Processing Speed Index (PSI)** measure's the client's speed and accuracy of visual identification, decision making, and decision implementation. Performance on the PSI is related to visual scanning, visual discrimination, short-term visual memory, visuomotor coordination, and concentration. The PSI assesses the client's ability to rapidly identify, register, and implement decisions about visual stimuli.

The **Full Scale (FSIQ)** is derived from seven subtests and summarises ability across a diverse set of cognitive functions. This score is typically considered the most representative indicator of general intellectual functioning, unless there is marked variability among the Index Composite Scores (ie 18+ difference between the Indexes). Subtests are drawn from five areas of cognitive ability: verbal comprehension, visual spatial, fluid reasoning, working memory, and processing speed.

WISC-V Ancillary Indexes:

The **Auditory Working Memory Index (AWMI)** is derived from the sum of scaled scores for the Digit Span and Letter-Number Sequencing subtests. These subtests require the client to listen to numbers and letters presented verbally, then recall or sequence them aloud. This index score measures the client's ability to register, maintain, and manipulate verbally presented information.

The **Nonverbal Index (NVI)** is derived from six subtests that do not require verbal responses. This index score can provide a measure of general intellectual functioning that minimises expressive language demands for individuals with special circumstances or clinical needs. Subtests that contribute to the NVI are drawn from four of the five primary cognitive domains (i.e., Visual Spatial, Fluid Reasoning, Working Memory, and Processing Speed).

The **General Ability Index (GAI)** is comprised of five subtests that provides an estimate of general intelligence that is less impacted by working memory and processing speed, relative to the FSIQ. The GAI consists of subtests from the verbal comprehension, visual spatial, and fluid reasoning domains.

The **Cognitive Proficiency Index (CPI)** comprises of four subtests, drawn from the working memory and processing speed domains. The CPI measures the client's ability to process cognitive information in the service of learning, problem solving, and higher-order reasoning

WISC-V Qualitative Descriptions:

Standard Score	Percentile	WISC-V-Qualitative Description
<70	<2	Extremely Low
70-79	2-8	Very Low
80-89	9-23	Low Average
90-109	25-73	Average
110-119	75-90	High Average
120-129	91-97	Very High
130+	98+	Extremely High

WISC-V Examiner's Details:

EXAMINER: Dr Shane Langsford
QUALIFICATIONS: BPsych, BEd(First Class Hons), PhD
TITLE: Senior Practitioner and AHPRA Registered Psychologist
TEST SITE: Psychological & Educational Consultancy Services– Subiaco O

Test Behaviour:

John had significant difficulty remaining still (e.g. fidgeting) and focussed (e.g. looking around the room) throughout the testing period. He was also observed to “give up” easily as the items increased in difficulty.

John demonstrated articulation error with /th/ sounds (e.g “fwee” for three, “bofe” for both, and “fing” for thing).

It is my opinion that the scores that John achieved on the WISC-IV are an accurate reflection of his cognitive functioning at this particular point in time.

Table 1: WISC-V Index Scores

WISC-V Indexes	Composite Score	Percentile Rank	95% Confidence Interval	Qualitative Description
PRIMARY INDEXES				
Verbal Comprehension Index (VCI)	78	7	72-87	Very Low
Visual Spatial Index (VSI)	94	34	87-103	Average
Fluid Reasoning Index (FRI)	91	27	84-99	Average
Working Memory Index (WMI)	94	34	88-101	Average
Processing Speed Index (PSI)	86	18	78-97	Low Average
Full Scale Intelligence Quotient (FSIQ)	84	14	79-90	Low Average
ANCILLARY INDEXES				
Nonverbal Index (NVI)	86	18	81-92	Low Average
General Ability Index (GAI)	82	12	77-89	Low Average
Cognitive Proficiency Index (CPI)	87	19	81-95	Low Average

Index scores have a mean Composite Score of 100 (50th percentile) and a standard deviation of 15.

Percentile Rank refers to John's standing among 100 individuals of similar age.

Therefore, a Percentile Rank of 50 indicates that John performed exactly at the average level for his chronological age.

Scores shaded red are considered significantly weaker than the true ability 'or' fall at or below the 15th percentile

Scores shaded orange fall within 10% of the critical value for statistical significance

Composite scores and Confidence Intervals are intentionally removed from parent copies of the report as per APS policy

Table 2: WISC-V Primary Index Discrepancy Summaries

WISC-V Index	Difference	Critical Cutoff	Exceeds .05 Statistical Significance	Base Rate
Verbal Comprehension – Visual Spatial	-16	13.47	Yes	14.6%
Verbal Comprehension – Fluid Reasoning	-13	10.59	Yes	15.9%
Verbal Comprehension – Working Memory	-16	11.75	Yes	12.2%
Verbal Comprehension – Processing Speed	-8	14.10	No	43.9%
Visual Spatial – Fluid Reasoning	3	12.47	No	41.5%
Visual Spatial – Working Memory	0	13.47	No	
Visual Spatial – Processing Speed	8	15.56	No	25.6%
Fluid Reasoning — Working Memory	-3	10.59	No	50.0%
Fluid Reasoning – Processing Speed	5	13.14	No	31.7%
Working Memory — Processing Speed	8	14.10	No	24.4%

Bolding appears where a significant difference between the Indexes has been elicited

Scores referred to as 'Almost' fall within 10% of the critical value for statistical significance

Base rate refers to the clinical significance (vs Ability Sample) - <15% = clinically significant.

Below is a set of characteristic difficulties relevant to lower ability in each Index. These are generic difficulties and are not provided as an illustration of John's individual difficulties.

Verbal Comprehension weaknesses can cause difficulty learning in the classroom and performing to ability in exams by:

- Trouble understanding verbal directions and/or instructions. This will be more so with complex language, or when multiple steps are included in an instruction.
- Increased difficulty completing exams that require a large written output (i.e. essays, long answer questions).
- Being seen as 'poor listeners'. These individuals can appear to be easily distracted and inattentive at times, especially when faced with high verbal task demands.
- Difficulty with 'word-based Mathematics problems' –generally these individuals will have adequate Mathematics abilities, but the individual will find it difficult to demonstrate this when the Mathematics questions are buried in text.
- Being stronger at Mathematics, and science, where they can 'show' what they know in ways that are not heavily language based.
- Improved learning from charts, visual materials, diagrams, videos, or hands-on learning demonstrations.
- Difficulty in terms of reading comprehension – they may need to re-read a given text in order to fully understand the meaning.
- Difficulty in understanding abstract concepts, particularly when asked to perform tasks that rely heavily on verbal abstract reasoning.
- Difficulty in understanding social conventions (i.e. what should you do if you find a wallet in a store).

