Pediatric Disorders

Paul C. McCabe
Steven R. Shaw

Current Topics
and
Interventions
for
Educators

A JOINT PUBLICATION
Caroline's parents brought her to a psychologist because, rather suddenly, she was presenting with a variety of behaviors unusual for her. Caroline, aged 9, had always been an excellent student, cooperative, and eager to learn. She was rather shy and serious in manner, and her passions were reading and horseback riding.

Within the month previous to her first session with the psychologist, Caroline's interest in all things related to school had waned dramatically. She often asked if she could stay home. She seemed generally lethargic and no longer showed much interest in reading, taking trips to the library, or playing with her friends. Perhaps most alarming to her parents was Caroline's refusal to continue her riding lessons. She was frequently distractible or "off in her own world," both at home and in school, and was often found napping in her room.

Caroline was also demonstrating increasingly anxious behaviors. For example, she worried that something bad would happen to her parents, worried that her friends did not want to play with her, stated that her teachers did not like her anymore, and expressed fear she would be hurt while riding. None of these had ever been her concerns previously.

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INTRODUCTION

Education publications contain few articles on the impact of Lyme disease and associated tick-borne infections on the capacity of school-aged children to function successfully within an educational program. This oversight is of considerable concern, as educators are front-line service providers for children and adolescents presenting with symptoms of behavioral, cognitive, learning, and/or psychological problems. Educators can play a significant role in recognizing impaired school performance due to Lyme disease or other tick-borne infections and advocate for the child within the medical/school community.

BACKGROUND

Lyme disease (LD) and associated tick-borne infections (TBIs) are multisystem diseases caused by the following bacteria: *Borrelia burgdorferi* (Lyme disease spirochete), *Ehrlichia* and *Anaplasma* species (rickettsial bacteria), *Bartonella* species (bacterium), *Mycoplasma* species (bacterium), Southern tick-associated rash illness (STARI; a spirochete), and *Babesia* species (a protozoan parasite). These infectious microorganisms are generally transmitted to children from rodents or small mammals by the attachment and feeding of a deer tick or a lone star tick. The nymphal tick, whose attachment is responsible for causing the majority of infections, is the size of a poppy seed and often goes unnoticed.

The initial indications of LD infection can include but are not limited to a reddish rash, flulike illness (fever and chills), fatigue, joint pain, headache, stiff neck, mental confusion, and sleep disturbance. A single tick may transmit several of these microorganisms in the same attachment, and several of the coinfections may present with symptoms similar to those of LD. Although the risk of coinfection differs by geographic location, every tick attachment has the potential of transmitting multiple infections (Swanson, Neitzel, Reed, & Belongia, 2006). In addition, the LD spirochete...
possesses molecular survival strategies, enabling it to evade the immune response and to persist in its human host (Rupprecht, Koedel, Fingerle, & Pfister, 2008). Misdiagnosis and delayed treatment frequently lead to debilitating chronic illness with relapses and deterioration, especially in musculoskeletal, cognitive, and neuropsychiatric impairments (Fallon, Kochevar, Gaito, & Niels, 1998; Halperin, 2004). Symptoms often have puzzling presentation in patients, especially in children (Fallon et al.). Although some school nurses are alert to the impact of LD and associated TBIs on school-aged children (e.g., Healy, 2000), information on these diseases is generally absent from the education and psychology literature. Educators require a basic understanding of the diagnosis and treatment of TBIs. They must also be able to recognize and articulate the impaired school performance frequently caused by these illnesses and advocate for the student with illness within the school, family, and medical communities.

Infection Incidence and Risk

Lyme disease is the fastest-growing vector-transmitted disease in the United States, with a 38% increase in the Centers for Disease Control surveillance cases from 2006 to 2007 (CDC, 2007; 2008). Roughly 20,000 new cases of LD are diagnosed each year, and the CDC (2007) acknowledges underreporting. This is particularly troublesome because of the incidence of pediatric cases (Young, 1998). Lyme disease is endemic in the Northeastern and mid-Atlantic states, in the upper North-Central region, and in northern California. Twelve states—Connecticut, Delaware, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Wisconsin—account for 95% of cases reported nationally (CDC, 2007). Lyme disease has been documented in every state, and associated TBIs are reported in the same geographical areas as LD.

