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ABSTRACT

Two workshops for school psychologists focus on psychoeducational assessment and development of individualized education programs (IEPs) for emotionally handicapped (EH) students. Each workshop includes a rationale statement, statements of purpose, scope, and prerequisite skills, learning activities, supplementary reports or case studies, and bibliography. The workshop on assessment, whose purpose is to present a best practice procedure for identification of EH students, addresses the topics of eligibility, problem identification, and data collection. Among purposes cited for the IEP workshop is the development of goals and objectives of a social and emotional nature, based on psychological evaluation data. Application activities for this workshop concentrate in particular on the development of statements of annual goals and short-term objectives. A pretest/posttest is provided. Appendices, which comprise the bulk of the document, consist of handouts to accompany each workshop. Handouts include family history and information forms, request for special education services, medical history inventory, a behavior questionnaire to be completed by teachers, summary descriptions of behavioral and personality assessment instruments, and suggested strategies for managing social, emotional, and behavioral problems which can be used as recommendations for implementing IEP objectives. (JW)

TRAINING MODULES

FOR

SCHOOL PSYCHOLOGISTS

Division of Special Education
Indiana Department of Education

Indiana Committee on the Emotionally Handicapped
Shirley J. Amond, Chairperson

September 1987

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Under the leadership of the Indiana State Advisory Council on the Education of Handicapped Children and Youth, the Indiana Committee on the Emotionally Handicapped has continued its efforts to resolve those issues which inhibit the development of programs for seriously emotionally handicapped students.

This publication is the result of the cooperative efforts of many individuals. Those individuals have contributed time and shared their expertise toward the completion of this activity.

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School Psychologists Training Module

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INTRODUCTION

Rationale

Rule S-1 requires that in order for a child/adolescent to be determined eligible for a seriously emotionally handicapped program, that child must have a current psychoeducational evaluation which must include:

a. Documentation of those related services such as counseling, non-testing psychological services, and services rendered by other educational support personnel received by the child;

b. Documentation of systematic observation of the child in the classroom and/or school;

c. A report of academic and behavioral patterns including strengths and weaknesses; and

d. Recommendations for an individualized education program.

The educational evaluation shall also include information regarding social/emotional development; language and communication patterns; behavior patterns; and any other factors affecting the child's learning.

In order to fulfill that aspect, a comprehensive psychoeducational assessment is required that measures intellect, academics, perceptual motor, social-emotional development, behavior, etc.

With the changes in the licensing of School Psychological personnel, many psychologists have found themselves in the position of being required to provide social-emotional assessments without the opportunity to expand their skills.

Purpose

Upon completion of this module,

1. The School Psychologist will understand and be able to explain the eligibility criteria for seriously emotionally handicapped programming as prescribed by Rule S-1.

2. The School Psychologist will investigate problem(s) indicated by the referral through a basic evaluation and determine if further behavior analysis is necessary.

3. The School Psychologist will collect additional data from a variety of sources to determine if the child meets eligibility criteria of SEH under Rule S-1 and to examine specific aspects as they relate to the five factors of an emotional handicap.

Scope

This module will provide Psychologists with an understanding of the five factors of SEH. It will also assist psychologists in screening for SEH problems and in making decisions about pursuing a more indepth evaluation. If further assessment is necessary, it will provide a format for summarizing that data. Finally, this module will provide an overview of many of the current evaluation tools on the market, the population they assesses and validity of that assessment.

Prerequisite Skills

This module is designed for practicing School Psychologists. It is designed to be presented in its entirety. (Workshop 1 and 2)

Materials needed:

Set of Psychological tests

Copies of Handouts and Activities

WORKSHOP I

Assessment

Purpose: To present a best practice procedure of identification of SEH students.

I. Eligibility

The school psychologist will understand and be able to explain eligibility criteria for SEH programming as per Rule S-1.

Programs for the Seriously Emotionally Handicapped

A. Definition. (Rule S-1)

A seriously emotionally handicapped is a child with a severe condition exhibited over a long period of time and to a marked degree, which adversely affects educational performance and is characterized by one or more of the following: (a) an inability to learn which cannot be explained by intellectual, sensory, or health factors (including children who are autistic); (b) an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; (c) an inappropriate type(s) of behavior or feeling under normal circumstances (does not include children who are only socially maladjusted); (d) a general pervasive mood of unhappiness or depression; (e) tendency to develop physical symptoms or fears associated with personal or school problems.

B. The above 5 factors are explained and expanded (from "Operationalizing the Definition"):

In general, an Emotionally Handicapped student has problems involving a lack of awareness and/or understanding of self and environment of such duration, frequency, or intensity as to result in an inability to control behavior or express feelings appropriately thereby significantly impairing performance in the classroom and in school related activities. The general characteristics include one or more of the following:

(a) an inability to learn which cannot be explained by intellectual, sensory, or health factors (including children who are autistic).

Significant deficits in the level of functioning may be the most pronounced characteristic of emotionally handicapped children in school. This significant deficit in the learning process may be manifested as impairments in classroom performance and school learning experience as well as failure to master skill subjects. The difference between a child's performance and level of expectancy becomes more significant as a student advances through his/her school career. This discrepancy may appear to be insignificant in a child's early school years, therefore, making it more difficult to identify a young student based on the inefficiency in functioning level.

Following are some descriptors that may be related to this characteristic:

1. Basic Skills - reading/mathematics/language:
   -academic regression
   -decline in grades
   -change in skill acquisition
   -change in skill application

2. Short attention span, unable to concentrate:
   -shows erratic flighty behavior
   -easily distracted
   -lacks perseverance
   -daydreams, gets lost in his/her thoughts
   -does not complete assignments, fails to finish things he/she starts

3. Unable to retain:
   -poor memory
   -forgets easily

4. Does not complete tasks, careless and disorganized:
   -disorderly
   -unable to sequence
   -loses or misplaces materials

5. Does not follow academic directions:
   -inattentive
   -omits all or parts of things
   -makes many errors

6. Lacks comprehension of assignments:
   -tasks at skill level incorrectly completed
   -displays anxiety
   -many wrong or poor responses
   -assignments late or not handed in

7. Seeks excessive attention:
   -makes weird noises
   -acts like class clown, shows off
   -seeks excessive praise
   -disrupts others
   -silliness, childishness
   -excessive pouting
   -quarrelsome, argumentative
   -plans and carries out hostile acts
   -bragging, boastful
   -excessive swearing

(b) an inability to build or maintain satisfactory interpersonal relationships with peers and teachers.

The term "satisfactory interpersonal relationships" refers to the ability to establish and maintain close friendships; the ability to work and play cooperatively with others; the ability to demonstrate sympathy, warmth, and sharing with others; the ability to be assertively constructive; and the ability to make appropriate choices for social interaction. In most instances, children who have difficulty building or maintaining satisfactory interpersonal relationships are readily identified by both peers and teachers.

Following are some descriptors that may be related to this characteristic:

1. Difficulty understanding and accepting the point of view of another person and then responding appropriately:

   -feels persecuted and acts as if others are out to get him/her
   -repeatedly annoys others, insensitive to the social cues given
   -lacks empathy, insensitive to the feelings of others
   -teases others in a hurtful manner
   -tactless or rude in social interaction
   -cruel or mean to others, a bully
   -does not feel guilt or remorse when such a reaction is appropriate
   -unrealistically fearful or untrusting of others
   -egocentric
   -inability to predict the consequences of his/her actions
   -poor problem solver, cannot develop alternative solutions to social conflicts

2. Failure to establish a normal degree of affection or bond with others:

   -difficulty maintaining friendships longer than six months
   -blames or informs on companions
   -does not extend self for others unless immediate advantage is likely
   -isolated, complains of loneliness
   -prefers playing with younger children
   -not liked by age mates
   -lies to companions, cheats at games
   -reluctant to participate in activities with peers
   -jealous of others
   -excessively possessive of the friendship of others
   -substitutes adult company for peer relationships
   -elective mutism, continuous refusal to talk in almost all social situations, including school (not due to inability to speak or comprehend language or to mental or physical disorder)

3. Difficulty dealing with authority figures:

   -resents constructive criticism or advice
   -highly confrontive with those in authority
   -insists on having own way
   -resists rules, structure
   -unreasonable, rigid, unwilling to compromise
   -absences or tardiness due to disciplinary actions

(c) an inappropriate type(s) of behavior or feeling under normal circumstances (does not include children who are only socially maladjusted).

Behavior is seen as inappropriate when disturbed internal states lead to socially aberrant or self-defeating behavior; that is, behavior which is clearly discordant with that which would normally be expected from other children of similar age under similar circumstances.

Following are some descriptors that may be related to this characteristic:

1. Obsessive - compulsive behavior:

-ritualistic, ste. ,typed actions directed toward meticulous detail
-constantly erases or recopies
-excessively strives for perfection
-cannot accept change of activities out of sequence
-perseveration, persistently repeats certain acts over and over
-stores up things he/she does not need
-overly concerned with neatness or cleanliness

2. Distorted perception of reality:

-magical thinking, believes in ability to influence an event defying laws of cause and effect
-excessive fantasizing, imagined thoughts to gratify wishes
-hallucinating, sees things that are not there
-disorientation, confusing regarding time, place, identity
-loose associations, in conversation jumps from one topic to another with no apparent connection
-misinterprets situations, illogical thinking with erroneous conclusion reached
-delusions - false belief in spite of contradictory evidence (not including simple denial of guilt)

3. Problems with sexual issues:

-sexual behavior which is developmentally inappropriate
-sexual preoccupation
-provocative behavior
-conflicts with sexual identity
-exhibitionism
-public masturbation

4. Chronic violation of age appropriate and reasonable home or school rules:

-destroys property, either his/her own or others
-blatantly defiant of classroom and school routine
-sets fires
-cruelty to animals
-persistent lying
-impulsively steals objects that are not for immediate use or their intrinsic value

5. Violent anger reactions, temper tantrums:

-anger is disproportionate to the situation
-explosive, uncontrolled anger
-unanticipated violence or destruction of property, throws objects
-easily provoked
-unplanned physical harm of others

6. Regressive behaviors:

-thumb sucking
-wetting self during the day
-playing with or smearing feces
-markedly increased attachment to parent figure
-infantile speech or mannerism

(d) a general pervasive mood of unhappiness or depression.

Children who are unhappy or depressed may exhibit a loss of interest or pleasure in all or most all usual activities and pastimes. These behaviors may be expressed verbally or nonverbally, as in frequently sad facial expression, changed peer relations, social isolation, reduced academic achievement, hyperactivity, or restless agitated behavior.

Feelings of worthlessness are common and may range from feelings of inadequacy to complete self-rejection and may be manifested in self-aggressive/self-abusive behavior.

Following are some descriptors that may be related to this characteristic:

1. Depressed mood or marked loss of pleasure in all, or almost all, usual activities and pastimes:
   -insomnia or hypersomnia
   -low energy level or chronic tiredness
   -feelings of inadequacy, loss of self-esteem or self-depreciation
   -decreased effectiveness or productivity at school
   -decreased attention, concentration or ability to think clearly
   -social withdrawal, isolates self
   -loss of interest or enjoyment of pleasurable activities
   -irritability or excessive anger
   -inability to respond with apparent pleasure to praise or rewards
   -general unresponsiveness
   -less active or talkative than usual
   -pessimistic attitude toward the future, brooding about past events or feeling sorry for self
   -excessive tearfulness or crying
   -recurrent thoughts of death or suicide
   -does not eat well, loss of appetite
   -presents a feeling of hopelessness or dejection
   -social withdrawal, apathy, or sadness
   -lacks motivation to complete academic tasks

2. Self-aggressive, physical abuse toward self:
   -deliberately harms self
   -attempts suicide
   -excessive scratching, picking, biting of fingernails
   -takes inordinate risks
   -accident prone, gets hurt a lot
   -excessive weight gain
   -excessive weight loss
   -change in personal habits
   -repeated running away from home overnight

3. Restless, agitated:
   -nervous, high strung or tense
   -always in motion
   -cannot sit still
   -short attention span
   -impulsive, acts without thinking
   -decreased need for sleep
   -inappropriate laughing
   -difficulty concentrating
   -excessive anxiety
   -extreme mood swings
   -compulsive talking

(e) a tendency to develop physical symptoms or fears associated with personal or school problems.

A child may exhibit physical symptoms such as excessive fatigue, dizziness, nausea, rashes, or an unexplained loss of or alteration in physical functioning; unrealistic fears, such as harm to parents or occurrence of calamities; or pains, such as headaches or stomachaches. Possible physical etiologies should be ruled out prior to attributing the behavior(s) to a psychogenic cause.

Following are some descriptors that may be related to this characteristic:

1. Excessive anxiety when separated from those to whom child is attached:

   -unrealistic fear about possible harm befalling major attachment figures or fears they will leave and not return
   -persistent reluctance or refusal to go to school in order to stay with major attachment figure(s) at home
   -persistent reluctance or refusal to go to sleep without being next to major attachment figure or to go to sleep away from home
   -repeated nightmares involving theme of separation
   -complaints of physical symptoms on school days, e.g., headaches, stomachaches
   -difficulty concentrating and attending to work or play when not with a major attachment figure

2. Generalized and persistent anxiety or worry:

   -unrealistic worry about future events
   -preoccupation with the appropriateness of the individual's behavior in the past
   -overconcern about competence in a variety of areas, e.g., academic, athletic, social
   -excessive need for reassurance about a variety of situations or events
   -somatic complaints
   -marked self-consciousness or susceptibility to embarrassment or humiliation
   -marked feelings of tension or inability to relax
   -persistent and irrational fear of a specific object, activity, or situation that results in a compelling desire to avoid the phobic stimulus
   -absence or tardiness due to stress-related illness

3. Self-concept so low as to impair normal functioning:

   -lacks confidence, insecure, afraid to try new things
   -assumes blame inappropriately when things go wrong
   -severe avoidant behavior which interferes with social relationships
   -excessive dependency on adults or others
   -persistent and excessive shrinking from contact with strangers
   -easily frustrated and upset by failure
   -overwhelmed by new tasks and tries to avoid
   -does not complete routine tasks
   -persistent feelings of failure

C. Establishment of eligibility for services in special education programs for children who are seriously emotionally handicapped shall be made by the Case Conference Committee upon the basis of a written educational evaluation which shall include, but not be limited to:

1. Documentation of those related services such as counseling, non-testing psychological services, and services rendered by other educational support personnel received by the child;

2. Documentation of systematic observation of the child in the classroom and/or school;

3. A report of academic and behavioral patterns including strengths and weaknesses; and

4. Recommendations for an individualized education program.

The educational evaluation shall also include information regarding social/emotional development; language and communication patterns; behavior patterns; and any other factors affecting the child's learning.

In addition, a written report of an individual evaluation by one or more of the following shall be utilized:

1. A physician with an unlimited license to practice medicine and who has had special training in psychiatry or neuropsychiatry;

2. A school psychologist or clinical psychologist certified by the Indiana State Board of Examiners in Psychology;

3. A school psychologist who is licensed by the Indiana Teacher Training and Licensing Commission.

SEE FLOWCHART - Handout # 2

II. Problem Identification

The school psychologist will investigate the referral problem through a basic evaluation and determine if further behavioral analysis is necessary.

A. The components of a basic evaluation include background data, behavior observations, perceptual motor skills, intellectual assessment, academic assessment and behavioral/emotional screening.

1. A basic evaluation will provide a summary of background data including family, developmental, medical, and school histories. Records of previous treatment for emotional problems will be noted. Services provided by other agencies will be documented where relevant. (Examples of three sample referral and history forms are attached. See Handouts 1, 2, 3, 4, & 5.)

2. A basic evaluation will include a direct systematic behavior observation of the student in the environment in which maladaptive behavior are occurring. (Examples for four behavior observation forms are attached. See Handouts 6, 7, 8, & 9.)

3. A basic evaluation will include a test of perceptual motor skills.

4. A basic evaluation will include the administration of a multifactored, standardized individual intelligence test which is appropriate for the child.

5. A basic evaluation will include measures of individual achievement. Achievement tests will render current levels of academic functioning, in order that a student's strengths and weaknesses may be determined.

6. A basic evaluation will include observation of the student's behavior during assessment.

7. A basic evaluation will include a social/emotional screening consisting of:

   a. Anecdotal records from the teacher (See Handout #10).

   b. Behavior rating scales intended to screen for behavior/emotional problems to be completed by the teacher, parent, and student. These behavior rating scales will yield standard scores to compare the referred student's behaviors with others in the normative sample.

   c. Self-report measures should be given as needed. Occasionally, the types of behaviors assessed on behavioral screening devices will not identify certain emotional problems of an internalized nature. In this instance, the examiner may want to choose other self-report assessments from the Test List to be sure that the student is being screened in the area of the referral problem, i.e., anxiety, depression, etc. (See Handout #20.)

      B & P Instrument List (Behavior Rating Profile, Behavior Evaluation Scale, Walker Problem Identification)

B. After the basic evaluation data has been collected, the referral problem will be reviewed. If the child is eligible for another area of special education, the further consideration for SEH may not be necessary. If the child's needs are not severe enough and do not meet the criteria of the SEH definition, no further assessment will be done. The child's behavior and functioning will be examined from environmental, normative, and developmental perspectives. Do the child's behaviors occur in only one environment? If so, environmental intervention is probably indicated, not further assessment. Are the child's behaviors significantly different from others in his/her peer group? Are the child's behaviors significantly different from developmental expectations for this child's chronological age? If the maladaptive behaviors are seen in different environments, if they differ significantly from those of the child's peer group, and if they would not be predicted as typical for the child's age, then further behavior/emotional assessment is indicated, (Knoff). If further behavioral assessment appears to be indicated, a staffing could be convened to review the existing data and assign responsibility for further evaluation. (See staffing checklist, Handout #11.)

(1) For further discussion of this issue, see Knoff, H. M. (1986). A conceptual model and pragmatic approach toward personality assessment referrals. In H. M. Knoff (Ed.), The Assessment of Child and Adolescent Personality. New York: Guilford Press.

III.

The school psychologist will collect additional data from a variety of sources to determine if the child meets eligibility criteria of SEH under Rule S-1 and to examine specific aspects as per the five factors indicated above.

A. Data needed by school psychologist:

Areas to be assessed included the child's perceptions of self and the world (self-concept, reality testing, self-awareness, etc.), relationships with children and adults (the total range of the child's social interactions includes attitudes toward authority figures, age-appropriateness of peer interactions, withdrawn behavior, aggression, etc.), and affective behavior (mood, attitude, fears and phobias, level of anxiety, psychosomatic complaints, etc.). This evaluation should include the assessment of the frequency, duration, and intensity of the child's inability to build or maintain satisfactory interpersonal relationships with peers and/or teachers; inappropriate types of behaviors or feelings under normal circumstances; a general pervasive mood of unhappiness or depression; and tendency to develop physical symptoms or fears associated with personal or school problems.

Behavior rating scales used at this level will go beyond screening and provide information in terms of categories of behavior or traits.

Behavior rating scales which are thoroughly researched yield a significantly higher reliability than do projectives. Behavioral assessment involves direct observation of the child, direct ratings from the child (self-report) and indirect ratings from significant others, i.e., the parent and teacher. Comparison of the child's targeted behavior with that of a peer's behavior is one best practices method of obtaining reliable data. (See Handout #7.) A comprehensive analysis, then, will focus on how a child is coping and dealing with his/her world in a number of settings as he/she learns, feels, and communicates in a culture with others who are like him/her.

In choosing instruments for assessment of behavioral questions, consideration should be given to choosing instruments with high objectivity/low inference quality for decision making. Assessment measures may be grouped hierachially (Huberty, IPA Workshop) in this fashion:

I. Projectives

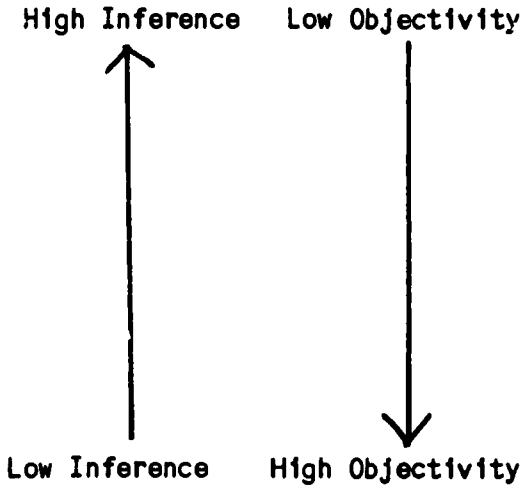
II. Informal Measures (sentence completion, etc.)

III. Interview/history

IV. Standardized test, Questionnaire

V. Behavior Rating Scales

VI. Direct Observation



Multiple sources of data are included in this evaluation because the SEH child will exhibit inappropriate behaviors across all areas of his life, not just in school.

a. Child

1. Include measures reported from the child such as: anxiety, depression, self-concept, etc. See Handout #20. Personality and Behavioral Assessment Instruments Handout.

2. Interview.

3. Projective data (should only be used with specific training in this area.

b. Parent

1. Parent interview. See Handout #13 for example indepth interview.

2. Parent rating scales are crucial because SEH child will exhibit inappropriate behaviors across all settings of his/her life, not just in school. See Handout #14.

c. School

1. Teacher rating scales. See Handout #15.

2. Teacher interview. See Handout #16, Behavior Questionnaire.

d. Direct Observation

Attention should be given to noting specific behaviors and their frequency, duration, and intensity. Intensity is the relative seriousness of the behavior, the degree to which it disrupts the student's own learning or adjustment, or that of his immediate environment (e.g., a child who sets a fire - environmental; a child who demonstrates severe depressions - personal). Frequency is the number of times the behavior occurs over a given period of time (e.g., somatic complaints - high frequency; suicide attempts - low frequency). Duration is the average length of time for which the behavior exists (e.g., high duration - lasting over one month; low duration - being a month or less). See Handouts #6, 7, 8, and 9, Behavior and Personal Assessments Instruments.

1. Formal Setting - Classroom

2. Informal Setting - lunch room, recess, halls, etc.

B. Report

1. The report should answer the referral questions:

   a. it should discuss the initial reason/referral for assessment;
   b. it should discuss initial perceptions of referring parties (teachers, parents) along with the larger problem identified and results of continued evaluation;
   c. it should discuss child's perspective of the problem (this may radically differ from reasons for referral); and
   d. it should suggest interventions.

2. The report's contents should include: For example of a composite report, see Knoff, pp 550-55, Handout #18.
   a. Report Heading;
   b. Tests Administered;
   c. Reason for referral;
   d. Background information;
   e. Assessment observations;
   f. Systematic behavior observation; and
   g. Summary and Recommendations.

3. The report's characteristics should include specific referral concerns and relate them to the assessments and potential intervention. The reports should reflect the results of objective assessment measures. The report should be simple, concise and readable with minimal use of jargon, written in style meaningful to the reader. See Handout #19, Knoff.

4. Evaluating one's own reports may lead to developing a more accurate style in presenting data pertinent in an SEH evaluation. One way to accomplish this evaluation is presented in Handout #21.

C. Summary/Recommendations/Suggestions

Following summary of test results, the school psychologist should make a statement similar to "from this evaluation, this child could be considered eligible for programming within the SEH program." The Case Conference Committee will make recommendations for programming.

Additional suggestions for the specific child may follow. In developing the specific suggestions for the child, the areas of strengths and weaknesses observed during the evaluation should be addressed. Observations of behaviors affecting the child's conditions characterized by any of the 5 factors listed in Rule S-1 should indicate the need for specific suggestions for remediation. The descriptors listed under the specific factor (see section on eligibility) which are applicable to the child will indicate needs for goals/objectives developed on the IEP. See Handout #17, Evaluation Checklist for EH.

LEARNING ACTIVITY -- GOAL 1

Objective: To become familiar with the characteristics of the five factors within the seriously emotionally handicapped eligibility requirements.

Materials: Eligibility requirements for SEH.

Time Required: 20 Minutes

Activity:

1. Summarize in writing, a recent case study of a student with whom you are familiar who qualified for seriously emotionally handicapped programming.

2. Share your case with a partner. Ask your partner to identify which of the five factors were relevant to this child's eligibility. If your partner is not able to do this, ask him/her what additional information he/she would need to make an accurate eligibility statement.

LEARNING ACTIVITY -- GOAL 2

Objective: To discuss issue of problem identification and exclusionary factors relating to eligibility for SEH programming.

Time Required: 20 Minutes

Activity:

1. Think of a recent case with which you were involved, in which the child did not qualify for SEH programming.

2. List the reasons for exclusion from SEH programming.

3. What was the rationale for failure to qualify?

4. Share this case with the group.

5. Discuss in group, other reasons which might lead to exclusion from the SEH program for a particular child.

LEARNING ACTIVITY -- GOAL 3

Objective: To become familiar with behavior assessment tools in order to choose particular instruments for specific cases.

Materials: Case studies
List of Personality and Behavioral Assessment Measures
Behavior Rating Scale Handouts

Time Required: 30 minutes

Activity:

1. Disseminate case studies.

2. Describe task. Review case study and list of assessment measures and Behavior Rating Scales. Choose:
   a. An appropriate direct systematic behavior observation form;
   b. A parent rating scale;
   c. A teacher rating scale; and
   d. Child report measures.

3. Discuss your case study and rationale for test selection with the group.

CASE STUDY

Gerald King, Age 10

REASON FOR REFERRAL:

Immature, inadequate behaviors;
Told exaggerated stories and lies;
Tendency to fantasize;
Highly anxious;
Involved in episode of abuse at residential school; and
Abused while living with his mother

BACKGROUND INFORMATION

Gerald has, for the past eight years, lived with his mother. During that period of time, he was placed in a residential facility for one year. The Court awarded custody of Gerald to his father following the weld department's investigation of reported incidents of abuse by his mother.

Gerald has a history of treatment with Community Mental Health Services in Indianapolis. He was placed on Ritalin. At the exit staffing from the residential school, personnel felt Gerald had shown little improvement during his year's stay. They indicated he still tended to fantasize, lie, and did not do his schoolwork.

PROBLEM BEHAVIORS SEEN AT SCHOOL:

Low self-esteem;
Lying;
Telling stories;
Non-compliant behavior;
Explosive temper; and
Off-task behavior.

CASE STUDY

Serena Smithers, Age 12

REASON FOR REFERRAL;

Bizarre behavior and
Refusal to attend school.

BACKGROUND HISTORY:

Serena lives with her parents and one brother. Ms. Smithers indicates Serena was late in talking. She felt this was due to allergies. In kindergarten, Serena performed poorly and was retained. Her parents report that Serena has always had reading comprehension problems. She has done better in spelling and math.

Serena's family moved to Lexington, KY in her fourth grade year. She became increasingly withdrawn after that move. When the family moved back to Sellersburg the next year, Serena's behavior became even more withdrawn and she tended to become upset. She was referred to a psychiatrist who indicated that she was experiencing problems of a psychotic nature, including disorganized thinking, labile emotions, and possible hallucinations. Serena was placed on Homebound Instruction at the psychiatrist's request. She was subsequently hospitalized. Serena has been hospitalized one more time this fall, and her medications have been adjusted.

PROBLEM BEHAVIORS SEEN AT SCHOOL:

Erratic behavior;
Inappropriate affect;
Episodes of fearfulness;
Running out of school;
Refusal to attend school;
Episodes of hostility; and
Confused speech.

CASE STUDY

Francis Jones, Age 10

REASON FOR REFERRAL:

Physically aggressive behavior with peers;
Verbally abusive behavior;
Defiant attitude toward authority;
Non-compliance;
Poor peer relationships;
Self-abusive behavior; and
Obsessive behaviors.

BACKGROUND INFORMATION;

Francis was removed from his parents' custody because of suspected abuse. Background history is difficult to trace as Francis attended 5 schools in two years. He has been retained twice. An evaluation in Georgia recommended placement in a program for emotional handicaps.

Francis' evaluation by Psychological Services staff suggested some confusion in thinking and bizarre thought patterns. Francis tends to fantasize violent interactions with peers. He appears confused with regard to life/death situations, contending that both a natural brother and uncle who died have come back to life. Francis also demonstrated obsessive thought patterns. Inappropriate interpersonal reactions were noted. For example, he called examiner "Mom" and hugged her.