Processing Speed weaknesses can cause difficulty learning in the classroom and performing to ability in exams by:

- Difficulty processing large amounts of information, or being able to understand long, complex instructions.
- Poorer performance across timed tasks/exams relative to peers. These individuals need more time to be able to show what they do know.
- Being overall slower to complete tasks in class or for homework
- Being slower at copying information down from the board or writing down what the teacher is saying.
- Written work is very time consuming, it takes these individuals a long time to write down what they know.
- Easy to fatigue; these individuals need to use more cognitive resources to complete the same amount of work as their peers.
- Difficulty following conversations, or keeping track of the plot in books/movies

Table 3: WISC-V Subtest Scaled Scores

Subtests	Scaled Score	Percentile Rank	Age Equivalent
Verbal Comprehension Index			
Similarities	8	25	7:6
Vocabulary	4	2	<6:2
Visual Spatial Index			
Block Design	8	25	7:6
Visual Puzzles	10	50	8:10
Fluid Reasoning Index			
Matrix Reasoning	7	16	6:6
Figure Weights	10	50	9:2
Working Memory Index			
Digit Span	11	63	9:6
Picture Span	7	16	6:6
Processing Speed Index			
Coding	7	16	<8:2
Symbol Search	8	25	8:2

See Appendix 1 for complete subtest descriptions. * Supplementary Subtest

Table 4: WISC-V Core Subtest Discrepancies From 10 Primary Subtest Mean Score

Subtest	Scaled Score	Mean Scaled Score	Difference From Mean	Critical Cutoff Value	.05 Strength or Weakness	Base Rate@
Verbal Comprehension						
Similarities	8	8.0	0.0	3.17		
Vocabulary	4	8.0	-4.0	2.89	Weakness	<=2%
Visual Spatial						
Block Design	8	8.0	0.0	3.34		
Visual Puzzles	10	8.0	2.0	3.34		<=25%
Fluid Reasoning						
Matrix Reasoning	7	8.0	-1.0	2.59		>25%
Figure Weights	10	8.0	2.0	1.65	Strength	<=15%
Working Memory						
Digit Span	11	8.0	3.0	3.08	High	<=10%
Picture Span	7	8.0	-1.0	2.68		>25%
Processing Speed						
Coding	7	8.0	-1.0	3.27		>25%
Symbol Search	8	8.0	0.0	3.96		

Comparison score mean derived from the ten primary subtest scores (MSS-P).

@ Base rate refers to the clinical significance (vs Ability Sample) - <15% = clinically significant.

Scores referred to as 'High' or 'Low' fall within 20% of the critical value for statistical significance

*Supplementary Subtest

Educational Achievement Tests Administered:

<i>Tests</i>	<i>Date of Administration</i>
(1) Wechsler Individual Achievement Test-Third Edition-Australian (WIAT-III-Aust)	20/08/2018

WIAT-III Overview:

The WIAT-III^{A&NZ} is an individually administered clinical instrument designed to measure the achievement of students who are in Preschool through to the final year of Secondary School (i.e. Year 12), or ages 4 years 0 months to 50 years 11 months.

The WIAT-III^{A&NZ} consists of a total of 16 subtests used to evaluate listening, speaking, reading, writing, spelling, and mathematics skills.

The WIAT-III^{A&NZ} was standardised on a sample of 1360 Australian and New Zealand students and features comprehensive normative information.

WIAT-III Subtest Descriptions:

Please see Appendix for full subtest descriptions.

WIAT-III Qualitative Descriptions:

Standard Score	WIAT-III-Qualitative Description
≤69	Extremely Low
70-79	Very Low
80-89	Low Average
90-109	Average
110-119	High Average
120-129	Very High
146+	Extremely High

WIAT-III Examiner’s Details:

EXAMINER:	Dr Shane Langsford
QUALIFICATIONS:	BPsych, BEd(First Class Hons), PhD
TITLE:	Senior Practitioner and AHPRA Registered Psychologist
TEST SITE:	Psychological & Educational Consultancy Services–Subiaco Office

Test Behaviour:

John was seen to reverse numerals and letters.

It is my opinion that the scores that John achieved on the WIAT-III are indicative of his general educational ability at this particular point in time.

WIAT-III Results:

Grade Level at Testing: 9

Age Level at Testing:

13 years 0 months

Table 1: WIAT-III Summary Statistics

WIAT-III Subtest	Standard Score	95% Confidence Interval	Percentile	Year / Grade Equivalent	Age Equivalent	Qualitative Description	≤ 15 th %ile
READING							
Word Reading	89	85-93	23	7.2	7:4	Low Average	
- Word Reading Speed			50				
Pseudoword Decoding	89	85-93	23	6.1	7:0	Low Average	
- Pseudoword Decoding Speed			50				
Oral Reading Fluency	81	69-93	10	5.2	6:4	Low Average	Yes
- Oral Reading Accuracy	81	69-93	10	5.2	6:4	Low Average	Yes
- Oral Reading Rate	82	70-94	12	5.4	6:8	Low Average	Yes
Reading Comprehension	95	90-99	39	5.9	7:9	Average	
MATHEMATICS							
Numerical Operations	103	94-112	58	8.4	9:0	Average	
Maths Reasoning	100	92-110	50	8.2	8:9	Average	
Maths Fluency	102	93-113	56	8.3	9:0	Average	
WRITTEN LANGUAGE							
Alphabet Writing Fluency	97	81-113	42	8.2	8:4	Average	
Sentence Composition	107	97-117	68	8.4	9:8	Average	
Essay Composition	75	64-86	5	4.1	<8:0	Very Low	Yes
- Word Count	86		18			Low Average	
- Theme Dev. and Text Org.	68		2			Extremely Low	Yes
- Grammar and Mechanics	82		12			Low Average	Yes
Spelling	83	76-90	13	3.4	6:8	Low Average	Yes

Subtest scores have a mean Standard Score of 100 (50th percentile) and a standard deviation of 15.

Percentile Rank refers to Jaxon's standing among 100 individuals of similar age.

Therefore, a Percentile Rank of 50 indicates that Jaxon performed exactly at the average level for his chronological age.

Composite Scores are not reported as the respective academic areas consist of multiple diverse skills areas within the area

Year/Grade Norms have been used in the above table

Age and Grade equivalents are based on a median RAW score and must be interpreted with caution as they don't always make sense. Standard or normalised scores are better than raw scores

SUMMARY OF DSM-5 SPECIFIC LEARNING DISORDER CRITERIA

A. Difficulties learning and using academic skills, as indicated by the presence of at least one of the following symptoms that have persisted for at least 6 months, despite the provision of interventions that target those difficulties:

1. Inaccurate or slow and effortful word reading (e.g., reads single words aloud incorrectly or slowly and hesitantly, frequently guesses words, has difficulty sounding out words).
2. Difficulty understanding the meaning of what is read (e.g., may read text accurately but not understand the sequence, relationship, inferences, or deeper meanings of what is read).
3. Difficulties with spelling (e.g., may add, omit, or substitute vowels or consonants).
4. Difficulties with written expression (e.g., makes multiple grammatical or punctuation errors within sentences; employs poor paragraph organisation; written expression of ideas lacks clarity.)
5. Difficulties mastering number sense, number facts or calculation (e.g., has poor understanding of numbers, their magnitude, and relationships; counts on fingers to add single-digit numbers instead of recalling the math fact as peers do; gets lost in the midst of arithmetic computation and may switch procedures).
6. Difficulties with mathematical reasoning (e.g., has severe difficulty applying mathematical concepts, facts, or procedures to solve quantitative problems).