People of all ages are vulnerable to LD, and significant infection rates occur in children aged 5 to 14 years (CDC, 2007). Children in suburban residential areas surrounded by tick-infested woods and those who participate in outdoor recreational activities are at the greatest risk of getting LD or other TBIs. Infection can occur from childhood activities in a shady home environment, especially where ground cover, moist humus, and leaf litter dominate play areas (Klein, Eppes, & Hunt, 1996). Each spring, the risk of infection increases significantly; as temperatures reach 40°F (4.5°C), ticks become active, and outdoor activities increase (Lane, Steinlein, & Mun, 2004). Although every tick might not be infected, every tick attachment has the potential for transmitting LD and associated TBIs.

Diagnosis

The central diagnostic difficulty responsible for the current debate within the medical community on diagnosis and treatment of LD and TBIs is the lack of definitive and readily available laboratory tests for active infection (Coulter et al., 2005). Physicians are challenged to diagnose early TBIs based on clinical presentations (patient history, exposure risk, and
symptoms). Laboratory test data, including those for coinfections, can be supportive in diagnosis (Sherr, 2004). The Food and Drug Administration (FDA; Brown, Hansen, Langone, Lowe, & Pressly, 1999) has questioned the reliability of commonly marketed LD test kits and stated that they “should never be the primary basis for making diagnostic or treatment decisions” (p. 1). The CDC (2007) has commented that test data based on CDC LD surveillance case definition, as reported with the test kits, is not to be used in diagnosis and treatment decisions. Both the CDC and FDA have acknowledged that a clinical diagnosis is the “best practice.” No test can rule out the possibility of infection (Coulter et al., 2005). School psychologists and nurses, educators, pediatricians, and primary care physicians need to be aware of the occurrence rates, potential severity, and diagnostic dilemmas of all TBIs. With our mobile society, this is true in both TBI-endemic and nonendemic areas.

**Neurological and Cognitive Deficits**

Lyme disease is characterized by a strong pro-inflammatory response, which can involve the brain, and an aberrant innate pro-inflammatory response, which is involved in chronic illness (Rupprecht et al., 2008). Cognitive symptoms are a direct result of dysfunction of the cerebral cortex where cognitive processing occurs (Bransfield, Brand, & Sherr, 2001). Although children with LD and TBIs can experience a variety of symptoms, it is often the subtle neurological and cognitive deficits, which may elude detection, that have the most negative effect on a child’s school performance and social life. Children with multiple TBIs frequently present with more diverse and severe symptoms compared to children with LD alone (Swanson et al., 2006).

These symptoms should be red flags for unrecognized LD and associated TBIs:

- Headache (can be severe), neck stiffness
- Peripheral neuropathy (nerve pain) in back, legs, or hands; musculoskeletal pain (can be severe)
- Distal paresthesia (tingling sensation, often in legs and hands) and facial paralysis
- Deficits with short-term memory, including with sequential, spatial, and tracking tasks; slowed word and name retrieval, letter and number reversals
- Decreased reading comprehension and handwriting skills
- Impaired speech fluency, including stuttering and slurred speech
- Inability to perform accurately previously mastered mathematical calculations
- Vision problems, including difficulty in the classroom in seeing and following visually presented material, frequent blinking or tics, inability to coordinate eye movement, and targeting difficulties
- Movement and coordination impairment, balance problems, clumsiness, or vertigo
- Executive function impairment, including the inability to activate or sustain effort and attention or manage frustration, confusion and lethargic thinking, and difficulty expressing thoughts
• Frequent errors in speaking, writing, spelling; dyslexic-like behaviors
• Severe and chronic fatigue unrelieved by rest, which may be evidenced by falling asleep in class; missing class because of sleep disturbance and/or sporadic night sweats
• Emotional and uncharacteristic behavioral presentation, including withdrawal from peers or a shift to a lower-functioning group, depersonalization (loss of a sense of physical existence), cessation of involvement in sports or other extracurricular activities, inattentiveness, attention deficit behavior, obsessive-compulsiveness, depression, anxiety, panic, aggression, defiance, explosive outbursts, mood swings, irritability, hyperactivity, nightmares, and sudden suicidal thoughts
• Inability to perform at grade level, which may be evidenced as inconsistent or sloppy schoolwork, late assignments, lower grades, feeling overwhelmed by schoolwork, missed school days, and school phobia
• Other neurological manifestations, including tinnitus, trigeminal neuralgia, facial numbness, sensory hyperacusis (unusual sensitivity to sound), photophobia, and intrusive and distorted visual images

