

ASSESSMENT OF STUDENTS WITH CO-MORBID DISORDERS AND MULTIPLE ELIGIBILITIES UNDER IDEIA/ADA (1.0)

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OSPA

Oregon School
Psychologists Association

Disclosure

- My expenses for this talk are supported by Multi-Health Systems.
- I have developed tests marketed by Multi-Health Systems, Pro-Ed and Western Psychological Services.
- I have authored books marketed by Springer, Wiley, Guilford, Double Day, McGraw Hill, Brookes, Kluwer and Specialty Press.
- I am Editor in Chief of the Journal of Attention Disorders (Sage) and Co-Editor of the Encyclopedia of Child Development (Springer)

Preschool Graduation Part I



Preschool Graduation Part II



Goals for This Session

- Place our role as evaluators in context.
- Provide an overview of development, behavior diagnosis and eligibility.
- Discuss role of impairment in assessment.
- Discuss critical variables influencing assessment.
- Provide a framework for a comprehensive assessment.
- Review tools and methods.

I Had a Revelation in St. Augustine

The World Operates Along a Normal
Curve!

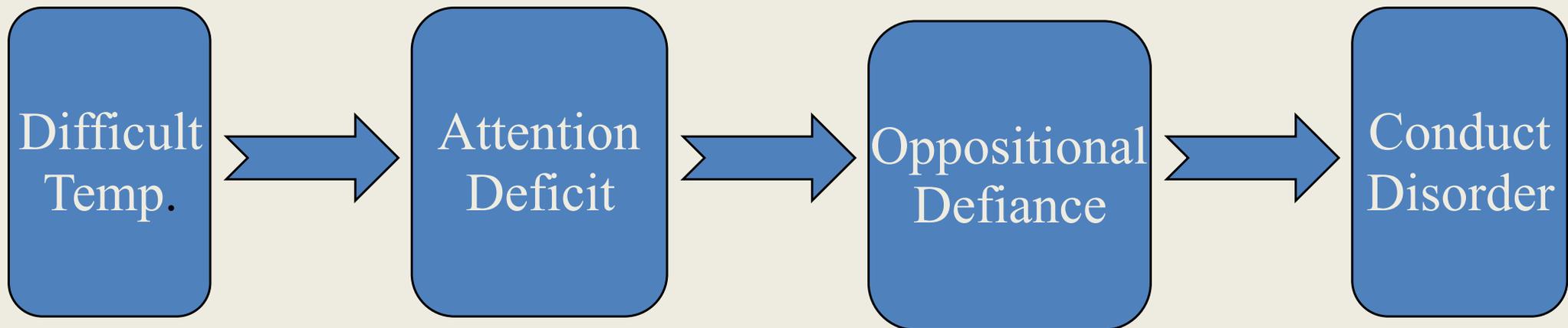
Not surprisingly all but two things we do as school psychologists are dimensional!

Diagnosis

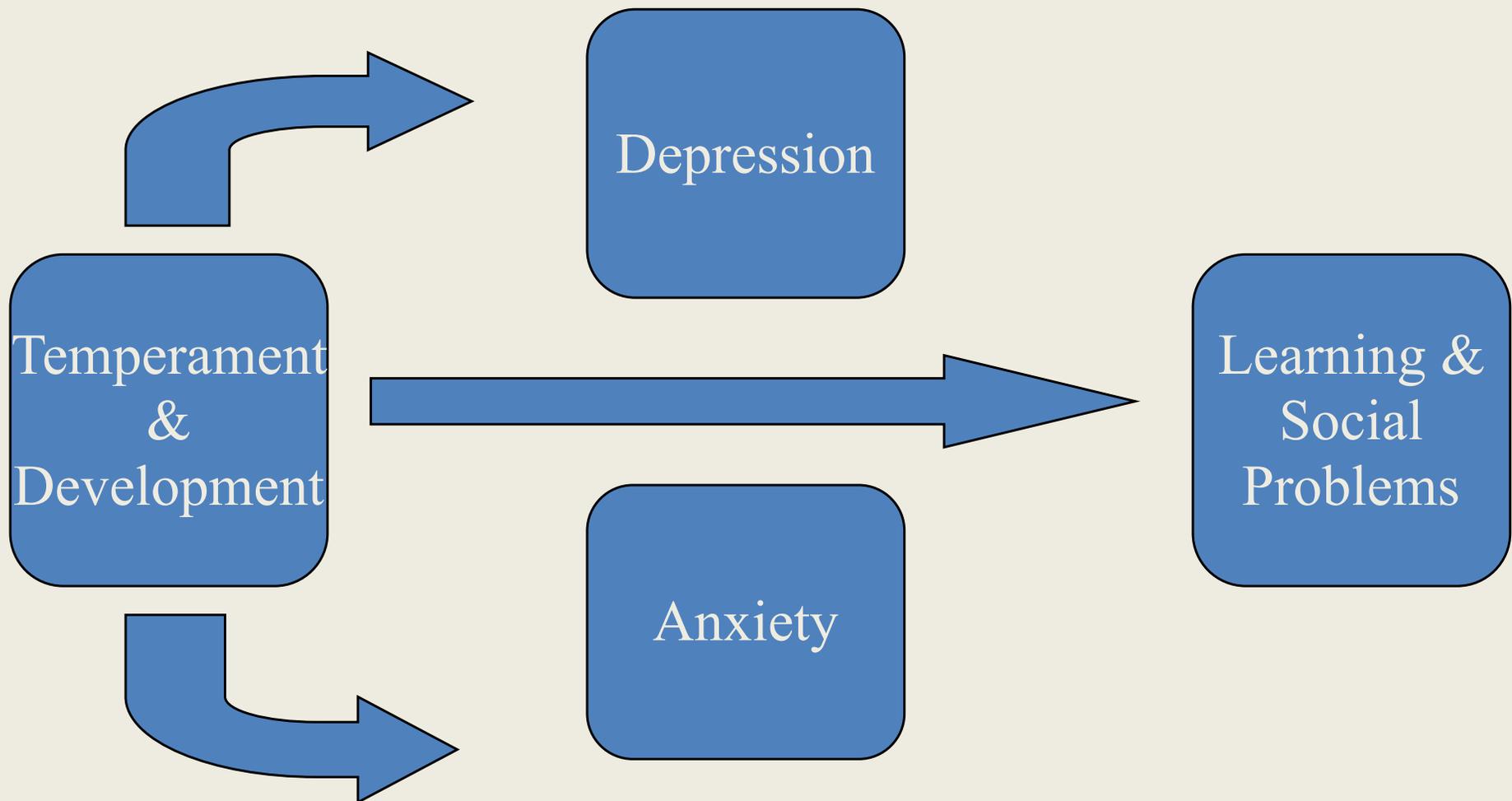
Eligibility Determination

Does diagnosis equal eligibility?

The Disruptive Continuum of Behavior



The Non-disruptive Continuum of Behavior



How distinct are these disorders
from each other?

Much less so than makes me
comfortable!

Attention Deficit Hyperactivity Disorder

- 44.3% of children with ADHD were also diagnosed with ODD (Cuffe et al., 2015); Kessler et al. (2014) found a lifetime prevalence of 47% for ODD.
- 13.5% of children with ADHD were also diagnosed with CD (Cuffe et al., 2015); Kessler et al. (2014) found a lifetime prevalence of 22% for CD.
- In a recent study by the CDC, 59% of children with ASD were also diagnosed with ADHD (Stevens, Peng, & Barnard-Brak, 2016)
- 2% of children with ADHD were also diagnosed with Major Depressive Disorder (Cuffe et al., 2015); Kessler et al. (2014) found a lifetime prevalence of 41% for MDD/Dysthymia. For youth with MDD, researchers have found an odds ratio for an ADHD diagnosis of *2.58 (Avenevoli, Swendsen, He, Burstein, & Merikangas, 2015).

ADHD

- In a review of the literature, researchers found prevalence estimates of LD in youth with ADHD between 8% and 76%, with a median of 47% and a mean of 45.1% across studies (DuPaul, Gormley & Laracy, 2013). In a sample of youth with SLD, Margari et al. (2013) found that 33% had comorbid ADHD.
- 6.4% of children with ADHD were also diagnosed with Generalized Anxiety Disorder, 10.2% with Separation Anxiety Disorder, and 7.6% with Social Phobia (Cuffe et al., 2015); Kessler et al. (2014) found a lifetime prevalence of 35% for any anxiety disorder

*An odds ratio (OR) is a measure of association between an exposure and an outcome. The OR represents the odds that an outcome will occur given a particular exposure, compared to the odds of the outcome occurring in the absence of that exposure.

Oppositional Defiant Disorder

- For individuals with ODD, researchers have found a lifetime prevalence of 42% for Conduct Disorder (Nock, Kazdin, Hiripi, & Kessler, 2007)
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- For youth with ASD, a systematic review revealed prevalence estimates for ODD from 4% to 37% (Kaat & Lecavalier, 2013).

ODD

- For individuals with ODD, researchers have found a lifetime prevalence of 39% for Major Depressive Disorder
- (Nock, Kazdin, Hiripi, & Kessler, 2007) In a study of Finnish adolescents with ODD/CD, researchers found that 55% of girls and 65% of boys had either a reading or math disorder (Lehto-Salo, Närhi, Ahonen & Marttunen, 2009).
- For individuals with ODD, researchers have found a lifetime prevalence of 62% for any anxiety disorder (Nock, Kazdin, Hiripi, & Kessler, 2007)

Conduct Disorder

- 13.5% of children with ADHD were also diagnosed with CD (Cuffe et al., 2015); Kessler et al. (2014) found a lifetime prevalence of 22% for CD.
- For individuals with ODD, researchers have found a lifetime prevalence of 42% for Conduct Disorder (Nock, Kazdin, Hiripi, & Kessler, 2007)
- For youth with ASD prevalence estimates for CD range from 1% to 10% (Kaat & Lecavalier, 2013).