PROBLEM BEHAVIORS SEEN AT SCHOOL:

Low self-esteem;
Non-compliant behavior;
Off task behavior and refusal to work;
Inappropriate ve alizations to peers;
Poor peer relations; and
Immature and distracting behaviors.

CASE STUDY

Sam Jones, Age 8

REASON FOR REFERRAL:

Acting out aggressive behaviors directed
toward peers leading to frequent suspension;
Non-compliance;
Verbally abusive language; and
Failure to complete work.

BACKGROUND INFORMATION:

Sam has been living with his grandmother who is his legal guardian. Sam has contact with his natural mother and half-sister who resides with his mother. He appears confused over the family arrangements. As his grandmother works second snift, when Sam comes hove from school, he goes to his aunt's who watches him. In the home, Sam violates curfew, selects older boys as friends, and has been involved in acting out behaviors in the community.

Recent evaluation suggested that Sam was extremely anxious over his living situation. He has been acting out at school in a hostile aggressive fashion. Although Sam has average to above average ability, teachers reported he was becoming increasingly non-compliant, refusing to work, and becoming more aggressive toward peers.

PROBLEM BEHAVIORS SEEN AT SCHOOL:

Refusal to work;
Acting out aggression;
Poor peer relations;
Verbal abuse of peers;
Immature and distracting behaviors;
Hyperactivity; and
Disruption of classroom activities.

CASE STUDY

Robert Wright, Age 8

REASON FOR REFERRAL:

Verbally abusive behavior toward teacher and peers;
Physically abusive behaviors;
Destruction of school property;
Explosive behavior;
Stealing; and
Hyperactivity.

BACKGROUND INFORMATION:

Robert lives with his mother, stepfather, and two older sisters. His parents divorced at the time of his birth, and his mother remarried when he was eight months old. Severe behavior problems were noted when Robert was 4 and 5 years old. At that time, he reportedly destroyed property, set fires, and shoplifted. He also got into a semi-trailer and started driving it.

Robert's family moved when he was in the second grade. He was noted by his teacher to have acting out aggressive behaviors, poor peer relationships, and psychosomatic symptoms. Disturbed family relationships were noted to be an ongoing problem, with investigations by welfare for physical abuse.

PROBLEM BEHAVIORS SEEN AT SCHOOL:

Verbally abusive behavior;
Temper tantrums;
Low self-esteem;
Hyperactivity;
Non-compliant behavior; and
Disruptive and immature behaviors.

CASE STUDY

Rudolf Herzberg, Age 10

REASON FOR REFERRAL:

Negativistic;
Over-critical;
Obsessive;
Compulsive pattern of behavior; and
Tendency to fantasize.

BACKGROUND HISTORY:

Rudolf lives with his mother. His older brother has been placed in a foster home because of unmanageable behavior at home. His mother works third shift and Rudolf has not always been properly supervised. His mother needs to sleep in the daytime so leaves him with a babysitter. This pattern of work and lack of supervision has existed for at least 6 years.

Rudolf was first identified in kindergarten as having problems. He had a short attention span, lack of readiness skills and speech problems. Rudolf developed several phobias. He refused to sit next to girls and went into an explosive tantrum if forced to sit near a girl. He also tried to hang himself in despair over his babysitter's moving. He was treated at Mental Health.

Last fall, problem behaviors again increased. His teacher reported that Rudolf became so explosive she had to evacuate her room several times. He exhibited phobic behavior with regard to reading, becoming angry and explosive if the teacher said, "Let's read". He also would leave her room. One time he ran away from school and police had to be called. Preoccupations with fantasies of violence and an explosive negative attitude were noted. Rudolf began counseling with a private agency along with his mother.

PROBLEM BEHAVIORS NOTED AT SCHOOL:

Self-punishing behaviors;
Negativism;
Preoccupations with violence;
Bizarre stories;
Obsessive and compulsive rituals;
Preoccupation with his own perfection;
Low self esteem; and
Poor peer relations.

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WORKSHOP II
DEVELOPING IEP FOR STUDENTS WITH EMOTIONAL HANDICAPS

Rationale

94-142 requires that each child placed in a special education program must be provided with an Individual Educational Plan (IEP). With children who have emotional handicaps, it is essential that data from the psychoeducational evaluation be used in determining the goals, objectives, and strategies that become a part of the Individual Educational Plan (IEP).

Goals dealing with the affective realm and with specific behaviors are essential. School psychologists need to be able to assist in making sure that these needs are addressed when the IEP is developed.

Purpose

Upon completion of the module,

- The School Psychologist will be able to describe the procedural safeguards contained in P.L. 94-142.
- The School Psychologist will be able to describe the content of an IEP for students with emotional handicaps.
- The School Psychologist will be able to develop goals and objectives of a social and emotional nature, based on the data from psychological evaluation data.

Scope

This module will provide school psychologists with 1) an overview of the IEP process, 2) an overview of prescribed components for an IEP for students with emotional handicaps, and 3) the ability to recognize and develop appropriate goals based on psychological data.

Prerequisite Skills

This module is designed for members of the diagnostic team. Knowledge of the definition of emotionally handicapped is necessary.

Materials Needed:

- overhead projector
- handouts
- copies of activity materials (including pretest/post-test)
- copy of local IEP for overhead and/or each participant

School Psychologists
Application Activity #1

Introduce self and participants
Administer Pretest

1. The psycnologist will be able to describe procedural safeguards provided in P.L. 94-142.

   a. Policies and procedures must be in effect to protect the confidentiality of personally identifiable information.

   b. Handicapped children must be educated with nonhandicapped children to the maximum extent possible.

   c. Nondiscriminatory testing practices must be used.

   d. IEP's must be written for each handicapped student and must be reviewed at least annually.

   e. Due Process procedures must be guaranteed with respect to all matters of identification, evaluation, and placement.

   f. Parents have the right to due process in the identification, evaluation, and placement and the right to obtain an independent educational evaluation.

   g. A surrogate parent will be assigned to any child whose parents are unknown or unavailable or to any child who is a ward of the state.

   h. Parents must receive a written notice prior to any change in placement or evaluation of a child.

   i. Notice must be in the parents' native language.

   j. Parents must sign permission for any evaluation or for a change of placement.

Discuss Handouts: Placement Process Flowchart (Handout II-1)
Mandatory Components of IEP (Handout II-2)
Best Practice Standards (Handout II-3)

2. The Psychologist will be able to describe the content of the IEP for students with emotional handicaps.

   a. Current level of performance.
      1. Determined from completing nondiscriminatory multifactored assessment which includes intellectual, achievement, social-emotional and adaptive behavior information.

   b. Annual goals and short term objectives.

   c. Related services to be provided.
      1. Any service necessary for a handicapped student to benefit from his placement; i.e., transportation, speech pathology, counseling services, etc.

   d. Extent the student will participate in regular education.

   e. Evaluation criteria and how goals and objectives are to be monitored.
      1. Criteria for mastery is based on type of handicap instructional goals, and conditions.
      2. Academic goals and objectives are more easily measured than social and emotional goals and objectives.

   f Projected date for initiation and anticipated duration of services.

   g Placement.
      1. Various options for placement are listed.
      2. Reason for selected placement given.

   h. Persons involved in implementing IEP.
      1. Teacher of students with emotional handicaps, parents, related services personnel, regular educators.

   i. Case Conference Team members.
      1. All persons attending the case conference, including administrators, regular teachers, special education personnel, psychologist, parents, persons of parents' choice who may provide additional information and expertise relating to the student, and the student, if appropriate. Although not specifically required by Rule S-1, the school psychologist should participate in the case conference following 3-year retests for SEH students.

APPLICATION ACTIVITY

Presenter uses overhead listing the required components of the IEP. Presenter will have copies of local IEP form to distribute. The participants will compare their local form to listed components. Discussion will follow on compliance using the local IEP form.

Handout: Federal Register, I.E.P. Development.

Presenter will discuss what should happen in a case conference.

3. The Psychologist will be able to develop goals and objectives of a social and emotional nature based on the data from the psychoeducational data.

   a. Annual goals are statements that describe what a student can reasonably be expected to accomplish within one calendar year in his special education placement.

   b. Annual goals are based on assessment data.

      - Goals address a student's specific needs.

   c. Annual goals should reflect past achievements.

      - Avoid expectations that are too high or low.

   d. Annual goals should reflect current performance.

      - Represents starting point.

   e. Annual goals should consider high-priority areas by members of IEP team.

      1. Goals should address student's immediate social, emotional and academic needs.
      2. Social and emotional goals <u>always</u> take priority in the development of students with emotional handicaps.

   f. Annual goals should include the cognitive, psychomotor, and affective domains.

      1. Cognitive - Jimmy will increase his knowledge of U.S. History.
      2. Psychomotor - Jimmy will walk across a room unassisted.
      3. Affective - Jimmy will follow classroom rules.

   g. Short-term objectives are measurable steps between present level of functioning and the annual goal.

   h. Short term objectives must include:

      1. Description of desired performance.
      2. Given conditions under which behavior occurs
      3. Listing of criterion for adequate performance

   i. Short term objectives describe specific terminal behaviors and are written in behavioral terms.

      - Describes what learner will be doing when having completed the objective.

   j. Short term objectives define standards of performance.

      - What level must the student master before moving on to another objective?

   k. Goals and objective should always be written in a positive manner.

Discuss Handout: Guide to Discussion of Needs for IEP Development (Handout II-4)

Presenter will direct application activity #2

APPLICATION ACTIVITY #2

Below each criteria statement from the educational definition of seriously emotionally handicapped, develop four objective statements that might be used on an IEP.

I. . . . an inability to learn which cannot be explained by intellectual, sensory, or health factors . . .

LRG: In a group situation, the student will demonstrate compliance of tasks.

S.T.O.: 1. Student will maintain attention to task for a 3 minute period for a maximum of 1 teacher cue.

2.

3.

4.

5.

II. . . . an inability to build or maintain satisfactory interpersonal relationships with peers and teachers . . .

LRG: The student will demonstrate appropriate ways to gain peer interaction.

S.T.O.: 1. The student will greet another student appropriately.

2.

3.

4.

5.

III. . . . inappropriate types of behavior or feelings under normal circumstances . . .

LRG: Student will appropriately respond to situations with self-control.

S.T.O.: 1. Student will verbalize alternative ways of expressing anger.

2.

3.

4.

5.

IV. . . . a general pervasive mood of unhappiness or depression . . .

LRG: Student will verbalize feelings.

S.T.O.: 1. Student will accurately label personal feelings.

2.

3.

4.

5.

V. . . . a tendency to develop physical symptoms or fears associated with personal or school problems . . .

LRG: Student will develop appropriate coping skills for managing anxiety and stress.

S.T.O.: 1. Student will verbalize feelings of anxiety and frustration.

2. Student will recognize situations that cause him/her anxiety.

3.

4.

5.

Handout: Goals & Objectives: Social/Emotional Development Related to Educational Definition of SEH (Handout II-5).

OBJECTIVES:

1. The student will verbalize alternative ways of expressing anger.
2. The student will express anger with nonaggressive words rather than physical actions.
3. The student will respond when angry or upset by seeking adult support in an appropriate manner.
4. The student will respond when angry or upset by initiating self-removal from the situation.

IV. A general pervasive mood of unhappiness or depression.

GOAL: The student will verbalize feelings.

OBJECTIVES:

1. The student will accurately label personal feeling to the teacher.
2. The student will verbally acknowledge negative feelings with teacher assistance.
3. The student will verbally acknowledge and describe his personal feelings without teacher assistance.

V. A tendency to develop physical symptoms or fears associated with personal or school problems.

GOAL: The student will develop appropriate coping skills for managing anxiety and stress.

OBJECTIVES:

1. The student will recognize situations that cause him/her anxiety.
2. The student will stop and count to 10 when feeling anxious.
3. The student will practice deep breathing exercises for 10 seconds before attempting the assignment.
4. The student will request help with problem.

HANDOUT: Suggested Strategies for Managing Social and Emotional, and Behavioral Problems (Handout II-6).

Presenter will direct application activity #3

APPLICATION ACTIVITY #3

Following is a sample psychoeducational report. After reviewing this information, participants will develop goals and objectives using the identified behaviors and needs of the student. Handout "Suggested Strategies for Managing Social, Emotional, and Behavioral Problems" and discuss.

PSYCHOEDUCATIONAL REPORT

Bill Smith, Age 11-8
DOB: 5/21/73
North Elementary School
Grade: 5

Examiners: Psychologist
Educational Diagnostician

Dates of Examination: 2/11, 2/12 and 2/14/85

REASON FOR REFERRAL:

Bill was referred for evaluation because of academic and behavioral problems experienced in the regular program.

BACKGROUND INFORMATION:

Bill is a fifth grader at North Elementary School. He lives in Albany with his mother, older sister, and younger brother. His parents are divorced. Bill sees his father sporadically; his father has remarried. Bill also has an older half-brother in the service. According to Ms. Smith, Bill has few friends.

Developmental and social history was provided by Ms. Smith. She indicated that Bill was the product of a normal pregnancy and passed developmental milestones at normal times. At age three, Bill had problems with his kidneys. Bill also has had a "high" sugar problem, but tests for diabetes have been negative. Bill's present health is reported as normal. Ms. Smith says Bill has no responsibilities at home. She uses grounding as a method of discipline.

Bill attended kindergarten through fourth grade in Sidney. Upon moving to Albany, he repeated fourth grade. He is presently in the fifth grade. His mother reports he does not express interest in schoolwork.

School personnel report delays in academics, distractibility, lack of task completion, social isolation, failure to follow rules, and lack of self-confidence as problems.

Using the sample instructional objectives page of an IEP (Handout II-7), write goals and objectives for Bill. Social and emotional goals should be given primary emphasis on the IEP of an emotionally handicapped child.

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School personnel report delays in academics, distractibility, lack of task completion, social isolation, failure to follow rules, and lack of self-confidence as problems.

OBSERVATION IN THE CLASSROOM:

Bill was observed in his regular fifth grade classroom. The class was discussing safety rules in the community. Bill was quiet during the period observed and appeared to be listening to the discussion. He raised his hand three times to volunteer an answer. No inappropriate behaviors were observed.

OBSERVATION DURING TESTING:

Bill was cooperative during testing. He maintained good eye contact and appeared to exert good effort. Although he smiled frequently, he did not volunteer a lot of information about himself. He indicated his interests were playing outside.

TEST RESULTS:

Intellectual/Cognitive Functioning

WECHSLER INTELLIGENCE SCALE FOR CHILDREN - REVISED (WISC-R)

Full Scale Score:	94 ± 5
Verbal Score:	94
Performance Score:	96

Subtest Scores (10 is Mean)

Information:	8	Picture Completion:	10
Similarities:	8	Picture Arrangement:	12
Arithmetic:	10	Block Design:	9
Vocabulary:	8	Object Assembly:	12
Comprehension:	11	Coding:	5
(Digit Span:	12)		

On the measure of intellectual ability, the Wechsler Intelligence Scale for Children-Revised, Bill earned a full scale score of 94 ± 5 which indicates that 90% of the time his functioning falls in the average to low average range. His verbal and performance scale scores also fell in the average range.

On the verbal scale, there was little significant difference between subtest scores most of which ranged from low average to average. The optional subtest of short-term memory was an area of significant strength and fell in the high average range.

On the performance scale, most scores fell in the average to high average range. The score on the subtest of visual-motor speed was in the deficit range and suggested a significant weakness in this area.

Visual-Motor Functioning

DEVELOPMENTAL TEST OF VISUAL-MOTOR INTEGRATION (VMI)

Percentile: 7th
Standard Score: 4

On the measure of visual-motor integration, Bill earned a standard score of four which fell at the seventh percentile and suggested a severe deficit in this area. Errors were primarily of distortion of shape.

Receptive Vocabulary

PEABODY PICTURE VOCABULARY TEST - REVISED (PPVT-R)

Standard Score: 85
Percentile: 58th

On the measure of receptive vocabulary, Bill was required to respond by pointing to the picture representing the word spoken by the examiner. Bill earned a standard score of 85 which fell at the 58th percentile and which was similar to his expressive vocabulary score on the Wechsler.

Social/Emotional Functioning

BEHAVIOR RATING PROFILE

Parent: 3
Teacher: 5
Student
Home: 5
School: 9
Peer: 8

LOUISVILLE BEHAVIOR CHECKLIST - PARENT

CHILD BEHAVIOR CHECKLIST - TEACHER

CHILDREN'S MANIFEST ANXIETY SCALE

CHILDREN'S DEPRESSION INVENTORY

PIERS-HARRIS SELF-CONCEPT SCALE

DRAW A PERSON

SENTENCE COMPLETION TEST

THEMATIC APPRECIATION TEST

Bill's social/emotional functioning was assessed by use of behavior rating scales, by measures of anxiety, depression, and self-concept, and by projective tests of underlying problems and concerns.

On the Behavior Rating Profile, Bill's mother his teacher, and Bill himself completed ratings. Bill's mother rated his behavior in the deficit range. She noted that he talks back, doesn't follow rules and directions, lies to avoid punishment, is not a leader, is self-centered, is overly sensitive, and demands that his needs be met immediately.

Bill's teacher also rated his behavior in the deficit range. He noted that Bill lacked motivation, failed to follow directions, tended to be passive and withdrawn, was socially isolated, has dental hygiene problems, daydreams, and says he's picked on by others. Bill also fails to follow class rules.

Bill rates his adjustment at school and with peers as average but perceives problems at home. He notes he has nightmares, fails to meet parental expectations, tends to argue, and is restricted in activity at home.

The Louisville Behavior Checklist was completed by Ms. Smith. On this measure of childhood psychopathology, the only significant area was learning disability. Ms. Smith does note that Bill disobeys her, tends to develop a nervous blinking of his eyes under stress, and is shy. In the past, he has been encopretic.

On the CHild Behavior Checklist completed by Bill's teacher, numerous behaviors are of concern in the areas of social withdrawal, anxiety, compulsive behavior, immaturity, and inattentiveness.

On the Children's Manifest Anxiety Scale, Bill's overall score was significantly higher. Significant areas of concern were physiological anxiety (somatic symptoms), worry and oversensitivity, and poor concentration.

On the Children's Depression Scale, Bill's score was also significantly high, suggesting that Bill is very depressed. Bill notes characteristics of depression including indecisiveness, poor sleep habits, failure at school, and low self-esteem.

Similarly on the Piers-Harris Children's Self-Concept Scale, Bill rated his self-concept at the second percentile suggesting low self-esteem. Bill feels rejected by others and physically unattractive. He is aware he behaves badly and feels he is failing at school.

Bill's drawing of a person was well-detailed and contained all expected features. One emotional indicator for feelings of aggression was noted.

The Sentence Completion Test was administered as a projective. Bill's responses suggested feelings of rejection and fearfulness. Similarly on the Thematic Apperception Test, another projective measure, themes of stories told by Bill were of depression and loneliness.

Reading Skill and Comprehension

WOODCOCK READING MASTERY TESTS, FORM B

Subtest	Grade Score
Letter Identification:	3.8
Word Identification:	3.7
Word Attack:	4.5
Word Comprehension:	4.4
Passage Comprehension:	5.4
Total Reading:	4.2

GILMORE ORAL READING TEST, FORM C

Basal Level: Third Grade Paragraph
Ceiling Level: Fourth Grade Paragraph

DURRELL ANALYSIS OF READING DIFFICULTY: THIRD EDITION

Sounds In Isolation
Listening Comprehension

BRIGANCE DIAGNOSTIC COMPREHENSIVE INVENTORY OF BASIC SKILLS

TEST OF READING COMPREHENSION (TORC)

Subtest	Scaled Score (7-13: Average Range)
Reading the Directions of Schoolwork	9

Bill's reading skills were evaluated at a 4.2 grade level utilizing the Woodcock Reading Mastery Tests. This total test grade score should be interpreted with caution, however, due to the scatter noted among the individual subtests. The first task introduced involved letters of the alphabet printed in manuscript, cursive, and special script. He identified 42 of these 45 letters, experiencing difficulty with cursive q and Z and responding "i" for l. Single and multisyllable words listed in order of increasing difficulty were next shown in order to assess Bill's word identification mastery. He read 20 of the 30 words he attempted with his overall performance yielding a high third grade level score. Informal testing suggested fourth grade level word recognition skills. Bill attempted to sound out unfamiliar words with his errors involving both mispronunciations and substitutions (e.g., "mutt" for mute; "another" for amateur; "sugary" for surgery).

Graded paragraphs of increasing length and complexity were next shown in order to evaluate Bill's oral reading skills (Gilmore). A basal level (i.e., a selection read with two or fewer errors) occurred on the third grade passage. He then read the next paragraph with thirteen errors suggesting a fourth grade ceiling level (i.e., a selection read with ten or more errors). Most of the word accuracy errors recorded again involved substitutions (e.g., "carton" for certain; "assign" for assist; "with" for which) and mispronunciations. When asked comprehension questions requiring the recall of facts/details contained in these selection (i.e., five questions after each passage), Bill successfully answered eighteen of twenty. His overall performance on the Gilmore yielded a similar pattern to that of the Woodcock suggesting nigh third grade level word accuracy when dealing with vocabulary in context and high fourth grade level literal comprehension skills at a recall level.

Tasks utilized in evaluating Bill's word attack skills included single/multi-syllable nonsense words listed in order of increasing difficulty and sounds presented in isolation. When dealing with the letters shown individually, he responded with the appropriate sound for 49 of 52 consonants, blends, digraphs, and phonograms (e.g., udge, eeze, ock) and 11 of 16 affixes. Mid-fourth grade level skills were then evidenced on the Woodcock as he decoded 34 of 50 nonsense words. Most of Bill's errors involved difficulty with vowel sounds.

Comprehension items introduced on the Woodcock involved word analogies (e.g., cat - animal; tree - _____) and incomplete passages utilizing a modified coze technique (e.g., Breakfast is usually eaten in the _____). When dealing with the analogies, Bill read each one aloud and received credit for 27 of the 45 items he attempted. His overall performance yielded a mid-fourth grade level score. Bill experienced particular difficulty with first-third word analogies (e.g., pen - pencil; ink - ___). Bill was particularly successful in completing the passages, suggesting a strength in his ability to utilize context clues as a means to identify unfamiliar words. He received total credit for 49 items yielding a mid-fourth grade level score. Fourth grade listening comprehension skills were then suggested as that was the highest level at which he answered most of the questions asked after listening to material read aloud by the examiner.

The remaining reading activities introduced involved a further analysis of Bill's comprehension skills. When presented with multiple choice questions following his silent reading of story-like passages, he answered five of five questions after low second to high third grade level material; three of five questions after a fourth grade level paragraph; and four of five questions after the fifth grade selection. Bill next obtained a scaled score within the average range on a test designed to measure his ability to follow written directions such as those commonly found in his everyday schoolwork (e.g., Number these sentences in order; Write these words in alphabetical order; Underline each root word).

Written Expression

TEST OF WRITTEN LANGUAGE (TOWL)

Subtest	Standard Score (7-13: Average Range)
Vocabulary:	6
Thematic Maturity:	7
Word Usage:	10
Style:	6

TEST OF WRITTEN SPELLING (TWS)

Predictable Words:	4.6
Unpredictable Words:	3.5
Total Test Score:	4.0

BRIGANCE DIAGNOSTIC INVENTORY OF BASIC SKILLS

INFORMAL HANDWRITING ANALYSIS

Skills evaluated in the area of written expression were word usage, capitalization, punctuation, spelling, story composition, and handwriting. When presented with sentences written with one word missing (e.g., I wish I _____ seen the movie), Bill filled in an appropriate noun, verb, adjective, or pronoun form for 18 of 25 items. His overall performance yielded a standard score well within the average range when comparing his score to that of other eleven year old students. Bill's errors involved difficulty with irregular noun plurals, pronouns, and verb forms.

Sentences written without any capital letters or punctuation were next shown with Bill's directions being to rewrite each. He received credit for only two of the ten items he attempted, suggesting Style skills within the below average range. Difficulty with both punctuation and capitalization rules was evidenced. An informal task was then attempted which only required Bill to circle all words requiring capitals. He was more successful in completing this activity, receiving credit for 18 of the 22 sentences he marked. Some of the words consistently capitalized by Bill involved names of people; months of the year; special days; street names; and city, state, and country names. When given a second punctuation task, he again experienced difficulty, marking only one of ten sentences correctly. It was noted that he included both a period and a question mark at the end of several sentences.

Bill's spelling skills were evaluated utilizing a list of words spelled phonetically or according to common rules (predictable) and words requiring visual memory (unpredictable). His overall performance yielded a low fourth grade level score as he received credit for 31 of the 47 words dictated. However, Bill was more successful in recording the predictable words. Particular difficulty was noted with phonetic irregularities (e.g., "althow" for although; "enoof" for enough; "eigat" for eight) with Bill also experiencing difficulty with the "al" ending (e.g., "hospetl" for hospital).

Three interrelated pictures were next shown with Bill's directions being to make up and write a good story to go with them. He attempted this task as requested, composing a sixty-three word story. Bill's Vocabulary score was then calculated by totaling all of the words involving seven or more

letters. However, he received credit for only five (i.e., "planting, saucers [written twice], different," and "happily") and thus his score fell within the below average range. Bill's ability to write in a logical sequential manner (Thematic Maturity) was assessed by comparing his score to twenty various item (e.g., writes in paragraphs; names objects pictured; has a definite ending). He received credit for three of these items, yielding a standard score at the lower end of the average range based on an age-level comparison.

Bill's handwriting skills were assessed informally utilizing various samples taken from the TOWL and TWS. His cursive writing was neat and legible with no significant difficulties noted as to letter formation or integration. He also utilized manuscript when completing some of the assignments.

Mathematical Reasoning and Calculations

KEYMATH DIAGNOSTIC ARITHMETIC TEST
Total Test Grade Score: 4.5

Bill's strengths and weaknesses in the math content, operations, and applications areas were evaluated utilizing the KeyMath Diagnostic Arithmetic Test. His total test grade score on this particular measure was 4.5 with strengths noted on the Missing Elements and Money Subtests. Weaknesses for Bill were evidenced on those items requiring numerical reasoning and measurement skills.

Written problems successfully completed by Bill included addition of two and three multidigit whole numbers with and without regrouping. He also completed all of the computations required when adding decimal and money amounts but recorded his answers as whole numbers (i.e., 5,139 for $51.39; 50,299 for $502.99). In the area of subtraction, Bill received credit for those problems involving one to three digit whole numbers with and without regrouping. He again omitted the decimal point from his answer when subtracting decimal amounts. Bill also experienced some difficulty with those problems involving multiple zeros. Multiplication items created involved basic facts as well as one problem involving a single digit multiplier with regrouping. In the area of division, Bill only attempted those items involving basic facts and was successful in his computations.

Individual subtest items successfully completed by Bill in the Applications areas included telling time to the hour, half hour, and quarter hour; computing the amount of time involved in an interval when given the beginning and ending times; computing future time to the nearest hour; reading the temperature setting of a room thermometer; stating the number of inches in a foot; and recognizing the unit of measurement needed to determine distance. He also totaled a set of coins and bills valued at $3.02 and made change for a purchase valued at 39 cents when given fifty cents. Difficulties noted required reading the alarm setting of a clock to the nearest hour; stating the month of the year associated with a major holiday notation; indicating the relative comfort level of a room temperature; recognizing the unit of measurement needed to determine cloth length; and indicating why a purchase represented the better buy.

SUMMARY:

Bill is an eleven year old boy who lives with his mother, his brother, and his sister. He sees his natural father sporadically. Bill was referred because of failure to achieve and because of concerns with his withdrawal and apparent lack of motivation.

Results of intellectual assessment suggest that Bill has average intellectual ability. A significant weakness is noted on the test of visual-motor speed. Bill's visual-motor functioning was severely deficit. Bill's receptive vocabulary score fell in the low average range.

Academically, Bill's reading ranged from a high third grade level in word identification to a mid-fifth grade level in passage comprehension. While his overall performance suggested low fourth grade level spelling skills, he was more successful in recording predictable words. Bill's word usage skills fell within the average range with a weakness suggested in basic capitalization and punctuation rules. His cursive writing was neat and legible. Mid-fourth grade level achievement was evidenced in math.