Every child with LD or TBIs has a unique symptom profile that varies significantly during the process of infection. In addition to declining cognitive ability and declining school performance, additional presenting physical symptoms include gastrointestinal manifestations, such as chronic abdominal pain, gastritis, duodenitis, and colitis (Fried, Abel, Pietrucha, Kuo, & Bal, 1999); and cardiac complications, such as irregular rhythm, carditis, and heart block (Chen, 2008). In addition, ocular symptoms, including optic neuritis, neuropathy, conjunctivitis, uveitis, keratitis, ocular pain, or vision loss, are common (Rothermel, Hedges, & Steere, 2001).

**Developmental Delay, Attention Disorders, and Autism Spectrum Disorders**

Clinical experience suggests that in a subset of pediatric patients, LD and TBIs can mimic developmental delay and autism spectrum disorders (Bransfield, Wulfman, Harvey, & Ysman, 2008; Bransfield, 2009; Nicolson, 2007). Cognitive and behavioral difficulties are also similar to those observed in affective, oppositional defiant, and attention deficit disorders (Tager et al., 2001). Infection can also exacerbate pre-existing behavioral or psychiatric illness (Bransfield, 2007).

**Depressive, Panic, and Aggressive Disorders**

Rarely are children initially diagnosed with psychiatric manifestations of LD or TBIs, because their complaints are vague and thought to be functional in nature. If the undiagnosed disease process has psychiatric manifestations that lower the child’s frustration tolerance and/or increase irritability and impair cognitive functioning, then a referral from the school or treating physician to a psychiatrist addressing the assumed psychogenic or functional disorder is likely (Bransfield, 2007). Although much
of the data on psychiatric illness in children due to LD and TBIs is anecdotal, 60% of confirmed LD adult patients reported an episode of major depression during their illness (Rachman & Garfield, 1998). Moreover, significant numbers of hospitalized psychiatric patients were found seropositive for *B. burgdorferi* relative to healthy comparison subjects (Hajek et al., 2002). Clinical experience suggests a link between TBIs and aggression in children and adolescents (Bransfield, 2001).

**Long-Term Outcomes**

When facial nerve palsy was the initial symptom of LD and appropriately treated with antibiotics, neuropsychological and cognitive functioning and general health outcomes (based on neuropsychologic tests) were comparable to those in patients who did not have LD (Vazquez, Sparrow, & Shapiro, 2003). With initial dermatological or neurological symptoms, studies also indicated significant recovery (Adams, Rose, Eppes, & Klein, 1999). However, Bloom, Wyckoff, Meissner, and Steere (1998) reported that in patients with late neurologic manifestations of LD, improvement was often gradual or with continuing multiple neurocognitive symptoms requiring IV antibiotics. Adolescents with a history of treated LD can be at risk for long-term problems in cognition and school functioning (McAuliffe, Brassard, & Fallon, 2008).