CD

- For youth with MDD, researchers have found an odds ratio for a behavior disorder (ODD or CD) diagnosis of 4.20 (Avenevoli, Swendsen, He, Burstein, & Merikangas, 2015).
- In a study of Finnish adolescents with ODD/CD, researchers found that 55% of girls and 65% of boys had either a reading or math disorder (Lehto-Salo, Närhi, Ahonen & Marttunen, 2009).
- Youth with CD are at elevated risk for anxiety disorders, with odds ratios of 3.54 for phobias, 3.27 for social anxiety, and 3.46 for generalized anxiety disorder (Marmorstein, 2007).

Autism Spectrum Disorder

- In a recent study by the CDC, 59% of children with ASD were also diagnosed with ADHD (Stevens, Peng, & Barnard-Brak, 2016)
- For youth with ASD, a systematic review revealed prevalence estimates for ODD from 4% to 37% (Kaat & Lecavalier, 2013).
- For youth with ASD prevalence estimates for CD range from 1% to 10% (Kaat & Lecavalier, 2013).

ASD

- A review of the literature revealed wide variation in the estimated rates of depression in children with ASD, ranging from 1.4% to 38% (Magnuson & Constantino, 2011).
- In a sample of children with ASD, Stacy et al., (2014) found that 75% of girls and 72% of boys had a current co-morbid learning disorder.
- Simonoff et al. (2008) found that, among children with ASD, 13% had co-morbid generalized anxiety disorder and 42% had any type of anxiety disorder.

Depression

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- For youth with MDD, researchers have found an odds ratio for an anxiety disorder diagnosis of 3.96 (Avenevoli, Swendsen, He, Burstein, & Merikangas, 2015). A review indicated that 25% to 50% of youth with depression have a co-morbid anxiety disorder and 10% to 15% of youth who have an anxiety disorder have co-morbid depression (Garber & Weersing, 2010)

Learning Disorders

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- In a sample of youth with SLD, Margari et al. (2013) found that 29% had a co-morbid anxiety disorder.

Anxiety

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Special Education Legislative History

- 1975 — The Education for All Handicapped Children Act (EAHCA) became law. It was renamed the Individuals with Disabilities Education Act (IDEA) in 1990.
- 1990— IDEA first came into being on October 30, 1990 when the "Education of All Handicapped Children Act" (itself having been introduced in 1975) was renamed "Individuals with Disabilities Education Act." (Pub. L. No. 101-476, 104 Stat. 1142). IDEA received minor amendments in October 1991 (Pub. L. No. 102-119, 105 Stat. 587).
- 1997— IDEA received significant amendments. The definition of disabled children expanded to include developmentally delayed children between three and nine years of age. It also required parents to attempt to resolve disputes with schools and Local Educational Agencies (LEAs) through mediation, and provided a process for doing so. The amendments authorized additional grants for technology, disabled infants and toddlers, parent training, and professional development. (Pub. L. No. 105-17, 111 Stat. 37).

Special Education Legislative History

- 2004— On December 3, 2004, IDEA was amended by the Individuals With Disabilities Education Improvement Act of 2004, now known as IDEIA. Several provisions aligned IDEA with the No Child Left Behind Act of 2001, signed by President George W. Bush. It authorized fifteen states to implement 3-year IEPs on a trial basis when parents continually agree. Drawing on the report of the President's Commission on Excellence in Special Education,[46] the law revised the requirements for evaluating children with learning disabilities. More concrete provisions relating to discipline of special education students was also added. (Pub. L. No. 108-446, 118 Stat. 2647).
- 2009— Following a campaign promise for "funding the Individuals with Disabilities Education Act",[47] President Barack Obama signed the American Recovery and Reinvestment Act of 2009 (ARRA) on February 17, 2009, including \$12.2 billion in additional funds.
- 2009— Americans with Disabilities Amendments Act was signed into law in September 2008 and became effective on January 1, 2009

Six Foundations of IDEA

- Individualized Education Program
- Free Appropriate Public Education
- Least Restrictive Environment
- Appropriate Evaluation
- Parent and Teacher Participation
- Procedural Safeguards

IDEA

Children are placed in special education services through an evaluation process. If the evaluation is not appropriately conducted, or does not monitor the information that is needed to determine placement it is not appropriate.

The goal of IDEA's regulations for evaluation is to help minimize the number of misidentifications, to provide a variety of assessment tools and strategies, to prohibit the use of any single evaluation as the sole criterion of which a student is placed in special education services, and to provide protections against evaluation measures that are racially or culturally discriminatory.

Overall, the goal of appropriate evaluation is to get students who need help, extra help that is appropriate for the student and helps that specific student to reach his or her goals set by the IEP team

Eligible

adjective

having the right to do or obtain something; satisfying the appropriate conditions.

"customers who are eligible for discounts"

synonyms: entitled, permitted, allowed, qualified, able

"those people eligible to vote"

(of a person) desirable or suitable as a partner in marriage.

"the world's most eligible bachelor"

synonyms: desirable, suitable;

Diagnosis

Medicine/Medical.

the process of determining by examination the nature and circumstances of a diseased condition.

the decision reached from such an examination.

Eligibilities Under The School Psychologist's Direct Consideration

- Emotional Disturbance (depression/anxiety related conditions, social impairments, schizophrenia)
- Autism
- Language
- Intellectual
- Specific Learning Disorder
- Other Health Impairment (ADHD)

Eligibilities Under The School Psychologist's Indirect Consideration

- Other Health Impairment (e.g. diabetes)
- Orthopedics
- Hearing
- Vision

California

§ 3030. Eligibility Criteria.

5 CA ADC § 3030 BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations [Currentness](#)

Title 5. Education

Division 1. California Department of Education

Chapter 3. Individuals with Exceptional Needs

Subchapter 1. Special Education

Article 3.1. Individuals with Exceptional Needs

(7) Multiple disabilities means concomitant impairments, such as intellectual disability-blindness or intellectual disability-orthopedic impairment, the combination of which causes such severe educational needs that they cannot be accommodated in special education programs solely for one of the impairments. "Multiple disabilities" does not include deaf-blindness.

(6) Intellectual disability means significantly subaverage general intellectual functioning, existing concurrently with deficits in adaptive behavior and manifested during the developmental period that adversely affects a child's educational performance.

Colorado

A child with Multiple Disabilities shall have two or more areas of significant impairment, one of which shall be an intellectual disability. The other areas of impairment include: Orthopedic Impairment; Visual Impairment, Including Blindness; Hearing Impairment, Including Deafness; Speech or Language Impairment; Serious Emotional Disability; Autism Spectrum Disorders; Traumatic Brain Injury; or Other Health Impaired. The combination of such impairments creates a unique condition that is evidenced through a multiplicity of severe educational needs which prevent the child from receiving reasonable educational benefit from general education

New Jersey

"Multiply disabled" corresponds to "multiply handicapped" and "multiple disabilities," and means the presence of two or more disabling conditions, the combination of which causes such severe educational needs that they cannot be accommodated in a program designed solely to address one of the impairments.

Multiple disabilities includes cognitively impaired-blindness, cognitively impaired-orthopedic impairment, etc. The existence of two disabling conditions alone shall not serve as a basis for a classification of multiply disabled. Eligibility for speech-language services as defined in this section shall not be one of the disabling conditions for classification based on the definition of "multiply disabled." Multiply disabled does not include deaf-blindness.

Maryland

"Multiple disabilities" means concomitant impairments, such as intellectual disability-blindness or intellectual disability-orthopedic impairment, the combination of which causes such severe educational problems that the student cannot be accommodated in special education programs solely for one of the impairments. (b)

"Multiple disabilities" does not include students with deaf-blindness.

Determining eligibility is an outcome best understood and obtained by a thorough assessment.

How Shall We Understand, Define and Categorize Mental Illness?

- By etiology or cause?
- By emotions, behaviors and thoughts?
- By impaired function in activities of life?

What is the Goal of a Comprehensive Evaluation?

- Identify and define symptoms?
- Identify and define strengths and weaknesses?
- Appreciate the relationship of a set of symptoms to a unitary condition?
- Meet eligibility criteria?
- Define limits of functional impairment to set a baseline for intervention?

Components of a Thorough Assessment

- History
- Broad Spectrum Questionnaires (Parent and Teacher)
- Narrow Spectrum Questionnaires (Parent and Teacher)
- Self report Questionnaires
- Ability Assessment
- Achievement Assessment
- Clinical Assessment (e.g ASD, personality, etc.)
- Interview with student

Ability
Knowledge
Skill

General Guidelines for a Comprehensive School Psychology Evaluation

- A distinction should be made between acute vs. chronic problems.
- Assessment should be strength focused.
- Test results should be presented in ways that are useful to consumers (e.g. family, school, etc.).
- The least amount of assessment needed to answer referral questions should be completed.

Person Attributes Associated With Successful Coping*

- Affectionate, engaging temperament.
- Sociable.
- Autonomous.
- Above average IQ.
- Good reading skills.
- High achievement motivation.
- Positive self-concept.
- Impulse control.
- Internal locus of control.
- Planning skills.
- Faith.
- Humorous.
- Helpfulness.

* Replicated in 2 or more studies

Environmental Factors Associated With Successful Coping*

- Smaller family size.
- Maternal competence and mental health.
- Close bond with primary caregiver.
- Supportive siblings.
- Extended family involvement.
- Living above the poverty level.
- Friendships.
- Supportive teachers.
- Successful school experiences.
- Involvement in pro-social organizations.

*Replicated in 2 or more studies.

The pathways that lead to positive adaptation despite high risk and adversity are complex and greatly influenced by context therefore it is not likely that we will discover a magic (generic) bullet.

