Background History Collection Matters

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Overview

- This webinar describes why the collection of background history is important for both diagnostic and intervention purposes. It will offer case scenarios to illustrate how effective background history collection can assist clinicians in making decisions in complex client cases.

Learner Outcomes

- By the end of this presentation participants will be able to:

1. List components of a thorough and complete background history report
2. Explain why a thorough background history documentation can lead to important diagnostic discoveries relevant for assessment and treatment purposes

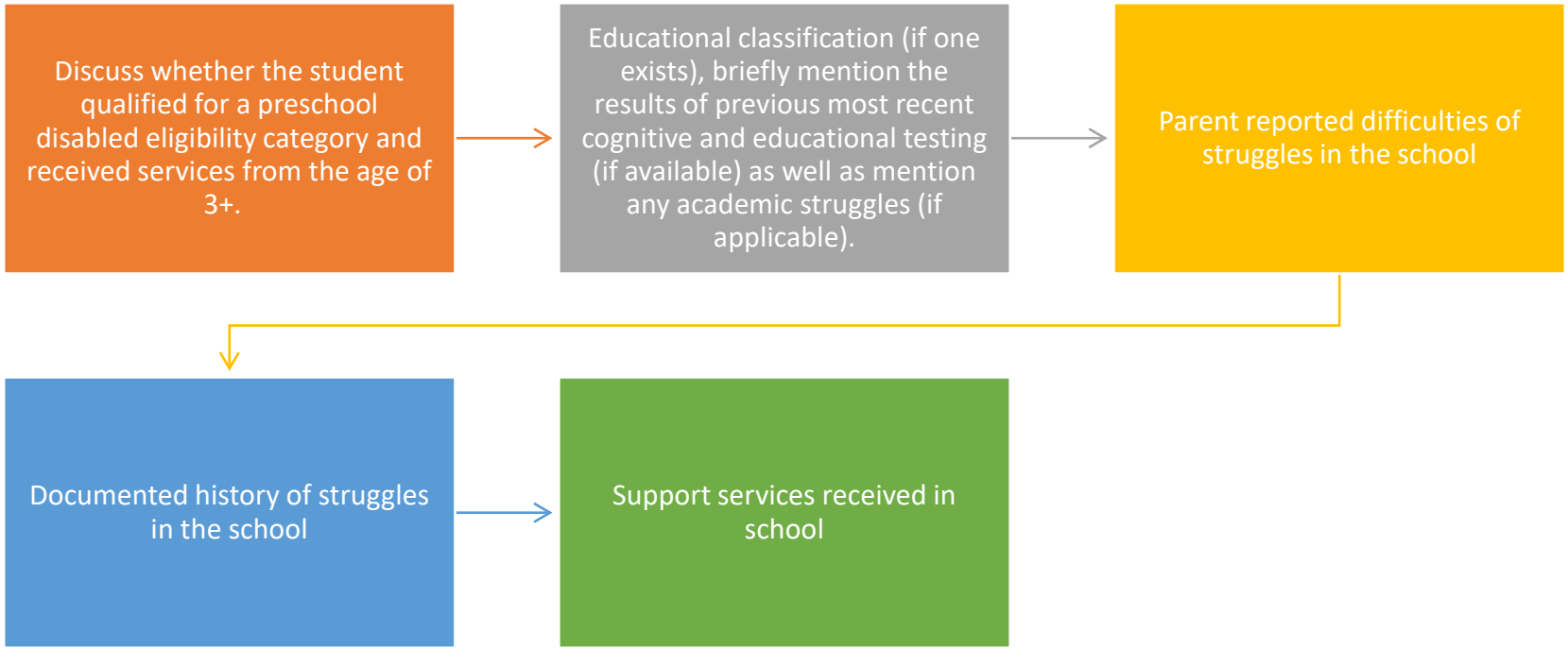
Background History Components

- Introduction
  - ____, a 13-11-year-old male was seen at Smart Speech Therapy LLC, by Tatyana Elleseff MA CCC-SLP, for a comprehensive language and literacy assessment for 5 testing sessions in December 2020 (see footnote on the first page of this report for all assessment dates). Assessment was requested by his parents in order to determine an appropriate educational environment for __, establish present level of his language and literacy functioning (strengths and needs), as well as to develop a comprehensive treatment goal hierarchy in order to improve his social and academic functioning.
- Source of provided information
- Family composition (who lives in the house, where is the house)
- Medical History (prenatal, perinatal, and early childhood). Please list pertinent diseases and problems
- Developmental History: all developmental milestones incl. speech and language milestones OT, PT, etc. List all mentions of delayed development here.
- List history of early interventions
- Is there a psychiatric or behavior history
  - When did the emotional behavioral problems first arose, and what had been done about them to date (out of district placements, variety of psychiatric services, etc.)
  - Student's most recent psychiatric
- Family history
- Genetic disorders, psychiatric impairments, special education placements, as well as language, learning, and literacy deficits.
  - This section plays a vital importance in determination of the contributions to the student's language difficulties as well as guides assessment recommendations in the presence of borderline assessment results.

