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ABSTRACT

The current intervention trend for many of the mental health and behavioral problems faced by today's youth is an integrative approach that involves the community, families, and schools. Clinical assessment for serious mental health and behavioral problems can be an important component in the development of school-based screening programs. The most viable approach to assessment includes direct observation, self-report measures, behavior rating scales, interviews, and record reviews. In addition to their use in broadband assessment, self-report measures, behavior rating scales, and interviews can also be used in conjunction with narrowband assessment to provide more specific information to detect disorders. Clinical assessment frequently is used to evaluate young people for attention and concentration problems, eating disorders, suicidal ideation, schizophrenia, and post-traumatic stress disorder. Assessment techniques for each of these disorders are discussed in this chapter. (Contains 52 references.) (GCP)

Assessing Students With Serious Mental Health and Behavioral Problems: Clinical Assessment for Educators

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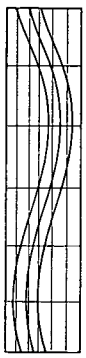

Chapter 14

Assessing Students with Serious Mental Health and Behavioral Problems

Clinical Assessment for Educators

Jo-Ida C. Hansen & Amy L. Conlon

The current intervention trend for many of the mental health and behavioral problems faced by today's youth is an integrative approach that involves the community, families, and schools. These collaborative efforts seek to provide person- and context-protective factors that can serve as sources of adolescent resiliency (Christenson & Sheridan, 2001). The National Association of School Psychologists Position Statement on Home-School Collaboration emphasizes, for example, that "schools can take the lead in providing opportunities for collaborative partnerships to be developed" (NASP, 1999). Clinical assessment for serious mental health and behavioral problems can be an important component in the development of school-based screening programs. The screening programs, in turn, can be useful for identifying students who will benefit from referrals to mental health professionals. Also, techniques such as template matching (Hoier & Cone, 1987), progress monitoring (Shinn, 1997), and the keystone behavior strategy (Nelson & Hayes, 1996) show promise for linking social-emotional and behavioral assessment information to interventions.

The most viable approach to assessment includes direct observation, self-report measures, behavior rating scales, interviews, and record reviews. However, time constraints often preclude the use of multiple measures. Self-report instruments, behavior rating scales, and structured interviews are three approaches that have been shown to provide valid and reliable assessment results (Merrell, 2001).

Advances in the development of self-report instruments for assessing the social-emotional concerns of children and youth have made these instruments the preferred choice in many instances (Merrell, 1999). Self-report measures are especially useful for assessing internalized problems (e.g., depression) that are not easily detected through observation or third-party ratings. One of the best known self-report measures, the Minnesota Multiphasic Personality Inventory for

Adolescents (MMPI-A) is a broadband instrument designed to assess personality domains relevant to various clinical disorders and psychopathologies (Butcher et al., 1992). The MMPI-A is appropriate for students between 14 and 18 years of age. Respondents answer 478 true-false items, and scores are provided on 10 clinical scales (e.g., Depression, Anxiety, Social Introversion) as well as on a number of special content scales. The MMPI-A parallels the adult version of the test in terms of scale interpretation; however, items on the MMPI-A were designed to reflect the background and experiences of adolescents (Wodrich, 1997). Moreover, the MMPI-A includes several content scales developed exclusively for adolescent populations, such as School Problems, Low Aspirations, Alienation, and Conduct Disorder (Hood & Johnson, 1997). Although the information provided on the MMPI-A is not sufficient to offer a formal diagnosis, the profile suggests a set of hypotheses regarding the nature of a student's problems that can be refuted or supported with additional data.

Behavior rating scales, sometimes called third-party instruments, also are widely used to evaluate a range of problems. The raters are typically teachers or parents of the child who rate the frequency and intensity of behaviors they have observed during a specified interval. Behavior rating scales provide a standard format for conducting the evaluations and also provide information for developing norm-referenced scores. Norm referencing allows a comparison between an individual child's scores and those of a reference group, which typically is a national sample of same-age, same-gender youth.