Critical Issues

- Demographics
- Symptoms vs. consequences
- Categories vs. dimensions
- Eligibility vs. diagnosis
- Developmental pathways: accept a moment in time
- There are no shortcuts
- Assess the environment

Critical Issues

- Assess for intervention
- Understand positive and negative predictive power
- Understand sensitivity vs. specificity
- Begin with the disruptive/non-disruptive continuum
- Keep low incidence problems in mind
- Consider resilience (protective) factors
- Measure impairment



**Why is the assessment
of impairment critical
to a comprehensive
evaluation?**

An exhaustive review of the literature demonstrates that the relationship between symptoms and functioning remains unexpectedly weak and often bidirectional (McKnight and Kashdan, 2009).

Need

- Clinicians are required to demonstrate the impact psychological and psychiatric diagnoses have on children and adults.
- There is a clear need to measure “impairment” when using the IDEIA, Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) or the International Classification of Diseases (ICD) as a guide to eligibility determination and/or diagnosis.
- The need to measure impairment is increasing.

Impairment is the reduced ability to meet the demands of life because of a psychological, physical, or cognitive condition.



SYMPTOMS VS. IMPAIRMENT

Impairment is not the same as symptoms

- ❑ Symptoms are physical, cognitive or behavioral **manifestations** of a disorder.
- ❑ Impairments are the functional **consequences of these symptoms.**



Inattention



Difficulty completing homework

SYMPTOMS VS. IMPAIRMENT

Impairment can exist absent of formal diagnosis.
(Balazs et al., 2013; Wille et al., 2008)

In one study 14.2% of a sample of children were significantly impaired without a formal diagnosis.
(Angold et al., 1999)

A young woman with long, straight brown hair is shown in a close-up, looking slightly to her right with a thoughtful expression. The background is a soft-focus outdoor setting with green grass and trees. In the background, two other people are visible but out of focus; one is wearing a bright blue top and the other is wearing a teal top. The text is overlaid on the right side of the image.

**How does
impairment differ
from adaptive
behavior?**

IMPAIRMENT VS. ADAPTIVE BEHAVIOR

A skill deficit occurs when a person does not know how to perform an everyday task, whereas a deficit in performance occurs when an individual has acquired a skill, yet does not seem to use it when needed.

(Ditterline & Oakland, 2009)

IMPAIRMENT VS. ADAPTIVE BEHAVIOR

Thus, while measures of adaptive behavior emphasize the presence of adaptive skills in daily functioning, measures of functional impairment tend to emphasize the outcome of a behavior or the performance of an individual rather than the presence or absence of the skill.

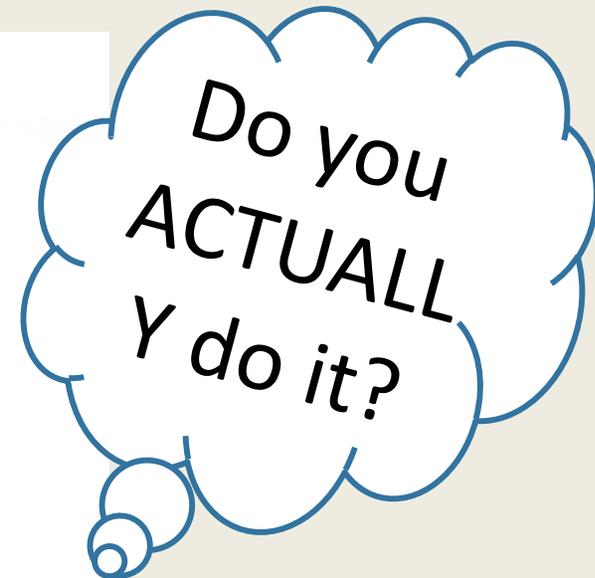
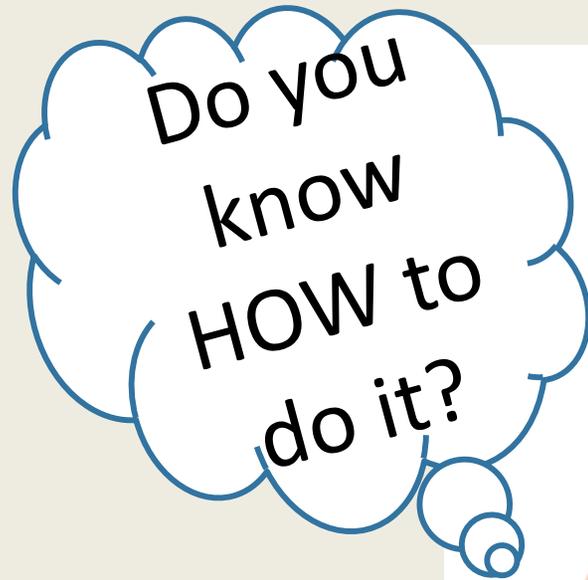
Ditterline & Oakland (2009);
Dumas et al. 2010);
Gleason & Coster (2012)

Adaptive Behavior vs. Impairment

Skill

vs.

Performance



Adaptive Behavior vs. Impairment



Using
utensils

VS.



Not using utensils
to eat

Child with a Disability

IDEIA defines this term as follows:

- (a) **General.** (1) Child with a disability means a child evaluated in accordance with §§300.304 through 300.311 as having an intellectual disability**, a hearing impairment (including deafness), a speech or language impairment, a visual impairment (including blindness), a serious emotional disturbance (referred to in this part as “emotional disturbance”), an orthopedic impairment, autism, traumatic brain injury, an other health impairment, a specific learning disability, deaf-blindness, or multiple disabilities, and who, by reason thereof, needs special education and related services.

Child with a Disability

IDEIA defines this term as follows:

- (2)(i) Subject to paragraph (a)(2)(ii) of this section, if it is determined, through an appropriate evaluation under §§300.304 through 300.311, that a child has one of the disabilities identified in paragraph (a)(1) of this section, but only needs a related service and not special education, the child is not a child with a disability under this part.

Symptoms vs. Impairment



Inattention

VS.



Difficulty completing
homework

Rating Scale of Impairment (RSI) Forms

RSI (5-12 Years)

RSI (13-18 Years)

Parent Form

Teacher Form

Parent Form

Teacher form

41 items

29 items

49 items

29 items

Total Score

Total Score

RSI Scales
School
Social
Mobility
Domestic
Family

RSI Scales
School
Social
Mobility

RSI Scales
School/
Work
Social
Mobility
Domestic
Family
Self-care

RSI Scales
School
Social
Mobility

Relationship Between The RSI And Other Measures

RSI Total Score	
Adaptive Behavior	
-.54	Adaptive Behavior Assessment System-II
Psychopathology	
.26	Conners CBRS — Content Scales
.29	Conners CBRS — Symptom Scales
Social-Emotional Competency	
-.71	Devereux Student Strength Assessment
Executive Function	
-.78	Comprehensive Executive Function Inventory
Ability & Achievement	
-.05	Wechsler Intelligence Scale for Children-IV
-.06	Woodcock Johnson III Tests of Achievement
-.03	Cognitive Assessment System

Relationship Between The RSI And Other Impairment Measures

- RSI and the Barkley Functional Impairment Scale (BFIS–CA)
 - Child Sample corrected $r = .55$ to $.67$
 - Youth Sample corrected $r = .63$ to $.71$
- RSI and the Children’s Global Assessment Scale (CGAS)
 - Corrected $r = -.34$ to $-.51$

RSI Total Score			
Other Impairment Scales			
.59	Barkley Functional Impairment Scale	-.41	Children’s Global Assessment Scale

Begin with history, impairment measure and a broad spectrum rating like the Conners Behavior Rating Scale

Content: Scales & Subscales



Emotional Distress → *Upsetting Thoughts¹;
Worrying¹; Upsetting Thoughts/Physical
Symptoms²; Social Anxiety²*

Defiant/Aggressive Behaviors

Academic Difficulties

Social Problems¹

Separation Fears²

Hyperactivity⁵/Impulsivity

**Perfectionist &
Compulsive Behaviors⁴**

Physical Symptoms

¹ Within Emotional Distress scale on Conners CBRS-P; ² Within Emotional Distress scale on Conners CBRS-T; ³ Subscale of Academic Difficulties scale; ⁴ Scale on Conners CBRS-P & CBRS-T forms only; ⁵ Scale on Conners CBRS-T form only.



DSM Scales

ADHD Inattentive

ADHD Hyperactive-
Impulsive

ADHD Combined

Conduct Disorder

Oppositional Defiant
Disorder

Major Depressive
Disorder

Manic Episode

Mixed Episode

Autism Spectrum
Disorder

Generalized
Anxiety Disorder

Separation
Anxiety Disorder

Social Phobia

Obsessive-Compulsive
Disorder

¹Scale on Conners CBRS-P & CBRS-T forms only.

Other Clinical Indicators



Bullying Perpetration

Bullying Victimization

Enuresis/Encopresis¹

Panic Attack

Pervasive Developmental Disorder³

Pica²

Post-Traumatic Stress Disorder

Specific Phobia

Tics

Trichotillomania

¹ Scale Conners CBRS-P & CBRS-T forms only; ² Scales on Conners CBRS-P & CBRS-SR forms only; ³ Scales on Conners CBRS-SR form only.