In the area of social/emotional functioning, numerous problems are noted. Bill is a withdrawn, socially isolated child who expresses feelings of low self-esteem, anxiety, and depression. Feelings of fearfulness and rejection are noted.

Bill is currently exhibiting characteristics of a seriously emotionally handicapped student.

RECOMMENDATIONS:

1. Bill requires a highly structured program which can meet his emotional and academic needs.

2. Bill needs to improve his self-concept. Involvement in activities in which he can achieve success will be helpful in this regard.

3. Opportunities for Bill to express his feelings should be provided on a daily basis.

4. Bill needs to improve his on-task and completion of task behavior.

5. Bill needs to behave responsibly in the classroom.

6. Bill would benefit from participation in a highly structured multi-sensory reading program. Activities designed to improve his long term retention of vocabulary appear warranted.

7. Bill's spelling program should be coordinated with his reading instruction. Particular emphasis should be placed on those words requiring visual memory.

8. A review of basic capitalization and punctuation rules would be beneficial.

9. Bill's mother may wish to seek help in working with Bill's behavior. A parenting group which would provide her with support might be helpful.

Psychologist

Educational Diagnostician

BIBLIOGRAPHY

Teacher training modules. (July 1986). Division of Special Education, Indiana Department of Education, Indiana Committee on the Emotionally Handicapped. Shirley J. Amond, Chairperson.

Strategies for improving Indiana's programs for seriously emotionally handicapped. (January 1986). Division of Special Education, Indiana Department of Education, Indiana Committee on the Emotionally Handicapped, Shirley J. Amond, Chairperson (unpublished).

Walker, Hill M., (1979). Exploring issues in the implementation of 94-142: I.E.P. developing criteria for evaluation of individualized education program provisions. Research for Better Schools.

PRETEST/POST-TEST

_____ 1) The extent the child will participate in regular education must be stated in percent.

_____ 2) The IEP for students with emotional handicaps must include various alternative placements considered and the reason they were rejected.

_____ 3) The placement determined for every student with an emotional handicap must be reviewed every three years.

_____ 4) Parents may bring any supporting persons of their choice to the case conference meeting.

_____ 5) Annual goals and objectives are more effective when stated negatively.

_____ 6) Social and emotional goals and objectives should always come first on the IEP for a student with an emotional handicap.

_____ 7) It is easier to measure social and emotional goals than academic goals.

_____ 8) An IEP is developed for each student with emotional handicaps after placement has been determined.

_____ 9) An individualized educational program must be in effect before special education and related services are provided for a student with emotional handicaps.

_____ 10) Counseling services and parent training are related services.

_____ 11) The native language of the parent and child must be considered during the IEP process.

_____ 12) P.L. 94-142 suggests that administrators, regular education teachers, special education personnel, parents and the student, when appropriate, participate in the placement process.

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Appendix A

Handout 1

FAMILY HISTORY FORM

Child's Name:_____ Date of Birth:_____

Parent's Name:_____ Age:_____

Address:_____ School:_____

_____ Grade:_____

Phone Number:_____ Teacher:_____

Has the Child been referred to a physician or other agencies for this or related problems: If so, list:_____

_____

Child lives with: ___Mother ___Father ___Grandmother

___Grandfather ___Foster Parents ___Stepmother

___Stepfather ___Other_____

Natural parents are: ___living together ___separated ___divorced

___deceased

FAMILY DATA: List immediate family (Parents, stepparents, foster parents, brothers and sisters, step and half siblings) and other persons living in the home.

Name & Relationship	Occupation	Age	Place of Birth	Grade Completed	At Home?

Number of years family has lived in community?_____

How does your child get along with his brothers and sisters?_____

_____

With playmates?_____

DEVELOPMENTAL FACTORS:

Was pregnancy with this child normal?_____ Delivery?_____

Evidence of injury at birth?_____Explain_____

_____

Can you recall the age at which your child began to:

sit alone___(months); walk alone___(months); say words___(months).

Any serious illnesses, accidents, or unusual features in infancy or childhood?___Explain_____

Convulsions?_____ How many?_____ Most recent one?_____

Does child control bladder at night?___ Daytime?___ Bowels?_____

Do you suspect a hearing loss?__ Explain_____

Do you suspect a vision loss?___ Explain_____

Does child have a physical handicap?___ Explain_____

Present condition of health_____ Explain_____

Family Physician_____ Date of last exam_____

Has the child received any special help this year?_____ Before?_____
In Speech?__ Hearing?___ Vision?___ Reading?___ Tutoring?___
Special Class?___ Other?_____

HOME ROUTINE:

Time child goes to bed_____ Time child gets up _____

Does child eat breakfast?_____ Hot lunch?_____Dinner?_____

Does child earn money?____ Explain_____

Explain child's responsibilities at home_____

Has child been in trouble with neighbors?_____ Authorities?_____

Explain_____

What form of punishment is used in your home?_____

Who disciplines your child?_____

RECREATION AND PLAY:

Where does the child play: own yard?___ Playground?___ Neighbors?___

Playmates: Younger_____ Same Age_____ Older_____

Same sex_____ Opposite sex_____ Mixed_____

Many?_____ Some?_____ None?_____

Playthings: Many_____ Some_____ None_____ Share_____

Favorite pastime:_____

Television viewing habits are: Often____ Selected Programs___ None___

Special Instructions: Music lessons___ Dancing___ Sports___

Others_____ Explain_____

SCHOOL HISTORY:

Did child attend kindergarten?___ Age entered first grade?_____

Number of schools attended_____ Has attendance been irregular?_____

Explain_____

Which grades, if any, have been repeated?_____ Promoted early?___

Have grades prior to this year been low?_____ Average?_____ High?____

Have grades during this year been low?_____ Average?_____High?_____

What subjects are especially difficult for the child?_____

What is the child's attitude toward school?_____

Describe your child's problem as you (the parent) see it and understand it.

_____ _____

Signature of parent/guardian completing this form. Date

FAMILY INFORMATION FORM

Date sent:_____

Date returned: _____

Name: _____ Birthdate:_____ Age:_____ Sex:____

Information supplied by:_____ Relationship:_____ Date:____

****

Any prior contact with this clinic? (who and when):_____

Who suggested you consult this clinic?_____

Why?_____

Any special help from a tutor or other agencies and clinic (who and when):

_____

Did your child ever repeat a grade?_____ Highest grade completed_____

Regular or special class?_____

Family Doctor:_____ Address:_____

Child under medical care of:_____

I. HISTORY:

Any complications during pregnancy?_____

Walked at:_____ months. Talked at:_____ months. Any speech problems?___

Natural or adopted?_____ Single or multiple births?_____

Ever been unconscious? (Cause and duration):_____

Any malformations or operations? (specify):_____

Serious illnesses? (specify):_____

Frequent colds?_____ Frequent headaches?_____

Frequently fatigued?_____ How is appetite?_____

From Knoff, H. M. (1986) A conceptual model and pragmatic approach toward personality assessement referrals, in H.M. Knoff (EU.) The assessment of child and adolescent personal. NY, New York: Guilford Press.

Date of last physical exam:_____Circumstances and results:_____

Date of last vision check:_____Any corrections or training?_____

Date of last hearing exam:_____Current weight_____Hours of sleep per night:_____

Any medicine being taken now? (what and why):_____

_____

Any language other than English spoken in the home?_____

Parents: (both natural or specify relationships)_____

II. FAMILY:

Name:_____ _____

Age: _____ _____

Occupation:_____ _____

Highest School Level Completed:_____ _____

General Health:_____ _____

Serious Illnesses:_____ _____

Learning Problems?_____ _____

Parent(s) Marital Status and appropriate dates:

Married_____ Separated_____ Divorced_____

Single_____ Mother or Father Remarried?_____

Does mother and/or father live outside the home? If so, give address:

_____

Persons living in home where child lives:

	Name	Relationship	Birth Date	Occupation or School & Grade	Employer
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

Other siblings living outside of home:

	Name	Relationship	Birth Date	Occupation or School & Grade	Employer
1.					
2.					
3.					
4.					
5.					

Is there or has there been any psychiatric/psychological counseling for anybody in the family? If so, who, when, where, why?

Have any other members of the family (parents or siblings) had serious illnesses or specific learning problems?

III. PRESENTING PROBLEM(S)

1. What is currently concerning you about your child or family?

2. When did the problem(s) start?

3. What happended that led you to come here?

4. What changes in your family have you noticed since this problem began?

5. What would you like to change?

6. Do both parents see the problem the same way?

7. Does the child agree that there is a problem?

8. What major changes have occurred in your family over the past few years (moves, changes in income or employment, changes in family composition?

IV. RELATIONSHIPS WITH PARENTS:

A. Child's relationship with father:
   1. Describe nature of contacts with father in home:

   2. Have there been separations?
      a. How old was child at time of separation?

      b. How often does father see child?

      c. Under what circumstances?

B. Child's relationship with mother:
   1. Describe nature of contacts with mother in home:

   2. Have there been separations?
      a. How old was child at time of separations?

      b. How often does mother see child?

      c. Under what circumstances?

C. Discipline:
   1. What kinds of things does child do that mother disciplines him for?

   2. What does she do about it?

   3. What kinds of things does child do that father disciplines him for?

   4. What does he do about it?

Feelings between parents and the child:

1. Do you like being with the child? (Elaborate)

2. Do you find it difficult to be with child? (Elaborate)

3. What things do you most enjoy about the child?

4. What does the child do well?

LEGAL PROBLEMS

1. Has child ever been in trouble with the law?
2. If so, how many times?
3. Give approximate date(s):
4. What was the court's disposition?
5. Is the child currently on probation
6. If yes, who is the probation officer? Telephone:
7. Is there any legal action currently pending?

Please comment on any other behaviors or attitudes that you feel might be important for me to know.

HANDOUT 3

REQUEST FOR SPECIAL EDUCATION CO-OP SERVICES

DATE_____

The Indiana State Department of Public Instruction requires that certain procedures be followed and information be made available prior to children receiving special education services. This form should be completed by the referring teachers, specialists, parents, and principal, signed and forwarded to the Coordinator of Special Education at School Psychological Services, 630 Meigs Avenue, Jeffersonville, IN 47130.

I. IDENTIFYING INFORMATION:

Student_____ Birthdate_____
Parent/Guardian_____ Age_____
Address_____ School_____
_____ Grade_____
Telephone_____ Referring person(s):
_____
_____

II. FAMILY, HEALTH, AND EDUCATIONAL HISTORY:

A. Educational Assessments:

Please complete this section by reviewing all past school records. Include all group and individual intelligence and achievement tests, including WRAT, PIAT, etc.

Name of Test	Test Date	Scores (including subtests)	Evaluated By

B. Attendance Record:

1. Has the child attended more than one school in the past five years? If so, please list: YES_____ NO_____

_____
_____
_____
_____
_____

2. School attendance for the past three years:

School Year	Days Present	Days Absent	Comments (if pertinent)

C. Past Educational Performance:

1. If the child has been retained, please list grade levels and comments on reason for retention:

Grade Level	Reason for Retention

2. Please list all subject areas and grades which the student has received during the past two (2) years.

GRADE_____

1st semester

D. Health: (list date & results of most recent examination - to be filled out by school nurse)

1. General Physical_____
2. Vision_____
3. Neurological_____
4. Other_____
5. List prescribed medication and corrective devices, such as glasses, hearing aids, etc._____
6. List current involvement with outside agencies. Attach copies of any available reports or signed releases of information._____

E. Speech/Hearing/Language: (to be completed by the speech clinician or teacher)

1. Has this child recently been screened for hearing impairments? If so, what were the results?_____
2. Is the child receiving Speech/Language therapy? If so, when and for what reasons?

MINUTES OF PARENT CONFERENCE

MEMBERS ATTENDING CONFERENCE: TITLE:

REASON FOR CONFERENCE:

_____ is being referred to School Psychological Services (SPS) because of educational difficulties in the regular program. The specific problems presently exhibited by _____ include:

These difficulties continue to exist despite the adaptations which were made in the regular classroom program to remediate them. These adaptations include:

Due to _____'s lack of success in the regular education program psychoeducational assessment to determine cause, extent, and/or possible remediation of suspected learning difficulties and handicapping conditions is being requested from SPS.

RELEVANT FACTORS:

The referral, as completed by _____, was reviewed (including background information, teacher assessment, strategies attempted to remediate the problem).

ASSESSMENT TECHNIQUES:

_____will be evaluated in the following areas:

_____Academic	_____Intellectual	_____Articulation
_____Classroom Behavior	_____Social and/or Emotional	_____Fluency
_____Functional Vision	_____Visual Motor	_____Language
		_____Voice

Specific tests to be utilized were described to the legal guardian(s).

PARENTAL RIGHTS:

_____ _____received a copy of parental rights. These rights were explained and written permission for testing was obtained.

Signature of parent/guardian_ _____

Signature of administrator directing case conference _____

Time of Conference:_____

Date of Conference:_____

Date Sent to SPS:_____

Date Received & Accepted at SPS:___ _____

CC: Director of Special Education
Parents/Guardian
School

Name_____

Grade_____

Teacher_____

Subject_____/Period_____

A. Please complete this entire section.

I. Academic Assessment (Describe strengths and weaknesses and current functioning level)

Reading_____

_____

Writing_____

_____

Math_____

_____

Spelling_____

_____

II. General Observations: Study Skills (Check all items that describe the student)

_____academic performance is erratic
_____frequently inattentive
_____completes tasks
_____listens to others
_____accepts responsibility
_____readily understands new concepts
_____has difficulty understanding subject matter
_____fails classroom tests
_____comes to class prepared to work (bring pencils, paper, notebooks, etc.)
_____has difficulty with reading materials
_____turns in homework assignments
_____attends class regularly
_____difficulty organizing belongings
_____other (explain_____)

III. Auditory Observations: (Check all items that describe this student)

_____seems to hear but not to listen
_____makes inappropriate responses
_____hesitates before responding to oral questions
_____ignores, confuses, and/or forgets verbal directions
_____often seems to misunderstand
_____has problems of articulation, enunciation, grammar, limited vocabulary, speech pace
_____has trouble blending syllables or pronounces words as they physically appea.
_____has difficulty understanding and paying attention (daydreaming, hyperactive, blank expression on face) to oral activities and presentations
_____seems perplexed when trying to understand people who speak quickly or quietly, as well as those who move while talking
_____has problems with academic subjects taught orally
_____spells poorly
_____easily distracted by noises inside and outside classroom (noises unnoticed by other students)

III. Auditory Observations, continued

_____frequently asks what just has been said (What?, Huh?)
_____substitutes gestures for words
_____watches the speaker's lips
_____often looks at others before following directions
_____other (explain_____)

IV. Visual/Visual Motor Observations: (Check all items that describe this student)

_____difficulty copying words or designs
_____loses place easily
_____seems to have difficulty recalling visually presented information
_____shows signs of eye problems (rubbing, headache, etc.)
_____places answers in wrong spots
_____cannot draw lines on matching test
_____poorer performance when using separate answer sheet
_____poor recall of visual information
_____problems with oral and silent reading
_____word by word - syllable by syllable reading
_____excessive lip movement on vocalizing during silent reading
_____body motion during silent reading
_____poor comprehension
_____mistaking words that look similar
_____using finger to keep place
_____does better with material presented verbally in class
_____oral spelling better than written spelling
_____reverses letters
_____writing seems sloppy or careless
_____consistently refers to visual model
_____responds better to verbal directions
_____difficulty looking from blackboard to seat work
_____other (explain_____)

V. Behavioral Observation: (to be completed if an emotional evaluation is needed) (check all items that describe this student)

_____easily distracted by external stimuli (e.g., hallway noises; hum in light fixture; movement in classroom; other distractions)
_____easily distracted by internal stimuli (something which goes unnoticed by others)
_____responses are frequently bizarre
_____demonstrates little/no logical reasoning
_____responds fearfully to social and/or classroom situations
_____lies
_____engages in daydreaming
_____appears anxious
_____behavior cannot be predicted
_____generally disruptive
_____frequently talks to self
_____generally disorganized
_____laughs at inappropriate times or at situations which lack humor
_____disrespectful toward adults
_____content of drawings is weird/bizarre
_____exhibits short attention span when compared to peers
_____demonstrates little or no self-control
_____dislikes contact (e.g., hugging; touching)

V. Behavioral Observation, continued

_____angers easily
_____unable to accept responsibility for own behavior
_____stressful situations precipitate explosive behaviors
_____hostile toward peers
_____hostile toward adults
_____demonstrates little or no empathy
_____is a loner (withdraws from others)
_____does not show emotion
_____responds inconsistently to routine events
_____unable to follow logical thought processes
_____is destructive (e.g., destroys material objects)
_____generally uncooperative
_____demands excessive amount of attention
_____follows school/classroom rules
_____completes tasks
_____uses appropriate judgment in social situations
_____initiates and accomplishes work independently
_____exhibits an even temperament
_____has close friends
_____accepts responsibility for assigned tasks
_____nervous habits (nail biting, tics, hair twisting, etc.)
_____other (explain_____)

B. Summarize the program you implemented during the past four to eight weeks to remediate the problems indicated in the above sections.

1. What academic objectives have you tried to teach the student?

_____

_____

_____

_____

_____

_____

_____

2. What adaptations have you made in your teaching strategies and in your materials to accomplish these objectives?

_____

_____

_____

_____

_____

_____

_____

3. How did you evaluate student succes. and what were the results?

4. If the student was exhibiting behavioral problems, what behavior did you attempt to change or develop?

5. What techniques did you use to accomplish this (ex.: token economy, positive reinforcement, praise, punishment, restructuring the environment)

6. What were the results of your interventions?

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(Signature of Teacher)

Permission for Evaluation

I/We, the legal guardian(s) of _____

give consent for the to provide special services to my/our child for the purpose of determining cause, extent, or possible remediation of suspected learning difficulties or handicapping conditions. I/We understand the reason my/our child has been referred and I/We am(are) aware of my/our parental rights and due process procedures as guaranteed by Rule S-1 through a personal interview at the Parent Conference or by written report.

Academic Assessment	_____	Student/Parent Interview	_____
Classroom Observation	_____	Teacher Interview	_____
Functional Vision	_____	Visual Motor Evaluation	_____
Intellectual Evaluation	_____	Articulation Assessment	_____
Review of Records	_____	Fluency Assessment	_____
Social and/or Emotional	_____	Language Assessment	_____
Hearing Evaluation	_____	Voice Assessment	_____

Check one:

____ I/We give my/our consent for evaluation.

_____ I/We refuse my/our consent for evaluation.

Signature _____

Address _____

_____

Telephone _____

Date Signed _____

Date Received at _____

cc: School

Handout 4

SCHOOL INFORMATION FORM

Date Sent: _____

Date Returned: _____

The person listed below has been referred to us. We will need the following information. Please be as thorough as possible in filling out the form, and add any further information you feel would help.

****

Name: _____ Birthdate: _____ Age: _____ Grade: _____

Parents: _____ Phone: _____

Address: _____ City: _____ Zip: _____

School: _____ Phone: _____

School Address: _____ City: _____ Zip: _____

Name of Principal: _____

_____

What is the general academic performance level? _____

_____

What are the strongest and weakest academic performance areas? _____

_____

_____

Has child ever repeated a grade? _____ When? _____ What grade? _____

How effective was the non-promotion? _____

Is non-promotion or exclusion now an issue or under consideration? _____

_____

_____

From: Knoff, H.M. (1986). A conceptual model and pragmatic approach toward personality assessment referrals in M.H. Knoff (Eds.), The assessment of child and adolescent personality. New York; Guilford Press

Has the child previously had special help through the schools? (By whom, date, purpose and results, if known)?_____

Has the child been seeen by any other service or referral agency or by a private tutor? (By whom, address, date, for what (reading, speech, emotional, etc.):_____

Other information relevant to problems(i.e. behavior, medical history, siblings, relations, home situation, excessive absences, etc.):_____

Describe any extra or special methods or materials used in the classroom to aid this child:_____

What is the greatest problem presented in the classroom?_____

_____

_____

_____

Describe classroom behavior:_____

_____

_____

Is the child now receiving special services? _____ Where?_____

Purpose:_____

_____

Please list all test results in space provided below and on following page. Wherever possible, please include photo copies of the test data. Please add any additional comments which will help us to better understand this child's problems.

Standardized Test Results

Intelligence

Name of test	Date	C.A.	M.A.	I.Q.	Examiner

Achievement

Name of test	Date	Age Norm	Grade Placement	Examiner

Other

Name of Test (Please include any relevant data):

_____

_____

_____

Do other children in the family attending your schools present problems? _____ Explain: _____

_____

_____

_____

Signature: _____

Title: _____

Date: _____

Handout 5

MEDICAL HISTORY INVENTORY FOR CHILDREN AND ADOLESCENTS (P) *

Name _____ Date _____

Relationship to child _____

Name of child _____ Sex _____

Age _____ Date of birth _____

School _____ Grade _____

Address _____

_____

Telephone number _____

PRENATAL HISTORY

1. Check the degree to which the child's mother had each of the following symptoms during pregnancy:
   a. Nausea
      Not at all _____ A little _____ A fair amount _____ Much _____ Very much _____
   b. Vomiting
      Not at all _____ A little _____ A fair amount _____ Much _____ Very much _____
   c. Vaginal bleeding
      Not at all _____ A little _____ A fair amount _____ Much _____ Very much _____
   d. Water retention
      Not at all _____ A little _____ A fair amount _____ Much _____ Very much _____
2. How much did the child's mother smoke during pregnancy?
   Not at all _____ A little _____ A fair amount _____ Much _____ Very much _____
3. How much did the child's mother drink alcoholic beverages during pregnancy?
   Not at all _____ A little _____ A fair amount _____ Much _____ Very much _____
4. How much weight did the child's mother gain during pregnancy? _____
5. What medications, if any, did the child's mother take during pregnancy?

Medication	*Dosage*	*Effectiveness*

6. What vitamins, if any, did the child's mother take during pregnancy?

Vitamin	*Dosage*	*Effectiveness*

7. Were there any complications due to this pregnancy? Yes _____ No _____ If so, please describe. _____

_____

* Cautela, J. R., Cautela, J. , & Esonis, S. (1983). Forms for behavior analysis with children. Champaign, IL: Research Press.

BIRTH HISTORY

8. How many months pregnant was the child's mother when she gave birth? _____
9. What was the place of birth? _____
10. What was the child's weight at birth? _____ Length at birth? _____
11. How long was the child's mother in labor? _____
12. Were forceps used for the delivery? Yes _____ No _____
13. What type of delivery was it? Caesarian _____ Vaginal _____
14. Did the child's mother have any complications in the hospital before going home?
    Yes _____ No _____ If so, please describe. _____
    _____
15. Did the child have any complications in the hospital before going home?
    Yes _____ No _____ If so, please describe. _____
    _____

EARLY MEDICAL HISTORY

16. Was there any difficulty in feeding the child? Yes _____ No _____ If so, please describe. _____
    _____
17. Check any of the following problems that the child had as an infant:
    a. Allergies _____
    b. Colic _____
    c. Constipation _____
    d. Diarrhea _____
    e. Other (specify) _____
18. When did the child first walk without support? _____
19. When did the child speak his or her first word? _____
    Several words? _____
20. When was the child toilet trained? Urine _____ Stool _____
21. Check any of the following childhood illnesses that the child has had. Describe the frequency of the illness, problems the child has had with it, and how much it presently limits normal activities.
    a. Allergies _____ Describe. _____
    b. Anemia _____ Describe. _____
    c. Asthma _____ Describe. _____
    d. Chicken pox _____ Describe. _____
    e. Convulsions _____ Describe. _____
    f. Eczema _____ Describe. _____
    g. Hay fever _____ Describe. _____
    h. Measles _____ Describe. _____
    i. Meningitis _____ Describe. _____
    j. Mumps _____ Describe. _____
    k. Rheumatic fever _____ Describe. _____
    l. Rubella _____ Describe. _____
    m. Scarlet fever _____ Describe. _____

n. Tuberculosis _____ Describe. _____

o. Whooping cough _____ Describe. _____

p Other (specify) _____

22. Has the child ever had any serious injuries? Yes _____ No _____ If so, please describe. _____

23. What medications has the child taken previously?

Medication	*Dosage*	*Dates*

24 What medications is the child taking presently?

Medication	*Dosage*	*Date begun*

25 Has the child ever been hospitalized? Yes _____ No _____ If so, please give dates and list reasons. _____

26. Does the child presently have any illnesses? Yes _____ No _____ If so, please describe. _____

PRESENT PROBLEMS OR SYMPTOMS

27. Check the degree to which the child has the following problems or symptoms:

a Hearing difficulties
Not at all _____ A little _____ A fair amount _____ Much _____ Very much _____

b. Visual problems
Not at all _____ A little _____ A fair amount _____ Much _____ Very much _____

c. Headaches
Not at all _____ A little _____ A fair amount _____ Much _____ Very much _____

d. Ear infections
Not at all _____ A little _____ A fair amount _____ Much _____ Very much _____

e. Nosebleeds
Not at all _____ A little _____ A fair amount _____ Much _____ Very much _____

f. Bleeding gums
Not at all _____ A little _____ A fair amount _____ Much _____ Very much _____

g Toothaches
Not at all _____ A little _____ A fair amount _____ Much _____ Very much _____

h. Coughing
Not at all _____ A little _____ A fair amount _____ Much _____ Very much _____

dd. Tries to eat material besides food

Not at all _____ A little _____ A fair amount _____ Much _____ Very much _____

ee. Has trouble falling asleep

Not at all _____ A little _____ A fair amount _____ Much _____ Very much _____

ff. Tires easily

Not at all _____ A little _____ A fair amount _____ Much _____ Very much _____

28. Does the child eat enough? Yes _____ No _____ Eat too much? Yes _____ No _____

29. Please list any other physical symptoms or problems the child has. _____

_____

_____

_____

_____

_____

HANDOUT 6

BEHAVIOR OBSERVATION REPORT Observed by_____

Name of Student_____

Date_____Time of Observation_____Length of Observation_____

Class or Classes Observed (Specify)_____

Teacher(s)_____Class Size_____

School_____

Conditions in the Classroom_____

_____

_____

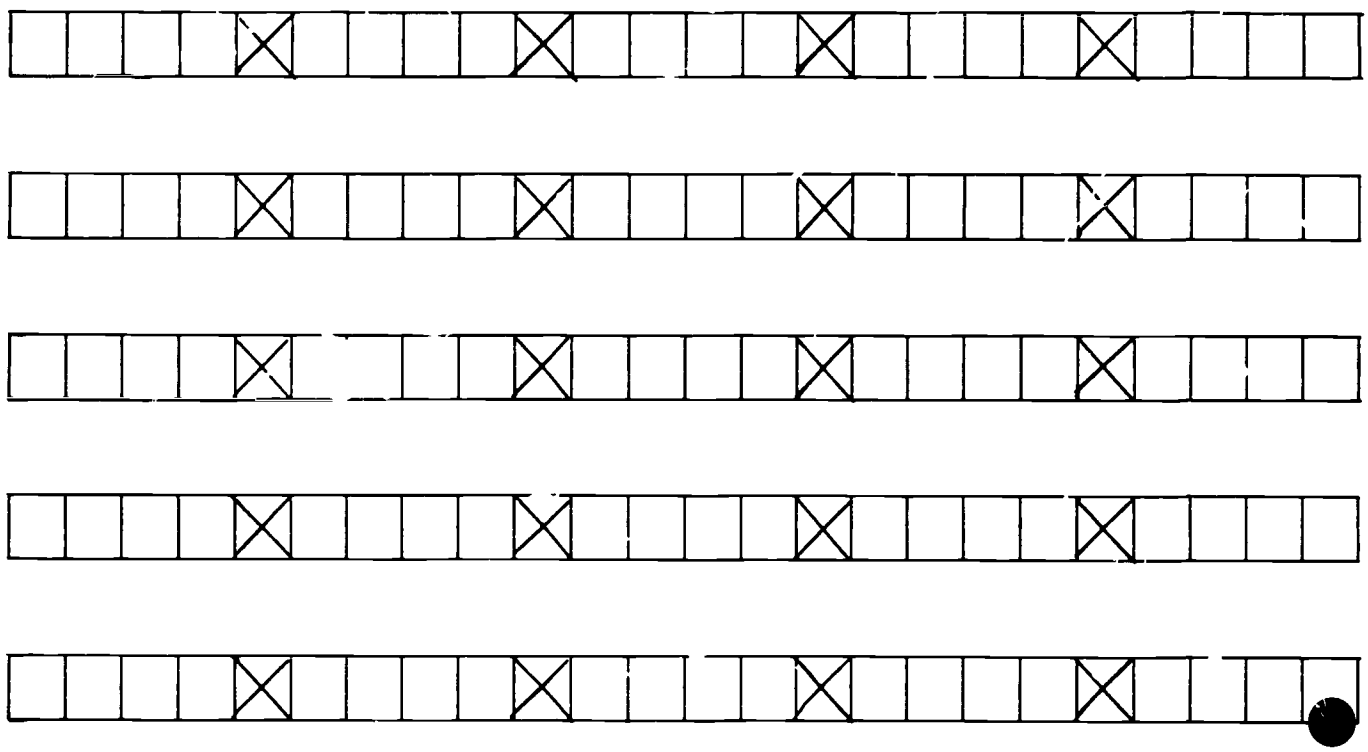
INTERVAL RECORDING

Target Behavior:_____

Beginning time_____ Ending time_____

Length of time intervals_____

+ if target behavior occurs - if target behavior does not occu



80

Target Behavior: _____

_____

_____

TIME	A B C NARRATIVE A- Antecedent B-Behavior C-Consequence	FREQUENCY TALLEY	TOTAL