Components (cont.)

- Results of all past assessments (not just language) tell a story!
- To date, a number of assessments had been administered to the student secondary to significant academic difficulties.
  - In January 2011, an occupational therapy evaluation administered by ____, OTR/L in the form of **Peabody Developmental Motor Scales – 2 (PDMS-2) Fine Motor Scale** revealed a gross motor quotient of ___, placing her fine motor abilities in a scattered range of functioning, characterized by immature grasp patterns, inability to copy age level geometric designs, as well as draw recognizable shapes and letters. Weaknesses in the area of self-care skills characterized by difficulties with dressing and managing closing fasteners have also been noted.
  - In April 2015, a speech and language evaluation administered by _____, Speech-Language Therapist in the form of **t**he **Test of Language Development: Primary, 4th Ed. (TOLD-P: 4)** as well as the **Receptive and Expressive One- Word Picture Vocabulary Tests (ROWPVT and EOWPVT)** revealed average language abilities in the areas of receptive and expressive vocabulary as well as listening, speaking and spoken language, organizing, grammar, and semantics.

History of Academic Functioning



Background History and Literacy Deficits

- At risk family history of literacy problems
- Early onset difficulties recognizing letters and numbers
- Requires/d extensive time to learn to recognize/write letters in own name
- Easily frustrates during reading/writing tasks
- Social immaturity (as compared to same aged peers)
- Social awkwardness (difficulty interpreting social cues/body language of others)
- Acts as a class clown (attempts to entertain peers with antics)
- Low self-esteem
- Low motivation (especially during literacy based tasks)
- Lacks confidence during learning tasks
- Poor/negative self-image
- Frequent somatic complaints (physical complaints such as stomachache, headache, fatigue, etc.)
- Aggression
- Anxiety
- Frequently distracted and unfocused

Prenatal History and FAS

- What was the age of the mother when she gave birth to the child in question?
- How many other pregnancies occurred prior to/post this one?
- How many children does the mother currently have?
- Were maternal rights ever terminated in the past and if so with which children and due to what factors?
- Is there a history of maternal neglect?
- Is there a history of abuse in the family
  - Physical, sexual, emotional?
- Is the father known? If so is he involved in the family?
- Is the father the same for all the children?
- Is there a family history of mental illness?
- Is there a family history of substance abuse?
- What is the maternal (family's) socioeconomic status?
- Is maternal geographic region known for history/tolerance of heavy drinking?
- Is there a maternal history of substance abuse?
  - Was the biological mother taking any substances prior to finding out she was pregnant?
  - Alcohol?
    - If yes, how frequently per day?
      - What amount?
      - What type?
  - Any drugs including marijuana?
    - If yes, what type and how frequently per day?
- If yes, how many months along was the mother when she found out she was pregnant?
- Were the parental rights ever terminated with the child in question?
  - If yes, why?
    - Ask to see/find court order if available

FAS and Developmental Milestones

- Does the child have history of:
- Significant medical issues?
  - If so list what type and how were they treated?
    - Failure to thrive?
    - Swallowing deficits?
    - Feeding deficits?
- Delayed speech/language milestones?
  - At what age did the child start babbling?
  - At what age did the child start using first words?
  - At what age did the child start using word combinations?
- Did the child ever have inconsistent language gains (e.g., had the skill then lost it?)
- At what age did the child started to
  - Sit
  - Crawl
  - Walk
  - Was potty trained?
- How are the child's self help skills?
  - Dressing?
  - Feeding?
  - Bathing?
  - At what age did they develop?
- Did/does the child have self-regulation difficulties?
  - Was s/he difficult to soothe?
  - Excessively irritable?
  - Cried a lot as an infant/toddler?
  - Does the child had/have severe temper tantrums and behavioral outbursts?
- Is the child socially inappropriate with peers/adults?
  - If yes explain and provide details.
- Is the child inattentive and hyperactive?
  - Does the child have poor impulse control?
  - Does the child have poor decision making skills?
- Is the child anxious?
- Easily over stimulated?
- Oppositional?
- Ignores what s/he is told?
- Does the child have challenges with transitions/changes

FAS Questions Relevant to School-Aged Students

- Has a child been diagnosed with a psychiatric disorder?
    - Concomitance of psychiatric impairments with FASD is very high
    - Does the child have learning disabilities?
        - Reading and Writing Deficits
        - Listening Comprehension Deficits
        - Information Processing Deficits
- Are the child's language abilities significantly poorer than those of his/her peers?
    - Does s/he speak in shorter less complex sentences
    - Has Immature Vocabulary?
    - Has Impaired Story Telling Skills?
- It does not have to be the case with all children with FASD. Some researchers found that some children with FASD may present with "good superficial speech and sociability that belie later deficits in both language and peer relationships" (Weinberg, 1997, p. 1182)
- Does with child from at–risk background present with adequate communication skills but has
    - Problem solving deficits?
    - Social skills deficits?
        - Emotional Immaturity
        - Does s/he understand abstract information?
        - Can s/he see the "big picture" in messages/text?
        - Can s/he socially relate to others?
        - Does s/he have significant difficulty learning from experience?