One example of a multiperspective rating system is the Achenbach Scales, which include the Child Behavior Checklist (CBCL; Achenbach, 1991a), the Teacher's Report Form (TRF; Achenbach, 1991b) as well as the Youth Self-Report (YSR; Achenbach, 1991c). Like the MMPI-A, the CBCL is a general purpose or broadband assessment that evaluates a range of problems and competencies. The CBCL, which is appropriate for ages 2 years to 18 years, is completed by a parent. Problem areas are clustered into internalizing (e.g., anxious/depressed) and externalizing (e.g., aggressive) behaviors; and competence items assess adjustment with respect to activities, school, and social domains (Kronenberger & Meyer, 2001). The CBCL offers a comprehensive description of student emotional, social, and behavioral adjustment but is not designed for diagnosis. Moreover, proper use of the instrument requires a thorough understanding of its structure and properties (Wodrich, 1997). The problem items on the TRF parallel those on the CBCL; however, the competence items on the TRF differ from those

on the CBCL (Kronenberger & Meyer, 2001). For students who exhibit serious emotional or behavioral disturbances, the TRF might serve as a good screening device for psychopathology. The instrument is less useful for screening normal social behaviors because items tend to be fairly clinical in nature (Merrell, 2000). The final instrument in the Achenbach system is the YSR, which can be used with students ages 11 to 18. Most of the YSR items are identical to the items on the CBCL (but worded in the first person). The components of the Achenbach Scales collectively provide information about students' functioning and adjustment across multiple situations and from multiple perspectives, which might be especially useful in identifying target behaviors (i.e., school-based or home-based behavior) for intervention (Kronenberger & Meyer, 2001).

Another broadband, multiperspective rating scale is the Symptom Inventories-4. This set of checklists was designed to reflect diagnostic criteria for major behavioral disorders of childhood and adolescence as laid out in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV), which is the primary diagnostic system used by mental health professionals. Parents and teachers complete the checklists, which have been developed for three age groups: the Early Childhood Inventories (ECI) for children ages 3 to 6 (Sprafkin & Gadow, 1996); the Child Symptom Inventory (CSI) for ages 5 to 12 (Gadow & Sprafkin, 1997b); and the Adolescent Symptom Inventory (ASI) for ages 13 to 18 (Gadow & Sprafkin, 1997a). Because these inventories do not take into account duration of symptoms, time of onset, or exclusionary criteria, they are not sufficient for assigning a diagnosis. Nonetheless, the inventories are unique in the breadth of disorders covered and the direct link between items and DSM-IV criteria (Kronenberger & Meyer, 2001).

Structured and semistructured interviews are another approach for obtaining information about students' functioning in a broad range of domains. These interviews include an organized set of questions geared toward assessing behaviors and feelings, and are typically based on a specific diagnostic classification system, such as the DSM-IV. Detailed information about the nature of problems in various domains is collected through these interviews, including the history, frequency, duration, intensity, antecedents, consequences, and past treatment of the problem. Additionally, questions address school functioning, relationships with family and peers, and developmental history (Kalfus, 1995). The Diagnostic Interview Schedule for Children and Adolescents (DICS; Reich, Welner, Herjanic, & MHS Staff, 1997) and the Diagnostic

Interview Schedule for Children (DISC-R; Shaffer et al., 1993) are two widely used structured interviews. These interviews, which yield information on duration, onset, and severity of 185 symptoms, are highly structured in that the wording and order of questions as well as the coding of responses are specified (Mezzich, Bukstein, & Grim, 1995). The Child Assessment Schedule (CAS; Hodges, 1987) and the Kiddie Schedule for Affective Disorders and Schizophrenia for School-Aged Children (K-SADS; Puig-Antich, Chambers, & Tabrizi, 1983) are semistructured interviews that include open-ended as well as yes-no questions. These less structured approaches require the interviewer to make judgments about the presence or absence of symptoms and thus require more clinical skill to administer than highly structured approaches, such as the DICS and DISC. Structured and semistructured interviews are rarely used in clinical practice due in part to the length of time required for administration (one to four hours, typically). Their utility in schools may be further limited by the questionable validity of self-reports for children under age 12 (Kronenberger & Meyer, 2001).