Six or more months of Intensive, Individualised Tier 3 intervention has been implemented for the following areas: Reading Writing, and Spelling.

This criterion is rated as having been Met.

B. The affected academic skills are substantially and quantifiably below (i.e., <85 ; $\leq 15^{\text{th}}$ percentile) those expected for the individual's chronological age, and cause significant interference with academic or occupational performance, or with activities of daily living, as confirmed by individually administered standardized achievement measures and comprehensive clinical assessments. For individuals age 17 years and older, a documented history of impairing learning difficulties may be substituted for standardised assessments.

This criterion is rated as having been Met.

C. The learning difficulties begin during school-age years but may not become fully manifest until the demands for those affected academic skills exceed the individual's limited capacities (e.g., as in timed tests, reading or writing lengthy complex reports for a tight deadline, excessively heavy academic loads).

This criterion is rated as having been Met.

D. The learning difficulties are not better accounted for by intellectual disabilities, uncorrected visual or auditory acuity, other mental or neurological disorders, psychosocial adversity, lack of proficiency in the language or academic instruction, or inadequate educational instruction.

This criterion is rated as having been Met.

E. Severity Level:

Severity Level	Qualitative Information
Mild	Some difficulties learning skills in one or two academic domains, but mild enough severity that the individual may be able to compensate or function well when provided with appropriate accommodations or support services, especially during the school years.
Moderate	Marked difficulties learning skills in one or more academic domains, so that the individual is unlikely to become proficient without some intervals of intensive specialized teaching during the school years. Some accommodations or supportive services at least part of the day at school, in the workplace, or at home may be needed to complete all activities efficiently
Severe	Severe difficulties learning skills, affecting several academic domains, so that the individual is unlikely to learn those skills without ongoing intensive individualized and specialized teaching for most of the school years. Even with an array of appropriate accommodations or services at home, at school, or in the workplace, the individual may not be able to complete all activities efficiently.

DSM-5 SLD OVERALL SUMMARY:

John meets the DSM-5 criteria for a diagnosis of a Specific Learning Disorder – with impairment in Reading (Reading rate or fluency) and Written Expression (Spelling accuracy; Grammar and punctuation accuracy; Clarity or organisation of written expression).

The level of severity is deemed to be Severe.

HANDWRITING SPEED TEST

Handwriting Speed Test Administered:

(1) The Handwriting Speed Test (Wallen, Bonney, & Lennox, 1996)

Date of Administration
18/09/2018

HWST Overview:

The Handwriting Speed Test is a three-minute standardised assessment of a child's speed of handwriting.

HWST Categories:

The authors provide the following category cut-offs as a measure of handwriting speed ability.

<i>Scaled Score</i>	<i>Category</i>
17-19	Superior Performance
14-16	Above Average Handwriting Speed
7-13	Average
4-6	Handwriting Speed Impaired
1-3	Handwriting Speed Significantly Impaired

HWST Results:

John was able to write 222 letters during the three-minute time period; which equates to a speed of 74 letters per minute.

This result (Scaled Score = 6; 9th percentile) indicates John has Impaired writing speed.

PHONOLOGICAL PROCESSING ASSESSMENT

Test Administered:

Test
Comprehensive Test of Phonological Processing (CTOPP-II)

Date of Administration
23/09/2018

CTOPP-II Overview:

The CTOPP-II is an individually administered assessment battery that measures the aspects of phonological awareness, phonological memory, and rapid naming.

A deficit in one or more of these kinds of phonological processing abilities is viewed as the most common cause of learning disabilities in general, and of reading disabilities in particular.

The CTOPP-II can be used for individuals aged 5 years 0 months to 24 years 11 months.

CTOPP-II Subtests and Composites:

Table 1: CTOPP-II Subtests

Elision (EL)	This 34-item subtest measures the extent to which an individual can say a word, then say what is left after dropping out designated sounds.
Blending Words (BW)	This 33-item subtest measures an individual's ability to combine sounds to form words.
Phoneme Isolation (PI)	This 32-item subtest measures the extent to which an individual can isolate different phonemes within individual words.
Memory for Digits (MD)	This 28-item subtest measures the extent to which an individual can repeat a series of numbers ranging in length from two to eight digits.
Nonword Repetition (NR)	This 30-item subtest measures an individual's ability to repeat nonwords that range in length from 3 to 15 seconds.
Rapid Digit Naming (RD)	This 36-item subtest measures the speed with which an individual can name the numbers on two pages.
Rapid Letter Naming (RL)	This 36-item subtest measures the speed with which an individual can name the letters on two pages.

The six subtests from the CTOPP-II are combined to form three Composites that provide information about the three key areas of phonological processing: Phonological Awareness, Phonological Memory and Rapid Naming.

Table 2: CTOPP-II Composites

Phonological Awareness (PACS)	Measures an individual's phonological awareness – awareness of and access to the phonological structure of oral language.
Phonological Memory (PMCS)	Measures the examinee's ability to code information phonologically for temporary storage in working memory or short-term memory.
Rapid Naming (RNCS)	Measures the examinee's efficient retrieval or phonological information from long-term or permanent memory, as well as the examinee's ability to execute a sequence of operations quickly and repeatedly.

CTOPP-II Results:*Grade Level at Testing: 9**Age Level at Testing: 13 years 9 months***Table 3: CTOPP-II Summary Statistics**

CTOPP-II Subtest	Scaled Score	Percentile	Age Equivalent	Grade Equivalent
Elision	8	25	7:6	2:4
Blending Words	8	25	8:9	3:7
Phoneme Isolation	7	16	10:6	5:4
Memory for Digits	8	25	7:6	2:4
Nonword Repetition	8	25	8:9	3:7
Rapid Digit Naming	7	16	10:6	5:4
Rapid Letter Naming	5	5	9:9	4:7

*Subtest scores have a mean Standard Score of 10 (50th percentile) and a standard deviation of 3**Percentile Rank refers to John's standing among 100 children of similar age. Therefore, a Percentile Rank of 50 indicates that John performed exactly at the average level for his chronological age.***Table 4: CTOPP-II Composite Results**

Composite	Composite Score	Percentile Rank	Classification
Phonological Awareness	88	21	Below Average
Phonological Memory	88	21	Below Average
Rapid Naming	76	5	Poor

*Composite scores have a mean Standard Score of 100 (50th percentile) and a standard deviation of 15**Percentile Rank refers to John's standing among 100 children of similar age. Therefore, a Percentile Rank of 50 indicates that John performed exactly at the average level for his chronological age.***Table 5: WISC-V vs CTOPP-II Comparative Results**

Composite	Percentile Rank	Classification
WISC-V		
WISC-V FSIQ	84	High Average
CTOPP-II		
CTOPP-II Phonological Awareness	21	Below Average
CTOPP-II Phonological Memory	21	Below Average
CTOPP-II Rapid Naming	5	Poor

Summary of CTOPP-II results:

John's CTOPP-II results indicate that he scored at the **21st percentile** for Phonological Awareness, **21st percentile** for Phonological Memory, and at the **5th percentile** for Rapid Naming.