Case Example: Early Intervention

- *"I have no idea why your child isn't speaking so I bet it's CAS".*
  - *2nd opinion* adopted 2.5-year-old girl, who had been receiving early intervention services for several months prior, still "wasn't speaking", and the treating therapist had no idea why.
  - Parent was feeling very frustrated because she was being told by the SLP that her child "probably has apraxia of speech" but no concrete evidence was being offered to her to either support or refute that diagnosis.
- Original speech language evaluation didn't contain any relevant background history details
- Detailed intake questionnaires were now sent to the parent asking in depth questions regarding the child's biological parents (which was accessible to the adoptive parents).
  - Revelation: Both biological mother and grandmother of the child had significant language delays and started speaking after the age of 3. The child's biological mother was even reported to "make up her own language" to such an extent that the family had to interpret her words.
- New assessment revealed a *severe phonological disorder*.
- Client was chatty with appropriate prosody, pitch and loudness, good range of vowels as well as frequent spontaneous verbalizations.
- Highly unintelligible due to decreased phonetic inventory and phonotactic repertoire as well as simplification of sound sequences.
- This diagnosis also explained why she wasn't making any progress in speech therapy.
- The treating therapist was not using appropriate intervention strategies relevant to the treatment of her phonological disorder.
- After appropriate interventions were implemented, therapy gains were seen on the first session.

Case Example: Preschool

- "Help!: *I can't tell if this student has a language difference or a language disorder."*
- 2nd opinion evaluation on a bilingual 4.5 year old preschooler, whose parents were concerned about his language abilities and pre-academic readiness.
- Child had previously been assessed by the school district SLP and found to be not eligible for services.
    - assessing clinician judged that the child's limited English proficiency was due to limited English exposure and stronger primary language, stating that given English language immersion, the child will 'catch-up'.
    - Parents became very concerned when after a 1.5 years of significant English immersion in a private preschool, the child still continued to fall further and further behind both monolingual and bilingual peers with respect to language abilities and academic performance.
- Review of initial evaluation report yielded information on observations plus formal and clinical testing results.
- No information regarding this child's background history beyond the minimal requisite blurb in the beginning of the report explaining why the child was referred for an assessment.
- Parents were asked to fill out intakes regarding early language development as well as family history.
- Parental input revealed a family history of reading and learning disabilities on maternal side of the family, as well as history of late primary language development.
- Reassessment revealed that the child's language difficulties were not due to a language difference but to a language disorder, which originated in the child's primary language and later transferred to English.
- After therapy services were implemented and the necessary support to the child was provided, immediate gains were noted.

- "Just stop misbehaving!"
- Psychiatrist referral for social pragmatic language evaluation on a post-institutionalized, internationally adopted early elementary aged child, who had been displaying significant behavioral difficulties at school.
- Review of available school showed academic performance was at grade level and his general language abilities have been assessed a few years prior to the present referral and were found to be WNL.
- The child's 'misbehaviors' were described by school staff (as per intake) as significant overactivity, difficulty with transitions, difficulty "winding down", tantrums when 'he doesn't get what he wants', inappropriate interruptions of others, as well as 'excessive emphasis on own agenda'.
- Phone interviews with the SLP who performed the original language assessment, the classroom teacher and the school psychologist revealed a similar theme: "There's nothing wrong with his language, he is just acting out when he doesn't get his way.
- School based language assessment did not contain any of the child's background pre-and post adoption history so parents were asked to provide this information + preadoption records were requested.
    - Found court order from the child's birth country, which stated that prior to the orphanage placement, the child's biological mother's rights were revoked by the court due to alcohol abuse and child neglect. Coupled with parental interviews regarding this student's post adoption language development, this information revealed that the child wasn't merely 'misbehaving' but most likely had undiagnosed alcohol related deficits, which were adversely impacting his academic functioning in the school.
- A language reassessment confirmed the presence of significant social pragmatic language deficits.
- A referral to FAS team substantiated the diagnosis of alcohol related disability, which was not readily apparent due to the child's age as well as relatively high academic and linguistic functioning.
- After the child began receiving social pragmatic therapy services and relevant behavior management techniques were implemented, many of the above described behaviors significantly improved.

Case Example: School-Age

Conclusion

Thorough background history collection provided the key to the puzzle of what was wrong with each child.

However, without knowing this history these children would have continued to struggle due to lack of appropriate diagnoses and relevant targeted interventions.

It is critical that SLPs and other related professionals (e.g., psychiatrists, psychologists, social workers, etc.) obtain a detailed background information of the child's early development and family history as it will allow them to make an appropriate and accurate diagnosis of the child's difficulties, which will in turn allow the child to receive relevant classroom placement, appropriate accommodations and modifications as well as targeted and relevant therapeutic services.

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