**IMPLICATIONS FOR EDUCATORS**

Educators address few phenomena that are as emotionally and clinically challenging as diagnosing the cause of a child’s cognitive deterioration (Shaw, 2005). When pediatric TBIs are diagnosed early and treated promptly, few children develop long-term cognitive deficits (Vazquez et al., 2003) or require significant educational services. However, some children remain ill even after appropriate treatment (Berenbaum, 2004; Bransfield et al., 2001; McAuliffe et al., 2008). Often these children have had symptoms for months or years and been seen by several physicians who have erroneously labeled the child hypochondriac, psychosomatic, depressed, or malingering (Healy, 2000). The school psychologist and educator should perceive the symptoms as red flags when conducting intelligence testing, curriculum-based assessments, and direct student observation. Educators should play a multifaceted role in the identification of this illness by interviewing parents, as well as teachers or child care workers from previous years, to compare past with current performance. In addition, the school psychologist can be a postdiagnosis student advocate and active participant in the school and community medical management of the student’s illness. Follow-up skill assessment to provide discrete data to audit the effects of educational accommodation and progress of medical treatment is necessary.

Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) of 1990, and the 2004 Individuals with Disabilities Education Act (IDEA) mandate that students with disabilities in elementary,
secondary, and postsecondary schools receiving federal financial assistance cannot be discriminated against because of their disabilities. In many cases, schools are required to provide accommodations and/or supportive individual educational programs to help ill students achieve their academic goals (Betz, 2001). Accommodations include shortened days, untimed tests, the dropping of unnecessary requirements, alternative testing methods, separate/quieter testing locations, and modified home instruction programs (Msall et al., 2003).

IDEA obliges school districts to identify disabled and potentially disabled children and refer them to a Child Study Team, on which the school psychologist is an active member, to develop an Individualized Educational Program (IEP), monitor the IEP, and revise the IEP as needed (Boyce, Gelfman, & Schwab, 2000). Children with Lyme disease or TBIs should lead as full and normal a life as possible, given the severity of their illness. They are covered under Section 504, ADA, and IDEA legislation.

Because educational personnel may not be familiar with the physical, neurological, and emotional ramifications of LD or associated TBIs in the school setting, the school psychologist, in cooperation with the school nurse and special education teacher, can provide insight about the illness and needed educational accommodations (Cavendish, 2003).

Whenever a change in a child’s behavior, mood, or overall functioning occurs, including a suspected attention deficit/hyperactivity disorder, LD or TBIs should be considered quickly, as delays in diagnosis are associated with chronicity and morbidity (Fallon et al., 1998). Children and adolescents with LD who display considerable impairment and whose diagnosis and treatment are delayed have significantly more school-related cognitive and psychiatric sequelae than healthy children (McAuliffe et al., 2008; Tager et al., 2001). School psychologists, educators, nurses, and teachers may be the first adults with an opportunity to recognize the possible underlying infectious origin of presenting symptoms.

Effects of LD and TBI include fatigue, school tardiness, memory problems, distractibility, attention difficulties, and inability to understand complex information. These children also have behavioral disorders (e.g., irritability, anxiety, and depression) and school performance deterioration. Less is known about the long-term outcome for children with coinfections, as less research has been published. Clinical experience suggests that when the coinfections are effectively treated before treating LD, the outcome is favorable. Untreated coinfections, however, can lead to chronic illness, often involving severe neurological and cognitive problems.

### Educational Strategies

- Communicate with parents and, with appropriate permission, medical professionals concerning the child’s medical status. Educators can provide important information to physicians and parents on changes in academic performance, social and emotional functioning, and eating habits.
• Being flexible with assignments is critical. Children with LD or TBIs often have fluctuating levels of attention and alertness.
• Plans for itinerate homebound instruction may be necessary when children are not able to attend school.
• Allowing additional time for assignments may be necessary.
• Other strategies include shortened days, untimed tests, the dropping of unnecessary requirements, alternative testing methods, separate/quieter testing locations, and modified home instruction programs.