Average Occurrence during ____ minute period _____

HANDOUT 7

BEHAVIOR OBSERVATION FREQUENCY

SUBJECT (S)_____ NAME (control)-(C)_____

DATE_____ OBSERVER_____

TIME OBSERVED_____ GRADE_____

		5 Min	5 Min	5 Min	5 Min	5 Min	5 Min	5 Min	5 Min
Following Teacher's Directions	S								
	C								
Not Attending to Task	S								
	C								
Talking Out	S								
	C								
Out of Seat	S								
	C								
Physical Aggression	S								
	C								
Excessive Motor Movements	S								
	C								
Started Task on Time	S								
	C								
Socializing with Peers Distracting Others	S								
	C								

COMMENTS:

Handout 8

DURATION BEHAVIOR CHART

NUMBER OF MINUTES

20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
19	19	19	19	19	19	19	19	19	19	19	19	19	19	19
18	18	18	18	18	18	18	18	18	18	18	18	18	18	18
17	17	17	17	17	17	17	17	17	17	17	17	17	17	17
16	16	16	16	16	16	16	16	16	16	16	16	16	16	16
15	15	15	15	15	15	15	15	15	15	15	15	15	15	15
14	14	14	14	14	14	14	14	14	14	14	14	14	14	14
13	13	13	13	13	13	13	13	13	13	13	13	13	13	13
12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
11	11	11	11	11	11	11	11	11	11	11	11	11	11	11
10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
9	9	9	9	9	9	9	9	9	9	9	9	9	9	9
8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
7	7	7	7	7	7	7	7	7	7	7	7	7	7	7
6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
5	5	5	5	5	5	5	5	5	5	5	5	5	5	[illegible]
4	4	4	4	4	4	4	4	4	4	4	4	4	4	[illegible]
3	3	3	3	3	3	3	3	3	3	3	[illegible]	[illegible]	3	3
2	2	2	2	2	2	2	2	2	2	2	[illegible]		2	2
1	1	1	1	1	1	1	1	1	1	1			1	1

Dates >>

Directions:

Indicate behavior counted ____________________

Enter date or time period ____________________

Circle the length of time the behavior occurred during that period

Connect circles to form graph

(Shea & Bauer, 1986)

Handout 9

CLASSROOM OBSERVATION

STUDENT'S NAME:

DOB:

SCHOOL:

GRADE:

TEACHER/OBSERVER:

DATE:

THE STUDENT:	Very Much Like the Student	Like the Student	Not Much Like the Student	Not At All Like the Student
- enters classroom on time	☐	☐	☐	☐
- brings necessary materials to class	☐	☐	☐	☐
- remains in seat	☐	☐	☐	☐
- follows classroom rules	☐	☐	☐	☐
- listens and follows teacher directions	☐	☐	☐	☐
- begins assignments	☐	☐	☐	☐
- completes assignments	☐	☐	☐	☐
- works independently	☐	☐	☐	☐
- interacts appropriately with peers	☐	☐	☐	☐
- participates in classroom discussions/ activities	☐	☐	☐	☐
- attends to task	☐	☐	☐	☐

COMMENTS:

HANDOUT 10

ANECDOTAL BEHAVIOR LOG

In order to measure progress, it is important to have anecdotal records of students behavior. Checklists can provide partial information (time students didn't earn points), but they do not allow for detailed accounts of either positive or negative behaviors. Classroom environments should be recorded along with the specific behavior and the consequences that follow that behavior. This information can be used to avoid problems in the future. Behavior logs are also beneficial for writing progress reports, for providing information at parent conferences, and for reviewing the child's behaviors with him/her at the end of the day.

ANECDOTAL BEHAVIOR LOG

Date/Time	ANTECEDENT	BEHAVIOR	CONSEQUENCE

Supervisor of Psychological Services: _____
Date: _____

Handout 11

E.H. Summary Sheet
Staffing Checklist

Student's Name: _____ School: _____ Age/Grade: _____

School Psychologist: _____ Evaluation Date(s): _____

	Note Date Yes	No
Teacher Documentation: (Anecodotal Record)		
Systematic Observation(s)		
Psychoeducational Evaluation:		

	Note Date Yes	No
Referral for Staffing		
Further in depth behavioral evaluation needed		
Checklist completed by School Psychologist		

Developmental history _____ Intellectural _____
Medical history _____ Achievement _____
Social history _____ Perceptual Motor _____
Social/emotional _____

	Yes	No
Behavior Rating Scale		
Self-report measure (if relevant)		

	Yes	No
Intervention attempted		

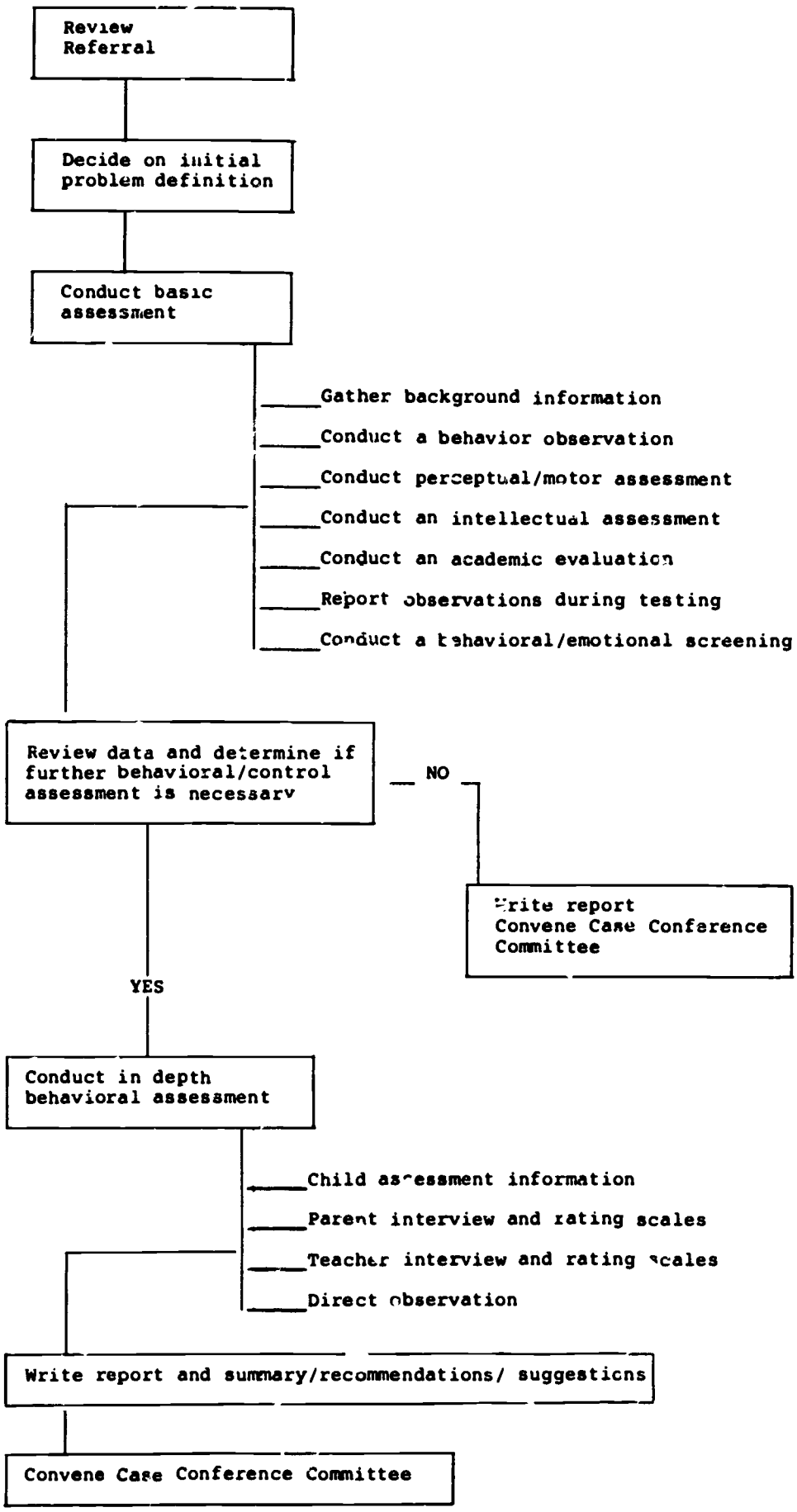
Describe. _____

RULE S-1 QUALIFIERS--

	Over long period of time	To a marked degree
a. An inability to learn which cannot be explained by intellectual, sensory, or health factors (including children who are autistic.)		
b. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.		
c. An inappropriate type of behavior or feeling under normal circumstances (does not include children who are only socially maladjusted.)		
d. A general pervasive mood of unhappiness or depression.		
e. A tendency to develop physical symptoms or fears associated with personal or school problems.		

HANDOUT 12

FLOW CHART



HANDOUT 13

PARENT INTERVIEW

Identification

Name_____ _____Age_____D.O.B.___ _____

Address_____ Sex _____

_____ Phone _____

Family

Father_____ Mother_____

Occupation_____ _____ Occupation_____

Education_____ Education_____

Age_____ Age_____

Siblings_____ Ages_____ Sex_____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Entrance Complaint: Parental Description of Problem

What are the child's problems/problem?
When did they/it begin? Why?
How does the family react to problem?
What has been done to alleviate the problem? (i.e. other referrals, clinics, professional help? etc.)
Describe a typical day of the child's.

Pregnancy

Past pregnacies and results.
Medications taken during these pregnancies.
Were the pregnancies planned?
What was the mother's health condition during pregnancies?
Any sickness? (excessive vomiting, measles, etc.)
Were any drugs taken during the pregnancy? What? When?
Who administered pre-natal care?
What was the length of the pregnancy?
Where was the child delivered? (Hospital, home, etc.)

From Knoff, H.M. (1986) A conceptual model and pragmatic approach toward personality assessment referrals, in H.M. Knoff (EU.) The assessment of child and adolescent personality. New York: Guilford Press

Birth

Was the birth spontaneous, induced, or Ceasarian?
Was there anethesia? What kind?
Were forceps used during delivery?
Forceps marks on child? Where?
How long was labor?
Any complications?
Weight of child at birth, injuries?
Condition of child at birth. (Jaundiced, blue, yellow, etc.)
At birth did the child cry immediately, or need oxygen?

Neonatal Course

How long was mother in hospital?
How long was baby in the hospital?
Any special procedures used? (Incubator, intravenous feeding, given oxygen?)
Was the sucking reflex strong?
Breast or bottle fed?

Feeding

Any colic?
Did child have trouble eating or good appetitie?
Were any special diets required?
Age of weaning.

Sleeping

What age when child slept all night?
Are there any sleep problems, past or present? (nightmares, restlessness, sleep walking, etc.)
Is there rocking behavior, head banging?
Where does the child sleep? With parents, with siblings?

Toilet Training

When did training begin? Bowel-Bladder.
When was toilet training completed?
What were the methods used?
Attitudes of parents to training.
Child's responses. (resistance, smearing)
Does child wet or soil now? When?

Speech

Vocalization as infant?
At what age did child speak?
What language is used in the home?
Problems, if any, with speech. (stuttering, no speech, reversals)

Motor Development

What age did child roll over, sit with support, no support, crawl, walk?
What type of coordination does the child have? (slow, sluggish, quick, level of activity)
What is the child's preferred activity? What does he like to play with the best?

Health

How is the child's general health?
Accidents? When? What.
Child's response to accident.
Illnesses? When? What?
At what age did these illnesses occur?
Hospitalization? When? Where? Why?
Operations.
Effect of hospitalization on parents, on child.
Is child taking any medications? Past medication?

School History

Pre-school or nursery? Age? Where?
Kindergarten?
Reaction of child to beginning school?
Feeling of child towards school?
Separation anxiety?
Strongest and weakest academic areas.
Relationship with teachers.
How well does child get along with classmates?

Play Activity

Does child play well with others, or prefer to play alone?
Will he share things easily?
Are the child's friends, older, younger, or the same age?
Does the child frequently play by himself?
Favorite play activity.

Expression of Feeling

Does the child show affection easily?
Is the child's personality: shy, sociable, even-tempered, tantrums, moody, reserved, aggressive?
Does the child strike out at parents or siblings?
What does parent do when child shows aggressive behavior?

Discipline

Who administers discipline?
What approach is used?
Parents attitudes
Child's responses.

Relationships

Who is the child closest with?
How does the child relate to: Parents, siblings, relatives, teachers?
Does the child have any special relationships? (Teacher, neighbors, etc.)

Special Comments

Are there any events that would be significant in affecting the child's development?
If so, what were the child's responses to these events.

HANDOUT 14

Parent Checklist*

*The following is a list of behaviors that the child may exhibit. Please rate each item on a 1-5 bas[illegible] each of the questions that are asked regarding each behavior.

1 = Not at all

2 = A little (or now and then)

3 = A fair amount (or sometimes)

4 = Much (or often)

5 = Very much (or very often)

	How often does this occur?	How much does the behavior bother you?	How often do you punish the behavior?	How effective is the punishment?
a. Says no when asked to do something				
b. Cries				
c. Screams loudly				
d. Whines				
e. Won't clean room				
f. Won't pick up toys				
g. Tracks in dirt				
h. Eats in sloppy manner				
i. Urinates in pants or bed				
j. Defecates in pants or bed				
k. Takes food without permission				
l. Runs wild in house				
m. Argues with brother or sister				
n. Fights with (hits) brother or sister				
o. Tears or soils clothes				
p. Refuses to wash himself or herself				
q. Destroys property				
r. Steals				
s. Calls mother or father names				
t. Leaves home without permission				
u. Won't come home when called				
v. Won't get out of bed when called				
w. Other (specify) _____				

* From Cautela, J. R., Cautela, J., & Esonis, S. (1983). Forms for behavior analysis with children. Champaign, IL: Research Press.

HANDOUT 15

Psychological Services
Teacher Rating Scale

Child's Name: _____ Date: _____

School: _____ Time: In _____ Out _____

Grade: _____ Teacher: _____ Observer: _____

Subject or Activity Observed: _____ Seating in Classroom _____

RATE OBSERVATIONS IN COMPARISON TO CLASSMATES:

I. Organizational/Task-Related Skills

Check: 1-Strength; 2-Average; 3-Weakness

		1	2	3	Specific Behaviors
1.	Initiating Task	( )	( )	( )	_____
2.	Attending to spoken word	( )	( )	( )	_____
3.	Attending to written word	( )	( )	( )	_____
4.	Following directions	( )	( )	( )	_____
5.	Managing materials	( )	( )	( )	_____
6.	Working independently	( )	( )	( )	_____
7.	Working in groups	( )	( )	( )	_____
8.	Remaining on task	( )	( )	( )	_____
9.	Completing task	( )	( )	( )	_____
10.	Appropriately seeking help	( )	( )	( )	_____
11.	Staying in seat	( )	( )	( )	_____
12.	Participating in class discussion	( )	( )	( )	_____
13.	Interrupting/talking	( )	( )	( )	_____

II. Interpersonal Relations

1.	Peer interaction (cooperative; friendly; respectful)	( )	( )	( )	_____
2.	Adult interaction (cooperative; friendly; respectful)	( )	( )	( )	_____

III. Other Behaviors:

Check: 1-Observed; 2-Not Observed			
1. Uses inappropriate language	( )	( )	_____
2. Harrasses other students	( )	( )	_____
3. Abuses property	( )	( )	_____
4. Cheats	( )	( )	_____
5. Daydreams	( )	( )	_____
6. Demands excessive attention	( )	( )	_____
7. Distractible	( )	( )	_____
8. Impulsive	( )	( )	_____
9. Excessively active	( )	( )	_____
10. Withdrawn/Shy	( )	( )	_____
11. Hostile/Defiant	( )	( )	_____
12. Physically Aggressive	( )	( )	_____
13. Appears anxious, tense	( )	( )	_____
14. Demonstrates frustration	( )	( )	_____
15. Unmotivated; lethargic	( )	( )	_____
16. Exhibits poor self-concept	( )	( )	_____
17. Persevarates	( )	( )	_____
18. Talks to self	( )	( )	_____
19. Acceptable appearance	( )	( )	_____

HANDOUT 16

Sample of interview form to be used with teachers.

BEHAVIOR QUESTIONNAIRE
(Identifier)

*STUDENT*_____ *BIRTHDATE*_____

*SCHOOL*_____ *GRADE*_____

*REFERRING TEACHER*_____ *SUBJECT MATTER AREA*_____

*Teacher Interviewed*_____ *Date*_____

*Interviewed by*_____ *Position*_____

*Length of Interview*_____ *Location*_____

*Length of Time Student Known by the Informant*_____

*Teacher Interviewed*_____ *Date*_____

*Interviewed by*_____ *Position*_____

*Length of Interview*_____ *Location*_____

*Length of Time Student Known by the Informant*_____

This questionnaire is designed to assist school personnel conducting an interview with a referring teacher, in order to better assess the extent to which the student is described by any of the five characteristics included in the Indiana definition of Seriously Emotionally Handicapped. These characteristics are:

a. *an inability to learn which cannot be explained by intellectual, sensory, or health factors (including children who are autistic);*

b. *an inability to build or maintain satisfactory interpersonal relationships with peers and teachers;*

c. *an innappropriate type(s) of behavior or feeling under normal circumstances (does not include children who are only socially maladjusted);*

d. *a general pervasive mood of unhappiness or depression;*

e. *a tendency to develop physical symptoms or fears associated with personal or school problems.*

Directions: Behaviors associated with these five characteristics are listed. Check any of those which describe the student referred. The "Comments" section should be used by the interviewer to provide additional information regarding behaviors which are of greatest concern. Be specific as to the duration, frequency, or intensity of the observed behavior.

1. Basic Skills - reading/mathematics/language:

-academic regression
-decline in grades
-change in skill acquisition
-change in skill application

Comments: _____

_____

_____

_____

2. Short attention span, unable to concentrate:

-shows erratic, flighty behavior
-easily distracted
-lacks perseverance
-daydreams, gets lost in his/her thoughts
-does not complete assignments, fails to finish things he/she starts

Comments: _____

_____

_____

_____

3. Unable to retain:

-poor memory
-forgets easily

Comments: _____

_____

_____

_____

4. Does not complete tasks, careless and disorganized:

-disorderly
-unable to sequence
-loses or misplaces materials

Comments: _____

_____

_____

_____

5. *Does not follow academic directions:*

- *-inattentive*
- *-omits all or parts of things*
- *-makes many errors*

Comments: _____

_____

_____

_____

6. *Lacks comprehension of assignments:*

- *-tasks at skill level incorrectly completed*
- *-displays anxiety*
- *-many wrong or poor responses*
- *-assignments late or not handed in*

Comments: _____

_____

_____

_____

7. *Seeks excessive attention:*

- *-makes weird noises*
- *-acts like class clown, shows off*
- *-seeks excessive praise*
- *-disrupts others*
- *-silliness, childishness*
- *-excessive pouting*
- *-quarrelsome, argumentative*
- *-plans and carries out hostile acts*
- *-bragging, boastful*
- *-excessive swearing*

Comments: _____

_____

_____

_____

8. *Difficulty understanding and accepting the point of view of another person and then responding appropriately:*

-feels persecuted and acts as if others are out to get him/her
-repeatedly annoys others, insensitive to the social cues given
-lacks empathy, insensitive to the feelings of others
-teases others in a hurtful manner
-tactless or rude in social interaction
-cruel or mean to others, a bully
-does not feel guilt or remorse when such a reaction is appropriate
-does not show concern for welfare of friends or companions
-unrealistically fearful or untrusting of others
-egocentric
-inability to predict the consequences of his/her actions
-poor problem solver, cannot develop alternative solutions to social conflicts

Comments: _____

_____

_____

_____

9. *Failure to establish a normal degree of affection or bond with others:*

-difficulty maintaining friendships longer than six months
-blames or informs on companions
-does not extend self for others unless immediate advantage is likely
-isolated, complains of loneliness
-prefers playing with younger children
-not liked by age mates
-lies to companions, cheats at games
-reluctant to participate in activities with peers
-jealous of others
-excessively possessive of the friendship of others
-substitutes adult company for peer relationships
-elective mutism, continuous refusal to talk in almost all social situations, including school (not due to inability to speak or comprehend language or to mental or physical disorder)

Comments: _____

_____

_____

_____

10. Difficulty dealing with authority figures:

-resents constructive criticism or advice
-highly confrontive with those in authority
-insists on having own way
-resists rules, structure
-unreasonable, rigid, unwilling to compromise
-absences or tardiness due to disciplinary actions

Comments: _____

_____

_____

_____

11. Obsessive - compulsive behavior:

-ritualistic, stereotyped actions directed toward meticulous detail
-constantly erases or recopies
-excessively strives for perfection
-cannot accept change of activities out of sequence
-perseveration, persistently repeats certain acts over and over
-stores up things he/she does not need
-overly concerned with neatness or cleanliness

Comments: _____

_____

_____

_____

12. Distorted perception of reality:

-magical thinking, believes in ability to influence an event by defying laws of cause and effect
-excessive fantasizing, imagined thoughts to gratify wishes
-hallucinating, sees things that are not there
-disorientation, confusion regarding time, place, identity
-loose associations, in conversation jumps from one topic to another with no apparent connection
-misinterprets situations, illogical thinking with erroneous conclusion reached
-delusions-false belief in spite of contradictory evidence (not including simple denial of guilt)

Comments: _____

_____

_____

_____

13. Problems with sexual issues:

-sexual behavior which is developmentally inappropriate
-sexual preoccupation
-provocative behavior
-conflicts with sexual identity
-exhibitionism
-public masturbation

Comments: _____

_____

_____

_____

14. Chronic violation of age appropriate and reasonable home or school rules:

-destroys property, either his/her own or others
-blatantly defiant of classroom and school routine
-sets fires
-cruelty to animals
-persistent lying
-impulsively steals objects that are not for immediate use or their intrinsic value

Comments: _____

_____

_____

_____

15. Violent anger reactions, temper tantrums:

-anger is disproportionate to the situation
-explosive, uncontrolled anger
-unanticipated violence or destruction of property, throws objects
-easily provoked
-unplanned physical harm of others

Comments: _____

_____

_____

_____

16. Regressive behaviors:

-thumb sucking
-wetting self during the day
-playing with or smearing feces
-markedly increased attachment to parent figure
-infantile speech or mannerism

Comments: _____

_____

_____

_____

17. Depressed mood or marked loss of pleasure in all, or almost all, usual activities and pastimes:

-insomnia or hypersomnia
-low energy level or chronic tiredness
-feelings of inadequacy, loss of self-esteem or self-deprecation
-decreased effectiveness or productivity at school
-decreased attention, concentration or ability to think clearly
-social withdrawal, isolates self
-loss of interest or enjoyment of pleasurable activities
-irritability or excessive anger
-inability to respond with apparent pleasure to praise or rewards, general unresponsiveness
-less active or talkative than usual
-pessimistic attitude toward the future, brooding about past events or feeling sorry for self
-excessive tearfulness or crying
-recurrent thoughts of death or suicide
-does not eat well, loss of appetite
-presents a feeling of hopelessness or dejection
-social withdrawal, apathy, or sadness
-lacks motivation to complete academic tasks

Comments: _____

_____

_____

_____

20. *Excessive anxiety when separated from those to whom child is attached:*

- *-unrealistic fear about possible harm befalling major attachment figures or fears they will leave and not return*
- *-persistent reluctance or refusal to go to school in order to stay with major attachment figure(s) at home*
- *-persistent reluctance or refusal to go to sleep without being next to major attachment figure or to go to sleep away from home*
- *-repeated nightmares involving theme of separation*
- *-complaints of physical symptoms on school days, e.g., stomachaches, headaches*
- *-difficulty concentrating and attending to work or play when not with a major attachment figure*

Comments: _____

_____

_____

_____

21. *Generalized and persistent anxiety or worry:*

- *-unrealistic worry about future events*
- *-preoccupation with the appropriateness of the individual's behavior in the past*
- *-overconcern about competence in a variety of areas, e.g., academic, athletic, social*
- *-excessive need for reassurance about a variety of situations or events*
- *-somatic complaints*
- *-marked self-consciousness or susceptibility to embarrassment or humiliation*
- *-marked feelings of tension or inability to relax*
- *-persistent and irrational fear of a specific object, activity, or situation that results in a compelling desire to avoid the phobic stimulus*
- *-absence or tardiness due to stress-related illness*

Comments: _____

_____

_____

_____

18. Self-aggressive, physical abuse toward self:

-deliberately harms self
-attempts suicide
-excessive scratching, picking, biting of fingernails
-takes inordinate risks
-accident prone, gets hurt a lot
-excessive weight gain
-excessive weight loss
-change in personal habits
-repeated running away from home overnight

Comments: _____

_____

_____

_____

19. Restless, agitated:

-nervous, high strung or tense
-always in motion
-cannot sit still
-short attention span
-impulsive, acts without thinking
-decreased need for sleep
-inappropriate laughing
-difficulty concentrating
-excessive anxiety
-extreme mood swings
-compulsive talking

Comments: _____

_____

_____

_____

22. *Self-concept so low as to impair normal functioning:*

- *-lacks confidence, insecure, afraid to try new things*
- *-assumes blame inappropriately when things go wrong*
- *-severe avoidant behavior which interferes with social relationships*
- *-excessive dependency on adults or others*
- *-persistent and excessive shrinking from contact with strangers*
- *-easily frustrated and upset by failure*
- *-overwhelmed by new tasks and tries to avoid*
- *-does not complete routine tasks*
- *-persistent feelings of failure*

Comments: _____

_____

_____

_____

Evaluation Checklist for EH

Student's Name _____

School _____ Grade _____ C.A. _____

Date of Evaluation _____

The following areas have been assessed and considered in diagnosis:

I. Observed in school:

	Yes	No	Intense	Frequent	Long Duration
A. Inability to learn which cannot be explained by intellectual, sensory or health factors (including children who are autistic)	[ ]	[ ]	[ ]	[ ]	[ ]

Documentation (please indicate specific problems over what period of time):

_____

_____

_____

B. Inability to maintain satisfactory interpersonal relationships with:

	Yes	No	Intense	Frequent	Long Duration
Peers	[ ]	[ ]	[ ]	[ ]	[ ]
Teachers	[ ]	[ ]	[ ]	[ ]	[ ]

Documentation: _____

_____

_____

	Yes	No	Intense	Frequent	Long Duration
C. Inappropriate behavior or feeling under normal circumstances.	[ ]	[ ]	[ ]	[ ]	[ ]

Documentation: _____

_____

_____

D. A general mood of unhappiness or depression. Yes [] No [] Intense [] Frequent [] Long Duration []
Documentation:_____

E. Tendency to develop physical symptoms or fears associated with personal or school problems. Yes [] No [] Intense [] Frequent [] Long Duration []
Documentation:_____

F. Evidence of excessive physical or verbal agression. Yes [] No [] Intense [] Frequent [] Long Duration []
Documentation:_____

G. Evidence of high frequency of inattention to tasks associated with regular classroom performance. Yes [] No [] Intense [] Frequent [] Long Duration []
Documentation:_____

H. Evidence of persistent withdrawal from peer or adult interactions associated with the expected social development in a regular educational environment. Yes [] No [] Intense [] Frequent [] Long Duration []
Documentation:_____

I. Behavior adversely affects academic performance. Yes [] No [] Intense [] Frequent [] Long Duration []
Documentation:_____

II. Confirmation by outside sources (if relevant)
(Other agencies; developmental history, etc.)

A. Behavior is exhibited in

Home_____ Community_____

	Yes	No
B. Other mental health agency's evaluation indicates evidence of emotional disturbance.	[]	[]

Documentation (please indicate instruments/procedures used):_____

_____

_____

_____

Other Information:_____

_____

_____

_____

_____

III. Exclusions

Can one of the following be documented as the primary cause of the student's learning problems?