In addition to their use in broadband assessment, self-report measures, behavior rating scales, and interviews can also be used in conjunction with narrowband assessment to provide more specific information to detect disorders. Clinical assessment frequently is used to evaluate young people for attention and concentration problems, eating disorders, suicidal ideation, schizophrenia, and post-traumatic stress disorder (PTSD). Assessment techniques for each of these disorders are discussed in this chapter.

Attention and Concentration Problems

Attention deficit/hyperactivity disorder (ADHD) has been diagnosed in about 3 to 5 percent of all school-age children (Daw, 2001). Despite debate about the potential overuse of the ADHD diagnosis, it is clear that students experiencing the attention and concentration problems characteristic of ADHD encounter significant difficulties academically, socially, and emotionally. The central features of ADHD are inattentiveness, impulsivity, and physical overactivity. It is also common for children with ADHD symptoms to exhibit conduct problems and antisocial behavior, such as aggression and oppositional behavior (Kazdin, 1994).

A number of factors complicate the diagnosis of ADHD, including the ambiguity of many ADHD criteria and a belief on the part of parents and teachers that they can recognize ADHD symptoms without a

thorough assessment (Wodrich, 1997). A comprehensive assessment strategy is vital to accurate diagnosis and should include interviews with primary caregivers, examination of school records and past treatment, and a complete psychological evaluation in which information is collected from multiple perspectives. A medical evaluation is also recommended to rule out physical conditions that may be mimicking ADHD symptoms. Assessing for problems that frequently co-occur with ADHD, such as conduct disorder, learning disabilities, substance use, and low self-esteem, should be part of the assessment strategy as well (Evans, Vallano, & Pelham, 1995; Tripp & Sutherland, 1999). Moreover, an awareness of developmentally normal behaviors that may be similar to ADHD symptoms, such as excessive energy, is important in ensuring that a child is properly diagnosed (Tripp & Sutherland, 1999). Including broadband measures (e.g., CBCL; Behavior Assessment System for Children, BASC; Reynolds & Kamphaus, 1992) in the assessment process is also important because symptoms such as discouragement, poor concentration, and irritability, associated with other disorders, tend to be similar to ADHD symptoms (Wodrich, 1997).

A number of ADHD rating scales and checklists are useful for structuring the evaluation of symptoms and provide a means for collecting information from multiple sources. These assessment tools typically lay out the ADHD symptoms that are described in the DSM-IV and ask the rater to indicate the frequency with which the symptoms occur (Kronenberger & Meyer, 2001). The transparency of items on these types of scales, however, make them vulnerable to manipulation by individuals hoping for a specific diagnostic outcome (Wodrich, 1997). There is evidence that unintentional distortion of ratings may also occur because parents have been shown to use only the upper ends of scales, and teachers' ratings are often distorted for overly aggressive students (Tripp & Sutherland, 1999). Nonetheless, although ADHD rating scales should never be used in isolation to make diagnostic decisions, they may serve as one component in a comprehensive assessment strategy.