Obtain a Thorough History

- Immediate and extended family risks.
- Pregnancy and delivery
- Infancy and toddlerhood (temperament)
- Preschool and school history
- Socialization
- Family relations
- Sleep, appetite and hygiene
- Past treatments or educational services
- Discipline
- Situational problems

Decide on Narrow Spectrum Questionnaires

- Anxiety
- Depression
- Autism Spectrum
- Resilience
- Executive Functioning
- Personality

Autism Spectrum

Autism Spectrum Rating Scales Forms

FULL-LENGTH FORMS

ASRS (2-5)
Ages 2-5 Years (70 items)

ASRS (6-18)
Ages 6-18 Years (71 items)

SHORT FORMS

ASRS Short (2-5)
(15 items)

ASRS Short (6-18)
(15 items)

Total Score

ASRS Scales

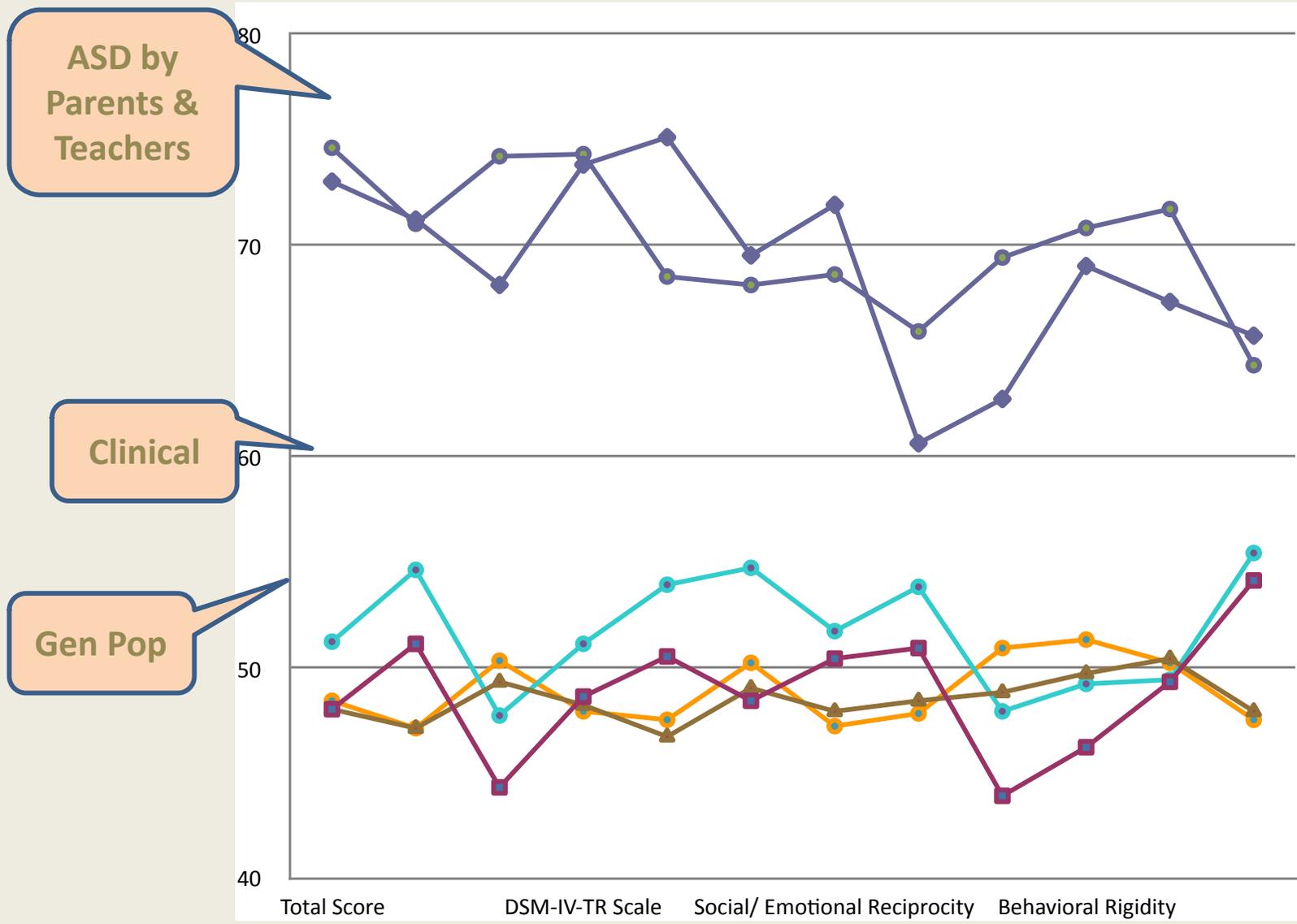
- Social/Communication
- Unusual Behaviors

DSM 5

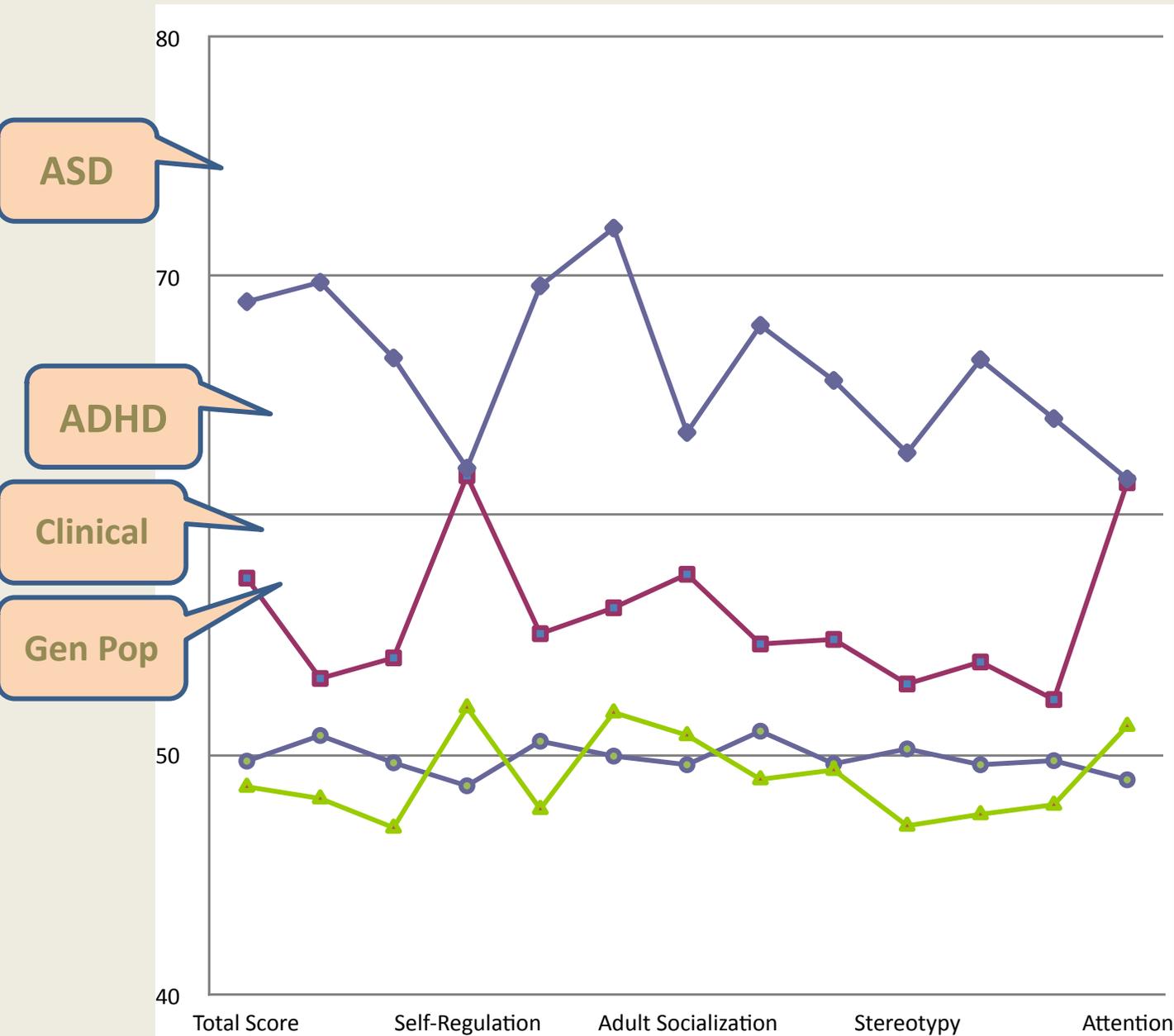
Treatment Scales

- Peer Socialization
- Adult Socialization
- Social/Emotional Reciprocity
- Atypical Language
- Stereotypy
- Behavioral Rigidity
- Sensory Sensitivity
- Attention/Self-Regulation