	Yes	No
Visual Acuity	[]	[]
Hearing Impairment	[]	[]
Physical Handicap	[]	[]
Cultural Factors	[]	[]
Instructional Factors	[]	[]
Mental Retardation	[]	[]

IV. Other Considerations

	Yes	No
A. Is (or has) the student being served by another area of Special Ed? Program_____	[]	[]
B. Have management techniques been employed in the classroom? Documentation_____	[]	[]

_____

_____

V. Conclusions:_____

_____

_____

HANDOUT 18

PERSONALITY ASSESSMENT REPORT

Descriptive, Interpersonal, Situational, and Intrapersonal Observations to Assess during Individual Assessment

---

NAME: _____ BIRTHDATE: _____

GRADE: _____ CHRONOLOGICAL AGE: _____

SCHOOL: _____

DATES(S) OF TESTING: _____

DATE OF REPORT: _____

EXAMINER: _____

TEST(S) ADMINISTERED: _____

Instructions: Place an "X" on the appropriate line for each scale.

I. Descriptive Observations

A. Behavior or Physical Reactions during Test Session or Performance

1. Well-groomed	_ _ _ _ _ _ _	Disheveled
2. Age-appropriate Dress	_ _ _ _ _ _ _	Inappropriate-aged dressed

B. Behavior or Physical Reactions during Test Session or Performance

1. Normal Activity Level	_ _ _ _ _ _ _	Hyperactive
2. Appropriate Affects	_ _ _ _ _ _ _	Depressed/Excitable
3. Initiates Activity	_ _ _ _ _ _ _	Waits to Be Told
4. Relaxed	_ _ _ _ _ _ _	Overtly Anxious

C. Speech and Language

1. Age-appropriate Language Expression	_ _ _ _ _ _ _	Inappropriate-aged Language Expression
2. Age-appropriate Articulation	_ _ _ _ _ _ _	Inappropriate-aged Articulation
3. Age-appropriate Inflection	_ _ _ _ _ _ _	Inappropriate-aged Inflection

4.	Age-appropriate Language Quality	_ _ _ _ _ _ _	Inappropriate-aged Quality
5.	Quiet Volume	_ _ _ _ _ _ _	Loud Volume
6.	Spontaneous Conversation	_ _ _ _ _ _ _	Speaks Only When Spoken To
7.	Reality-Oriented Language	_ _ _ _ _ _ _	Bizarre Language

II. Interpersonal Observations

A. Attitude toward Examiner

1.	Cooperative	_ _ _ _ _ _ _	Uncooperative
2.	Passive	_ _ _ _ _ _ _	Aggressive
3.	Friendly	_ _ _ _ _ _ _	Unfriendly
4.	Trusting	_ _ _ _ _ _ _	Untrusting

B. Reaction to Examiner Style/Comments

1.	Comfortable in Examiner's Company	_ _ _ _ _ _ _	Ill at Ease
2.	Needs Little Praise and Encouragement	_ _ _ _ _ _ _	Needs Constant Praise and Encouragement
3.	Accepts Praise Gracefully	_ _ _ _ _ _ _	Accepts Praise Awkwardly
4.	Works Harder after Praise	_ _ _ _ _ _ _	Decreases Efforts after Praise
5.	Responds Directly to Examiner	_ _ _ _ _ _ _	Responds Vaguely to Examiner
6.	Responds Quicly to Examiner	_ _ _ _ _ _ _	Responds Only after Urged

III. Situational, Test-Related Observations

A. Reaction to Test Situation

1.	Absorbed by Tasks	_ _ _ _ _ _ _	Easily Distracted
2.	Persists until Finished	_ _ _ _ _ _ _	Gives Up Easily
3.	Not Aware of Failure	_ _ _ _ _ _ _	Aware of Success/Fairlure
4.	Works Harder after Success/Failure	_ _ _ _ _ _ _	Gives Up Easily after Success/Failure

5. Does Not Accept Failure Easily	_ _ _ _ _ _ _	Accepts Failure Easily

B. Problem Solving Behavior/Work Style

1. Fast	_ _ _ _ _ _ _	Slow
2. Deliberate	_ _ _ _ _ _ _	Impulsive
3. Thinks Verbally	_ _ _ _ _ _ _	Thinks Silently
4. Coordinated	_ _ _ _ _ _ _	Clumsy
5. Careful	_ _ _ _ _ _ _	Careless
6. Motivated	_ _ _ _ _ _ _	Not Motivated
7. Persistent	_ _ _ _ _ _ _	Perseverates
8. Eager to Continue	_ _ _ _ _ _ _	Avoids New Tasks
9. Challenged by Hard Tasks	_ _ _ _ _ _ _	Prefers Only Easy Tasks

IV. Intrapersonal Observations

A. Attitude toward Self

1. Confident	_ _ _ _ _ _ _	Shy, Reserved, Not Confident
2. Realistic	_ _ _ _ _ _ _	Unrealistic (either over-or underrealistic)
3. Self-Assured about Abilities	_ _ _ _ _ _ _	Unsure of Abilities
4. Accepts Abilities and Disabilities	_ _ _ _ _ _ _	Critical of Abilities and Disabilities
5. Able to Reinforce/Encourage Him/Herself	_ _ _ _ _ _ _	Self-Deprecating

Outline of the Test Results and Interpretation Section of the Personality Assessment Report

I. Cognitive Functioning
   A. Strengths and weaknesses
   B. Relationship to personality or behaviorally based referral problem and identified issues
   C. Assessment of reality testing or coherence of thinking

II. Academic Achievement
   A. Test results vs. Classroom achievement grades
   B. Relationship to personality referral and identified issues

III. Vocation Skills
   A. Strenghts and weaknesses
   B. Relationship to personality referral and identified issues

IV. Adaptive and Community Behavior
   A. Strengths and weaknesses
   B. Relationship to personality referral and identified issues

V. Individual Talents
   A. Description and analysis
   B. Relationship to personality referral and identified issues

VI. Personality/Ecosystem Issues
   A. Issues approach (these topics may organize this subsection; as adapted from Tallent, 1976)
      Aggressiveness
      Antisocial Tendencies
      Anxieties
      Attitudes
      Aversions
      Awarenesses
      Background/Socioeconomic Factors
      Cognitive Style/Locus of Control
      Competence and Perceptions of Competence
      Conflicts
      Content of Consciousness
      Defenses
      Deficits
      Developmental Factors
      Drives
      Emotional Controls and Situational Reactivity Fixations
      Flexibility
      Frustrations
      Goals
      Hostility
      Identity

Intellectual Controls
Interests
Interpersonal Relations and Skills
Needs
Outlook and Optimism
Perception of Self, Others, Environment
Personal and Social Consequences of Behavior
Psychopathology or DSM-III Classification
Rehabilitation Potential, Need, and Prospects
Sexual Role, Identity, Behavior, and Desire
Significant Others (peers, family, adults)
Social Role, Structure, and Identity
Subjective Emotional/Affective States
Symptoms-Physiological and Psychological
Value System and Perspective

B. Perceptions Approach
Perception of: Self
Peers
Family
School
Community
Past
Present
Future
Others

The Report's Contents were reproduced from The Assessment of Child and Adolescent Personality. Edited by Howard M. Knoff: pp. 550-559).

Goal 2: The Report's Contents

The personality assessment report goes far beyond a discussion of the initial referral concerns; it provides an in-depth analysis of the intrapersonal and interpersonal issues and circumstances which cause, support, or maintain the identified and related referral behaviors and/or affects. While there is no style, content, or format that has been empirically identified as "the best" approach to report writing, the literature in this area can be summarized to create a composite or prototypical report (see Sattler, 1982; Shellenberger, 1982; Tallent, 1976; Teglasi, 1983).

Report Heading. As noted above, the top of any psychological report should bear a conspicuous heading: "Confidential--Not to be Reviewed Without a Mental Health Practitioner Present." Below that, generally in block or outline form, are the identifying data on the referred child. This may include the child's name, birthdate, chronological age, address, phone number, parents, school, grade, and some assessment-related data such as date(s) of testing, date of report, and the examiner(s), his or her degree, title, and certification/licensure status. Other important information might include the dates of previous evaluation (especially if done in the same agency of school district) and the presence of any cultural, handicapping, or medical conditions (e.g., English as a second language, hearing impaired, Down's syndrome involved).

Tests Administered/Assessment Procedures. Here, the practitioner should list the tests administered during formal assessment with the referred child, behavior rating scales, or other information sources (e.g., checklists, adaptive behavior scales) completed with someone other than the referred child, and relevant conferences, interviews, or reviews of past records (including psychological interviews with the child, parents, and/or family). The names of all formal assessment tools should be written out in full with abbreviations in parentheses and any copyright dates, forms, or special scoring systems used. For example, a Rorschach evaluation could be listed as "Rorschach (Exner Comprehensive Scoring System)."

Reason for Referral. This section documents the initial reasons that triggered the referral to the practitioner or agency, and the assessment goals identified during the problem identification stage. If, for example, the child's parents and another referral source disagree on some of the referral reasons, this could be discussed in this section and the different concerns outlined separately.

Background Information. After the practitioner has thoroughly reviewed all the background data (previous assessments, reports, observations, clinical and conference notes, psychological, educational, medical, developmental, and social histories and impressions) and completed the necessary interviews or conferences (e.g., with the agency or child study team, parents, child, and family, and specialized professionals--doctors, teachers, therapists), he or she must clearly and concisely integrate this

material into the report. Governed by the assessment goals and the report's consumers, the practitioner includes only that information relevant to an understanding of the referral behaviors, environments, and/or ecology, and to a generation of intervention recommendations and plans. Thus, there is no standard length or format of the Background Information section. It should be as long or as short as is necessary to provide a context to the referral, the assessments chosen, and the comprehensive analyses and conclusions. This context may include previous disagreements about the child's behavior, therapeutic progress, or treatment plans, as well as descriptions of the child's strengths and weaknesses. Finally, a good Background section can summarize pertinent information, thereby making an extensive review at the feedback conference less necessary, and it can be used later to set the tone of the report, providing an introduction for comparison or clarification.

Assessment Observations. During the personality assessment process, the practitioner generally can observe the referred child in three separate ways: in a common or typical environment known to the child using formal behavior observation techniques (e.g., at home or in the classroom); during the individual assessment process where the practitioner and child are engaged in a one-on-one interaction; and/or during other assessment procedures where the practitioner-child interactions are more unplanned and open-ended (e.g., individual or family interviews, play interviews, informal conversations). Regardless of the format, all observations are samples of specific behavioral reactions and interactions at specific points in time. The practitioner must look for a generalized picture of the child's behavior based on a cross section of all observations and reports of observations. Deviant or atypical behavior should be noted if it is consistently present across many or all observed environments and situations, or if it recurs predictably in one type of environment or situation.

Previous chapters have comprehensively discussed naturalistic, *in situ*, contrived, and uncontrived observation formats and analyses (see the following chapters in this volume: Garbarino & Kapadia, Chapter 13; Ivey & Nuttall, Chapter 4; Keller, Chapter 11). Observations during individual assessment sessions will be described here.

As with any observation format, the amount of accurate, diagnostic information will be dependent on the practitioner's training, skill, and experience. The individual one-on-one assessment session does not lend itself to structured frequency or time-sampling approaches; securing the child's responses to the chosen test or technique (e.g., an IQ test, an Incomplete Sentence Blank) is the primary goal. Observational data, then, often are based on significant events or behaviors that occur during testing which are recalled by the practitioner either through clinical notes taken during the session or by memory or impression after the session. The observed behaviors and recollections eventually become diagnostic hypotheses which are compared with referral information, data from other observation formats, and other hypotheses to form a broader picture of the referred child.

To date, there is no empirically sound observation system available for completion by the practitioner during or immediately after the individual assessment session; nor are there procedures to control the potential bias when data (observed or recalled) are generalized into diagnostic hypotheses (Fogel & Nelson, 1983). Thus, the following recommendations are suggested: practitioners (a) should recognize that individual assessment observations

are based on a relatively narrow, artificial situation and may not represent the child's behavior in "real-life" situations; (b) should emphasize observed and documented behavior over recollections or inferences; (c) should utilize observers behind one-way mirrors (if available) and determine interrater reliabilities for observations and interpretations; (d) should receive supervision in this area when their training, skill, or experience is limited; and (e) should evaluate all data within the context of the entire situation or environment by considering consistencies across the entire assessment process, discounting inconsistencies that may be situation-specific and "chance fluctuations."

During the individual assessment session(s), the practitioner can complete four broad categories of observations: descriptive, interpersonal, situational, and intrapersonal. Descriptive observations focus on the referred child's physical or developmental characteristics (appearance, speech quality vocabulary level, overt nervousness or physical reactions). Interpersonal observations involve the child's behaviors and attitudes toward the practitioner (spontaneous conversation, cooperation, overt anger, level of acceptance and trust). Situational observations analyze the child's attitudes and reactions to the test situation based primarily on the test materials and demands (work style and tempo, reaction to materials, reaction to failure or praise). Finally, interpersonal observations evaluate the referred child's observed attitude toward him- or herself (self-depreciating statements, self-confidence and poise). Naturally, these categories overlap and are interdependent. Nonetheless, they represent one way to systematically organize assessment observations more meaningfully. These categories are expanded in Table 15-1 which provides a quantitative approach toward observation and diagnostic inference (adapted from Sattler, 1982).

When the Assessment Observations section is written in the personality assessment report, the practitioner must specify the number of observations; who, where, and under what conditions the observations were made; and their relationships to the referral problem or situation (Teglasi, 1983). Only reliable observations should be included in the report, and these observations should be necessary to a later discussion in the report which crystallizes a major assessment result or conclusion; that is, random or isolated observations should not be reported; the observations reported should relate to the clear, organized analysis and understanding of the child or situation. Finally, the individual assessment observations should provide a statement on the validity of the individual assessment results. When the child's test behaviors or attitudes are inappropriate and interfere with the assessment process, the practitioner should report this, discuss the validity of the present results, and comment on the diagnostic importance of the inappropriate behavior. The practitioner should never be afraid to invalidate a child's assessment results because of poor rapport, motivation, or participation. In fact, it is ethically necessary to do so.

Test Results and Interpretation. This section of the personality assessment report is generally the longest and certainly the most important. Conceptually, the practitioner should review the assessment goals agreed upon with the referring parties in this section as well as assessment goals which surfaced during the interview, observation, and assessment process. Pragmatically, the discussion should describe the child's and ecosystem's strengths and weaknesses along with potential other resources which may be applied during intervention(s). The data, analyses, and discussion should be clear and concise and should contribute directly to an understanding of the referred child and the referral environment and situation.

Most personality or behaviorally oriented referrals will ask related or additional questions which may involve other assessment domains: cognitive or intellectual functioning, academic aptitude and achievement, community and survival skill adaptive behavior and socialization, and vocational aspirations and capabilities. These assessment domains must be integrated into the Test Results and Interpretation section in a logical, organized fashion. Often, this integration involves discussions of domain-specific results and implications (e.g., the referred child's IQ and cognitive style), the referred child's relative strengths and weaknesses within that domain, and results which provide information or clarification of the personality-related referral or issues. A suggested breakdown of this section, integrating personality and other assessment domains, is outlined in Table 15-2.

Within the suggested breakdown for the Test Results and Interpretation section, the practitioner should strategically sue test data and descriptions of individual child responses and reactions. The practitioner, however, should avoid a blow-by-blow, test-by-test analysis in lieu of an integrated "case-focused" approach (Tallent, 1976). The practitioner's goal, to convey an understanding and analysis of the referral situation, should not become lost in a technical morass of numbers, norms, and scoring systems. These technical data should be used only to clarify and strengthen the discussion and the reader's understanding. The case-focused approach, therefore, discusses the pertinent assessment results, identified issues, and observed behaviors which support, cause, maintain, or interact with the referred child, situation, or environment. Thus, the Test Results and Interpretation section is best organized by specific case-related issues or analysis conclusions, not by the specific assessment procedures or techniques.

Currently, the practitioner must decide which procedures or techniques and which issues or conclusions to discuss and emphasize in the report. As yet, no pervasive decision-making (actuarial) model exists to guide the practitioner's analysis or report writing. The practitioner, however, should focus on data generated through the most reliable and valid assessment procedures and consider data and observations which are seen most consistently across numerous tests or techniques and observational or interview formats (Gresham, 1982; May, 1979). Ultimately, the practitioner must use the tests and data which best communicate his or her message; the data should be reported to describe and analyze the referral problem and to accomplish the assessment goals.

The part of the Test Results and Interpretation section that is devoted specifically to personality assessment and the personality or behavioral concerns of the referral can be approached in two ways: an issues approach and/or a perceptions approach. The issues approach clearly defines the specific issues which significantly relate to the referred child or situation, organizing the section's discussion with these issues. These issues may be descriptive (organized by a DSM-III classification with its specific symptoms), interpersonal (organized by specific conflicts with significant others), situational (organized by developmental or socio-economic factors), and/or intrapersonal (organized by the individual's needs, drives, perceptions, or behavioral reactions and tendencies). All assessment data and results are integrated into the issue-oriented discussion; there is no need to include data to explain or rationalize an issue's presence unless those data strengthen or clarify the reader's understanding.

The perceptions approach is testimony to the fact that the practitioner often reports the referred child's perceptions of him- or herself and significant others, and not necessarily the reality of these persons or the referral situation. Sometimes the practitioner will find a marked discrepancy between the referred child's perceptions and those of significant others interviewed or observed during data collection. At other times, neither the child's nor significant others' perceptions are congruent with the practitioner's view of the situation or environment. These incongruences are significant, should be documented, and may constitute major issues underlying the referral. Further, successful intervention will be very difficult if all referring parties and significant others cannot understand the child's and each other's perspectives, regardless of their feelings of their accuracy. To this end, the perceptions approach in the psychological report describes the referred child's perceptions of self, peers, family, school, community, past, present, future, and other significant areas. Again, this discussion is based on all the data collection procedures and individual assessments and techniques. The discussion outlines and describes these areas using specific techniques, data, and results only when greater clarity and understanding are needed.

To summarize, the Test Results and Interpretation section is written to describe, analyze, and discuss the significant strengths and weaknesses of the referred child; the characteristics, dynamics, and resources intrapersonally, interpersonally, and situationally within the child, significant others, and the specific ecosystem; and the issues and/or variables which support, cause, maintain, or otherwise interact with the referred child, situation, or environment. This section provides much of the foundation for the recommendations which follow and for the intervention plan discussed during feedback conference.

Summary and Recommendations. The summary often is the most read section of the psychological report; thus, it should be carefully written to emphasize the major aspects of the report. The summary should review the referral concerns and assessment goals which prompted the evaluation and any additional concerns which surfaced during or from parts of the assessment process. The major issues and conclusions discussed in the Test Results and Interpretation section should be reemphasized, especially noting their importance to and clarification of the referral and additional related concerns. No new diagnostic data or impressions are discussed in this section. The summary section is an organized, integrated paragraph or two which encapsulates the entire assessment process and findings.

The recommendations presented in the personality assessment report should be tailored to previous intervention and remedial attempts, the resources and organizational constraints of the intervention settings or environments, and the commitment and ability of the referring parties or significant others to implement them. The practitioner, while collecting background data and impressions, should have identified all previous successful and unsuccessful interventions attempted with the referred child and analyzed the variables and characteristics that made them successful or not. Obviously, the practitioner in the personality assessment report is not going to recommend an intervention that has previously failed unless he or she can demonstrate why it failed, why it will not fail again, and/or how it can be adapted so that it will now succeed.

During the data collection, the practitioner also should have analyzed any possible intervention sites (home, school, community mental health services) to assess the presence of resources (personal, financial, material, organizational) which will be necessary to the recommended program(s). Recommendations must be specific and realistic. The absence of any necessary resources diminishes the changes that the recommendation will be attempted and erodes confidence in the assessment report and the potential for successful change. This lowered confidence level will also occur when recommendations call for skills that the referred child or significant others do not have, may not be able to learn, or will not learn due to poor commitment and cooperation.

When writing recommendations into the personality assessment report, the practitioner should aim for clarity, specificity, and flexibility. If possible, the recommendations should clearly relate to an issue, dynamic, and situation presented earlier in the report. Recommendations should be specific enough that an intervention program can be developed from the report (or its references) and accurately contain the necessary "therapeutic" components, yet flexible enough to provide those implementing the program room to integrate their own styles and personal approaches (Sattler, 1982; Shellenberger, 1982; Teglasi, 1983).

There are times when it may be advantageous <u>not</u> to include recommendations in the personality assessment report until after the feedback conference: when the practitioner is uncomfortable with the commitment of the referred child or significant others or is pessimistic about the potential agreement and cooperation of two separate referring parties (home vs. school); when a comprehensive investigation of previous interventions and ecosystem resources was impossible to accomplish; when the practitioner wants the conference participants to generate ideas with his or her facilitation (as a strategic technique); and when social service or other agencies who have significant (financial and other) control over the final intervention program will be presented and have not yet met with the practitioner. In these cases, the practitioner should write a statement in the psychological report noting the reasons for withholding specific recommendations and should write a formal recommendations section after the conference as an addendum to the personality assessment report.

The recommendations sections of the report may differ based on where the practitioner is employed and to whom his or her responsibilities are allied. The private or community-based practitioner may provide individual <u>and</u> joint recommendations for the community agency, school, and parents, depending on the referral source, those participating during the assessment process, the referred child's age, and where the remedial services are needed or will be delivered from. If, for example, this practitioner is working as an independent evaluator, separate recommendations specific to the home and school or agency participants, respectively, and joint recommendations to be considered by both parties cooperatively may be best--therapeutically, organizationally, and ethically. Similarly, the school practitioner also may provide individual and joint recommendations to home and school individuals, but the school recommendations probably will better reflect the school's resources and organizational dynamics due to the practitioner's "insider" role. Finally, it must be recognized that the school practitioner often is the first to recommend a community-based agency or private practitioner as an intervention component. Thus, at times, the recommendation section may need to be individualized for the private practitioner who will receive the personality assessment report.

When addended recommendations are necessary, both types of practitioners, when they are fully cognizant of the available resources and the personal commitment and abilities of the referring (or participating) parties to change the referral situation or environment, may ultimately write them in one of three ways: (a) to reflect the actual intervention programs agreed upon by the conference participants and the specific referral concerns and issues that they will address; (b) to reflect the ideal intervention programs necessary for the referral situation, knowing that the conference participants are not psychologically or developmentally ready to provide or commit to these programs or that there are insufficient resources to support these programs; or (c) to reflect the agreed-upon intervention programs and how they may be adapted or extended to approximate the ideal intervention programs considered necessary by the practitioner.

To summarize, the report summary reviews the major aspects of the assessment process: the assessment goals, analyses, and conclusions. The recommendations provide individually tailored interventions which are integrated into a comprehensive plan. The recommendations will reflect and be individualized given the practitioner's employment setting (community/agency or school), the referring parties (parents, agency, or school officials), and the age and circumstances of the referred child or adolescent.

HANDOUT #20

Behavioral and Personality Assessment Instruments
(Behavioral Chicklist and Rating Scales)

1. Behavior Evaluation Scale

2. Behavior Rating Profile - An Ecological Approach to Behavior Assessment

3. Bristol Social Adjustment Guides - 1970 edition

4. Burks Behavior Rating Scales
   - Pre-school and Kindergarten
   - Grades 1-6

5. Child Behavior Checklist and Child Behavior Profile

6. Child Behavior Rating Scale

7. Conners Teacher Rating Scales

8. Conners Parent Rating Scale

9. Devereaux Child Behavior Rating Scale (Ages 8-12)
   Devereaux Elementary School Behavior Rating Scale (K-6)
   Devereaux Adolescent Behavior Rating Scale

10. Hahnemann Elementary School Behavior Rating Scale
    Hahnemann High School Behavior Rating Scale

11. Jesness Behavior Checklist (ages 13-20)

12. Revised Behavior Problem Checklist (1983) - Quay

13. Stress Response Scale

14. School Behavior Checklist - Miller

15. Test of Early Socioemotional Development

16. Walker Problem Behavior Identification Checklist

Instrument: The Behavior Evaluation Scale (BES), 1983

Developer: Stephen B. McCarney, James E. Leigh, and Jane A. Cornbelt

Available: Pro-Ed
5341 Industrial Oaks Blvd.
Austin, Texas 78735

Intent: For use with students from K-12 grades to assist school personnel in making decisions about eligibility, placement, and programming for any student with behavior problems who has been referred for evaluation.

Items: The 52 items appear objectively phrased with few inferences needed except in determining the degree to which the behavior is observed. Face validity of the items is related directly to the learning environment and appear applicable to all grade levels. Little is known of the item source. Content, criterion-related, diagnostic and construct validation studies are strongly supported as indicated by the data in the manual. The BES was standardized on 1,018 students from grades K-12. The sample closely approximates the distribution within the United States.

Format: The scale's 42 items are located in a convenient protocol with a cover sheet profile. The items appear overt in quality with few inferential phrasings of the items. The rater is directed to respond to each item through referring to a 7 statement continuum which describes the item's frequence of occurrence. The continuum appears most innovative in comparison with other checklists. The degrees related on the continuum range from "Less than once a month to continuously throughout the day." The items are clustered into five major characteristics or subscales, with value weightings attached to each item. The subscales are then converted into standard scores and plotted on the cover's profile.

Reliability: Both internal consistency and test-retest reliability data are provided, with coefficients exceeding .90.

Utility: This instrument was not compared to other instruments contained in this manuscript. It is a new 1983 rating scale that appears to have much validity and possible high utility. This is an instrument that needs to be more thoroughly examined and experimented with by this writer. It was included in this review section due to its striking design, but with limited perusal for endorsement. More information on this instrument can be obtained through writing to: Behavior Evaluation Scale; Educational Services; P.O. Box 1835; Columbia, MO 65205.

Instrument: Behavior Rating Profile: An Ecological Approach to Behavioral Assessment

Developers: Linda Brown and Donald Hammill

Available: Pro-Ed
333 Perry Brooks Building
Austin, Texas 78701

Intent: Grades 1-7. Designed to examine children's behavior in a variety of settings; home, school, peers and self. It appears descriptive in use and useful in documenting behavior to pertinent settings.

Items: The author selected items submitted from parents and teachers of behaviorally disordered students. The refining rating scales were standardized on 1,326 students by 645 teachers and 847 parents throughout eleven states including Iowa (9 percent of sample). The items appear to have statistically significant coefficients at all age levels.

Format: The BRP contains six independent components; five checklists and one sociometric device. Three of the checklists are student rating scales which are completed by students themselves. It further contains a home scale, a school scale and a peer scale. Each component can be employed independently. A composite profile is provided and is measured in scaled score. The Teacher and Parent Rating Scales contain a list of 30 descriptive words and phrases. The rater responds to each item on a continuum of four degrees from "Very much like..." to "Not at all like..." Much inference is required when responding. The items also refer to the practice of discipline used; i.e., sent to the principal, kept in from recess, is kept after school. The Sociogram component consists of a peer nominating technique.