The ADHD Rating Scale-IV (ADHDRS-IV; DuPaul, Power, Anastopoulos, & Reid, 1998) is a brief and easy-to-use inventory that has separate forms for parents and for teachers (Merrell, 2000). The scale is based on DSM-IV criteria for ADHD and provides age- and sex-stratified normative data that enable scores to be converted to percentiles (Kronenberger & Meyer, 2001). Similarly, the ADHD Symptoms Rating Scale (ADHD-SRS; Holland, Gimple, & Merrell,

2000) is completed by teachers or parents and evaluates ADHD symptoms as defined in the DSM-IV. The ADHD-SRS is relatively brief (56 items) and easy to use, thus making it ideal for initial assessment of students and for progress tracking (Merrell, 2000). The home and school versions of the Attention Deficit Disorders Evaluation Scale (ADDES; McCarney, 1995) describe typical ADHD behaviors, also based on DSM-IV criteria. A benefit to using the ADDES is the companion manual that offers suggestions for interventions depending on the pattern of symptoms observed (Kronenberger & Meyer, 2001). A self-report measure useful for gathering information on adolescents' and young adults' self-perceptions of ADHD symptoms is the Brown Attention Deficit Disorder Scales (BADDS; Brown, 1996).

In contrast to the global rating scales described previously, the Home Situations Questionnaire (HSQ; Barkely, 1981) and the School Situations Questionnaire (SSQ; Barkely, 1981) describe situation-specific ADHD behaviors and ask parents or teachers to rate whether a child exhibits the problem behavior and to rate the severity of the problem in specific situations. Scores on the HSQ and SSQ indicate the pervasiveness, severity, and location of the symptoms. Compared to global rating scales, these situation-specific measures might be easier for teachers and parents to complete because ADHD symptoms are often observed only in certain settings.

Conners' Continuous Performance Test (CCPT; Conners, 1995) and Test of Variables of Attention (TOVA; Leark, Depuy, Greenberg, Corman, & Kindschi, 1996) are sets of computer-based tasks used to assess attention, impulsivity, and distractibility in children and adolescents. These assessment techniques require a child to respond to a stimulus that flashes on the screen by, for example, pushing a specific button. Responses are then scored based on accuracy, speed, and consistency, from which conclusions about ADHD symptoms are drawn. Generally, scores on these types of tests are moderately related to scores on symptom checklists and other cognitive measures of attention, distractibility, and impulsivity (Kronenberger & Meyer, 2001). However, some researchers have found only minimal associations between CCPT/TOVA approaches and other ADHD measures, leading to questions about the reliability, validity, and theoretical bases of CCPT and TOVA techniques (Evans et al., 1995).

Eating Disorders

Concerns about physical appearance, especially weight and body size, have become increasingly common among young people. High levels of dissatisfaction with body weight and size have been noted in adolescent girls in particular; however, these concerns are observed in grade school children and among boys as well. Anorexia nervosa and bulimia nervosa are two clinical disorders that might emerge when body dissatisfaction becomes extreme. The characteristic symptom of anorexia nervosa is a relentless drive for thinness that results in dangerously low body weight, typically achieved by limiting food intake and exercising excessively. In addition, individuals with anorexia nervosa have a distorted view of their own bodies such that they see their emaciated bodies as fat. Bulimia nervosa is characterized by consumption of large quantities of food in short time periods followed by purging behaviors that may include excessive exercise, vomiting, or abuse of laxatives and diuretics.

Assessment of eating disorders is a multistep process that should include an evaluation of eating behaviors and symptoms as well as collection of background information such as family constellation and dynamics. Given the potentially life-threatening nature of these disorders, assessment should also include a medical examination to rule out physiological contributors and to ensure that the individual's health is not in peril (Woodside, 1995).

The Eating Disorder Inventory-2 (EDI-2; Garner, 1991) is a 91-item self-report measure that assesses common behavioral and psychological symptoms of anorexia and bulimia. Adolescents with anorexia nervosa typically have elevated scores on all eight scales of the EDI-2, and the pattern of score elevations is useful in identifying the particular constellation of behaviors that characterizes the disordered eating (e.g., food restriction, exercise, or binging and purging behaviors; Kalfus, 1995).