Contrasted with his comparative WISC-V result (FSIQ = 84th percentile), this would suggest that John is having difficulty in all three phonological processing composites.

A deficit in **Phonological Awareness** is viewed as the hallmark of reading disability or dyslexia. Poor phonological awareness is associated with poor reading for both individuals whose poor reading levels are discrepant from their IQs and for individuals whose poor reading levels are consistent with their IQs.

A deficit in **Phonological Memory** does not inevitably lead to poor reading of familiar material but is more likely to impair decoding of new words, particularly words that are long enough to decode bit by bit, as a means of storing intermediate sounds. It is likely to impair both listening and reading comprehension for more complex sentences

Individuals who score poorly in **Rapid Naming** commonly have problems with reading fluency.

Below is a set of characteristic difficulties relevant to lower ability in each Index. These are generic difficulties and are not provided as an illustration of John's individual difficulties.

Phonological Awareness weaknesses can cause difficulty learning in the classroom and performing to ability in exams by:

- Children who have difficulty with phonological awareness will often be unable to recognise or isolate the individual sounds in a word, recognise similarities between words (as in rhyming words), or be able to identify the number of sounds in a word. These deficits can affect all areas of language including reading, writing, and understanding of spoken language.
- If a child lacks phonemic awareness, they will have difficulty learning the relationship between letters and the sounds they represent in words, as well as applying those letter/sound correspondences to help them "sound out" unknown words.
- Acquiring phonemic awareness is important because it is the foundation for spelling and word recognition skills.
- Auditory/sound blending skills (e.g. What word would you have if you put these sounds together? /s/ /a/ /t/).
- Trouble understanding spelling rules and conventions.
- Have trouble remembering new words and as a consequence have a weak vocabulary and/or word retrieval difficulty.
- Problems with reading fluency.

Phonological Memory weaknesses can cause difficulty learning in the classroom and performing to ability in exams by:

- Difficulty learning new written and spoken vocabulary.
- Difficulty remembering and therefore following complex instructions.
- Impaired ability to comprehend complex written and spoken sentences.
- Difficulty recalling factual information in written texts and lectures.
- Difficulty decoding unfamiliar words (i.e. sounding and blending words especially complex words).
- Poor concentration or attention (e.g. may daydream or distract others if they fail to recall/process instructions).
- Difficulty with rote sequences such as months of the year, the alphabet, times tables, phone numbers etc.
- Difficulty holding speech sounds in memory long enough to determine how to spell and read longer words.

Rapid Naming weaknesses can cause difficulty learning in the classroom and performing to ability in exams by:

- In the classroom, the decoding and naming of numbers, letters and words is practiced becoming automatic in order to develop speed of processing, efficiency or working memory and fluency and accuracy in speaking, reading and writing.
- Individuals who score poorly commonly have problems with reading fluency.
- Lack of automaticity with quickly and accurately identifying letter names/sounds, numbers, phonic patterns (e.g. 'ch' and 'th') and whole words (i.e. sight vocabulary).
- This can affect a child's ability to efficiently decode/encode unfamiliar words.
- It also affects the ability to efficiently recall/retrieve the names of objects, colours and even people's names.
- Slow naming speed can affect how well an individual will be able to integrate and organise ideas in their head, before these ideas are even put into words.
- Becomes more apparent as greater demands are placed on an individual's ability to retrieve information under timed conditions.

SUMMARY

REASON FOR REFERRAL:

John was referred to Psychological and Educational Consultancy Services (PECS) by Dr Jane Brown (Consultant Paediatrician) for a *Comprehensive Psychological Assessment* and indication of whether the results are reflective of an individual with a Specific Learning Disorder.

CURRENT CONCERNS:

From a presented list, John's parents identified concerns in the following areas:

- Academic
- Attention
- Learning
- Spelling
- Reading
- Written language
- Schoolwork/homework
- Suspected hyperactivity
- Memory

ACADEMIC AREAS:

Presented below are parent estimates of John's achievement in the main academic areas:

Maths:	<input type="checkbox"/> Well Below Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average	<input type="checkbox"/> Well Above Average
Reading:	<input type="checkbox"/> Well Below Average	<input checked="" type="checkbox"/> Below Average	<input type="checkbox"/> Average	<input type="checkbox"/> Above Average	<input type="checkbox"/> Well Above Average
Writing:	<input type="checkbox"/> Well Below Average	<input checked="" type="checkbox"/> Below Average	<input type="checkbox"/> Average	<input type="checkbox"/> Above Average	<input type="checkbox"/> Well Above Average
Spelling:	<input type="checkbox"/> Well Below Average	<input checked="" type="checkbox"/> Below Average	<input type="checkbox"/> Average	<input type="checkbox"/> Above Average	<input type="checkbox"/> Well Above Average
Language:	<input type="checkbox"/> Well Below Average	<input type="checkbox"/> Below Average	<input checked="" type="checkbox"/> Average	<input type="checkbox"/> Above Average	<input type="checkbox"/> Well Above Average

PAST INTERVENTION:

Six or more months of Intensive, Individualised Tier 3 intervention has been implemented for the following areas: Reading, Writing, and Spelling.

GLOBAL BEHAVIOURAL ASSESSMENT:

John self-reported positive screens for:

- Speech Sound Disorder
- Specific Learning Disorder – with Impairment in Reading
- Specific Learning Disorder – with Impairment in Written Expression

John's parents reported positive screens for:

- Attention-Deficit/Hyperactivity Disorder: Combined Presentation
- Language Disorder
- Speech Sound Disorder
- Specific Learning Disorder – with Impairment in Reading
- Specific Learning Disorder – with Impairment in Written Expression

John's teacher reported positive screens for:

- Attention-Deficit/Hyperactivity Disorder: Predominantly Hyperactive/Impulsive Presentation
- Language Disorder
- Oppositional Defiant Disorder
- Specific Learning Disorder – with Impairment in Reading
- Specific Learning Disorder – with Impairment in Written Expression

SOCIO-EMOTIONAL ASSESSMENT:

The BYI results indicate that the areas of Self-Concept, Anxiety, Depression, Anger, and Disruptive Behaviour **warrant further investigation.**

COGNITIVE BATTERY ASSESSMENT:

WISC-V Indexes	Composite Score	Percentile Rank	95% Confidence Interval	Qualitative Description
PRIMARY INDEXES				
Verbal Comprehension Index (VCI)	78	7	72-87	Very Low
Visual Spatial Index (VSI)	94	34	87-103	Average
Fluid Reasoning Index (FRI)	91	27	84-99	Average
Working Memory Index (WMI)	94	34	88-101	Average
Processing Speed Index (PSI)	86	18	78-97	Low Average
Full Scale Intelligence Quotient (FSIQ)	84	14	79-90	Low Average
ANCILLARY INDEXES				
Nonverbal Index (NVI)	86	18	81-92	Low Average
General Ability Index (GAI)	82	12	77-89	Low Average
Cognitive Proficiency Index (CPI)	87	19	81-95	Low Average

EDUCATIONAL BATTERY ASSESSMENT:

WIAT-III Subtest	Standard Score	95% Confidence Interval	Percentile	Year / Grade Equivalent	Age Equivalent	Qualitative Description	≤ 15 th %ile
READING							
Word Reading	89	85-93	23	7.2	7:4	Low Average	
- Word Reading Speed			50				
Pseudoword Decoding	89	85-93	23	6.1	7:0	Low Average	
- Pseudoword Decoding Speed			50				
Oral Reading Fluency	81	69-93	10	5.2	6:4	Low Average	Yes
- Oral Reading Accuracy	81	69-93	10	5.2	6:4	Low Average	Yes
- Oral Reading Rate	82	70-94	12	5.4	6:8	Low Average	Yes
Basic Reading Composite	89	86-92	23			Low Average	
MATHEMATICS							
Numerical Operations	103	94-112	58	8.4	9:0	Average	
WRITTEN LANGUAGE							
Alphabet Writing Fluency	97	81-113	42	8.2	8:4	Average	
Sentence Composition	107	97-117	68	8.4	9:8	Average	
Essay Composition	75	64-86	5	41	<8:0	Very Low	Yes
- Word Count	86		18			Low Average	
- Theme Dev. and Text Org.	68		2			Extremely Low	Yes
- Grammar and Mechanics	82		12			Low Average	Yes
Spelling	83	76-90	13	3.4	6:8	Low Average	Yes
Written Expression Composite						Not Calculated	

DSM-5 SLD SUMMARY:

John meets the DSM-5 criteria for a diagnosis of a Specific Learning Disorder – with impairment in Reading (Reading rate or fluency) and Written Expression (Spelling accuracy; Grammar and punctuation accuracy; Clarity or organisation of written expression).

The level of severity is deemed to be Severe.

HANDWRITING SPEED TEST:

John was able to write 222 letters during the three-minute time period; which equates to a speed of 74 letters per minute.

This result (Scaled Score = 6; 9th percentile) indicates John has Impaired writing speed.

ORAL READING ASSESSMENT:

GORT-5 Rate	= 25 th percentile
GORT-5 Accuracy	= 16 th percentile
GORT-5 Fluency	= 16 th percentile
GORT-5 Comprehension	= 5 th percentile
GORT-5 Oral Reading Index	= 19 th percentile

Comparison of John's WISC-V (FSIQ=84th percentile) versus his GORT-5 scores suggests that John is having relative difficulty with oral reading, in particular comprehension.

PHONOLOGICAL PROCESSING ASSESSMENT:

John's CTOPP-II results indicate that he scored at the **21st percentile** for Phonological Awareness, **21st percentile** for Phonological Memory, and at the **5th percentile** for Rapid Naming.

Contrasted with his comparative WISC-V result (FSIQ= 84th percentile), this would suggest that John is having difficulty in all three phonological processing composites.

A deficit in **Phonological Awareness** is viewed as the hallmark of reading disability or dyslexia. Poor phonological awareness is associated with poor reading for both individuals whose poor reading levels are discrepant from their IQs and for individuals whose poor reading levels are consistent with their IQs.

A deficit in **Phonological Memory** does not inevitably lead to poor reading of familiar material but is more likely to impair decoding of new words, particularly words that are long enough to decode bit by bit, as a means of storing intermediate sounds. It is likely to impair both listening and reading comprehension for more complex sentences

Individuals who score poorly in **Rapid Naming** commonly have problems with reading fluency.

CONCLUSION

SPECIFIC LEARNING DISORDERS:

When investigating the possibility of the presence of a Specific Learning Disorder, PECS aligns itself closely with the DSM-5 (see Appendix 1) and uses a best-practice approach which combines the clinical synthesis of background information and past testing, with a cross-battery assessment comprising the key elements of the major theoretical models; namely, Low Achievement model, Intra-Individual Differences model, and the Response to Intervention (RTI) model.

John meets the DSM-5 criteria for a diagnosis of a Specific Learning Disorder – with impairment in Reading (Reading rate or fluency) and Written Expression (Spelling accuracy; Grammar and punctuation accuracy; Clarity or organisation of written expression).

The level of severity is deemed to be Severe.

DEPRESSION:

The self-report Beck Youth Inventory results indicate depression warrants further investigation

ANXIETY:

The self-report Beck Youth Inventory results indicate anxiety warrants further investigation

ADHD:

John's PsychProfiler results and cognitive profile (i.e. depreciated Working Memory, Processing Speed, Auditory Working Memory, and Cognitive Proficiency) suggest ADHD is a possibility and warrants further investigation/consideration by Dr Brown.

Please note, ADHD can only be diagnosed by a Paediatrician, Psychiatrist or Clinical Neurologist. Therefore, if an individual's cognitive and/or behavioural results suggest that ADHD is a possibility, it is deemed appropriate of PECS to recommend that the appropriate medical professional be consulted for their expert opinion. PECS does not make the recommendation on the basis that they believe the individual has ADHD.

Please note that a GP referral is required to see a specialist.

ORAL LANGUAGE:

John's academic attainment in Listening Comprehension (Oral Language) was found to be very low and supports the earlier concerns with language and history of Speech Therapy.

RECOMMENDATIONS

Please note, PECS does not provide micro-strategies (e.g., sit student at front of classroom, etc) as part of their recommendations. PECS's provides recommendations on what further assessment is required, what intervention is necessary, and who is the most appropriate to provide the assessment/intervention recommended.

Paediatric Involvement:

- (1) John should once again be seen by Dr Brown, now that this new information is available for incorporation into his paediatric assessment.

School Involvement:

*These results confirm that John has a **Specific Learning Disorder – With Impairment in Reading and Written Expression**.*

*For children with Specific Learning Disorders to be successful at school, they require two areas of support, **remediation and accommodation**.*

***Remediation** involves direct instruction in skills by a specialist teacher and **accommodation** involves adaptations and modifications of curriculum and instructional practices.*

- (1) A case-conference involving John's parents, the school psychologist, and key school personnel should be held to discuss John's individual learning requirements.
- (2) In light of these new assessment results, an Individual Education Plan (IEP) / Curriculum Adjustment Plan (CAP) should be initiated / amended by John's teachers in an attempt to maximise John's access to the curriculum.
- (3) John should continue to undergo individualised, intensive, and targeted evidence-based interventions in reading, and writing, as part of an in-school programme or with an external private tutor/specialist.
- (4) On-going case management should be carried out by the school, and at the school's discretion, appropriate special examination arrangements (as per School Curriculum and Standards Authority guidelines) be granted to John for time-restricted tasks.
- (5) If deemed necessary by the school, at the time of his WACE examinations, an application should be made to the School Curriculum and Standards Authority for Special Examination Arrangements.