ASRS Validity for ages 2-5 Parents

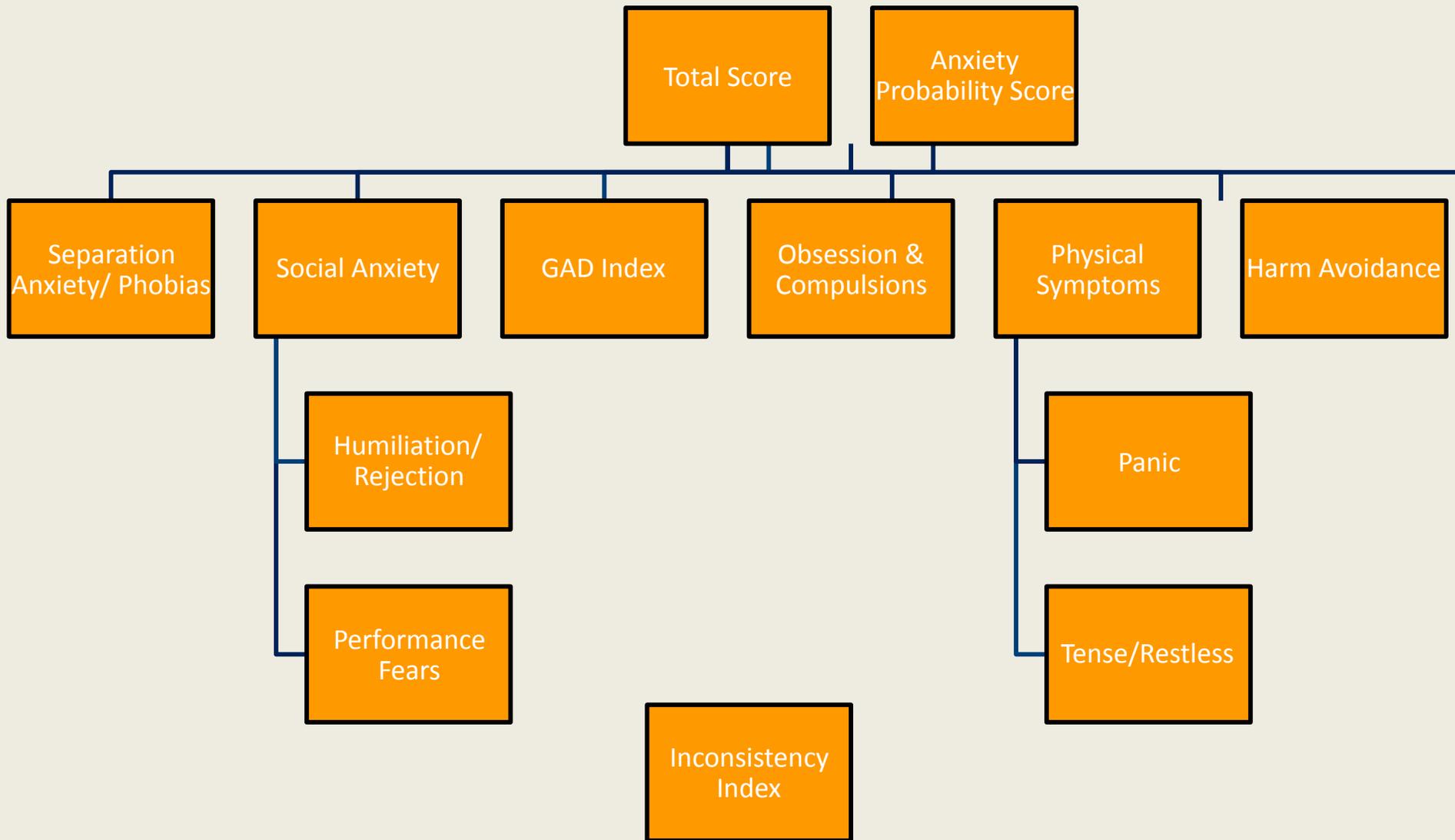


ASRS Validity: Ages 6-18 Parents



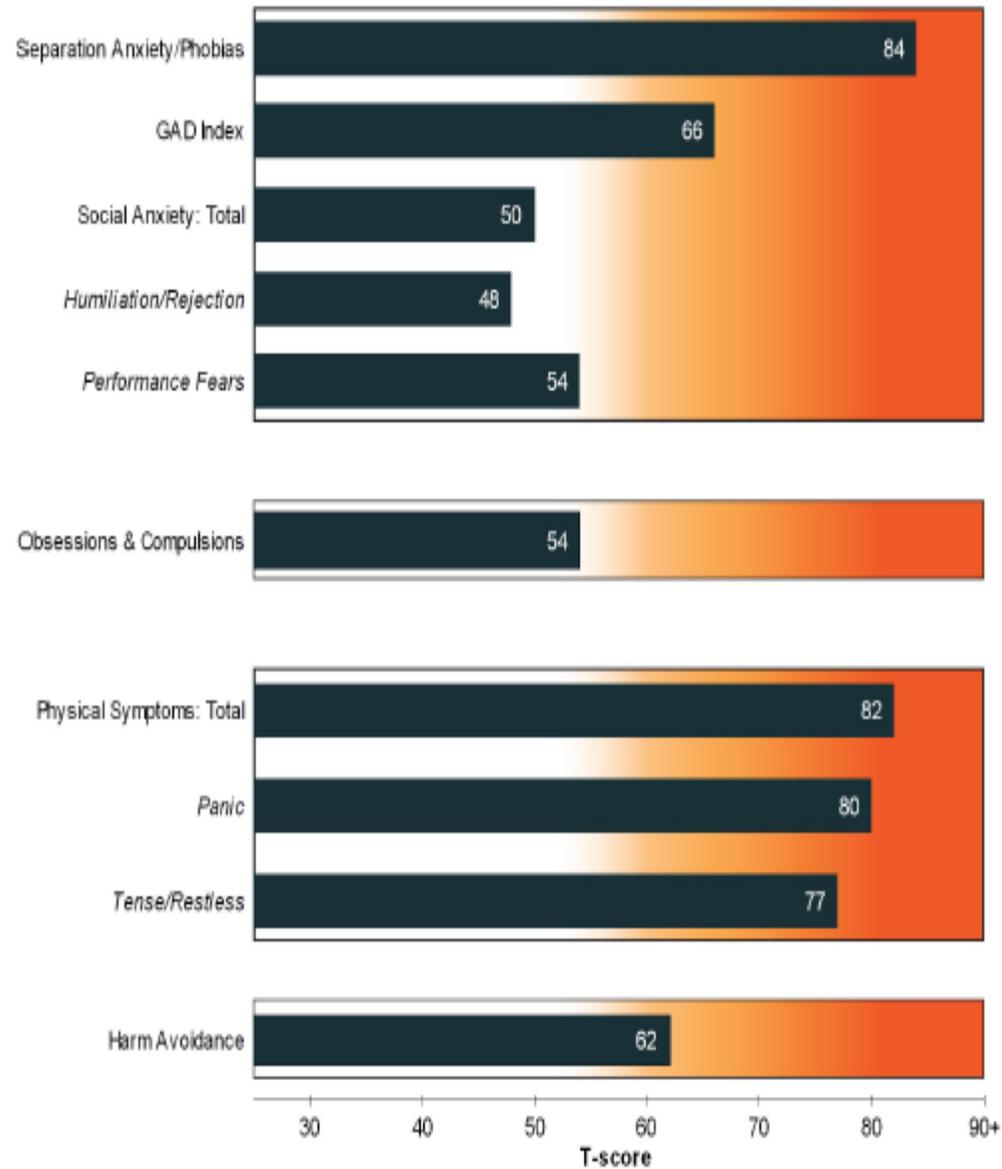
Anxiety

MASC-2 Scales



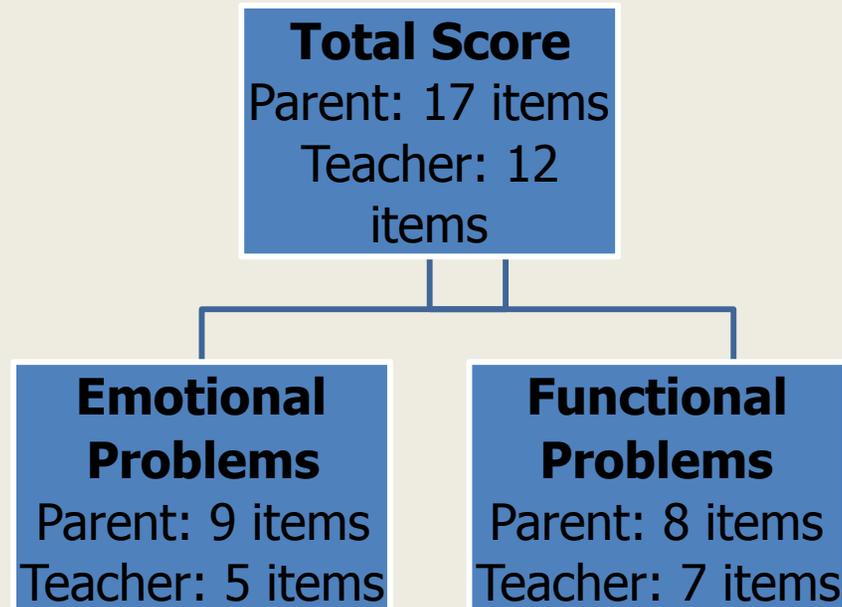
MASC 2 Scales

MASC 2 Scales



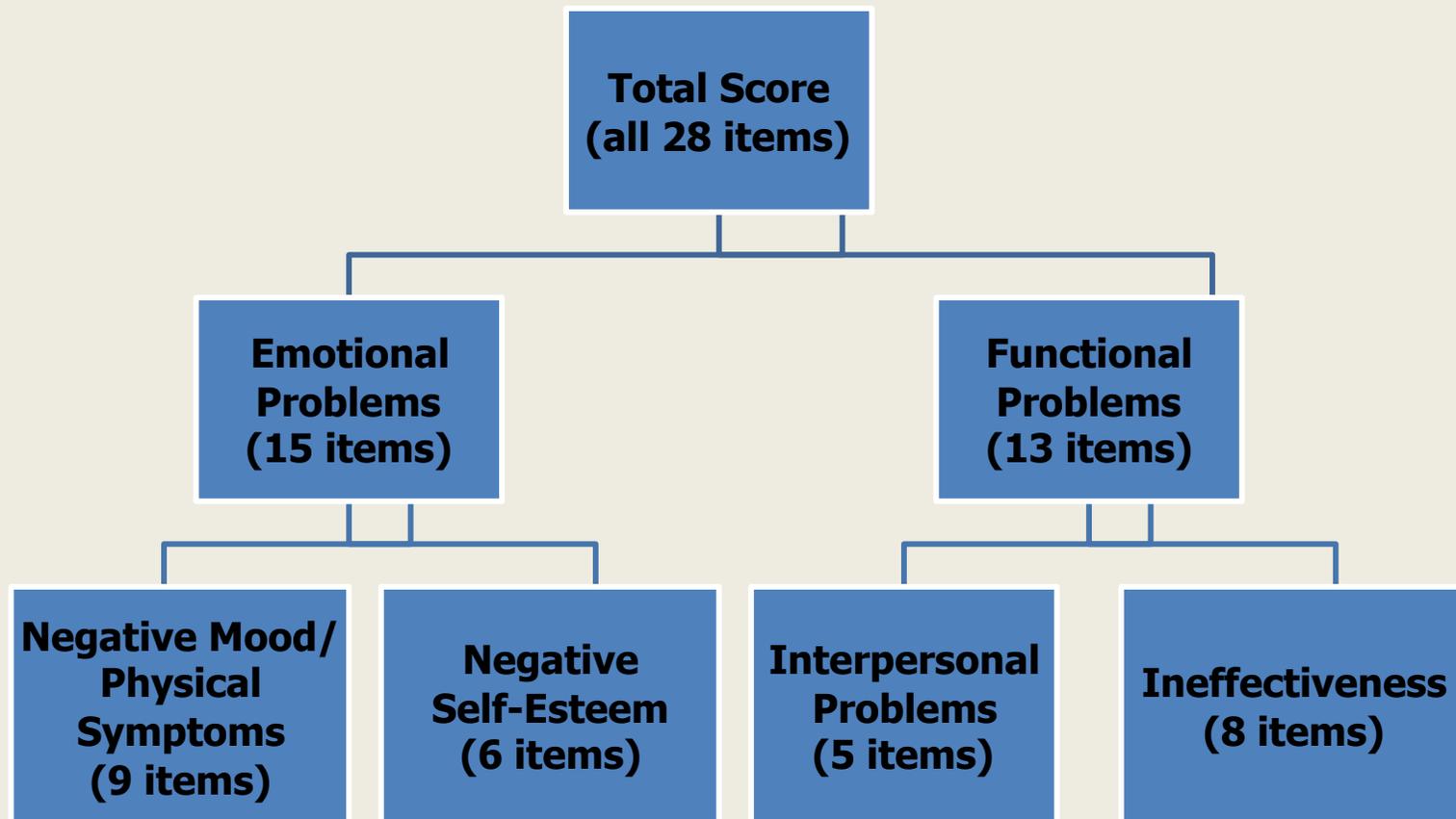
Depression

Scale Structure: Parent and Teacher

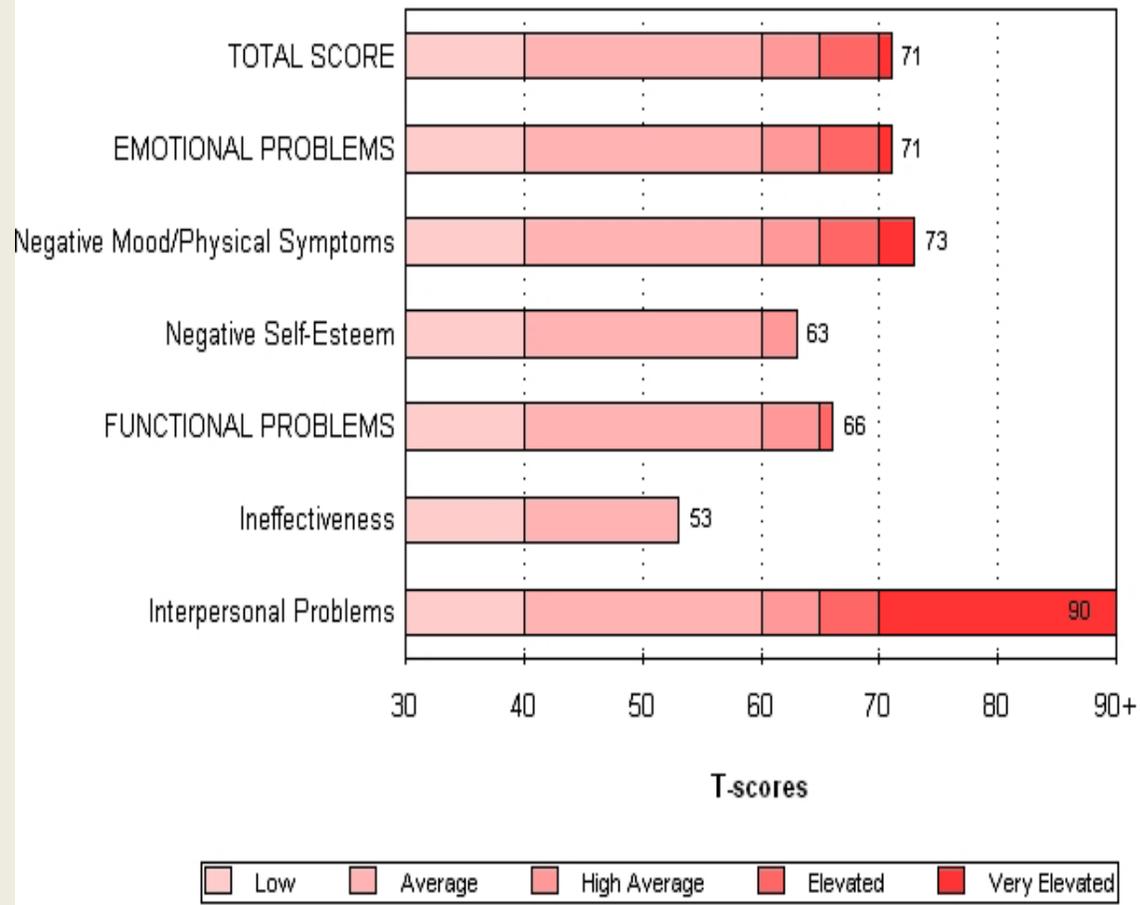


4-point Likert-type rating: 0="Not at All" ; 3="Much or Most of the Time"

Scale Structure: Self-Report (Full Length)



CDI Profile



Executive Functioning

CEFI Scales

Each form yields a **Full Scale** score and 9 separate content scales which contain items as follows...

Consistency Index
Negative Impression Scale
Positive Impression Scale

Full Scale

CEFI Scales

Attention
Emotion Regulation
Flexibility