Another self-report measure of disordered eating is the Eating Attitudes Test (EAT; Garner & Garfinkle, 1979), a 40-item measure that provides information on three general domains of eating behavior. The brevity of the EAT relative to the EDI-2 might be advantageous for educators and clinicians concerned about time efficiency. However, the cognitive and emotional elements of anorexia and bulimia are better covered on the EDI-2. Shorter versions of the EAT have been developed for use with preadolescent children, ages 3 and up; however, the appropriateness of the adult-level content items on these shortened scales

has been questioned (Kronenberger & Meyer, 2001).

Symptoms associated with bulimia nervosa are the focus of the Bulimia Test (BULIT; Smith & Thelen, 1984). This 36-item scale assesses symptoms across five domains—binging, feelings, vomiting, food, and weight (Kalfus, 1995). Although the BULIT has been shown to discriminate effectively between individuals with bulimia and individuals not diagnosed with disordered eating, scores on the test tend to be related to generalized psychological distress, which should be taken into account when interpreting the results.

Suicidal Ideation

Depression can exert moderate to severe effects on overall functioning and is one of the most persistent mental health problems over an entire lifespan. Many significant changes in mood that occur during adolescence persist into adulthood, making adolescence an important developmental stage for understanding and identifying depression problems. There is also a high degree of co-occurrence of depression with other symptoms and disorders, such as attention deficit disorders, eating disorders, and violence. Related to depression, there has been a dramatic increase in the suicide rate among teenagers; it is one of the leading causes of death among adolescents and children (James & Gilliland, 2001). Some estimates suggest that about 10 percent of all 9th and 10th graders have attempted suicide (Shaffer, Vieland, & Garland, 1990).

Although suicidal ideation can exist in the absence of clinical depression, depressed youngsters are at higher risk than their nondepressed peers for having thoughts about and attempting suicide. Broadband instruments such as the MMPI-A or the Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1994), or narrowband measures such as the Children's Depression Inventory (CDI; Kovacs, 1992), the Reynolds Adolescent Depression Scale (RADS; Reynolds, 1987), or the Reynolds Child Depression Scale (RCDS; Reynolds, 1989) can be used for school-based screening of depression and to provide an opening for assessment of suicidal ideation. Students exhibiting depressive symptoms should be routinely evaluated for suicide risk, and several structured measures exist to help in this evaluation. For example, the Inventory of Suicide-30 (ISO-30; King & Kowalchuk, 1994) is a 30-item self-report measure for use with 13- to 18-year-olds. Comparing total raw scores to cutoff scores offers a rough idea of a student's risk of orientation toward suicide. Scores on critical items that are especially

indicative of high suicide risk are highlighted.

Schizophrenia

The detection of schizophrenia in children and adolescents is difficult because the typical time of onset for the disorder is early adulthood. Although precursors to the behaviors seen in adults with schizophrenia may be present at an earlier age, they might manifest in children and adolescents differently than in adults. For instance, the hallucinations and delusions that are characteristic of adult schizophrenia might be less elaborate or bizarre in children and adolescents. Generally, children and adolescents with schizophrenia have been described as appearing physically and emotionally immature and exhibiting awkward body movements, ritualistic behavior, and tangential and peculiar patterns of speaking. Irritability, anxiety, and depression are also common among young people with schizophrenia (Keshavan, Vaulx-Smith, & Anderson, 1995).

Because of the complexity and range of symptoms associated with schizophrenia, projective tests and broadband assessment instruments, such as the MMPI-A, CSI/ASI, or BASC, are necessary. The Kiddie Formal Thought Disorder Rating Scale (K-FTDS; Caplan, Guthrie, Fish, Tanguay, & David-Lando, 1989) may also be part of the assessment strategy. This observer rating system requires coding a child's responses to a game called the Kiddie Formal Thought Disorder Story Game in terms of four patterns of disordered thinking—illogical thinking, loose association, incoherence, and poverty of speech. The procedure is time consuming and requires training to learn the coding system (Kronenberger & Meyer, 2001).