Reliability: Considerable reliability was obtained through internal consistency studies.

Utility: A most unique behavioral assessment battery, mainly due to the ecological approach. This does provide a broader sampling of the student's behavior. The directions are straightforward. The manual demonstrates the impressive construction components of the scales. Of concern would be the varying degrees of inference responding required and the rationale for including discipline measures. These instruments would not appear to be as beneficial as others in providing overt descriptive behavior documentation.

Instrument: Bristol Social Adjustment Guides, 1970 edition

Developers: D. H. Scott and N. C. Marston

Available: Educational and Industrial Testing Services
San Diego, California 92107

Intent: The object of the guide is to give a descriptive picture of the student's behavior and to help in the detection of emotional instability (manual). The guides are intended for use with children aged 5-16 years within a school setting.

Items: The descriptive phrases have been selected from teacher expression. Their descriptions were supplemented by systematic observation within the classroom by trained observers. "It therefore can be claimed with reasonable confidence that the School editions of the BSAG is capable of detecting all the manifestations of maladjustment...that are likely to be encountered by a teacher" (manual). The authors claim to have designed an instrument free from cliche, free from interpretation, observable rather than inference base. Possible consumers need definitely to review these item descriptions prior to endorsing the instrument. Some of the phrases are outright entertaining; they sound as if they came right out of a busybody teacher lounge (e.g., "cannot bring herself to be sociable," "too lacking in energy to bother," "will answer except in one of his bad moods"). A significant number of items assume motives on part of the exhibited behavior (e.g., "spiteful to weaker children when he thinks he is unobserved," "uses bad language which she knows will be disapproved of," "lies from timidity"). Several words need updating, such as: "has fits" and "lies with compunction."

Format: The descriptive phrases are arranged in paragraphs that modify defined situations. The teacher is instructed to underline ("no need to rule") those phrases which apply to the child being assessed. The BSAG is in no sense a forced choice checklist or a rating scale. After the rater has completed the paragraphs, a transparent template is fitted over each of the three pages of the schedule. This designates a pair of code letters and a numeral to each of the items. These scores then relate to the five "core syndromes and associated groupings." The core syndromes are based on the theoretical framework of Under-reaction (UNRACT) and Over-reaction (OVRACT).

Validity: The instrument was normed on 2,527 children born on the 15th or 16th of any month and in age from 5-14. Of these children, 133 had been involved with the police. Their scores correlated to the BSAG syndrome called "Hostility."

This instrument appears extremely lacking in validity studies.

Reliability: Studies reported from .48 to .77 coefficients for internal reliability as calculated by Winer's formula. Test-retest reliability were not statistically significant.

Utility: There are better instruments available.

Instrument: Burk's Behavior Rating Scales

Developer: Harold F. Burks, Ph.D.

Available: The Arden Press
8331 Alvarado Drive
Hunington Beach, CA 92646

Intent: The BBRS is specifically designed to identify patterns of pathological behavior shown by children grades 1-6. They attempt to gauge the severity of certain negative symptoms as seen by outside observers.

Items: The 116 items comprising the scale were selected after they had been used to evaluate over 2,000 children by 22 school psychologists. The items were judged as valid and useful by these psychologists and over 200 teachers in all kinds of disability classrooms. The items were selected from clinical studies and literature. Of concern is the degree of inference required for the rater's basis of responding. Many of the items are of a clinical nature. Comparison of scores to intelligence indicates no consociation exists. Apparent statistical significance of correlation exists in item content and construct validity. Patterns of typical traits are detailed through factor analysis revealing "Immature," "Hostile Aggressive," and "Neurotic" behavior patterns. The manual is of great assistance for interpretation.

Format: The items are assessed through agreement with descriptive statements and require the rater to assign a 1-5 numerical value. The scores are conveniently clustered into categories of related behaviors. Once tallied, the cluster scores are plotted on a profile indicating each cluster's signficance or nonsignificance. The profile provides a graphic illustration of the student's behavior.

Reliability: Correlation coefficients were established on test-retest reliability on 95 disturbed children in grades 1-6. Reliability appears high with a median coefficient score of .64.

Utility: This instrument appears well constructed, normed and validated. The behavior descriptors would be of high utility in communicating student behavior. The three patterns of behavior (factor analyzed) would be of use in documenting the 1983 BD cluster definition. The disadvantage of the scale would be the phrasing of the items and the tendency of the rater to attach labels through the interpretation of the profile. The manual is well designed and of benefit for intervention suggestions and for interpreting the scored profile.

Instrument: The Child Behavior Checklist and Child Behavior Profile (1981)

Developer: Thomas M. Achenbach, Ph.D.

Available: Thomas M. Achenbach, Ph.D.
Laboratory of Developmental Psychology
Bldg. 15 K. National Institute of Mental Health
9000 Rockville Pike
Bethesda, MD 20205

Intent: The CBC is designed to record in a standardized format the behavioral problems and competencies of children aged 4 through 16.

Items: The behavior problem items on the CBCL (parent) were selected from parent reports of children who had been referred for mental health services. The scales are derived separately for each age range and sex. Validation studies were completed on randomly selected parents of nonreferred children and reviews of comparability on ten other studies of empirically derived syndromes. Results indicate a statistically significant correlation of normal versus clinical samples. The CBC (teacher's edition) omitted items, teachers could not readily judge, but inclusion of items relating to classroom and achievement behavior were added. Validation studies by classroom teachers does not appear evident. Predictive validity studies indicated profiles replicated well across large samples of 12-16 year old disturbed boys.

Format: The instrument consists of three rating forms: Teacher's Report Form, Child Behavior Checklist (for parent ratings), and a Direct Observation Form (DOF) designed for recording observations of student's behavior noting on-task behavior in five second intervals. The checklist (TRF & CBC) consist of 112 items that describe pupils. The rater is instructed to circle the "2" if the item is very true or often true about the pupil or circle the "1" if the item is somewhat or sometimes true. The items are essentially overt but select items require inference based decisions prior to rating. The responses are scored on the social competence and behavior problem scales of the Child Behavior Profile. Separate editions of the profile have been standardized for each sex at ages 4-5, 6-11 and 12-16 years. The profile can be scored using either a computer program or by hand. In scoring by hand, templates are available that are placed over the forms and enable the scorer to cluster behavior

patterns. Patterns are plotted on profiles for interpretation.

Reliability: Reliability of the instrument was attempted in a variety of approaches. As a measure of test-retest reliability, mothers of normal children were asked to respond to the CBCL at intervals of about one week. Satisfactory stability was obtained veraging a .87 correlation coefficient. Interparent reliability was reported as .68 agreement. Six month follow-up of clinic children remained slightly stable at .72. The use of classroom instructors for reliability of the teacher rating scales was not part of the reliability studies.

Utility: Due to the construction design, this instrument would appear to be quite promising. The developer is encouraged to determine reliability and validity of its teacher rating scale, prior to endorsing its use as part of the school identification assessment. It appears to have high utility in comparing school referred students with clinically diagnosed youngsters.

Instrument: Child Behavior Rating Scale (BRS)

Developer: Russell N. Cassel, Ed.D.

Available: Western Psychological Services
Publishers and Distributers
12031 Wilshire Boulevard
Los Angeles, California 90025

Intent: This scale is designed to assess the personality assessment of K-3 graders who do not have sufficient reading skill to complete the group type psychological tests. The scale reports objective measurement of children in five adjustment areas.

Items: The 78 items were obtained through screening of 1,000 case studies of elementary school students referred for psychological or psychiatric services. Items were selected for their frequency of occurrence. Face validity is consequently assessed. Comparative validity was obtained when relating scores to achievement, intelligence and social development. The correlation showed highly signficant coefficients. Status and predictive studies were statistically significant.

Format: The CBRS consists of the manual and the rating booklet. Teachers familiar with the student are instructed to indicate the presence, absence or degree in between of 78 behavioral statements. Raw scores are converted into weighted scores. The weighted scores are changed into T scores through the use of a table in the manual. These T scores are then compared to scores obtained by typical children and diagnosed maladjusted children and plotted on the profile for interpretation. The results do require a deal of interpretive skill.

Reliability: Split Half reliablity studies were undertaken from the instrument, indicating a mean .873 correlation using the Spearman-Brown formula. Test-retest reliability indicates a high test consistency. Raters were teachers and parents.

Utility: Supportive documentation, particularly the predictive validity studies, appear well constructed. The instrument items will pose difficulties to teachers, especially the Home Adjustment category. Much inference is necessary in basing decisions for the responses. Scoring and interpreting the results hinder the utility of this instrument. The five adjustment scales are not factor analyzed nor seem to be helpful in grouping behavior concerns. The CBRS could be viewed as having moderate utility in grades K-3.

Instrument: Conners' Teacher Rating Scale-Revised

Developer: C. Keith Conners
Harvard Medical School

Intent: To be used as an instrument in differentiating hyperactive children from normal children.

Items: 28 items. The items were refined from clinical records of diagnosed "hyperactive" children. Responding requires little inference; the statements are observably overt.

Format: Rating scale of 28 items. Teacher is to indicate on a 4-category scale, the degree of the problem exhibited by the student. The rating categories are: Not at all, Just a little, Pretty much, Very much.

Validity: Extensive research has provided some validational evidence in defining hyperactive children from normal children. (Wallander & Conger, 1981; Whalen & Henker, 1976).

Reliability: Research on reliability has been minimal. Test-retest method revealed correlation factor of .72-.91. Interrater reliability results varied markedly (.31-.92). "Clearly there is a need for more extensive investigation of stability and reliability" (Conger, et al., 1983).

Utility: Limited to hyperactivity.

Instrument: Conners Parent Rating Scales (1982)

Developer: C. Keith Conners
Harvard Medical School

Description: The test is based on a listing of behavior problems compiled by Cytryn, Gilbert, and Eisenberg (1960). Five factors now comprise this new, shortened version of the original Parent Rating Scale (1969, 1973), which contained eight major factors for 683 children between 6 and 14. The shortened version was devised to simplify scoring and interpretation. It takes approximately 15 minutes to administer this scale.

Format: This 48-item instrument assesses five factors: Conduct Problems, Learning Problems, Psycho-somatic Problems, Impulsivity-Hyperativity, and Anxiety. The items lend themselves to screening for other specific child behavior problems. The test has been useful in assessing drug-induced treatments of hyperactive children (Sprague ~ Sleater, 1973).

Scoring/Interpretation: Each item is answered "Not at All," "Just a Little," "Pretty Much,"or "Very Much." The number of points assigned to each answer is 0., 1, 2, or 3, respectively. Scores are obtained by adding raw scores on different factors; means for each factor are obtained and tran. formed into T scores. A T score of 70 is used as a cutoff score for identifying significant behavior problems.

Norms: Normative data were obtained from parents of 750 children in Pittsburgh, Pennsylvania. The parents' names were selected from a telephone book, and the parents were asked to complete a questionnaire for each child between 3 and 17. the average age of the children was 9.9, but the number of children sampled at each age is not given. 55% were males and 45% were females. 98% of the sample was white. 1% was black, and 1% other.

Validity: Different factor structures have been found to have different validity.

Convergent (with Quay-Peterson Behavior Problem Checklist); Good validity. Hyperactivity has also been found to correlate significantly with the Werry-Weiss-Peters Activity Rating Scale; however, the hyperactivity measure can be useable across time, and does not correlate with objective measures of activity. Boys are assigned more pathological symptoms that girls. Mothers rate more harshly than fathers.

Reliability: Item-Total correlation: Ranging from r=.13 to r=.65.

Between Mother and Father: Stable reliability.

Between Teacher and Parent: Adequate, not as good as mother and father.

Test-Retest: Adequate, but it varies among the different factors, different ages, and different versions of the PRS.

Instrument: Devereux Elementary School Behavior Rating Scale (DESB, grades K-6)
Devereux Child Behavior Rating Scale (DCB, ages 8-12)
Devereux Adolescent Behavior Rating Scale (DAB, ages 13-18)

Developer: George Spivack, Ph.D.; Marshall Swift, Ph.D.; Jules Spotts, Ph.D.

Available: Devereux Foundations Press
Devon, Pennsylvania

Intent: These rating scales were designed to assist teachers and support team members concerned with educational behavior problems to focus upon behavioral difficulties which interfere with successful academic performances. The scales describe and communicate overt behavior symptoms which help define profiles of behavior dimensions.

Items: The DESB's 47 items were defined from within the framework of normal and special class programs. Normative data is available. The items appear pertinent to both adaptive and maladaptive behavior as related to achievement. Obtained scores were compared to age, IQ and achievement. Each of the eleven factors has been shown to have statistical significant validity.

Format: The rating scales are conveniently arranged on foldout questionnaires with the back page providing an interpretive profile. Each item requires a numerical response from continuums of agreement. The continuums vary in each section and may confuse the raters. The protocol enable the scorer to convert raw scores into factor clusters and consequently plotted in standard scores on a profile without guides or templates.

Reliability: Test-retest reliability estimates were recorded for the DESB, DAB, and the DCB. All factors were reported as statistically signficant. The DCB reported interscorer reliability to have a median coefficient of .83.

Utility: Of the three scales, the DESB seems to have the highest utility in the diagnosis of school related behavior disorders due to its total development on the school population. The aspect of providing adaptive behavior is beneficial in reporting student strengths as well as the deficits of behavior. The manuals of all three scales are highly descriptive of the behavioral dimensions reported on the profiles but are inadequate in reporting supportive documentation. The DAB does correlate between typical students and diagnosed adolescents. The reported behavior concerns of the DESB are helpful in initially planning for behavioral interventions.

Instrument: Hahnemann Elementary School Behavior Rating Scale (HESB), 1975
Hahnemann High School Behavior Rating Scale (HHSB), 1975

Developers: George Spivack, Ph.D. and Marshall Swift, Ph.D.

Available: George Spivack and Marshall Swift
Hahnemann Community Mental Health/Mental Retardation Center
Department of Mental Health Sciences
Hahnemann Medical College and Hospital
Philadelphia, PA 19102

Intent: Both scales were created to provide a standard system for identifying and measuring classroom behaviors of students in both regular and special education classrooms. The focus is upon behaviors which interfere with the student's level of ability to cope with academic expectations.

Items: The 54 items were derived from a careful analysis of literature and classroom teacher discussions, relating behavior interference to achievement in school. Approximately 200 teachers were involved in the refining process. The items are factor analyzed into 14 behavior dimensions. Normative data is provided in the manual and is related to open classrooms and regular classrooms. Correlations with achievement and IQ were completed but not statistically significant.

Format: Each of the 14 behavior dimensions is defined by 3 or 4 behavioral items. These items are rated on continuums of severity. The results are grouped together on the profile sheet and plotted in standardized scores. Profile "types" are described in the manual and are most helpful for interpretation.

Reliability: Studies of reliability were either not undertaken or at least not available in perusal of the manual.

Utility: These scales appear to have high utility in comparing student adjustment in open environment classrooms versus traditional approaches. As they are totally constructed and refined on school populations, they appear relevant in the educational referral process. Of concern in the lack of reported studies of comparative correlations with either clinically diagnosed emotionally disabled population or the special education student. They appear to have high face validity. The profiles are conveniently constructed, with the items generally requiring little inference. These scales do not seem to be designed for differentiating behaviorally disordered students from typical classroom students, but those students who are not meeting standard achievement success in the regular and open classroom.

Instrument: Jesness Behavior Checklist (ages 13-20)

Developer: Carl F. Jesness, Ph.D., Senior Behavior Research Analyst at the Institute for the Study of Crime and Delinquency

Available: Consulting Psychologists Press, Inc.
577 College Avenue
Palo Alto, California 94306

Intent: The JBC is designed to provide a systematic way of recording data about social behavior and adjustment.

Items: Items were chosen by critical incident techniques extracted from behavioral descriptions of boy offenders in juvenile correctional institutions in California. No comparable validity studies were completed and teacher input was not sought. The items appear highly overt and descriptive. The normative samplings are inadequate.

Format: The Jesness has both an observer rating scale and a self appraisal inventory (SAI). The 80 items are rated on descriptive continuums located adjacent to the items. The scale can either be hand scored or computer scored. In hand scoring, templates are used which cluster the behavior for plotting on a graphic profile in T scores and percentile scores. The items are factor related to 14 dimensions. Subscales often appear inappropriately labelled, particularly the bipolar factors. Validity data on the present scales may be available now but were not in the 1977 manual.

Reliability: Test-retest reliabilities are not statistically significant. Inter-rater reliability correlations were reported from .36 to .57 on individual scales.

Utility: This checklist is still in the development stages. It would appear of moderate utility in correlating juvenile delinquent or Cluster I behaviors of the BD definitions.

Instrument: Revised Behavior Problem Checklist (1983)

Developers: Herbert C. Quay, Ph.D. and Donald R. Peterson, Ph D.

Available: Herbert C. Quay, Ph.D.
Box 248074
University of Miami
Coral Gables, Florida 33124
Phone: 305/284-5208

Intent: The original BPC had been applied in clinical and school settings for purposes of screening and assessment of students displaying behavior deviance. Extensive research studies have supported its use in selecting contrasting groups of students as they relate to different dimensions of behavior.

Items: The initial item pool was limited in scope consequently limiting the scale's reliability. The revised scale has an augmented item pool (89 items) and factor analysis reveals five major and two minor scales. The original item pool was derived from an analysis of presenting complaints of children seen in a child guidance center. The Revised BPC was expanded through factor analysis on samples in private schools, private psychiatric residential facilities and a community-sponsored school for children with developmental disabilities. Concurrent, predictive and construct validity was established at a statistically significant level.

Format: The rater is instructed to respond to each item, indicating if it does not constitute a problem/constitutes a mild problem/constitutes a severe problem. A scoring stencil is placed over the checklist to enable the clustering of behavior responses. Items are related.

Reliability: Supportive studies of internal consistency and inter-rater reliability document high correlation coefficients for each scale.

Utility: The RBPC has high utility as an aid in clinical diagnosis and in providing supportive documentation for BD eligibility. Moderate utility is viewed when intending to use this instrument as an aid in communication between teacher and support personnel.

Instrument: The Stress Response Scale for Children

Developer: Louis A Chandler

Available: Louis A. Chandler
606 Illini Drive
Monroeville, PA 15146

Intent: The Stress Response Scale was developed for use in clinics, schools, and community agencies as one measure of children's emotional status. It was designed primarily for elementary school-age children (in grades one through eight).

Format: The current edition of the scale has 40 descriptors assigned to item positions so that they can be rated on a six-point scale (0, never to 5, always). Since the scale is designed to be completed by the adult making the referral, items are worded so that they can be rated by parents or teachers. The Stress Response Scale was constructed from a model which describes the response styles commonly used by children under stress. The model predicts four patterns of behavior; these have been labeled as Dependent, Impulsive, Passive-Aggressive, and Repressed.

Validity: The manual presents information concerning construct validity, content validity, factoral validity, discrimiant validity, and criterion-related validity.

Reliability: Initial reliability was found to be good with children in regular education classes (n=45) using teachers as raters, and a test-retest interval of two weeks 80.7 mean percent of agreement across all items). A reliability study with the current version of the scale shows good results (rs = .86) with a similar population (n = 25) in a test-retest procedure using a one-month interval. Test-retest coefficients for the five subscales were: Acting out, r=.85; Repressed, r=.78; and Dependent, r=.87.

A subsequent study was conducted using the ratings of teachers of 68 elementary school-aged children (age range 7 to 11 years) in a test-retest procedures with a 4-week interval (Mramor, 1986). The following coefficients were found: Total Score, r=.87; Acting Out, r=.83; Passive-aggressive, r=.83; Overactive, r=.72; Repressed, r=.80; and Dependent, r=.73

Coefficient alpha, a measure of internal consistency, was found to be .94 with the normative population.

Instrument: School Behavior Checklist

Developer: Lovick C. Miller
Child Psychiatry Research Center
University of Louisville

Copyright: 1977, 1981

Available: Western Psychological Services
12031 Wilshire Blvd.
Los Angeles, CA 90025

Intent: An inventory of behaviors designed to help teachers communicate their impressions of children in their classrooms. There are two forms of the checklist. Form A1 is for ages 4 through 6. Form A2 is for ages 7 through 13. Norm tables are presented for both forms.

Format: Form A1 consists of 104 statements of prosocial and deviant behavior which are answered "True" or "False" on a separate answer sheet. Six factor and three clinical scales have been constructed. These scales, the first six of which are factor scales, are: Low Need Achievement, Aggression, Anxiety, Cognitive Deficit, Hostile Isolation, Extra-version, Normal Irritability, School Disturbance, and Total Disability.

Form A2 is composed of 96 items of prosocial and deviant behaviors which are answered "True" or "False" on a separate answer sheet. Seven scales have been constructed. The Normal Irritability and School Disturbance scales are not available for Form A2. Replacing the Cognitive Deficit scale of Form A1 is the Academic Disability scale which composed entirely of items indicating poor academic skills and low intelligence.

Reliability: Split-half reliability and test-retest reliability coefficient for both test forms are presented in the manual. Both methods for computing stability indicate that scales range from a reliability coefficient of .70 to .90 with the exception of Hostile Isolations, which has a reliability coefficient of around .40.

Validity: The manual discusses Criterion-related Validity, Content Validity, and Construct Validity.

Instrument: Test of Early Socioemotional Development (TOESD)

Developers: Wayne P. Hresko and Linda Brown

Copyright: 1984

Available: Pro-Ed
5341 Industrial Oaks Blvd.
Austin, Texas 78735

Intent: The TOESD is intended to measure the socioemotional development in preschool children. It is an ecological measure permitting the evaluation of children's behavior in several settings and by several individuals. It is norm-referenced, tables are provided for children from 3-6 years to 7-11 years.

Format: The TOESD is composed of four independent components: Student Rating Scale, Teacher Rating Scale, Teacher Rating Scale, and Sociogram. The Student Rating Scale contains 30 items to which students themselves respond with "yes" or "no" answers. The purpose is to ascertain children's perceptions of their own personal behavior as it relates to authority figures and their behavior in interpersonal relationships with other children. The Teacher Rating Scale is the longest of the TOESD. It contains 36 descriptive phrases which are evaluated by the child's teacher or other personnel who see the student in an educational setting. The respondents rate each item as "very much like," "somewhat like," "not much like," or "not at all like" the student who is being rated. Again, the items relate to children's personal behavior, their behavior with authority figures at school, and their interpersonal relationships with classmates. The Parent Rating Scale provides input into the TOESD from the parents, guardians, or parent surrogates of the children being evaluated. There are 34 items on the Parent Rating Scale. Like those on the Teacher Rating Scale, these items are descriptive phrases which the parents rate "Very Much Like," "Somewhat Like," "Not Much Like," or "Not At All Like" their children. These items, too, were designed to assess perceptions of a child's personal behavior, behavior with authority figures in the home, and behavior with other children at home and in the neighborhood. There are three TOESD sociogram questions from which the examiner selects one.

Reliability: Student Rating Scale: Coefficients Alpha ranges from .86 for 3 year olds to .79 for 7 year olds.

Parent Rating Scale: Coefficients Alpha ranges from .91 for 3 year olds to .93 for 7 year olds.

Teacher Rating Scale: Coefficients Alpha ranges from .97 for 3 year olds to .98 for 7 year olds.

Validity: The manual discusses Content Validity, Criterion-Related Validity, and Construct Validity.

Instrument: Walker Problem Behavior Identification Checklist

Developer: Hill M. Walker, Ph.D., University of Oregon

Available: Revised Edition 1976-WPBIC
Western Psychological Services
Publishers and Distributors
12031 Wilshire Boulevard
Los Angeles, California 90025

Intent: Designed for use in the elementary grades. Standardized on grades 4, 5, 6. It is to be used as a supplement in the total identification process rather than as an instrument to simply classify children as emotionally disturbed. It appears descriptive rather than diagnostic or prescriptive.

Items: The 50 checklist items were drawn from teacher descriptions of classroom behavior problems in an Oregon school district. Observable descriptions of overt behavior were abstracted from each interview. Several items appeared clinical in origin.

Format: The rater is instructed to circle either the presence or absence of a particular item. Each item is columned by scale clusters (5) and yield a total score. Each scale score is converted to a T score and plotted on a profile analysis chart.

Validity: Research studies of criterion and constrasting group validity indicate this instrument has predictive efficiency of .33 correlation. Such results are limited in significance.

Reliability: Test-retest studies utilizing the Kuder-Pichardson split half method revealed a coefficient of .98 correlation. This indicates a considerable statistical reliability. Further inter-rater studies indicated a .83 correlational agreement between teachers.

Utility: The WPBIC is easy to use but limited to 4-6 grade levels. Normative data is not thorough. The instrument is uncluttered and convenient to score. Of concern in reviews (Spivack & Swift, 1973) is the selection of items. Walker employed concensus judgments in the selection of items rather than basing decisions upon data indicative of relative validity or reliability.

Self-Report Instruments (Child or Parent)

1. Children's Depression Inventory - Kovacs
2. Revised Children's Manifest Anxiety Scale
3. Children's Personality Questionnaire
4. Child Anxiety Scale
5. Coopersmith Self-Esteem Inventory
6. Early School Personality Questionnaire
7. High School Personality Questionnaire
8. Inferred Self-Concept Scale
9. Jesness Inventory
10. Louisville Behavior Checklist
11. Missouri Children's Picture Series
12. Minnesota Multiphasic Personality Inventory
13. Millon Adolescent Personality Inventory
14. Piers-Harris Children's Self-Concept Scale
15. Tennessee Self-Concept Scale
16. Personality Inventory for Children (PIC)

Instrument: Children's Depression Inventory (CDI)

Developer: Maria Kovacs, Ph.D.
Associate Professor of Psychiatry
Western Psychiatric Institute and Clinic
3811 O'Hara Street
Pittsburgh, PA 15261

Publisher: Author

Age Range: 8-17 years

Administration: Approximately 30 minutes.

Description: The CDI is a self-report scale designed to assess and define depression in children. It consists of 27 items with each consisting of statements graded from 0 (absent) to 3(severe). The scale reflects the child's feelings during the past week. The total CDI scores for an individual child may range from 0 to 51, depending on presence and severity of symptomatology. Cutoff levels for degrees of severity of depression have been identified.

Standardization: The initial version of the CDI was administered to 39 consecutively admitted hospitalized patients and 20 "normal" children aged eight to 13 years. A highly significant correlation occurred between the independent ratings of depression and the scores from the CDI items. Additional field testing with 127 fifth and sixth grade students resulted in a more psychometrically acceptable instrument, having 27 items and employing a three-choice format.

Reliability: Acceptable internal consistency (coefficient alpha =.86) and statistically significant item total score correlations ranging from .31 to .54. Test-retest reliability assessed over a one-month interval indicated that the CDI is a reasonably stable measure of depressive symptoms in children (r=.72, N=28).

Validity: Carlson and Cantwell (1980) administered the CDI to 102 randomly selected children between the ages of seven and 17 years. Of the 102 children who were evaluated on an outpatient basis, 93 were given Axis I DSM-III clinical diagnoses. Of the remaining nine children, five were undiagnosed and four were not found to have indications of emotional problems. Twenty-eight children diagnosed as having affective disorders had significantly higher scores on the CDI when compared to children with behavior disorders or anorexia nervosa. Global ratings of depression given by clinicians at the end of an interview revealed a similar trend. Poor self-esteem, which is considered an indication of depression in children, was found to be correlated with high CDI scores (Piers-Harris correlation=.66) by Friedman

Validity (cont'd): and Butter (1979). Kovacs and Beck (1977) found a highly significant correlation (r=.55) between the Interview Schedule for Children (a structured interview yielding global depression ratings) and scores from 20 items of the CDI in a sample of 39 hospitalized children. Interestingly, the CDI has a low correlation (r=0.23) with peer ratings obtained by the Peer Nomination Inventory for Depression (Lefkowitz & Tesiny, 1980). Hodges et al. (1982b) also found significant correlations between the depression symptom complex of the Child Assessment are also included. The Assessment of Coping Style consists of 20 projective pictures of children and children with adults in a variety of situations. Two forms have been developed, one for elementary school children and one for middle school children. The assessment can be given to groups as well as to individuals.