DISCUSSION QUESTIONS

1. What features are common to presentations of uncharacteristic behavioral and cognitive symptoms in school-aged children with Lyme disease or other tick-borne infections?
2. Are tick-borne diseases endemic, common, or rare in your location?
3. Why might blood and laboratory tests be unreliable in detecting tick-borne diseases?
4. Why might it be difficult to distinguish the symptoms of a tick-borne illness from behavioral and cognitive symptoms from other causes?
5. What other commonly diagnosed conditions may present symptoms similar to those of a tick-borne illness?
6. What consequences does delayed treatment have for children with a tick-borne illness?

RESEARCH SUMMARY

• Lyme disease and tick-borne diseases are common and often under-diagnosed.
• Lyme disease and tick-borne diseases have widely varied symptoms, including changes in cognitive and behavioral functioning.
• There are no clear laboratory tests for the diagnosis of Lyme and tick-based diseases. The diagnosis is made clinically on the basis of presenting symptoms.
• Several medical conditions have clinical symptoms similar to those of Lyme disease, making diagnosis extremely difficult.
• Treatment for Lyme disease can be challenging. The organism causing Lyme disease can lie dormant and then become active again at a later time. However, when treatment is effective, cognitive functioning, health status, and emotional functioning often return to pre-infection levels.

RESOURCES

Whenever a change in a child’s behavior, mood, or overall functioning occurs, including a suspected attention deficit/hyperactivity disorder, Lyme disease (LD) or tick-borne infections (TBIs) should be considered quickly as delays in diagnosis are associated with chronic impairment. Parents and educators need to be aware of the possibility of LD and TBIs as they may be first to recognize the possible underlying infectious origin of aberrant student behavior. Lyme disease and TBIs have become a permanent part of America’s public health landscape, affecting most perilously its young, their families, and school community. Many children seriously affected by these infections have alterations in personality, cognitive functioning, and behavior.

Infection Incidence and Risk

- Lyme disease is the fastest growing vector-transmitted disease in the United States with about 20,000 new cases reported each year.
- Lyme disease occurs nationwide; however, twelve states—Connecticut, Delaware, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Wisconsin—account for 95% of cases reported.
- People of all ages are vulnerable to LD, yet significant infection rates occur in school-aged children.
- Children in endemic suburban residential areas surrounded by tick-infested woods and those who participate in outdoor recreational activities are at risk of getting LD and associated TBIs. Even the city child on a nature outing is at risk with the greatest potential for infection in the spring.

Overview of Diseases

Lyme disease and TBIs are multi-system bacterial and protozoan diseases. These disease-causing microorganisms are transmitted to humans from rodents or small mammals through the attachment and feeding of a deer tick or a lone star tick. A single tick may co-transmit several of these microorganisms in the same attachment, which is often unnoticed due to the small, poppy seed-sized tick. Initial indications of infection can include but are not limited to a reddish rash, flu-like symptoms (fever, chills), fatigue, joint pain, headache, stiff neck, mental confusion, and sleeping disturbance. Symptoms are complex and often have puzzling presentations in children. An individual can have LD and TBIs repeatedly.

Diagnosis

Physicians are challenged to diagnose early TBIs based on clinical presentations (patient history, exposure risk, and symptoms). Laboratory test data are of limited reliability, identifying only about 50% of infections. A large body of clinical evidence illustrates that diagnosis of LD is especially difficult when the rash is absent, laboratory tests are negative, uncharacteristic symptoms occur (based on physician experience), and/or atypical psychiatric symptoms are present. The task of separating a primary pediatric psychiatric disorder from psychiatric LD and certain TBIs can be daunting and brain imaging technologies and psychological testing may be required. Misdiagnosis and delayed treatment of TBIs frequently lead to debilitating chronic illness and cognitive impairments.

School Performance

Every child with LD or TBIs has a unique profile of symptoms, which can vary significantly during the process of infection. Although children with TBIs can experience a plethora of symptoms, it is often the
subtle multiple cognitive and neurologic deficits that elude prior detection. These deficits have the most profound negative impact on a child’s school performance and social life.