Post-Traumatic Stress Disorder

The diagnostic category of post-traumatic stress disorder was intended to capture the impact of trauma and violence during times of war. However, similar symptoms are now recognized in victims of other violent acts, such as rape, family violence, child abuse, and robbery, or in victims of natural disasters. Across different forms of trauma, the core PTSD experiences of avoidance, intrusion, and physiological arousal are the same (Everett & Gallop, 2001). Like adults, children and adolescents who have experienced traumatic life events may exhibit anxiety symptoms in response to the trauma. If time permits, a comprehensive assessment of PTSD should be multimodal and include

gathering information on the student's symptoms, coping mechanisms, beliefs, and strengths and weaknesses.

Development of instruments to assess trauma and PTSD in children is a relatively recent phenomenon. The Trauma Symptom Checklist for Children (TSCC; Biere, 1996) is an example of an assessment instrument designed specifically for evaluating post-traumatic reactions. The TSCC is a 54-item self-report measure developed for children and adolescents ages 8 to 16 who have experienced traumatic events. The TSCC can enable quick evaluation of those children who are at risk and who may require follow-up care. The TSCC has six clinical scales that yield information on symptoms across six domains anxiety, depression, anger, post-traumatic stress, dissociation, and sexual concerns and two validity scales, under-response and hyper-response. Normative data are based on 3,000 inner city urban and suburban children and include nonclinical and clinical samples.

Conclusion

Schools are increasingly involved in issues related to the mental health of students. Educators and teachers are involved in implementing guidance programs, peer counseling, after-school and community outreach programs, and in coordinating efforts with police, city and county government, and other agencies. Often schools are called on to develop wide-ranging screening, prevention, and intervention programs. Assessment for severe mental health and behavioral problems is an important ingredient in school-based screening programs that identify students who are candidates for referral to school counselors, school psychologists, and other mental health professionals. Assessment results can also be used to guide development of prevention and intervention programs.

References

Achenbach, T. M. (1991a). *Manual for the Child Behavior Checklist/ 4–18 and 1991 Profile.* Burlington, VT: University of Vermont, Department of Psychiatry.

Achenbach, T. M. (1991b). *Manual for the Teacher's Report Form and 1991 profile.* Burlington, VT: University of Vermont, Department of Psychiatry.

Achenbach, T. M. (1991c). *Manual for the Youth Self-Report and 1991 Profile.* Burlington, VT: University of Vermont, Department of Psychiatry.

Achenbach, T. M. (1992). *Manual for the Child Behavior Checklist/2–3 and 1992 Profile.* Burlington, VT: University of Vermont, Department of Psychiatry.

Barkely, R. A. (1981). *Hyperactive children: A handbook for diagnosis and treatment.* New York: Guilford.

Biere, J. N. (1996). *Trauma Symptom Checklist for Children professional manual.* Odessa, FL: Psychological Assessment Resources.

Brown, T. E. (1996). *Brown Attention Deficit Disorder Scales.* San Antonio, TX: The Psychological Corporation.

Butcher, J. N., Williams, C. L., Graham, J. R., Tellegen, A., Ben-Porath, J. S., & Kaemmer, B. (1992). *MMPI-A: Manual for administration, scoring, and interpretation.* Minneapolis, MN: University of Minnesota.

Caplan, R., Guthrie, D., Fish, B., Tanguay, P. E., & David-Lando, G. (1989). The Kiddie Formal Thought Disorder Scale (K-FTDS): Clinical assessment, reliability, and validity. *Journal of the American Academy of Child Psychiatry, 28,* 408–416.

Christenson, S. L., & Sheridan, S. M. (2001). *Schools and families.* New York: Guilford Press.

Conners, C. K. (1995). *Conners' Continuous Performance Test Computer Program 3.0 user's manual.* North Tonawanda, NY: Multi-Health Systems.

Daw, J. (2001, June). The Ritalin debate. *Monitor on Psychology,* 64–65.