Instrument: Revised Children's Manifest Anxiety Scale (RCMAS)

Developers: Cecil R. Reynolds & Bert O. Richmond

Copyright: 1985

Available: Western Psychological Services
12031 Wilshire Boulevard
Los angeles, California 90025

Intent: The RCMAS, subtitled, "What I Think and Feel," is a self-report instrument designed to assess the level and nature of anxiety in children and adolescents from 6 to 19 years old.

Format: The child response with a "yes" or "no" answer to each of 37 items. The "yes" responses are counted to determine a total anxiety score. In addition to the Total Anxiety Score, there are four subscale scores: Physiological Anxiety, worry/Oversensitivity, Social Concerns/Concentration, and Lie.

Reliability: Coefficient alpha reliabilities are reported in the manual for white males, black males, white females, and black females. For the entire age range, reliability estimates were .84 for white males, .85 for black males, .85 for white females, and .78 for black females. Data concerning Test-Retest Reliability are available only for the Total Anxiety Score and the Lie subscale. A test-retest reliability coefficient of .68 for the Total Anxiety score and .58 for the Lie scale were reported in a 1981 study.

Validity: The manual provides considerable information concerning the validity of the RCMAS.

TITLE: CHILDREN'S PERSONALITY QUESTIONNAIRE
"What You Do and What you Think"

AUTHOR: Rutherford B. Porter
Raymond B. Cattell

COPYRIGHT: 1959-1982

PUBLISHER: Institute for Personality and Ability Testing
P.O. Box 188
Champaign, Illinois 61820

AGE RANGE: 8-12 years

ADMINISTRATION: Approximately 30-60 minutes. Four (4) forms are available.

DESCRIPTION: The CPQ consists of 140 items which are completed by the student who marks the response which best "fits" him or her.

According to its author the test measures the following fourteen (14) independent dimensions of personality.

Reserved	vs.	Warmhearted
Dull	vs.	Bright
Affected by feelings	vs.	Emotionally stable
Phlegmatic	vs.	Excitable
Obedient	vs.	Dominant
Sober	vs.	Enthusiastic
Expedient	vs.	Conscientious
Shy	vs.	Venturesome
Tough-minded	vs.	Tender-minded
Zestful	vs.	Circumspect
		Individualism
Forthright	vs.	Shrewd
Self-Assured	vs.	Guilt-Prone
Undisciplined	vs.	Controlled
Relaxed	vs.	Tense

The CPQ can be hand or machine scored. Each of the fourteen factors yields a raw score which is converted to a sten score (range: 1 to 10) from the normative tables.

By combining these primary scale scores, broad personality trait patterns may also be obtained. These broad patterns are: Extraversion, Anxiety, Tough Poise, and Independence.

STANDARDIZATION: Norm tables are available for boys and girls based upon a total sample of 15,000. Each score in the sample was weighted according to a formula to balance for geographic region, ethnic group, socioeconomic status, community size, and age.

MEASUREMENT CHARACTERISTICS: Reliability: Test - Retest Coefficients after a one week interval range from .28 to .82 for the 14 scales. The median is .63.

Validity: Concept Validity Coefficients are reported which range from .20 to .90. The median is .59.

Instrument: Child Anxiety Scale

Developer: John S. Gillis

Copyright: 1980

Available: Institute for Personality and Ability Testing, Inc.
P.O. Box 188
Champaign, Illinois 61820

Intent: A screening instrument for detecting anxiety-based disturbances in children between the ages of 5 years, 9 months to 12 years, 11 months.

Format: All instructions, together with the 20 actual test questions, have been recorded on an audio cassette tape. After listening to each test question, the child marks an "x" on one of two colored circles that represents whether or not the question describes the child. The total amount of time required for presentation of the instructions and questions on the cassette is about 15 minutes.

Reliability: Immediate Test-Retest procedure carried out with 127 children in Grades 1, 2, and 3 resulted in the following Pearson product moment reliability coefficients:

Grade 1 - .82
Grade 2 - .85
Grade 3 - .92

Test-retest results over a one-week interval with 78 children gave an overall coefficient of .81. A study of internal consistency resulted in a Kuder-Richardson 20 coefficient of .73.

Validity: Factor-analytic studies of validity and relationships with external criteria are presented in the manual.

TITLE: COOPERSMITH SELF-ESTEEM INVENTORY

AUTHOR: Stanley Coopersmith

COPYRIGHT: 1967

PUBLISHER: W. H. Freeman and Company
1736 Stockton Street
San Francisco, CA 94133

AGE RANGE: Age 9 to adult

ADMINISTRATION: Approximately 10 minutes

DESCRIPTION: The Coopersmith consists of 58 short statements which are answered by the student as "like me" or "unlike me." Within the Inventory there are 5 subscales. These are:

General Self
Social Self
Home-Parents
Lie Scale
School-Academics

STANDARDIZATION: The Coopersmith was normed on 102 students in New York state and 1,748 students in Connecticut.

MEASUREMENT CHARACTERISTICS: Reliability: Split-half reliability is reported as .90.

Validity: All items in the scale were agreed upon by 5 psychologists as indicating high or low self-esteem.

TITLE: EARLY SCHOOL PERSONALITY QUESTIONNAIRE

AUTHOR: Raymond B. Cattell
Richard W. Coan

COPYRIGHT: 1966-1982

PUBLISHER: Institute for Personality and Ability Testing
P.O. Box 188
Champaign, Illinois 61820

AGE RANGE: 6-8 years

ADMINISTRATION: Approximately 45-90 minutes if both part A-1 and A-2 are given.

DESCRIPTION: The ESPQ consists of 160 items which are read to a student who responds on a non-reading answer sheet. The test consists of thirteen independent scales which are thought to be important within personality development. These thirteen dimensions are:

Reserved	vs.	Warmhearted
Dull	vs.	Bright
Affected by feelings	vs.	Emotionally stable
Undemonstrative	vs.	Excitable
Obedient	vs.	Dominant
Sober	vs.	Enthusiastic
Disregards rules	vs.	Conscientious
Shy	vs.	Venturesome
Tough-minded	vs.	Tender-minded
Vigorous	vs.	Circumspect
Forthright	vs.	Shrewd
Self-Assured	vs.	Guilt-Prone
Relaxed	vs.	Tense

The ESPQ can be hand or machine scored. Each of the thirteen factors yields a raw score which is converted to a sten score (range: 1 to 10) from the normative tables. By combining scores on the primary 4 broad personality trait patterns: (Extraversion, Anxiety, Tough Poise, Independence) may also be obtained.

STANDARDIZATION: The normative tables were developed from a sample of 1,653 children. The sample is described according to age and sex. There is no description of the ethnic, geographic, or socio-economic make-up of the sample.

MEASUREMENT CHARACTERISTICS:

Reliability: Test - Equivalence coefficients describe the agreement of scores between parallel forms of test. To calculate these parts A_1 and A_2 were compared for each of the thirteen factors for males and females. The coefficients range from .16 to .73. The median is .31.

Also, the authors report what they consider to be "lower-bound" estimates of test-retest reliability coefficients for each of the factors. These coefficients range from .28 to .84. The median is .48.

Validity: Concept validities for the thirteen scales are reported. These have been obtained as multiple correlations between the actual scales and the pure factors determined through factor analysis. The coefficients range from .32 to .84. The median is .62.

TITLE: HIGH SCHOOL PERSONALITY QUESTIONNAIRE

AUTHOR: Raymond B. Cattell
Mary D. Cattell

COPYRIGHT: 1958-1983

PUBLISHER: Institute for Personality and Ability Testing
P.O. Box 188
Champaign, Illinois 61820

AGE RANGE: 12-18 years

ADMINISTRATION: Approximately 45-60 minutes. Four (4) alternate forms are available.

DESCRIPTION: The HSPQ consists of 142 items on which the student must choose among three possible answers. The test measures fourteen independent dimensions of personality. They are as follows:

Reserved	vs.	Warmhearted
Dull	vs.	Bright
Affected by feelings	vs.	Emotionally stable
Undemonstrative	vs.	Excitable
Obedient	vs.	Dominant
Sober	vs.	Enthusiastic
Disregards rules	vs.	Conscientious
Shy	vs.	Venturesome
Tough-Minded	vs.	Tender-Minded
Zestful	vs.	Circumspect
		Individualism
Forthright	vs.	Shrewd
Self-Assured	vs.	Guilt-Prone
Group Dependency	vs.	Self-Sufficient
Uncontrolled	vs.	Controlled
Relaxed	vs.	Tense

The test can be hand scored with stencils or machine scored. Each of the fourteen factors yields a raw score which is converted to a sten score (range: 1 to 10) from the normative tables. The sten scores are then plotted on a profile sheet to make a graphic representation of the student's personality.

Through various combinations of the primary factor scores, secondary scores may be obtained for exvia, anxiety, cortertia, independence, school achievement, neuroticism, delinquency proneness, recovery from delinquency, creativity, and leadership potential.

STANDARDIZATION: A total of 9,386 students comprised the normative group. However, many of them were administered more than one form of the test. The sample was balanced for age, sex, geographic region and ethnic background.

MEASUREMENT CHARACTERISTICS:

Reliability: Test-retest reliabilities are given which reflect immediate retest, retest after one day, and retest after two weeks. The coefficients for each of the fourteen factors on the retest after two weeks range from .55 to .76. The median is .67.

Validity: Concept validities for the fourteen scales are reported. These are given for various combinations of the different forms. The lowest concept validity coefficients are found when Form A of the HSPQ is used in isolation. These coefficients range from .57 to .77. The median is .68.

TITLE: INFERRED SELF-CONCEPT SCALE

AUTHOR: E. L. McDaniel

COPYRIGHT: 1973

PUBLISHER: Western Psychological Services
12031 Wilshire Boulevard
Los Angeles, CA 90025

AGE RANGE: 6-12 years

ADMINISTRATION: The scale can be completed in 5-10 minutes by the student's teacher.

DESCRIPTION: The scale is based on the assumption self-concept can be inferred from behavior. Specifically, it can be assessed through the systematic observation and rating of behavior manifest in the school setting. The observer rates the student on a 5-point scale (Always to Never) for 30 different behaviors. The total score is obtained by summing the ratings.

STANDARDIZATION: No real norms are available. Average scores for various groupings of 180 children in Austin, Texas are provided.

MEASUREMENT CHARACTERISTICS: Reliability: Interrater reliability, coefficients on the 30 items range from .07 to .58. The median is .32. The correlation coefficient between the total scores is .58.

Validity: Not demonstrated.

TITLE: THE JESNESS INVENTORY

AUTHOR: Carl F. Jesness

COPYRIGHT: 1966-1972

PUBLISHER: Consulting Psychologists Press
557 College Avenue
Palo Alto, California 94306

AGE RANGE: 8-18 years

ADMINISTRATION: Approximately 45 minutes

DESCRIPTION: The Jesness Inventory was designed for use in classification of disturbed children and adolescents. It contains 155 true-false items which are divided into eleven different scales. The eleven scales are as follows:

- Social-Maladjustment
- Value Orientation
- Immaturity
- Autism
- Alienation
- Manifest Aggression
- Withdrawal
- Social Anxiety
- Repression
- Denial
- Asocial Index

Once raw scores are obtained T-score equivalents may be found in the norm tables for the students age and sex.

STANDARDIZATION: The Inventory was developed with a sample of 3,306 delinquents and nondelinquents from California. Both males and females are included. The normative tables, however, are based on the nondelinquents only.

MEASUREMENT CHARACTERISTICS: Reliability: Split-half reliability for the individual subscales range from .62 to .88. The median is .71. Stability estimates are .40 to .79 with a median of .69.

Validity: Data are not available in the manual.

Instrument: Louisville Benavior Checklist

Developer: Lovick C. Miller, Ph.D.

Available: Western Psychological Services
12031 Wilshire Boulevard
Los Angeles, California 90025

Intent: The Louisville Behavior checklist was designed to aid mental health professionals in screening for deviant oehavior and to help parents communicate concerns they have about their children. There are two form El for ages four through six and E2 for ages seven through thirteen.

Format: The original items were selected from clinical literature, inventories and intake material given at a child guidance clinic. there are 164 items which represent behaviors. Factor analysis provided 11 scales: Infantile Aggression, Hyperactivity, Antisocial behavior, Social Withdrawal, Sensitivity, Fear, Academic Disability, Immaturity, Aggression, Inhibition, and Learning Disability. Normal Irritability (behaviors which appear at least 25% of the time in normals) and Rare Deviance (items which appear less than 1% of the time in normals) were added, as were seven scales based on clinical judgment: Psychotic Behavior, Neurotic Behavior, Sex, Somatic, School Disturbance Predictor, Severity Level and Prosocial Deficit. All of these scales are found on E2. On El, the academic disability scale is replaced by an intellectual deficit scale, composed of items mainly from the Minnesota Child Development Inventory. Also, the Learning Disability scale was changed to Cognitive Disability scale. El was constructed after the content changes for E2 but no reanalyses of data were performed on El.

Administration & Scoring: The parent is given the checklist and answer sheet with the directions to mark each item either true or false. A sixth grade reading level is required in order to complete the checklist.

Scoring templates for each scale are provided. The raw scores are converted to scaled scores and percentile scores (tables are in the manual). Profile sheets may be plotted with either scaled scores or percentile scores.

Standardization: A random sample of 133 male and 154 female children was used for form El. These children were balanced for family income and race, represent the general population Jefferson County, Kentucky . For form E2, 114 male and 122 female children were used, balanced for the same factors. In addition, data on socioeconomic status, religion, parents' marital status and educational level are included in the manual.

Reliability: Split-half reliabilities were computed for each scale of Form E1 for the sample of 267 children. These estimates ranged from .85 to .97, except for sex which was .60. Test-retest estimates for a three-month period ranged from .45 to .89 for Form E2. Split-half reliability estimates for E2 (n=236) ranged from .44 to .90. Because most of the items represent either very severe or very mild behaviors on some of the scales (especially Somatic and Sex scales), the split-half reliability estimates may be lower than would be the case with more adequate scaling.

Validity: Content validity appears to have been established through the method of item selection. In addition, there are tow studies reported which differentiated clinic and non-clinic samples, but the test forms are not the same as the 1977 edition (Miller, 1967, 1977). Other studies reported in the manual involved a phobic group (n=64), an autistic group (n=18), a learning disabled group (n=50), and a general population group (n=64). The author concluded that discrimination of all groups could be made, normal from pathological and within pathological groups. Data are presented in the manual for this criterion-related validity. Construct validity was studied through parent and teacher ratings of children's behavior. While aggressive behavior and learning disability appeared to have cross-situational congruence, other behaviors showed little cross-situational relationship.

TITLE: MISSOURI CHILDREN'S PICTURE SERIES

AUTHOR: Jacob O. Sines
Jerome D. Pauker
Lloyd K. Sines

COPYRIGHT: 1963-1964

PUBLISHER: Psychological Assessment and Services
P.O. Box 1031
Iowa City, Iowa 52240

AGE RANGE: Ages 5-16 years

ADMINISTRATION: Approximately 10 to 20 minutes

DESCRIPTION: The test consists of 238 picture cards which the student sorts in two groups. Those which look like fun go in one pile and those which don't look like fun go in another. The task is very simple, the directions are very straightforward and no reading is involved. The test measures eight personality dimensions. These are:

Conformity
Masculinity-Femininity
Maturity
Aggressions
Inhibition
Activity Level
Sleep Disturbance
Somatization

Through the use of norm tables raw scores are converted to T-scores for each of the dimensions.

STANDARDIZATION: The test was normed on 3,877 children in kindergarten through 11th grade. An approximately equal number of males and females were included in the group. However, no information about other demographic aspects of the sample is provided. Also, for the development of some of the test's scales a clinic sample of 404 boys was used. The user of this test should consult the manual for a detailed description of this norm development.

MEASUREMENT CHARACTERISTICS: Reliability: Split half reliabilities of the eight scales have been determined for males and females in the normative group. These coefficients range from .20 to .83. The median is .47. Ten day test-retest reliabilities have also been calculated for the eight scales. These coefficients range from .45 to .77. The median is .62.

Validity: The MCPS manual discusses the issue of criterion validity as it relates to the different subscales of the test. Also, data are presented regarding construct validity.

TITLE: MINNESOTA MULTIPHASIC PERSONALITY INVENTORY

AUTHOR: Starke R. Hathaway
J. Charnley McKinley

COPYRIGHT: 1942-1967

PUBLISHER: Interpretive Scoring Systems
P.O. Box 1416
Minneapolis, Minnesota 55440

AGE RANGE: Ages 14 or older

ADMINISTRATION: Approximately 45 to 90 minutes. The MMPI is available in three (3) different formats (card format, group format, Form R). The Form R has many advantages and can be either hand scored or machine scored.

DESCRIPTION: The MMPI is an inventory test which consists of 566 true-false items. Unless the items are read to the student a 6th grade reading level is required.

The test has four (4) validity scales and ten (10) clinical scales. The clinical scales are:

Hypochondriasis
Depression
Hysteria
Psychopathic deviate
Masculinity-femininity
Paranoia
Psychasthenia
Schizophrenia
Hypomania
Social Introversion

An MMPI profile is obtained by converting the raw scores on each scale to T-scores.

STANDARDIZATION: The scales were developed by contrasting the responses of normal groups, approximately 700 people who visited the University of Minnesota Hospital, with over 800 carefully selected clinical cases. Both males and females were included in the sample and the age range was from 16 to 55. Subsequently, norms have been developed for adolescents (age 14 to 17). These are based on a national sample of 1,766 normals and 834 teenagers who were involved in psychotherapy of one form or another. [Marks, P., Seeman, W. & Haller, D. (1974). The Acturial Use of the MMPI with Adolescents and Adults. Baltimore: Williams & Wilkins.]

MEASUREMENT CHARACTERISTICS: Over 6,000 books and articles have been written which reference the MMPI, its measurement characteristics, and its applicablity with different populations. The MMPI manual gives the following data:

Reliability: Test-retest coefficients for normals and psychiatric patients for the 10 scales range from .52 and .90. The median is .77.

Validity: A high score on a particular scale has been found to predict the corresponding clinical diagnosis in more than 60% of new psychiatric admissions.

Instrument: Millon Adolescent Personality Inventory (MAPI)

Developers: Theodore Millon
Catherine Green
Robert Meagher

Copyright: 1977, 1982

Available: National Computer System
Professional Assessment Services
P.O. Box 1416
Minneapolis, MN 55440

Intent: The MAPI is designed to assess the overall make-up of an adolescent's personality including his or her coping styles, expressed concerns, and behavioral patterns.

Format: The MAPI is a 150-item inventory for use with adolescents age 13 through 18. Items are written at the 6th grade reading level. completion time is approximately 20 minutes. There are 22 scales and indexes divided into four categories.

1. Personality styles - Introversive, Inhibited, Cooperative, Sociable, Confident, Forceful, Respectful, and Sensitive.

2. Expressed Concerns - Self-Concept, Personal Esteem, Body Comfor, Sexual Acceptance, Peer Security, social Tolerance, Family Rapport, Academic confidence.

3. Behavior Correlates - Impulse control, Societal Conformity, Scholastic Achievement, Attendance Consistency.

4. Reliability and Validity Indexes - Help identify poor test-taking attitudes and confused or random responding.

Reports: Two Interpretive reports are provided by Scoring Services:

1. Clinical Interpretive Report; designed for adolescents seen in private practice and mental health treatment settings, includes a narrative that synthesizes scale profiles.. DSM-III diagnostic suggestions that direct the clinician to specific problem areas and explain the therapeutic implications of the test are provided.

2. Guidance Interpretive Report, for use by school guidance personnel, deals with major features of the adolescent's personality, individual styles of self-expression, and scholastic behavior. The Report also flags potential problem areas.

Scoring Services: Mail-in scoring (24-hour turnaround for reports); teleprocessing; or MICROSOFT assessment software for the clinical Interpretive Report.

Validity & Reliability: Test-retest reliability and internal consistency studies are reported in the manual. Three validation steps were used in item selection and scale development: Theoretical-substantive, internal-structural, and external-criterion.

TITLE: PIERS-HARRIS CHILDREN'S SELF-CONCEPT SCALE
"The Way I Feel About Myself"

AUTHOR: Ellen V. Piers
Dale B. Harris

COPYRIGHT: 1969

PUBLISHER: Western Psychological Services
12031 Wilshire Boulevard
Los Angeles, CA 90025

AGE RANGE: 9-18 years. If the items are read by the examiner, younger children may take the test.

ADMINISTRATION: Approximately 15-20 minutes.

DESCRIPTION: The scale consists of 80 declarative statements which can be answered "yes" or "no." It provides a percentile rank of the child's self-concept compared with the normative group. Also, scores for the following 6 subscales may be obtained:

- Behavior
- Intellectual and School Status
- Physical Appearance and Attributes
- Anxiety
- Popularity
- Happiness and Satisfaction

STANDARDIZATION: The normative group consisted of 1,183 children in grades 4 through 12 in a large school district. There is a cross section of socioeconomic levels and mixture of slow, average, and bright students.

MEASUREMENT CHARACTERISTICS: Reliability: The test-retest reliability coefficient for a 4 month time span with 5th grade students is reported as .77.

Validity: The Piers-Harris correlates r = .68 with the Lipsitts 1958 Self-Concept Scale for Children. Also, it is reported to have a low, insignificant correlation with IQ.

TITLE: TENNESSEE SELF CONCEPT SCALE

AUTHOR: William Fitts

COPYRIGHT: 1964-1965

PUBLISHER: Western Psychological Services
12031 Wilshire Boulevard
Los Angeles, CA 90025

AGE RANGE: Ages 12 and over

ADMINISTRATION: Approximately 10-20 minutes. There are two forms of the scale. Form C is appropriate if the results will be used with a client. Form C + R yields additional measures and is appropriate for research.

DESCRIPTION: The scale consists of 100 self-descriptive statements which the student rates on a 5-point scale (completely true to completely false). Within it there is a total self-concept score and 8 other self-esteem scores. These are:

- Identity
- Self-satisfaction
- Behavior
- Physical Self
- Moral-ethical Self
- Personal Self
- Family Self
- Social

STANDARDIZATION: The norms were developed on a sample of 626 people from various parts of the country. There was some attempt to account for the variables of sex, age, race, education, and intelligence, but the norm group does not reflect the population as a whole in proportion to its national composition. However, the author states there is no need to improve the norms since these variables have almost no impact on the scale.

MEASUREMENT CHARACTERISTICS: Reliability: Test-retest reliability coefficients of all major scores on the test are reported. These range from .92 to .60. The median is .80.

Validity: There is a lengthy discussion in the scale manual regarding content validity, discriminant validity, correlation between the scale and other personality measures, and personality changes under particular conditions. Any user of this instrument should study these data very carefully.

TITLE: THE PERSONALITY INVENTORY FOR CHILDREN - REVISED

AUTHOR: Robert D. Wirt
David Lachar
James E. Klinedinst
Philip D. Seat
William E. Broen

COPYRIGHT: 1977-1982

PUBLISHER: Western Psychological Services
12031 Wilshire
Los Angeles, California 90025

AGE RANGE: 3-16 years

ADMINISTRATION: This self-administered inventory is completed by the student's parent in approximately 45 to 90 minutes.

DESCRIPTION: The PIC-R consists of a total of 600 true-false questions completed by a primary informant, usually the student's mother. By completing the first three parts of the test (the first 420 items), 4 validity and screening scales may be obtained, 4 broad based factor scores may be obtained, and 10 clinical scales may be obtained. The clinical scales are:

Achievement
Intellectual Screening
Development
Somatic Concern
Depression
Family Relations
Delinquency
Withdrawal
Anxiety
Psychosis
Hyperactivity
Social Skills

The responses are transferred to T-scores and a clinical profile of the 18 scales is obtained. In addition, if all 600 items are given there are 17 supplemental scales which may be obtained.

STANDARDIZATION: The PIC-R was standardized on 2,390 normal children from Minnesota. There were about 100 boys and 100 girls at each age level from 5 to 16. Also, 192 normal children between the ages of 3-5 were tested.

MEASUREMENT CHARACTERISTICS:

Reliability: Test-retest average reliability coefficient for the clinical scales is .86. Coefficients in normal samples for the individual scales have been found to range from .34 to .97.

Validity: Criterion validity ranges from .62 to .91 for the scales where data were reported.

Projective Instruments

1. Analysis of Coping Style and Assessment of Coping Style
2. Children's Apperception Test
3. Roberts Apperception Test
4. Rotter Incomplete Sentence Test
5. Thematic Apperception Test
6. The Michigan Picture Test - Revised

Instrument: Analysis of Coping Style - Assessment of Coping Style

Developer: Herbert F. Boyd

Copyright: 1981

Available: Charles E. Merrill Publishing Company
Columbus, Ohio 43216

Intent & Format: A cognitive-behavioral approach to behavior management, consists of two parts. The Analysis of Coping style is a complete package for the identification and treatment of children with behavior disorders. It includes a historical discussion of approaches that have been used in dealing with disturbed behavior and a history of the development of the assessment of coping style. Also included are instructions for administering the assessment and directions for recording, summarizing, and conducting the diagnostic inquiry. Intervention strategies for teachers are also included. The assessment of Coping Style consists of 20 projective pictures of children and children with adults in a variety of situations. Two forms have been developed, one for elementary school children and one for middle school children. The assessment can be given to groups as well as to individuals.

Instrument: Children's Apperception Test (CAT)

Developer: Leopold Bellak
Sonya Bellak

Copyright: 1949-1974

Publisher: The Psychological Corporation
7..5 Caldwell Avenue
Chicago, IL 6..48

Age Range: Ages 3-10 years

Description: The CAT consists of ten picture cards depicting animals in various situations. The student's task is to tell a story about each picture. The pictures were designed to elicit responses to various situations, e.g., feeding problems, sibling rivalry, aggression, toilet training.

Resource Material:

1. Haworth, M. (1966). The C.A.T.: Facts About Fantasy. New York: Grune & Stratton.

2. Bellak, L. (1975). The Thematic Apperception Test, the Children's Apperception Test, and the Senior Apperception Technique in Clinical Use (3rd Edition). New York: Grune & Stratton.

Instrument: Roberts Apperception Test for Children (1982)

Developer: Glen E. Roberts
Dorothea S. McArthur

Publisher: Western Psychological Services
12031 Wilshire Boulevard
Los Angeles, California 90025

Description:
1. Standardization Population - Standardized on a sample of 200 "well-adjusted" children of both sexes, with efforts to include representative cross sections of all SES statuses.

2. Time to Assess - Administered in 20-30 minutes and scored in 15-20 minutes.

Intent: This is a thematic technique for children aged 6-15 which uses an objective scoring system and norms. Designed to assess children's perceptions of interpersonal situations, including their thoughts, concerns, conflicts, and coping styles, the RATC is made up of 27 stimulus cards (11 with both male and female versions) of which 16 are administered at any one time. The child tells a story about each picture, including what led up to the picture and how the story ends.

Scoring/Interpretation: An explicit scoring system yields adaptive scales (reliance on others, support to others, support of the child, limit setting, problem identification, and three resolution scales) and clinical scales (Anxiety, Aggression, Depression, Rejection, Unresolved). In addition, there are other critical indicators and collections of scores, all of which are compiled on an Interpersonal Chart. Scores are compared to the normative data, and the manual provides numerous case examples.

Norms: Standardization data are organized into four age groupings (6-7, 8-9, 10-12, 13-15), and raw scores are converted and analyzed through T scores.

Validity: Convergent and Discriminate: Initial data appear promising. RATC able to separate clinical from nonclinical groups at a highly significantly level.

Reliability: Interrater and Split-Half: Acceptable.

Instrument: Rotter Incomplete Sentences Blank

Developer: Julian B. Rotter

Copyright: 1950

Available: The Psychological Corporation
7555 Caldwell Avenue
Chicago, IL 60648

Age Range: Ages 13 and over

Administration: Approximately 20-40 minutes

Description: The student is asked to complete 40 sentences, only the first word or words of which are supplied. It is assumed the subject reflects his/her own wishes, desires, fears, and attitudes in the sentences. In addition to usual clinical interpretation an objective scoring system is available for screening as an index of maladjustment. For the objective scoring system, each of the 40 responses is evaluated on a 7-point rating scale (0 to 6).