Frequently symptoms develop in a child who previously performed well within the school environment. A challenging manifestation of TBIs is that symptoms may persist or they may be episodic and fluctuating in type and severity, further confusing diagnosis. Based on teacher or parental observations, the child may not appear sick in the traditional sense. Disease onset can be gradual with increasing fatigue, social disinterest, or deteriorating school performance. An important finding is that multiple cognitive and behavioral difficulties are similar to those observed with affective, oppositional defiant, attention deficit, and possible autism spectrum disorders. Further complicating diagnosis is the inability of children and teenagers to express their feelings to parents, teachers or friends.

Children are not initially diagnosed with psychiatric manifestations of TBIs because their complaints are seen as vague and inconsequential. If the undiagnosed disease has psychiatric manifestations, then a referral from the school or treating physician to a psychiatrist is likely.

What Can Parents and Educators Do?

- The most important action for parents is to prevent infection. Many universities and public health departments can provide information on tick repellants, protective clothing, high risk areas and behaviors to avoid, landscape chemical applications, and tick control on pets.
- However, if symptoms and school problems occur due to LD or other TBIs, it is imperative that parents and teachers collaborate, in consultation with a school psychologist and/or nurse to take appropriate medical intervention. Effective parent/teacher communication is crucial to discuss events in the home and school life, the problems they encounter, and feelings that result. It is vital for the parents and school to monitor the ill child’s behavior, assessing positive and negative changes, and communicating these observations.
- Parents and educators can be post-diagnosis advocates and active participants in seeking necessary school accommodations. Frequently, children with LD or associated TBIs and who struggle to remain in school hear comments from their classmates (often behind their back) about their "drama" and that they are just faking for attention. This experience can be devastating to the child’s emotional stability and parents and teachers need to support the child and raise awareness in the school community.
- Federal law, that is, Section 504 of the Federal Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) of 2000, and the 2004 Individuals with Disabilities Education Act (IDEA), mandates that students with disabilities in elementary, secondary, and post-secondary schools receiving federal financial assistance not be discriminated against because of their disabilities. In many cases, schools are required to provide needed accommodations and/or supportive Individualized Educational Programs (IEPs).
- Accommodations include shortened days, un-timed tests, dropping unnecessary requirements, alternative testing methods, separate/quieter testing locations, and modified home instruction programs. Children with Lyme disease should lead as full and normal a life as they are capable of given the severity of their illness.


**Chapter 10**


Joseph A. Buckhalt, PhD, NCSP, is a Wayne T. Smith Distinguished Professor and the Director of the School Psychology Program at Auburn University. Dr. Buckhalt received his PhD from George Peabody College for Teachers, Vanderbilt University, and holds Licensure and National Certification in School Psychology. His research and scholarship have been related to assessment and treatment of children at risk for academic underachievement and poor emotional/behavioral adjustment. Most recently, his work has been in collaboration with Dr. Mona El-Sheikh in studying how individual differences in sleep are related to educational and health outcomes in children.

Mona El-Sheikh, PhD, is Alumni Professor of Human Development and Family Studies at Auburn University, Alabama. She received her PhD from West Virginia University. Dr. El-Sheikh has been Principal Investigator on numerous research grants from the National Institutes of Health and the National Science Foundation and is the recipient of The Creative Scholarship Award from Auburn University. Her research has addressed biobehavioral mechanisms in children affected by stressors. Further, her integration of paradigms across scholarly disciplines and across different psychophysiological systems has resulted in better understanding of emotional, immune, and sleep regulation in children.

Sarah Glaser, BA, is a graduate student within the School/Applied Child Psychology Program at McGill University in Montreal, Quebec. She holds an undergraduate degree from Boston University. Ms. Glaser conducts research on the interaction between intellectual disabilities and mental health issues.