Psychological Involvement:

- (1) John would benefit from on-going counselling given the levels of Self-Concept, Anxiety, Depression, Anger, and Disruptive Behaviour being reported.
- (2) Another psychometric and educational test will be required to be administered closer to his WACE examinations to satisfy School Curriculum and Standards Authority requirements (if applicable).

Educational Remediation:

- (1) John would benefit from specialist reading, spelling, writing, and language tutoring from one of the following place(s).

Dyslexia SPELD Foundation - Literacy and Clinical Services:

Head Office: 10 Broome Street, SOUTH PERTH WA 6051

Phone: (08) 9217 2500

www.dsf.net.au

DSF also has literacy clinics in Albany, Mt Hawthorn, and East Victoria Park.

Albany (Earl Street):	(08) 9842 2594	albany@dsf.net.au
Mt Hawthorn (The Mezz):	(08) 9443 8323	mezz@dsf.net.au
East Victoria Park (The Park):	(08) 9470 4140	park@dsf.net.au

www.dsfliteracyclinic.com.au/

DSF also has over 100 tutors across Western Australia, and online tutoring is also available.

To access tutors in your postcode area, you must be a member (\$75 per annum) and register at www.dsf.net.au/request-a-tutor

Tutoring is approximately \$65-\$80 per hour.

Kip McGrath Education Centres:

Offers tutoring to children from pre-school through to Year 12 in reading, spelling, comprehension, English and Mathematics.

There are Centres located in Balcatta, Booragoon, Bunbury, Busselton, Ellenbrook, Geraldton, Gosnells, Jandakot, Joondalup, Karratha, Margaret River, Mundaring, North Perth, Victoria Park, and Willetton.

In addition to the Centres, face-to-face real-time online tutoring at home is also available via webcam.

Education Centres: www.kipmcgrath.com.au Online Tutoring: www.kiponline.com.au

Number Works' n Words Subiaco:

Offers primary and secondary school tuition for students aged between 5 and 16 years in English and Mathematics.

Lower Level Forest Centre Building

14 – 16 Rowland St, SUBIACO WA 6008

Phone: (08) 9388 3727

Email: subiaco@numberworks.com

<http://www.numberworks.com.au/>

Health & Well-Being:

- (1) John needs to continue/implement regular exercise and maintain a healthy diet.

Please note, the above is a generic recommendation that should be followed by all and is not a recommendation specific to John due to any of his results or reported behaviours.

Speech Pathologist Involvement:

- (1) A current speech and language assessment is recommended. This formal speech and language assessment would help to pinpoint John's language weakness and ensure more targeted intervention.

See Appendix for information on Speech Sound Developmental Norms.

For other developmental speech sound norms tables, see:

<http://www.childdevelopment.com.au/home/197>

https://smartandstatic.com/speechcare/files/speech_norms.pdf

- (2) For assistance with locating a Speech Pathologist in their local area, John's parents may wish to utilise the "Find a Speech Pathologist" function on the Private Speech Pathologists Association of WA (PSPA WA) website.

www.pspawa.com.au/find-a-speech-pathologist

Alternatively, the parents may wish to contact:

Ms Angela Taylor

Principal Speech Pathologist

Bubbles Speech Pathology

Address: Unit 1 / 100 Walters Drive OSBORNE PARK WA 6017

(08) 6111 1365

ange.taylor@bubbles-speech.com.au

www.bubbles-speech.com.au

Bubbles Speech Pathology (BSP) provides speech pathology assistance to individuals of all ages. From a very early age, and through the pre-school years, BSP focuses on speech and language development, fluency (stuttering) and voice difficulties; and into the early primary school years, they assist with language and literacy.

or

Ms Jenny Baker

Principal Speech Pathologist

Fremantle Speech Pathology Services

Address: Unit 1 / 14 Cockburn Road HAMILTON HILL 6008

(08) 9433 4595

freospeech@westnet.com.au

www.freospeech.biz

Language, Speech & Learning Services assist to individuals and adolescents to develop their communication and learning and provide literacy services for individuals in Pre-primary through to Year 12.

Mr Tobias Hancock

Speech Pathologist

The Hub

1/94 Mandurah Terrace Mandurah WA 6210

08 9557 5942

toby@thehubwa.com.au

www.thehubwa.com.au

VISION:

- (1) A current vision test by a Behavioural/Developmental Optometrist is recommended due to previous testing being over two years ago. and also concerns with eyesight/eye movement reported.

Behavioural Optometrist/Developmental Optometrists test not just eye health and vision but also a whole range of other areas, such as fusion, stereopsis, convergence, eye tracking, focus, suppression, colour vision, eye-teaming, eye movement pursuits/saccades, and visual perception.

Difficulties in any of these areas can lead to underperformance in the classroom, difficulties completing homework/study, and/or reading and writing difficulties.

John's parents may wish to access the Australasian College of Behavioural Optometrists website (www.acbo.org.au) for assistance with locating a Behavioural Optometrist.

Alternatively, a small cross-section from around the Perth Metropolitan area is provided below:

Carine:	www.thefocalpointoptometrist.com.au
Karrinyup:	www.visionwest.com.au
Leederville	www.eyesonoxford.com.au
Leeming:	www.bullcreekoptometrist.com.au
O'Connor:	www.visioncarecentre.com.au

HEARING:

- (1) A current hearing test is recommended due to previous testing being over two years ago.

The below places have Paediatric Audiologists who specialise in diagnosing hearing loss and listening difficulties in children and adolescents.

Duncraig:	www.kidshear.com.au
Hamilton Hill:	www.earscience.org.au
Nedlands:	www.pamgabriels.com.au/
Padbury:	www.earscience.org.au
Subiaco:	www.earscience.org.au
Subiaco:	www.kidshear.com.au

Please note, Kids Hear Diagnostic Audiology in Duncraig and Subiaco is affiliated with the Perth ENT Centre. Therefore, Medicare rebates are applicable if you have been referred there by a GP.

Dr Shane Langsford
Managing Director -PECS
Registered Psychologist

Date of Report

APS College of Educational & Developmental Psychologists Academic Member

SPECIFIC LEARNING DISORDER: DSM-5

The upcoming fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association; DSM-5) takes a different approach to learning disorders than previous editions of the manual by broadening the category to increase diagnostic accuracy and effectively target care. Specific learning disorder is now a single, overall diagnosis, incorporating deficits that impact academic achievement. Rather than limiting learning disorders to diagnoses particular to reading, mathematics and written expression, the criteria describe shortcomings in general academic skills and provide detailed specifiers for the areas of reading, mathematics, and written expression.