Standardization: The instrument was standardized on 299 entering freshman at Ohio State University. There were 85 females and 214 males in the sample.

Reliability: Split-half reliability for the scoring system is .84. Inter-scorer reliability is reported as .91 for male records and .96 for female records.

Validity: Using the scoring system to classify students as "adjusted" or "maladjusted" correctly identifies 89% of the adjusted students and 52% of the maladjusted.

Instrument: Thematic Apperception Test

Developer: Henry A. Murray

Copyright: 1935-1943

Publisher: The Psychological Corporation
7555 Caldwell Avenue
Chicago, IL 60648

Age Range: Ages 10 and over

Description: The test consists of a series of 31 picture cards. In a typical administration, 10 cards are selected by the examiner to be shown to the subject who is encouraged to tell a story about the picture. The stories may reveal significant information about the subject's personality since people tend to interpret an ambiguous human situation in conformity with their past experiences and present desires.

Resource Material:

1. Murray, H. (1943). Thematic Apperception Test. Cambridge: Howard Press.

2. Tomkins, S. (1947). The Thematic Apperception Test. New York: Grune & Stratton.

Instrument: The Michigan Picture Test-Revised (MPT-R) (1980)

Developer: M. L. Hunt

Available: Grune and Stratton
121 Fifth Avenue
New York, New York 10003

Description:

1. Standardization Population - Standardized on a representative sample of children from public school populations and children with behavioral and personality problems from child guidance clinics.

2. Time to Assess - Approximately 40-50 minutes

Intent: A thematic instrument designed for children aged 8-14 or in grades 3-9, the MPT-R's major objective is to differentiate children with emotional maladjustment from those with satisfactory emotional adjustment. The MPT-R has 15 cards, and 5 "core" cards are recommended as the minimal battery, with up to 7 additional cards to "round out" the administration process. Children make up a story with a beginning and an ending for quantitative and qualitative analyses.

Scoring/Interpretation: Scoring criteria are available in the manual. Interpretation is based on the normative sample and a Tension Index, a Direction of Forces Index, a Tense Score, and a Combined Maladjustment Index. Other information scored includes psycho-sexual levels, interpersor relations, personal pronouns, and popular objects.

Norms: Available in the manual.

Validity & Reliability: Discriminate Validity: The scales were able to significantly discriminate adjusted from maladjusted children.

Interrater Reliability: Adequate.

These are preliminary results and the author notes that additional reliability and validity study is needed.

HANDOUT #21

The practitioner may choose to use the following 4 statements in evaluation his/her own reports for SEH evaluations:

	Low				High	No Data	Not Present
1. The psychological report describes the referred child using behavioral variables or characteristics	1	2	3	4	5	ND	NP
2. The Test Results and Interpretation section discusses the referred child's significant strengths and weaknesses	1	2	3	4	5	ND	NP
3. Technical terms and/or jargon in the psychological report have been minimized or eliminated, and fully explained where present	1	2	3	4	5	ND	NP
4. The psychological report integrates all data and results and does not utilize a test-by-test description and analysis	1	2	3	4	5	ND	NP

Appendix B

HANDOUT II-1
PLACEMENT PROCESS FLOW CHART

REFERRAL

a) student experiences difficulty learning
b) teacher makes attempts to help the student overcome difficulty
c) attempts are unsuccessful

PARENTAL PERMISSION OBTAINED FOR EVALUATION

a) personal interview with parents accompanied by written notice in native language or other mode of communication
b) parent consent in written form

DEVELOP ASSESSMENT PLAN AND CONDUCT EVALUATION

a) conducted in students native language or other mode of communication
b) tools administered to assess the education needs of the student
c) all relevant data and reports are assembled (multidisciplinary)

CONVENE CASE CONFERENCE COMMITTEE MEETING

a) adequate notice to parents
b) evaluation data and results interpreted
c) individualized education program, objectives, and services discussed
d) appropriate placement options which provide for the least restrictive environment determined

PARENTAL PERMISSION OBTAINED FOR PLACEMENT

a) Written copy of Case Conference Committee meeting Summary/IEP given to parents in native language
b) Parents Consent for Placement/Program given

HANDOUT II-2

MANDATORY COMPONENTS OF IEP

1. Current level of performance
2. Annual goals and objectives
3. Related services to be provided
4. Extent the child will participate in regular education
5. Evaluation criterion
6. Projected date for initiation and anticipated duration of services.
7. Placement and placement options, including reason for selected placement.
8. Persons involved in implementation of IEP.
9. Case Conference team members.

HANDOUT II-3

BEST PRACTICE STANDARDS

1. Insure that diagnostic information used to develop the IEP yields direct implications for teaching and programming efforts.

2. Insure that there is a logical, consistent relationship between annual goals, short term instructional objectives and the strategies used to achieve them.

3. Develop a separate and comprehensive IIP* for each annual goal listed on the IEP.

4. Insure that both long and short-term objectives are written in behavioral terms.

5. Consider multiple types and sources of evaluation is assessing the impact of IEPs, e.g., context, input, process and product evaluation.

6. Develop a defensible rationale for the placement decision reached in relation to each handicapped child to whom services are given.

7. Insure that the total service plan is written in a way that serves as a true guide to instruction.

*individual implementor plan (short term objectives) Hill M. Walker.

HANDOUT II-4

GUIDE TO DISCUSSION OF NEEDS
IEP DEVELOPMENT

The IEP must reflect the results of the psychoeducational evaluation. Goals, objectives and methods will be developed by addressing the following interactive domains:

* Academic
* Career/Vocational
* Affective Education
* Behavior Management
* Counseling
* Environmental Management
* Medical Considerations
* Family Considerations

I. Curricular Needs

Does any of the student's regular curriculum need to be adapted or changed relating to:

1. Method of presentation
   a. modality
   b. rate
2. Level of materials
3. Type of equipment and materials

II. Training Needs

1. Use of residual hearing or vision
2. Orientation and mobility
3. Gross or fine motor skills
4. Visual or auditory perception
5. Speech sound production
6. Language Development

(e.g., Receptive or expressive use of syntax, morphology, vocabulary)

III. Physical Environment Needs

Does the student need adaptations or changes in his physical environment relating to:

1. Noise level
2. Visual stimulation
3. Physical accessibility
4. Seating
5. Lighting

IV. Classroom Management Needs

Does the student need alternative styles of teacher-student interaction relating to:

1. Amount of structure
2. Group vs. individual instruction
3. Level of activity
4. Behavioral management techniques
5. Stress level
6. Adaptive teaching techniques unique to hearing or vision handicap

V. Social-Emotional Needs

Does the student's social/emotional environment need restructuring relating to:

1. Peer relationships
2. Self-concept
3. Knowledge and acceptance of his handicap or disability
4. Communication
5. Emotional expression
6. Self control

VI. Vocational/Avocational Needs

Does the student have unique needs to his disability relating to:

1. Economic and career awareness

2. Realistic occupational goals

3. Employability skills

4. Recreational and leisure time activities

VII. Home-School Interaction Needs

Does the student need a revision in the home-school interacting relating to:

1. Consistency

2. Reinforcement of training or educational concepts

VIII. Transportation Needs

Does the student need any modifications or adaptations in transportation relating to:

1. Length of ride

2. Equipment

3. Supervision

HANDOUT II-5

SUGGESTED STRATEGIES FOR MANAGING
SOCIAL, EMOTIONAL, AND BEHAVIORAL PROBLEMS

Following are interventions/strategies which can be used as recommendations for implementing the objectives on the IEP. These strategies include cognitive behavioral interventions, social skill training and counseling which may be implemented by teachers, psychologists and/or other related service personnel.

I. COGNITIVE - BEHAVIORAL INTERVENTION TRAINING

(Do I think therefore I act?)

An approach that has been successful in helping children increase self-control is the cognitive behavioral approach which combines a concern for behaviors along with the thought processes which influence behaviors. This position assumes that cognitions and behavior are compatible and that cognitive activities (such as expectations, self-statements, and attributions) are important in affective behavior. So, if the thinking process is changed or enhanced, the behavior is likely to be different.

The main strategies for the cognitive-behavioral self-control approach include:

a. self instructional training,
b. verbal mediation,
c. behavioral self-control, and
d. problem solving.

Cognitive behavioral strategies have been effective in alleviating fears, decreasing hyperactive and disruptive behavior, decreasing impulsivity, and increasing attention. These strategies are appropriate for all age levels, although materials obviously have to be adapted to the age and developmental level of the student. Training is time consuming, and if teachers choose to use the techniques, they should be committed to spending adequate time for ensuring mastery of individual steps and skills.

Since cognitive behavior modification is an approach to teach lifelong problem-solving skills, the skills should be reinforced informally throughout the day. Students should be cued to use them in natural settings. This requires fading cues as students learn skills. For instance, they may initially have cards on their desks which explicitly state the steps of the procedure. These may later be replaced by cards with one letter symbols of the steps and finally be removed altogether. The removal of cues allows for the development of images and verbalizations which are the basis of behavior change and regulation.

A. Self-Instructional Procedures

This approach has been applied effectively with a broad range of childhood disorders and with children of varied behavioral skills. These techniques are designed to help students identify problems and options and take action. Self-instructional techniques are primarily used to guide students from covertly describing behavior to internalizing control over their behavior.

1. Self-statements

Teach students simply to say a particular statement to themselves at a given time. For example, a child who is fearful of the dark may be taught to say to himself when he's in the dark. "I am a brave boy (girl). I can take care of myself in the dark."

2. Modeling and self-statements

a. Select target behavior and determine baseline (e.g., responding to taunts aggressively).
b. Play a game in which maladaptive behavior may be elicited (ask children to play game where they will be verbally taunted).
c. Show a film modeling desired behavior, thoughts, and actions of model. Discuss coping statements. (Model remains calm and makes coping self-statements [e.g., "I'm not going to let them bug me"].)
d. Play game again, instructing students to practice coping self-statements.
e. In real-life situations, cue students to use self-statements.

3. Think aloud program

The Camp and Bash Think Aloud Program (Camp & Bash, 1978) also uses cognitive modeling. They suggest the following steps:

a. Cue the child into attending to both verbal and physical behavior of the model, e.g., "We're going to play copycat."
b. Have the model use the verbal mediation approach:
   - What does the teacher want me to do? (Oh, she wants me to finish my work.)
   - List possible ways (I should sit down and get started). Select one (Yes, I'd better sit down now).
   - Evaluate (Did I follow my plan? Is it safe? How do I feel? I sat down and got started. I feel good about that).
   - Reinforce self (That was good. I'm doing a good job now).
c. Have students copy model's statement aloud as they complete task with the model.
d. Have students rehearse model's verbalization while thinking aloud (no teacher help).
e. Have students whisper self-verbalizations as they complete the task.
f. Have students use private speech while completing task.
g. Evaluate performance.
h. Reinforce students.

4. Self-directed verbal commands

Teach students to use self-directed verbal commands, such as "stop, look, and think" before responding. Visual reminder cards with these words printed on them can be used as cues.

5. Kendall's approach

Kendall & Braswell (1985) describes a 12-session format for self-instructional training which is sequenced from initially exposing the child to self-instructions and the reinforcement contingencies, having each session built upon the others, and ending with role-playing of real-life situations. Students complete activities on self-instruction for following directions, applying the techniques to skill acquisition in academic areas, applying techniques in games, identifying emotions, generating alternative ways of handling hypothetical situations, role-playing hypothetical situations, and finally role-playing real-life situations.

B. Verbal Mediation

Although this approach is similar to self-instructional training, it is easier for older students who have trouble learning to memorize or transfer learned material. Verbal mediation can take several forms, from prompting to actually recreating the problem.

1. Workman (1982) describes a method of verbal mediation with written essays that become the basis for teaching appropriate skills. Either the teacher or the student prepares an essay. When the teacher prepares the essay, it describes and discusses a type of inappropriate behavior. The essay details an alternative approach and defines why it is appropriate. The essays are written at the students' vocabulary level and should relate to the variety of situations experienced by the students. When students misbehave they copy the essay related to the misbehavior (e.g., out of seat, talking out). If the students are able to express themselves, then they are directed to develop an essay that answers four questions:

   a. What did I do wrong?
   b. What is wrong with that behavior?
   c. What should I have been doing instead?
   d. Why should I have been doing (the behavior)?

   After the essays are written, they are discussed with the teacher. In this way, the student has both oral and written feedback as the basis for skill building.

2. Meichenbaum and Goodman (1971) teach students another way to mediate behavior verbally by listing five types of statements:

   a. Definition of Problem: "let's see. Now what am I suposed to do?"

b. Approach to Problem: "What are the possibilities?"
c. Focus Attention: "I need to focus in and think of what I'm doing now".
d. Choose an Answer: "I think this is it."
e. Self-Reinforcement: "I did that okay."
or
Coping Statement: "Wait. I missed that, but next time, I'll go slower and concentrate more so I can get it right."

In this method, the teacher must model the procedure for the student until the student has mastered the sequence. The steps are:

a. The teacher models task performance and talks out loud while the child observes.
b. The child performs the task, instructing him/herself out loud.
c. The teacher models task performance while whispering the self-instructions.
d. The teacher performs the task, using covert self-instructions with pauses and behavioral signs of thinking (e.g., stroking chin).
e. The child performs the task using covert self-instructions.

C. Behavioral Self-Control

Rather than using images and verbalizations for changing behavior, behavioral self-control methods are used to foster independent regulation of behavior. These methods allow for students to accept greater responsibility for their behavior through learning techniques of self-assessment, self-monitoring, and self-reinforcement. These techniques have been found effective for increasing task behavior and reducing disruptive classroom behaviors. It is appropriate for students of all grade levels.

Self-control interventions are divided into two types: (1) self-maintenance where students use self-control procedures to maintain behaviors acquired through external teacher control, and (2) self-change where students are taught self-control procedures to acquire new behaviors. Both interventions have three stages: self-monitoring, self-assessment, and self-reinforcement.

1. Self-monitoring teaches students to observe and record their own behavior. It involves choosing behavior, defining the behavior, and selecting a measuring and recording method.

2. Self-assessment involves teaching students to assess or evaluate their behavior in order to improve it. In this step, self-instruction or self-rating may be helpful in evaluating the behavior. It is also useful to use self-monitored data when making comparisons of behavior.

3. Self-reinforcement involves teaching students to reinforce or reward themselves for appropriate classroom behaviors. These reinforcers may be tangible or covert.

The procedures can easily be translated into a systematic program. One example of the types of activities needed for a successful self-control program follows.

a. Select the target behavior to change (e.g., increase on-task behavior in main class).
b. Devise a rating system.
c. Determine the rating system interval (e.g., a kitchen timer set to ring every five minutes).
d. Design the mechanics of the rating system.
e. Implement the monitoring system.
f. Decide on back up reinforcers and list these on a reinforcement menu.
g. Determine the baseline number of intervals to measure success.
h. Set the criterion for reinforcement just above the number of intervals used as a baseline.
i. Change the criterion level as success is achieved.
j. Periodically change the reinforcement menu to ensure desirable reinforcers.

D. Problem Solving

Self-instructional programs involve problem solving, but all problem-solving approaches do not emphasize self-instructions. These approaches are cognitive-behavioral interventions because they increase the student's awareness of his or her own behavior. It is also believed that as problem-solving skills improve, social behavior improves. Problem-solving instructional experiences are most effective when they relate to real problems and experiences, increasing the student's identification with the experience and enhancing generalization.

Several problem-solving approaches are available for use in the classroom. Each incorporates similar strategies and requires that the strategies be implemented in sequence. Games, role-playing, films, literature, etc., are all utilized during instruction of the various components.

D'Zurilla and Goldfried (1971) designed a problem solving method that can be adapted to students of any age. It requires that the teacher lead the student through five steps:

1. General orientation (Why solve problem?).

2. Problem definition and formulation (What is the problem? What do I want to change?).

3. Generalization of alternatives (What are all the things I could do in this situation?).

4. Decision making (What are the consequences of each alternative? What is the best decision at this time?).

5. Verification (How will the decision be implemented?).

Spivack and Shure (1974) developed the Interpersonal Cognitive Problem-Solving Model to teach basic concepts and skills necessary for problem solving. Research has shown their model to be effective with preschoolers through adolescents. This model provides strategies and activities for teaching students to generate alternatives, develop means-end thinking, analyze the consequences of feelings and social behaviors, and increase social perceptiveness.

II. SOCIAL SKILL TRAINING

(If they learned to act that way, they can unlearn it.)

Emotionally handicapped students are deficient in social and interpersonal skills necessary for developing positive relationships in school, home, and the community. These students experience failure in social settings because of a failure to le n appropriate social skills.

The systematic teaching of social skills is crucial in curriculum for the emotionally handicapped. Instruction should be direct, systematic, and reality based. Goals and objectives in social skills are a vital part of the IEP.

Numerous social skill curricula are available for use in the classroom. These curricula should be adapted to the student's needs and the resources available to the teacher. As the curriculum is implemented, the teacher should elicit the suport of parents and others who interact with the students so that they can support the students' behavioral changes. As with all curriculum goals and objectives, criteria for success and a means for measuring success should be developed (Neel, 1984).

In general, the social skill curriculum packages include similar skills, yet vary in approach. The major skill categories include:

A. Initial interaction or activity (e.g., greeting, offering assistance).

B. Maintaining an interaction or activity (e.g., listening, conversing).

C. Following rules and regulations (e.g., listening to teacher, accepting consequences).

D. Reinforcing others/displaying affection (e.g., smiling, giving compliments).

E. Giving feedback to others (e.g., telling what you don't like).

F. Attending to social cues/social expectations (e.g., good grooming, eye contact).

G. Providing information (e.g., answering questions, expressing feelings).

H. Indicating preferences (e.g., dealing with choices, negotiating).

I. Coping with negative situations (e.g., seeking help, dealing with a fearful situation).

J. Dealing with anger (e.g., receiving accusations, apologizing).

K. Terminating an interaction or activity (e.g., leaving when an activity is completed, leaving when a situation is negative).

L. Problem solving (e.g., gathering information, accepting abilities and limitations).

An example of an approach used to teach social skills is structured learning therapy (Goldstein, A.P., Sprafkin, R.P., Gershaw, N.J., E. Klein, P. [1980]). Several steps are involved in setting up a program:

A. Select students for training (Which students would be amenable to/benefit from training?).

B. Determine skills to be taught. This would include a pretest, assessing student skills prior to training.

C. Assess pre-training performance levels. This would be included on the above pretest. Other assessment procedures may be sociometric data or direct observation.

D. Provide training, using the four-step teaching procedures:

1. Model the desired skill:

   a. demonstrate behaviors in a clear, detailed manner:
   b. in order from least to more difficult;
   c. with some repetition; and
   d. with several individuals serving as models.

2. Have students role play the desired skill. By practicing or role playing the behavior, the student is able to try out the new behaviors without risk of failure. This helps make them feel more confident and helps to prepare them for difficult interpersonal situations. This practice is the most important part of the training program and probably the one students will like most if they can overcome the initial feelings of being self-conscious and afraid of being laughed at. Some students will be resistive to practicing and will need to be urged. This urge should be non-threatening, maybe an expression of understanding.

3. Give feedback on performance. Crucial to the success of this program is the ability to give feedback in a constructive, non-threatening way. Always give a student a chance to be successful and reinforce his success. Also, provide a supportive atmosphere for feedback.

4. Practice the behavior in other settings (e.g., homework). Students think of situations at home or school where they are to practice the skills and evaluate their performance. A reinforcement system should be established, contingent upon group rules, for participating in role plays and practicing identified skills.

E. Evaluate the results. Re-assess student skills using the skill checklist.

1. The Walker Social Skills Curriculum (ACCEPTS) (1983).

This program was designed to: (1) facilitate social development of handicapped children, (2) prepare them to meet behavioral demands and expectations of less restrictive settings, and (3) improve social acceptance of handicapped children by nonhandicapped peers.

The instructional package includes training units in classroom skills, basic interaction skills, getting-along skills, making-friends skills, and coping skills.

The sequence for teaching the skills is:

Step 1: Definition and guided discussion
Step 2: Positive example
Step 3: Negative example
Step 4: Review and restatement of skill definition
Step 5: Positive example
Step 6: Activities
Step 7: Positive example
Step 8: Criterion role play
Step 9: Informal contracting

2. Getting Along with Others: Teaching Social Effectiveness to Children (Jackson, Jackson, & Monroe, 1983).

This program contains material for 17 two-hour sessions. Skills range from following directions to saying "no" to stay out of trouble, and each session follows a general format:

a. Go over homework for the session
b. Provide relaxation training
c. Introduce the skill (and steps involved in implementing it)
d. Model appropriate example
e. Ask students for behavior components of skill
f. Ask children to role play
g. Ask children to give positive feedback
h. Ask children for rationales for using skill
i. Lead children through reality check (what to do when the skill doesn't work)
j. Provide snack time
k. Provide activity time where students can informally exhibit skills

This program is best suited for mental health center groups rather than schools due to the length of the sessions. Adaptation is needed for groups in schools.

3. Social Skills in the Classroom (Stephens, 1978).

This book describes social skills, assessment tasks, and teaching strategies. The program emphasizes evaluation as to whether the skill is present and not being used appropriately or whether the skill is simply not present. The teaching strategy of choice is either modeling and teaching absent skills or reinforcing skills which the student has but doesn't use appropriately.

4. Teaching Children Self-Control: Preventing Emotional and Learning Problems in the Elementary School (Fagen, Long, & Stevens, 1975).

Fagen and Long's self-control curriculum is designed as a preventive program in teaching self-control skills. It helps children deal with feelings and emotions, teaches self-control, and helps students cope with pressures and frustration.

The curriculum contains eight skill clusters, the first four being more closely related to cognitive skills (e.g., sequencing and ordering) and the latter four related to affective skills (e.g., inhibition and delay). Each curriculum area contains an introduction, rationale, description of units, and learning tasks.

5. ASSET: Social Skills Training Program for Adolescents (Hazel, Schumaker, Sherman, & Sheldon-Wildgen, 1982).

This program is designed to teach specific social skills to adolescents with behavior problems. It contains a leader's guide with skill sheets and checklists and eight videotapes to model the skills being taught.

Specific steps are taught for each skill, including both verbal and nonverbal behavior. Skills are practiced and applied through games and home notes.

The eight skills to be taught include:

a. giving positive feedback
b. giving negative feedback
c. accepting negative feedback
d. resisting peer pressure
e. problem solving
f. negotiation
g. following instructions
h. conversation

6. Responsible Assertive Behavior (Lange & Jakubowski, 1976).

Assertiveness training programs are similar to social skills training. However, they include more emphasis on belief systems and help students discriminate between passive, aggressive, and assertive students.

III. COUNSELING STRATEGIES

(Let's talk . . .)

Counseling is "individual or group discussion to help students gain insight into themselves and their problems, to share feelings and concerns in a confidential and supportive manner and to plan and evaluate personal tools" (Colorado Department of Education, 1980).

In the class for emotionally handicapped students, counseling may be formal or informal. The teacher may take the counseling role which may be augmented by support personnel. Some techniques include:

A. Empathic/Reflective Listening in which the teacher responds to the child in a way that indicates empathy of understanding of the student's feelings. Example: Teacher verbally states students' feelings (e.g., "You seem angry because someone hit you" or "It really makes you happy when you make an A").

B. Redirection is guiding a child back to task through an alternative motivation. Example: Teacher notices a child behaving inappropriately (e.g., getting ready to throw paper across the room) and provides an alternative response (e.g., says, "Here's a waste-basket for you").

   This technique shows the child a more appropriate response, refocuses attention, and avoids unnecessary confrontation.

C. Interpretation involves assisting the child in connecting behavior and feelings. Example: "It makes you mad when you don't get what you want."

D. Reality Therapy uses direct questioning to help students examine actions and develop a plan for changing inappropriate behavior to appropriate behavior.

   At the individual level, the steps include:

   1. Establish good rapport with student.
   2. If the child behaves inappropriately, ask what he is or was doing (If he doesn't answer, teacher describes it).
   3. Guide student to evaluate behavior (Is it helping you? the class? me? If yes, how?). If the student says it helps, teacher may state his/her conclusions.
   4. Ask student to make a plan by listing alternative behaviors.
   5. Direct student to make commitment to one of alternatives (What will you try?). Be sure student commits himself to something.
   6. Follow through to see if plan was implemented.

7. If not implemented, allow student to experience natural consequences.
8. If student refuses to participate in the process, isolate him/her from class until he/she is ready to participate. (Isolation should be nonpunitive.)

At the group level, the following steps are followed:

1. Seat students in a circle.
2. Hold group meetings. Glasser (1965) recommends daily meetings at the elementary level (10-30 minutes) and two meetings per week for adolescents.
3. Decide on the type of meeting. (Teachers of EH students frequently use the meeting for arriving at solutions for individual or class problems.)
4. Introduce the topic. (The teacher may do this initially and later students are likely to bring up concerns.)
5. Ask students to respond to the problem, but be sure to (a) keep discussion directed toward solving the problem, (b) help students understand that many solutions exist, and (c) enforce the group's decision.

E. Relaxation Training involves teaching students to alternately relax and tense various muscle groups in a systematic order; e.g., from the facial area to feet and then the complete body.

Guided imagery is sometimes used in conjunction with relaxation. This approach requires the student to imagine a very pleasant environment or circumstance (which aids in relaxation) and then to recall this environment/situation in stressful situations. This strategy is useful for students who are anxious and worry excessively.

F. Supportive Peer Groups are designed to teach students new ways of behaving through using the strength and support of the peer group. This method helps students confront their problems and helps them change. It increases interpersonal communication. Supportive peer groups rely on group meetings.

1. Teacher and student develop a general problem list. The number of problems should be limited.
2. Teacher reviews rules of the group.
3. Students share a problem that occurred that day and what happened. Have peers offer alternatives to the problem behavior. Teacher must direct the group.
4. Peers and teachers resolve the issue.

G. Magic Circle Program helps children label affect and improves verbal skills. It requires minimal time and is easily interwoven into daily events. It contains a structured curriculum.

Methods in this program include approximately 15-20 minutes each day in set aside group time. Group rules are established, and students alternately respond verbally to a theme such as "a time when I was embarrassed. . . ."

H. Teacher Feedback and Review is important in helping individual students demonstrate appropriate behaviors. Life Space Interview is an example of feedback and review. This method facilitates open communication between teacher and student, encourages students' listening and verbal expression skills, provides verbal and social reinforcement for appropriate performance, encourages student self-monitoring and assessment, and clarifies and reinforces expectations.

I. Creative Activities include role play, music, art, creative writing, play, story telling, bibliotherapy, drama, and puppetry. Activities must be motivating for the student. Activities which entertain and arouse curiosity through creativity and fantasy accomplish this especially well in a deliberative, yet symbolic, means of expression.

J. Values Clarification is an approach which suggests that teachers should teach values in a systematic and responsible manner. In values clarification, teachers avoid moralizing and instilling values. Students are helped to develop their own value systems through activities based on the themes of prizing one's beliefs and behaviors, choosing one's beliefs and behaviors, and acting on one's beliefs (Simon, Howe, & Kirschenbaum, 1978).

HANDOUT II-6

SAMPLE GOALS AND OBJECTIVES FOR
SOCIAL AND EMOTIONAL DEVELOPMENT RELATED TO
EDUCATIONAL DEFINITION OF SEH

I. Inability to learn which cannot be explained by intellectual sensory, or health factors.

GOAL: In a group situation, the student will demonstrate completion of a task.

OBJECTIVES:
1. The student will maintain attention to task for a 3 minute period for a maximum of 1 teacher cue.
2. The student will maintain attention to task for a 6 minute period for a maximum of one teacher cue.
3. The student will complete individual and/or group tasks assigned by teacher.
4. The student will self-select appropriate activities when assigned tasks are completed and not disturb others.

II. Inability to build or maintain satisfactory interpersonal relationships with peers and teachers.

GOAL: The student will demonstrate appropriate ways to gain peer interaction.

OBJECTIVES:
1. The student will greet another student appropriately.
2. The student will participate appropriately in a structured play activity with teacher direction.
3. The student will participate in an unstructured play activity with teacher cues.

III. Inappropriate types of behavior or feelings under normal circumstances.

GOAL: The student will appropriately respond to situations with self control.