Inhibitory Control
Initiation
Organization
Planning
Self-Monitoring
Working Memory

Group Differences: ADHD

(Naglieri & Goldstein, 2013)

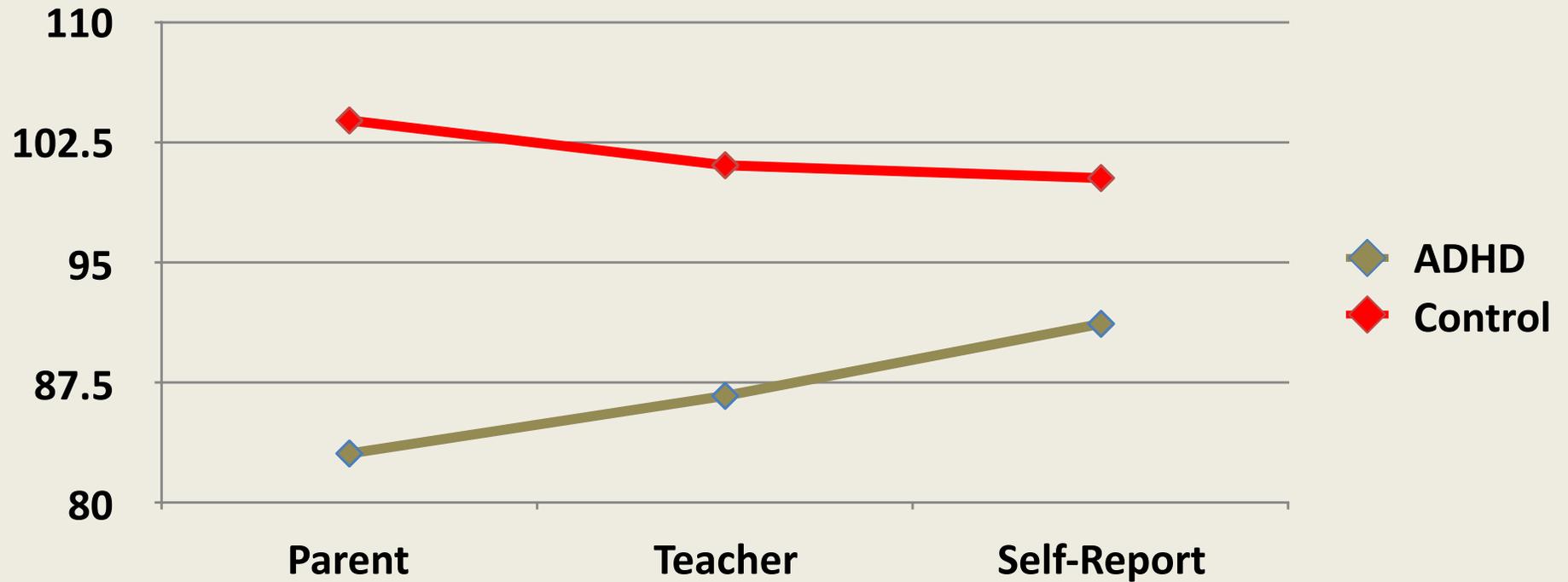


Table 8.19 Differences Between ADHD and Matched General Population Samples: CEFI Full Scale

Form		ADHD	Matched Gen. Pop.	<i>d</i> -ratio	<i>F</i> (<i>df</i>)	<i>P</i>
Parent	<i>M</i>	83.1	103.9	-1.59	216.56 (1, 340)	< .001
	<i>SD</i>	13.0	13.0			
	<i>N</i>	171	171			
Teacher	<i>M</i>	86.7	101.1	-1.07	79.93 (1, 278)	< .001
	<i>SD</i>	13.5	13.5			
	<i>N</i>	138	142			
Self-Report	<i>M</i>	91.2	100.3	-0.62	22.21 (1, 232)	< .001
	<i>SD</i>	14.7	14.7			
	<i>N</i>	117	117			

Note: ADHD = Attention Deficit/Hyperactivity Disorder; Gen. Pop. = General Population

Group Differences: ASD

(Naglieri & Goldstein, 2013)