Characteristics of Specific Learning Disorder

Specific learning disorder is diagnosed through a clinical review of the individual's developmental, medical, educational, and family history, reports of test scores and teacher observations, and response to academic interventions. The diagnosis requires persistent difficulties in reading, writing, arithmetic, or mathematical reasoning skills during formal years of schooling. Symptoms may include inaccurate or slow and effortful reading, poor written expression that lacks clarity, difficulties remembering number facts, or inaccurate mathematical reasoning.

Current academic skills must be well below the average range of scores in culturally and linguistically appropriate tests of reading, writing, or mathematics. The individual's difficulties must not be better explained by developmental, neurological, sensory (vision or hearing), or motor disorders and must significantly interfere with academic achievement, occupational performance, or activities of daily living.

Because of the changes in DSM-5, clinicians will be able to make this diagnosis by identifying whether patients are unable to perform academically at a level appropriate to their intelligence and age. After a diagnosis, clinicians can provide greater detail into the type of deficit(s) that an individual has through the designated specifiers. Just as in DSM-IV, dyslexia will be included in the descriptive text of specific learning disorder. The DSM-5 Neurodevelopmental Work Group concluded that the many definitions of dyslexia and dyscalculia meant those terms would not be useful as disorder names or in the diagnostic criteria.

Broader Approach for Targeted Care

Broadening the diagnostic category reflects the latest scientific understanding of the condition. Specific symptoms, such as difficulty in reading, are just symptoms. And in many cases, one symptom points to a larger set of problems. These problems can have long-term impact on a person's ability to function because so many activities of daily living require a mastery of number facts, written words, and written expression.

Early identification and intervention are particularly important. The broader DSM-5 category of specific learning disorder ensures that fewer affected individuals will go unidentified, while the detailed specifiers will help clinicians effectively target services and treatment. DSM is the manual used by clinicians and researchers to diagnose and classify mental disorders. The American Psychiatric Association (APA) will publish DSM-5 in 2013, culminating a 14-year revision process. APA is a national medical specialty society whose more than 36,000 physician members specialize in the diagnosis, treatment, prevention and research of mental illnesses, including substance use disorders. Visit the APA at www.psychiatry.org

Above information available at:

<http://www.dsm5.org/Documents/Specific%20Learning%20Disorder%20Fact%20Sheet.pdf>

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Clinical Cohort: Reading Disorder

The key feature of Reading Disorder (commonly known as dyslexia) is significant impairments in reading ability (as measured via standardised testing), relative to what would be expected for the child's age, intelligence levels and current level of education. Reading Disorder is specified in the DSM-IV-TR, with the criteria that the impairments observed in reading ability should significantly interfere with the child's academic achievements and their ability to deal with everyday activities which rely upon reading knowledge and skills. Difficulties in reading can manifest both in oral and silent reading, with both overall slowness in reading and comprehension errors are observed. Common areas of difficulty in children with Reading Disorder include:

- Slow reading speed
- Poor comprehension
- Omission/commission errors while reading
- Reversal of words or letters while reading
- Poor sight word vocabulary
- Difficulty associating letters and syllables to specific sound (phonics)

It has been estimated that approximately 4% of children have a Reading Disorder. Reading Disorder is not usually diagnosed before year one, when the child begins to learn reading skills at a more in-depth level. The earlier that Reading Disorder is identified the better the prognosis is for the child to engage successfully in remedial classes.

Cognitive:

WISC-IV Index Interpretation:

The performance of children with Reading Disorder was compared to matched control children on the WISC-IV, as part of the process of norm construction. The children with Reading Disorder were found to display **significantly lower** FSIQ scores (average 10.8 points lower) and significantly lower scores on all indexes, in particular WMI (average 12.8 points lower) and VCI (average of 9 points lower). Children with Reading Disorder were found to have WMI scores which were an average of 5 points lower than the VCI scores and 7.5 points lower than the PRI scores.

WISC-IV Subtest Interpretation:

When examining performance on individual subtests, the children with Reading Disorder were found to exhibit significantly lower scores on the Similarities, Comprehension, Vocabulary, Word Reasoning, Information, Picture Completion, Matrix Reasoning, Letter-Number Sequencing, Digit Span, and Arithmetic subtests. The subtests of Cancellation, Block Design, and Picture Concepts were demonstrated to be the least effected by Reading Disorder, of all the WISC-IV subtests.

The subtests of Vocabulary, Information, Letter-Number Sequencing and Arithmetic were found to demonstrate particularly large effect sizes, when comparing the performance of children with Reading Disorders on the WISC-IV and a matched control group.

The lower scores on the Vocabulary and Information subtests are likely to be a reflection of the limited availability of information that children with impaired reading are able to acquire from reading. The lower scores on the Letter-Number Sequencing and Arithmetic subtests suggest that impairments in working memory are also seen in children who have difficulties reading. Working memory is necessary for reading, as the words which are being read have to be held in one's mind, and then processed as a group, in order to allow for the meaning of the words and the overall writing to be fully understood and comprehended.

There are a number of measures available which assess different aspects of reading and comprehension, which can be used to determine in more detail the underlying areas of weakness in reading, which are specific to the individual child.

WISC-V Index Interpretation:

The performance of children with Reading Disorder was compared to matched control children on the WISC-V, as part of the process of norm construction. The children with Reading Disorder were found to display **significantly lower** ($p<.01$) average FSIQ scores (13.07 points lower) and significantly lower average scores on all indexes; VCI (11.63 points lower), VSI (8.37 points lower), FRI (9.40 points lower), WMI (16.23 points lower), and PSI (7.37 points lower). The largest effect sizes are observed for the WMI and VCI, which is consistent with research literature that suggests a relationship between reading achievement and difficulties with multiple components of working memory (Wang & Gathercole, 2013).

WISC-V Subtest Interpretation:

When examining performance on individual subtests within the WISC-V, the children with Reading Disorder were found to exhibit **significantly lower** ($p<.01$) scores on the Similarities, Vocabulary, Information, Comprehension, Visual Puzzles, Matrix Reasoning, Arithmetic, Digit Span, Picture Span, Letter-Number Sequencing, and Coding subtests.

The subtests of Picture Span and Digit were found to demonstrate particularly large effect sizes, when comparing the performance of children with Reading Disorders on the WISC-V and a matched control group.

Behavioural:

Reading Disorder can have a wide spread impact on the child's performance academically, with reading being an essential requirement for essentially all subjects at school. In a child with otherwise average intelligence, difficulties in reading can prevent them from achieving at their full academic potential. Studies have found that 20-55% of children with Reading Disorder have Attention Deficit/Hyperactivity Disorder (ADHD). The casual relationship between these two disorders is unclear, as ADHD could exacerbate a child's reading difficulties (reduce their ability to focus on the task) or the ADHD may be a reaction to the child's reading difficulties and the frustrations they are experiencing. Older children are more likely to display externalising behaviours if they have a Reading Disorder, possibly due to the long stading nature of the problems and their constant struggling to be able to read and understand.

It is important to be mindful that all child develop at different rates, thus it needs to be considered whether the child is displaying a genuine deficit in reading, as opposed to just a delayed pattern of development or low overall intelligence.