Rebecca Lakin Gullan, PhD, is a Research Fellow in the Community Schools Program in the Department of Psychology at The Children’s Hospital of Philadelphia. Dr. Gullan earned her PhD in Clinical Psychology at Bowling Green State University, Ohio, with a specialization in children and families. Dr. Gullan is currently the Principal Investigator of a grant from the NICHD/NIH (Kirschstein National Research Service Award for Individual Postdoctoral Fellows) to develop a community service program to promote civic and ethnic identity in African American, urban youth. Dr. Gullan also serves on the Editorial Advisory Board of School Psychology Quarterly and is an ad hoc reviewer for several additional journals. Dr. Gullan’s primary areas of research are (1) using partnership-based research methodology to develop culturally responsive interventions and measurement tools and (2) understanding, measuring, and promoting empowerment in disenfranchised populations.

Ron Hamlen, PhD, received his PhD in Plant Pathology and Nematology and postdoctoral training in Insect Pathology and Microbial Insect Control from the Pennsylvania State University. Dr. Hamlen also received a certificate in Health Risk Assessment from the Harvard School of Public Health. Dr. Hamlen is currently Vice President and Science Advisor for the Lyme Disease Association of Southeastern Pennsylvania and a member of the International Lyme and Associated Diseases Society, and he has served as a member of the Delaware Task Force to Examine the Prevalence of Lyme Disease in Delaware. Formerly a Biology Research Fellow and Global Technical Product Manager for E. I. DuPont de Nemours and Co., Inc. and
an Associate Professor of Entomology and Nematology with the University of Florida. Dr. Hamlen, now retired, conducts public and corporate workshops and training forums for state government employees on Lyme disease and related tick-borne infections. Dr. Hamlen has published research and several review articles on Lyme disease, related tick-borne infections, and their prevention.

Jessica A. Hoffman, PhD, NCSP, is an Associate Professor in the Department of Counseling and Applied Educational Psychology at Northeastern University, Boston. Dr. Hoffman received her PhD in School Psychology at Lehigh University and completed her predoctoral internship and postdoctoral fellowship in pediatric psychology at the Children’s Hospital of Philadelphia. Dr. Hoffman is a Massachusetts-licensed psychologist and school psychologist and holds the national certification in school psychology. She is the recipient of an early career (K) award from the National Institute of Child Health and Human Development to promote healthy eating in schools. Dr. Hoffman is on the editorial board of School Psychology Review. Her research focuses on the development of healthy eating behaviors among preschool and school-aged children.

Deborah S. Kliman, EdD, received her EdD from the University of Pennsylvania. Dr. Kliman also completed a postdoctoral fellowship in Structural Family Therapy at the Philadelphia Child Guidance Clinic. Dr. Kliman has had additional training in various types of psychotherapy, assessment, a variety of psychological disorders, and Lyme disease. Dr. Kliman’s professional career has included preschool and first-grade teaching, directing a Head Start program, being a demonstration teacher at Trenton State College, and consulting in various areas of education and psychology, including 18 years at a battered women’s shelter. Dr. Kliman was a professor of Child Development for 12 years at the University of Delaware and was a staff psychologist at a nonprofit clinic for families, children, and youth. Following her college teaching position, Dr. Kliman had a private practice in clinical psychology for more than 25 years and was licensed in Pennsylvania and Delaware. In the later years of her private practice, Dr. Kliman worked with many children and young people who were suffering from Lyme disease.

Fallon Lattari, MSEd, is a graduate of the School Psychologist Graduate Program at Brooklyn College of the City University of New York. She holds an undergraduate degree from Fordham University. Her research interests include early childhood issues, including food allergies and concomitant problems.

Tiffany Folmer Lawrence, MS, is a School Psychologist in the Avon Central High School, New York. She is a New York State-certified school psychologist. Ms. Lawrence received her MS and CAS in School Psychology from the Rochester Institute of Technology. She holds an undergraduate degree from Lafayette College. Professionally, Ms. Lawrence has an interest in response to intervention with secondary students, restorative justice practices in discipline, and Life Space Crisis Intervention.

Stephen S. Leff, PhD, is an Associate Professor of Clinical Psychology in the Department of Pediatrics at The Children’s Hospital of Philadelphia