Derogatis, L. R. (1994). *SCL-90-R administration, scoring, and procedures manual* (3rd ed.). Minneapolis, MN: National Computer Systems.

DuPaul, G. J., Power, T. J., Anastopoulos, A. D., & Reid, R. (1998). *ADHD Rating Scale-IV: Checklists, norms, and clinical interpretation.* New York: Guilford Press.

Evans, S., Vallano, G., & Pelham, W. E. (1995). Attention-deficit hyperactivity disorder. In V. B. Van Hasselt & M. Hersen (Eds.),*Handbook of adolescent psychopathology: A guide to diagnosis and treatment* (pp. 589–617). New York: Lexington Books.

Everett, B., & Gallop, R. (2001). *The link between childhood trauma and mental illness.* Thousand Oaks, CA: Sage.

Gadow, K. D., & Sprafkin, J. (1997a). *Adolescent Symptom Inventory-4 screening manual.* Stony Brook, NY: Checkmate Plus.

Gadow, K. D., & Sprafkin, J. (1997b). *Child Symptom Inventory-4 norms manual.* Stony Brook, NY: Checkmate Plus.

Garner, D. M. (1991). *The Eating Disorder Inventory-2.* Odessa, FL: Psychological Assessment Resources.

Garner, D. M., & Garfinkle, P. E. (1979). The Eating Attitudes Test: An index of the symptoms of anorexia nervosa. *Psychological Medicine, 9,* 273–279.

Hodges, K. K. (1987). Assessing children with a clinical interview: The Child Assessment Schedule. In R. J. Prinz (Ed.), *Advances in behavioral assessment of children and families.* Greenwich, CT: JAI Press.

Hoier, T. S., & Cone, J. D. (1987). Target selection of social skills for children: The template-matching procedure. *Behavior Modification, 11,* 137–164.

Holland, M. L., Gimple, G. A., & Merrell, K. W. (2000). *ADHD Symptoms Rating Scale.* Wilmington, DE: Wide Range.

Hood, A. B., & Johnson, R. W. (1997). *Assessment in counseling: A guide to the use of psychological assessment procedures* (2nd ed.). Alexandria, VA: American Counseling Association.

James, R. K., & Gilliland, B. E. (2001). *Crisis intervention strategies* (4th ed.). Belmont, CA: Brooks/Cole.

Kalfus, G. R. (1995). Behavioral assessment in adolescents. In V. B. Van Hasselt & M. Hersen (Eds.), *Handbook of adolescent psychopathology: A guide to diagnosis and treatment* (pp. 243–264). New York: Lexington Books.

Kazdin, A. E. (1994). Psychotherapy for children and adolescents. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed.) (pp. 543–594). New York: John Wiley & Sons.

Keshavan, M. S., Vaulx-Smith, P., & Anderson, S. (1995). Schizophrenia. In V. B. Van Hasselt & M. Hersen (Eds.), *Handbook of adolescent psychopathology: A guide to diagnosis and treatment* (pp. 465–496). New York: Lexington Books.

King, J. D., & Kowalchuk, B. (1994). *Inventory of Suicide-30 (ISO-30).* Minneapolis, MN: National Computer Systems.

Kovacs, M. (1992). *Children's Depression Inventory (CDI) manual.* North Tonawanda, NY: Multi-Health Systems.

Kronenberger, W. G., & Meyer, R. G. (2001). *The child clinician's handbook* (2nd ed.). Boston: Allyn and Bacon.

Leark, R. A., Depuy, T. R., Greenberg, L. M., Corman, C. L., & Kindschi, C. L. (1996). *T.O.V.A. Test of Variables of Attention Professional Manual, Version 7.0.* Los Alamitos, CA: Universal Attention Disorders.

McCarney, S. B. (1995). *Attention Deficit Disorders Evaluation Scale—School Version.* Columbia, MO: Hawthorne Educational Services.