Psychological:

60-80% of individuals with Reading Disorders who are diagnosed are males. This bias may be a consequent of boys tending to display disruptive externalising behaviours, in response to their difficulties with reading, which teachers find more of a problem in the classroom. Girls are likely to display internalising patterns of behaviour, particularly depression, often being quiet and withdrawn at school. Conduct disorder, Oppositional Defiant Disorder and depression are all observed at higher rates in children with Reading Disorder, than the overall population, which potentially indicates that if a child presents with these disorders the possibility of impairments in reading should be investigated as potential causal variables. Self-esteem and social problems are seen, as the child will be struggling in many areas at school, may have communication problems and as a consequence of poor reading, they may fail to acquire a advanced vocabulary and knowledge base from which to learn about new constructs and talk competently to their peers.

Clinical Cohort: Disorder of Written Expression and co-morbid Reading Disorder

The key feature of Disorder of Written Expression is significant impairment in a child's writing skills (as measured via standardised testing), relative to what would be expected for the child's age, intelligence levels and current level of education. Disorder of Written Expression is specified in the DSM-IV-TR, with the criteria that the impairments observed in writing ability should significantly interfere with the child's academic achievements and their ability to deal with everyday activities which rely upon writing skills. Children with Disorder of Written Expression may show impairments in writing in the following areas:

- Grammatical or punctuation errors in writing
- Numerous spelling errors
- Poor paragraph organisation and formatting
- Extremely poor handwriting.

It is important to ensure that a diagnosis of Disorder of Written Expression is not given if a child displays poor quality handwriting or spelling errors, when other difficulties of written expression are not observed. Diagnosis of Disorder of Written Expression is difficult, due to there being few available standardised testing instruments which focus exclusively on assessing a child's writing ability. Often the child is asked to copy written text, complete dictation tasks and write spontaneously, as a means of establishing a child's writing ability and whether they are performing at age and IQ appropriate levels.

Disorder of Written Expression is found to occur in conjunction with Reading Disorder in a majority of children, with its occurrence in isolation from another Learning Disorder (reading Disorder or Mathematics Disorder) being very rare. Due to this, most research and remediation programs focus on children with Disorder of Written Expression and co-morbid Reading Disorder. The disorder is also found with other language and perceptual/motor deficits. Disorder of Written Expression is not usually diagnosed until around second grade, where the child's writing ability begins to visibly fall behind that of their peers.

Cognitive:

WISC-IV Index Interpretation:

The performance of children with a Disorder of Written Expression and co-morbid Reading Disorder, was compared to matched control children on the WISC-IV, as part of the process of norm construction. The children with a Disorder of Written Expression and co-morbid Reading Disorder were found to present with **significantly lower** average scores on the FSIQ (average of 8.7 points lower) and on the WMI (average of 9.8 points) and PSI (average of 11.4 points) indices. The target children were also found to have differences between the indices of the WISC-IV, with the WMI found to be consistently lower than both the VCI (4.5 points) and the PRI (8 points).

WISC-IV Subtest Interpretation:

When examining performance on individual subtests of the WISC-IV, the children with Disorder of Written Expression and co-morbid Reading Disorder were demonstrated to scores significantly lower on the Vocabulary, Information, Picture Completion, Letter-Number Sequencing, Digit Span, Arithmetic, and Coding subtests. The subtests of Arithmetic, Coding, Information, Vocabulary, Letter-Number Sequencing, and Digit Span were found to be the most informative when assessing the cognitive performance of children with Disorder of Written Expression and co-morbid Reading Disorder. The WISC-IV subtests of Picture Concepts, Cancellation, and Block Design were shown to be the subtests that were the least informative of a child's cognitive ability if they had a Disorder of Written Expression and co-morbid Reading Disorder.

Children with Reading Disorder (in isolation) can be distinguished from children with Disorder of Written Expression and co-morbid Reading Disorder, using the WISC-IV, through examination of the child's PSI, which appears to show a higher degree of impairment in children with the two learning disorders, rather than Reading Disorder alone.

WISC-V Index Interpretation:

The performance of children with a Disorder of Written Expression and co-morbid Reading Disorder, was compared to matched control children on the WISC-IV, as part of the process of norm construction. The children with a Disorder of Written Expression and co-morbid Reading Disorder were found to present with **significantly lower** ($p < .01$) average scores on the VCI (8.09 points lower), FRI (9.45 points lower), WMI (12.95 points lower), and FSIQ (11.41 points lower). Of these significant differences, WMI had the largest effect size.

WISC-V Subtest Interpretation:

When examining performance on individual subtests of the WISC-IV, the children with Disorder of Written Expression and co-morbid Reading Disorder were demonstrated to scores **significantly lower** ($p < .01$) on the Similarities, Information, Figure Weights, Arithmetic, Digit Span, Picture Span, and Letter-Number Sequencing.

Behavioural & Psychological:

As with the other Learning Disorders, Disorder of Written Expression and co-morbid Reading Disorder, children are more likely to display externalising behaviours, poor self-esteem and depression as a consequence of their struggles with trying to perform tasks which they can see their peers doing with relative ease. Research has supported these children as having higher incidences of Attention Deficit/Hyperactivity Disorder (ADHD), Conduct Disorder and Oppositional Defiance Disorders, particularly boys. The casual relationship between these disorders is unclear, as ADHD could exacerbate a child's reading and writing difficulties (reduce their ability to focus on the task) or the ADHD may be a reaction to the child's reading and writing difficulties and the frustrations they are experiencing. Older children are more likely to display externalising behaviours if they have a Learning Disorder, possibly due to the longstanding nature of the problems and their constant struggling to be able to read and understand. Self-esteem and social problems are also commonly seen in these children, as they will generally struggle at school, may have communication problems and as a consequence of poor reading and writing, they may fail to acquire an advanced vocabulary and knowledge base from which to learn about new constructs.

Clinical Cohort: Left-Handedness and Cognitive Difficulties

A study assessing handedness in pre-school children was administered to a Viennese sample of 120 children of the ages 4 to 6.5 (18 left-handed, 17 ambidextrous and 85 right-handed).

For the purpose of validation, the handedness of the children was assessed via a questionnaire given to parents, observation of the hand used to draw and testing of visual-motor skills as well as general level of development using the Viennese Development Test (WET, Kastner-Koller & Deimann, 2002).

Compared to ambidextrous and right-handed children, **left-handed** children were found to have **significantly lower visual-motor skills**.

Goez & Zelnik (2008) investigated the distribution of hand dominance in 98 children (aged 5.5-17.0 years) with developmental coordination disorder.

Thirty children (30.6%) were found to be left-handed and 13 (13.3%) were identified as ambidextrous. The prevalence of left-handedness among their parents and siblings was found to be similar to that of the general population.

The results suggest that children with developmental coordination disorder present with a **higher frequency of left-hand dominance** compared with the general population.

Other studies have found that left-handedness is significantly over-represented among children with Dyslexia, ADHD, Learning Disabilities, and Autism (Goez & Zelnik 2008).