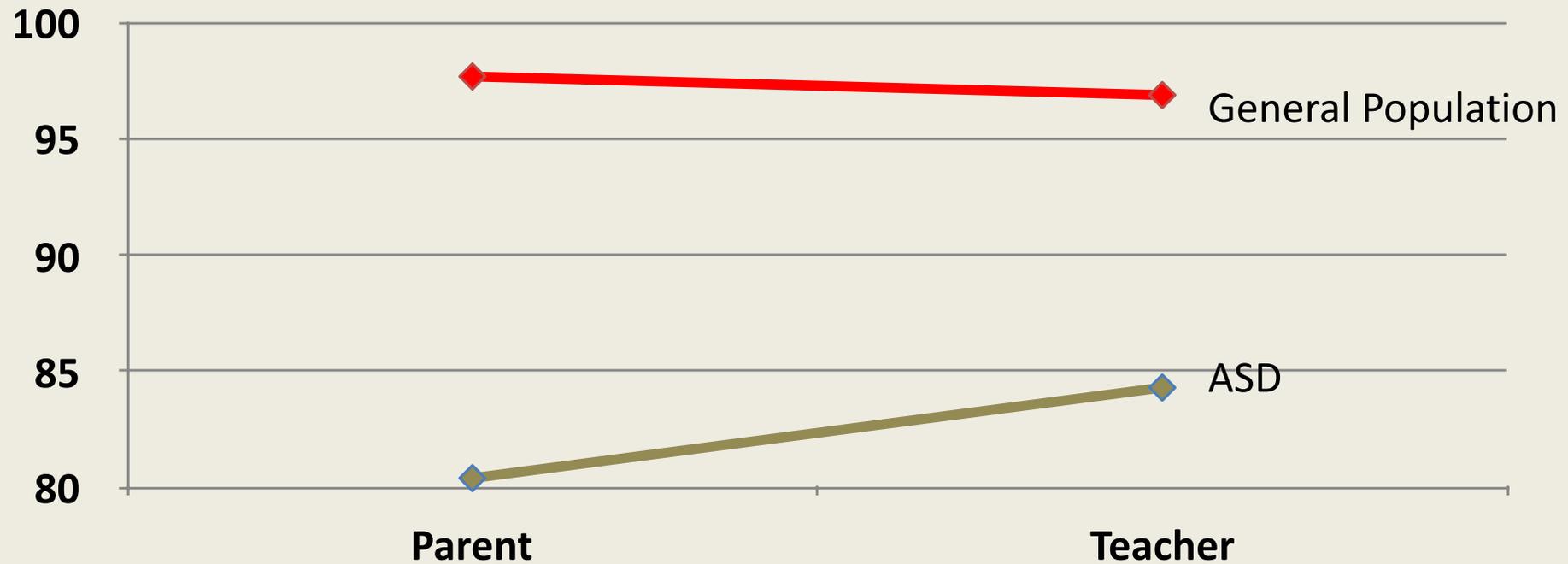


Table 8.20 Differences Between ASD and Matched General Population Samples: CEFI Full Scale

Form		ASD	Matched Gen. Pop.	<i>d</i> -ratio	<i>F</i> (<i>df</i>)	<i>P</i>
Parent	<i>M</i>	80.4	97.7	-1.41	48.96 (1, 96)	< .001
	<i>SD</i>	12.2	12.2			
	<i>N</i>	48	50			
Teacher	<i>M</i>	84.3	96.9	-0.99	23.11 (1, 92)	< .001
	<i>SD</i>	12.7	12.7			
	<i>N</i>	47	47			

Group Differences: Learning Disabilities

(Naglieri & Goldstein, 2013)

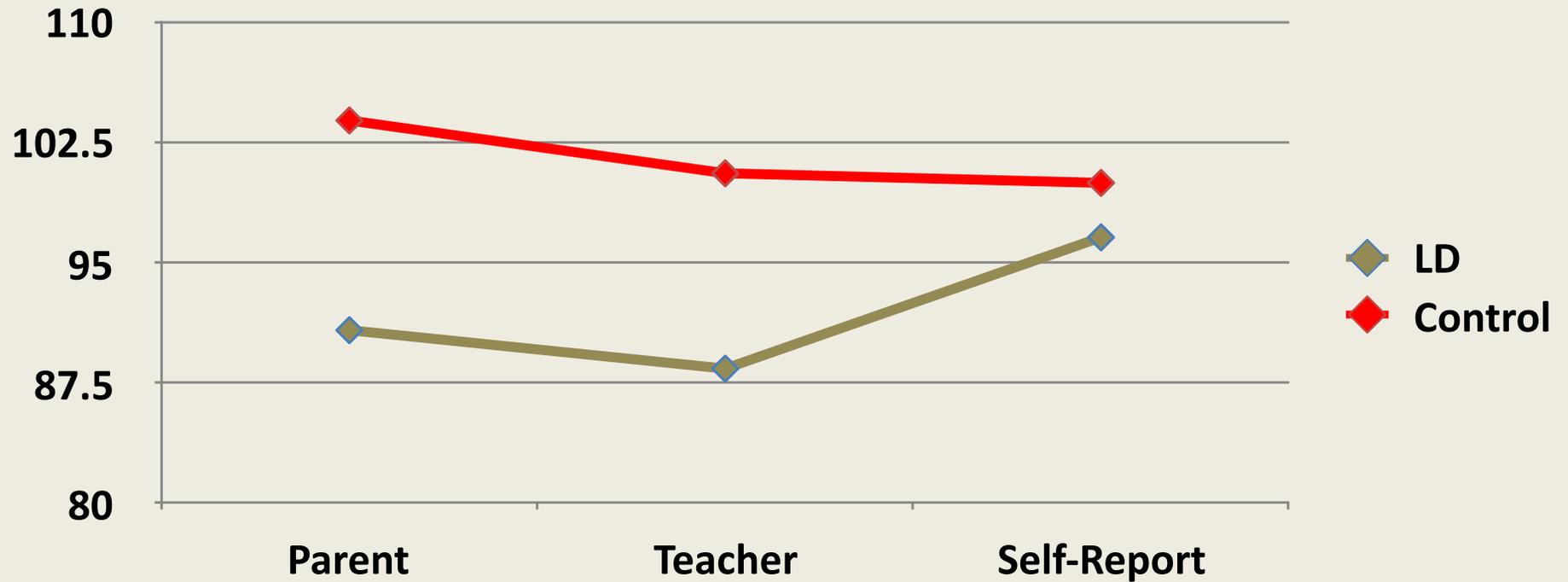


Table 8.22 Differences Between LD and Matched General Population Samples: CEFI Full Scale

Form		LD	Matched Gen. Pop.	<i>d</i> -ratio	<i>F</i> (<i>df</i>)	<i>p</i>
Parent	<i>M</i>	90.8	103.9	-0.92	19.89 (1, 93)	< .001
	<i>SD</i>	14.4	14.4			
	<i>N</i>	47	48			
Teacher	<i>M</i>	88.4	100.6	-0.91	37.29 (1, 178)	< .001
	<i>SD</i>	13.4	13.4			
	<i>N</i>	90	90			
Self-Report	<i>M</i>	96.6	100.0	-0.21	1.45 (1, 126)	0.231
	<i>SD</i>	15.9	15.9			
	<i>N</i>	64	64			

Group Differences: Mood Disorders

(Naglieri & Goldstein, 2013)

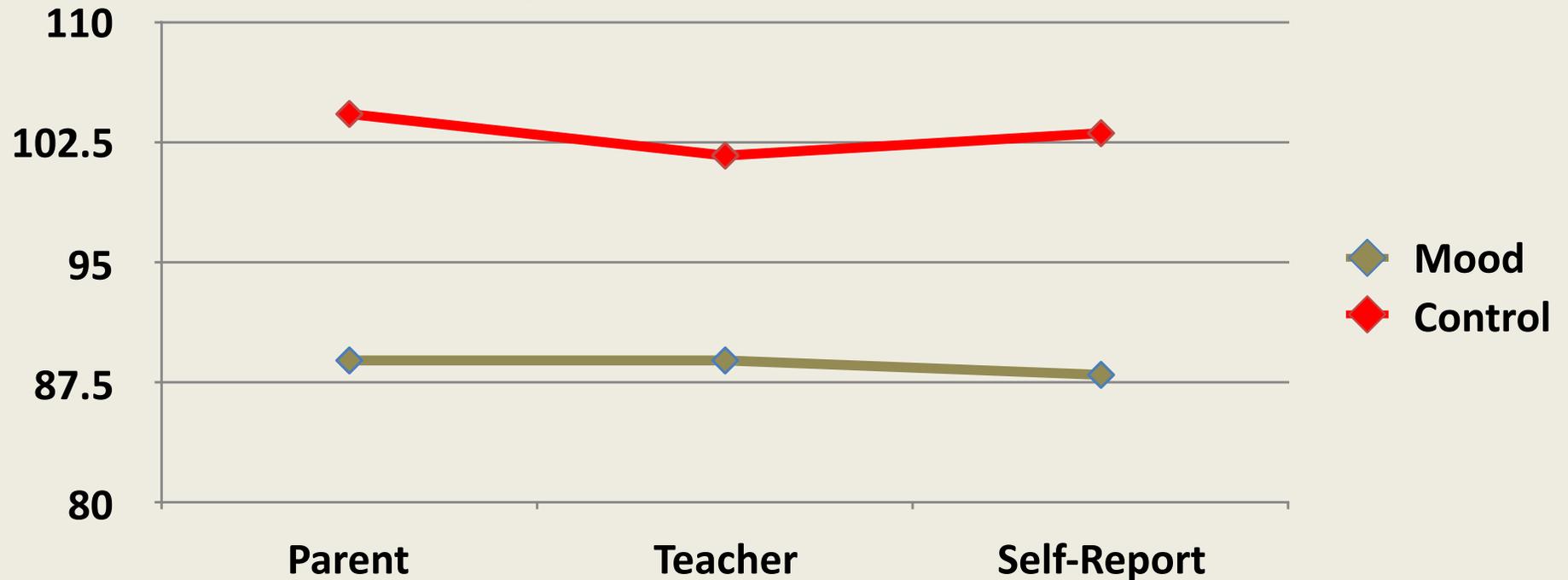


Table 8.21 Differences Between Mood Disorder and Matched General Population Samples: CEFI Full Scale

Form		Mood Disorder	Matched Gen. Pop.	<i>d</i> -ratio	<i>F</i> (<i>df</i>)	<i>p</i>
Parent	<i>M</i>	88.9	104.3	-1.11	22.66 (1, 71)	< .001
	<i>SD</i>	13.8	13.8			
	<i>N</i>	36	37			
Teacher	<i>M</i>	88.9	101.7	-1.01	14.9 (1, 57)	< .001
	<i>SD</i>	12.8	12.8			
	<i>N</i>	29	30			
Self-Report	<i>M</i>	88.0	103.1	-1.09	16.34 (1, 53)	< .001
	<i>SD</i>	13.9	13.9			
	<i>N</i>	27	28			

Resilience

Efforts to Measure Resilience in Clinical Practice

- Devereux Elementary Student Strength Assessment (81 item rating scale).
- Devereux Early Childhood Assessment. (45 items).
- Resiliency Scales for Children and Adolescents (60 + item rating scales).
- Psychological Resilience Scale (25 items).