Merrell, K. W. (1999). *Behavioral, social, and emotional assessment of children and adolescents.* Mahwah, NJ: Erlbaum.

Merrell, K. W. (2000). Informant-report: Rating scale measures. In E. S. Shapiro & T. R. Kratochwill (Eds.), *Conducting school-based assessments of child and adolescent behavior* (pp. 203–234). New York: The Guilford Press.

Merrell, K. W. (2001). *Helping students overcome depression and anxiety.* New York: Guilford Press.

Mezzich, A., Bukstein, O. G., & Grim, M. R. (1995). Epidemiology and adolescent diagnosis. In V. B. Van Hasselt & M. Hersen (Eds.), *Handbook of adolescent psychopathology: A guide to diagnosis and treatment* (pp. 265–294). New York: Lexington Books.

NASP [National Association of School Psychologists]. (1999). *National Association of School Psychologists position statement on home-school collaboration: Establishing partnerships to enhance educational outcomes* (rev.). Retrieved January 22, 2003, from www/nasponline.org/information/pospaper_hsc.html.

Nelson, R. O., & Hayes, S. C. (1996). *Conceptual foundations of behavioral assessment.* New York: Guilford Press.

Puig-Antich, J., Chambers, W., & Tabrizi, M. A. (1983). The clinical assessment of current depressive episodes in children and adolescents: Interviews with parents and children. In D. Cantwell & G. Carlson (Eds.), *Childhood depression* (pp. 157–159). New York: Spectrum.

Reich, W., Welner, Z., Herjanic, B., & MHS Staff. (1997). *Diagnostic Interview for Children and Adolescents Computer Program (DICS-IV).* North Tonawanda, NY: Multi-Health Systems.

Reynolds, C. R., & Kamphaus, R. W. (1992). *Behavior Assessment System for Children manual.* Circle Pines, MN: American Guidance Service.

Reynolds, W. M. (1987). *Assessment of depression in adolescents: Manual for the Reynolds Adolescent Depression Scale (RADS).* Odessa, FL: Psychology Assessment Resources.

Reynolds, W. M. (1989). *Reynolds Child Depression Scale: Professional manual.* Odessa, FL: Psychology Assessment Resources.

Shaffer, D., Schwab-Stone, M., Fisher, P., Cohen, P., Piacentini, J., Davies, M., Conners, C. K., & Regier, D. (1993). The Diagnostic Interview Schedule for Children Revised Version (DISC-R): Preparation, field testing, inter-rater reliability, and acceptability. *Journal of the American Academy of Child and Adolescent Psychiatry, 32,* 643–650.

Shaffer, D., Vieland, V., & Garland, A. (1990) Adolescent suicide attempters: Response to suicide prevention programs. *Journal of the American Medical Association, 64,* 3151–3155.

Shinn, M. R. (1997). *Advanced applications of curriculum based measurement.* New York: Guilford Press.

Smith, M. C., & Thelen, M. H. (1984). Development and validation of a test for bulimia. *Journal of Consulting and Clinical Psychology, 52,* 863–872.

Sprafkin, J., & Gadow, K. D. (1996). *Early Childhood Inventories manual.* Stony Brook, NY: Checkmate Plus.

Tripp, G., & Sutherland, D. M. (1999). Counseling boys with attention deficit/hyperactivity disorder. In A. M. Horne & M. S. Kiselica (Eds.), *Handbook of counseling boys and adolescent males* (pp. 293–312). Thousand Oaks, CA: Sage Publications.

Wodrich, D. L. (1997). *Children's psychological testing* (3rd ed.). Baltimore, MD: Paul H. Brookes.

Woodside, D. B. (1995). Anorexia nervosa and bulimia nervosa. In V. B. Van Hasselt & M. Hersen (Eds.), *Handbook of adolescent psychopathology: A guide to diagnosis and treatment* (pp. 407–434). New York: Lexington Books.

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