Assessment of Risk

- Risky Behaviors
- Protective Behaviors
- Risky Behaviors
 - Bullying
 - Delinquency
 - Health
 - Sexual
 - Substance Abuse
 - Suicide

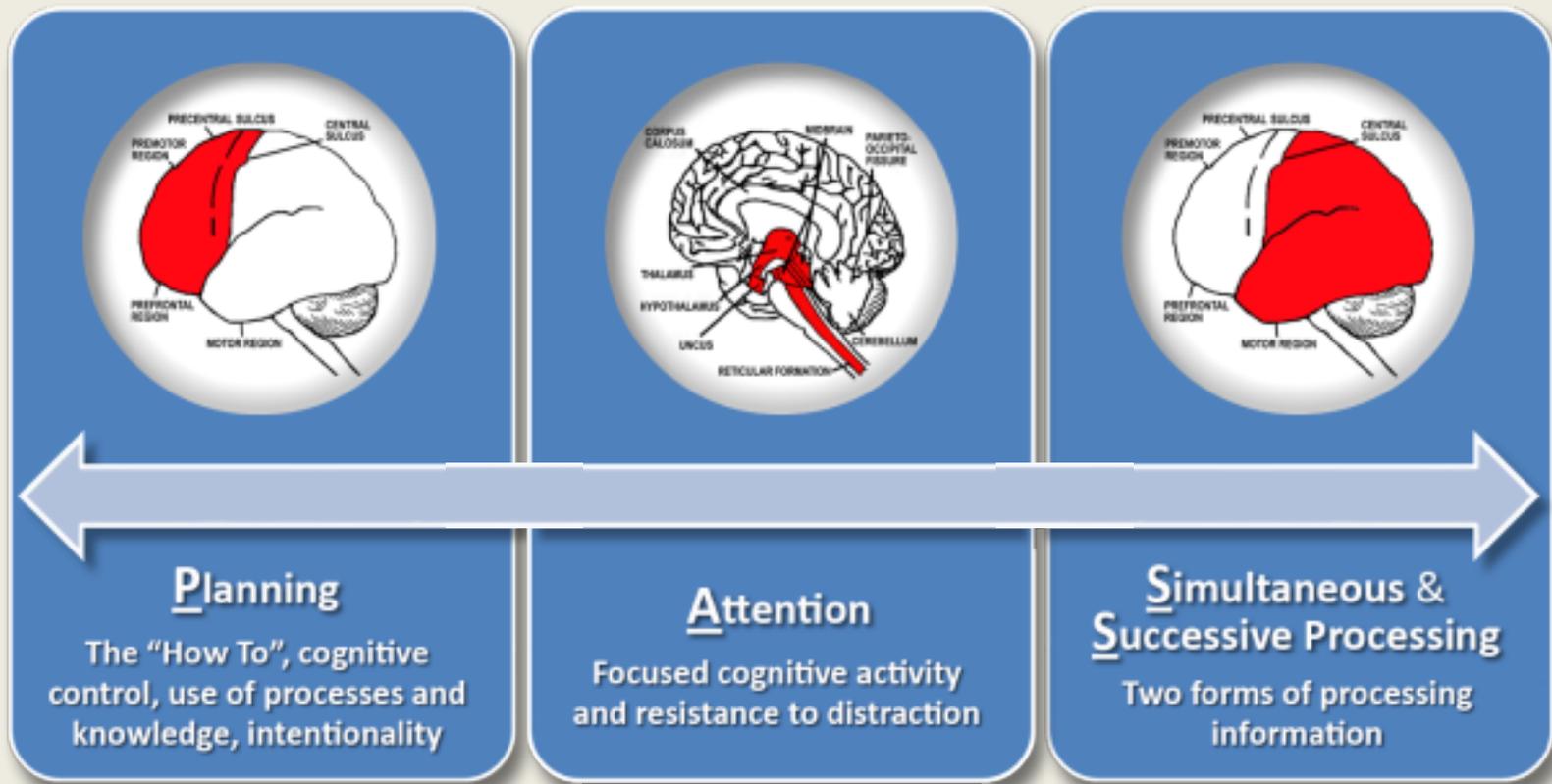
Ability and Achievement

PASS Theory

- **PASS** theory is a way to define functioning based on measuring neuropsychological abilities
- **P**lanning = Getting from point A to Point B
- **A**ttention = Attending to details
- **S**imultaneous = Solving problems
- **S**uccessive = Following a sequence

The Brain as PASS

PASS: A neuropsychological approach to the Brain based on three Functional Units described by A. R. Luria (1972)

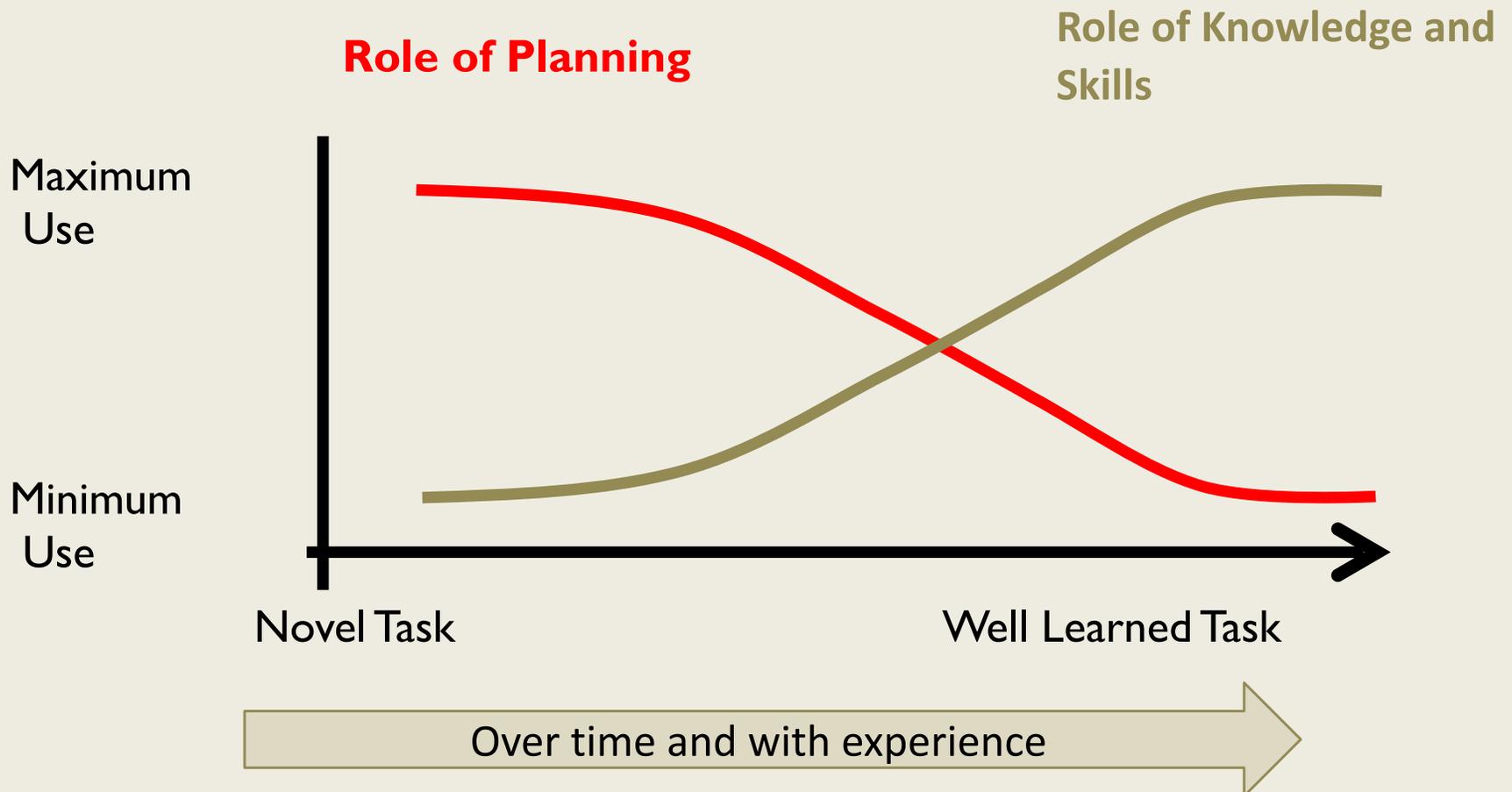


PASS Theory: Planning

- ▶ **Planning** is a neurocognitive ability that a person uses to determine, select, and use efficient solutions to problems
 - developing plans and using strategies
 - retrieval of knowledge
 - impulse control and self-control
 - control of processing

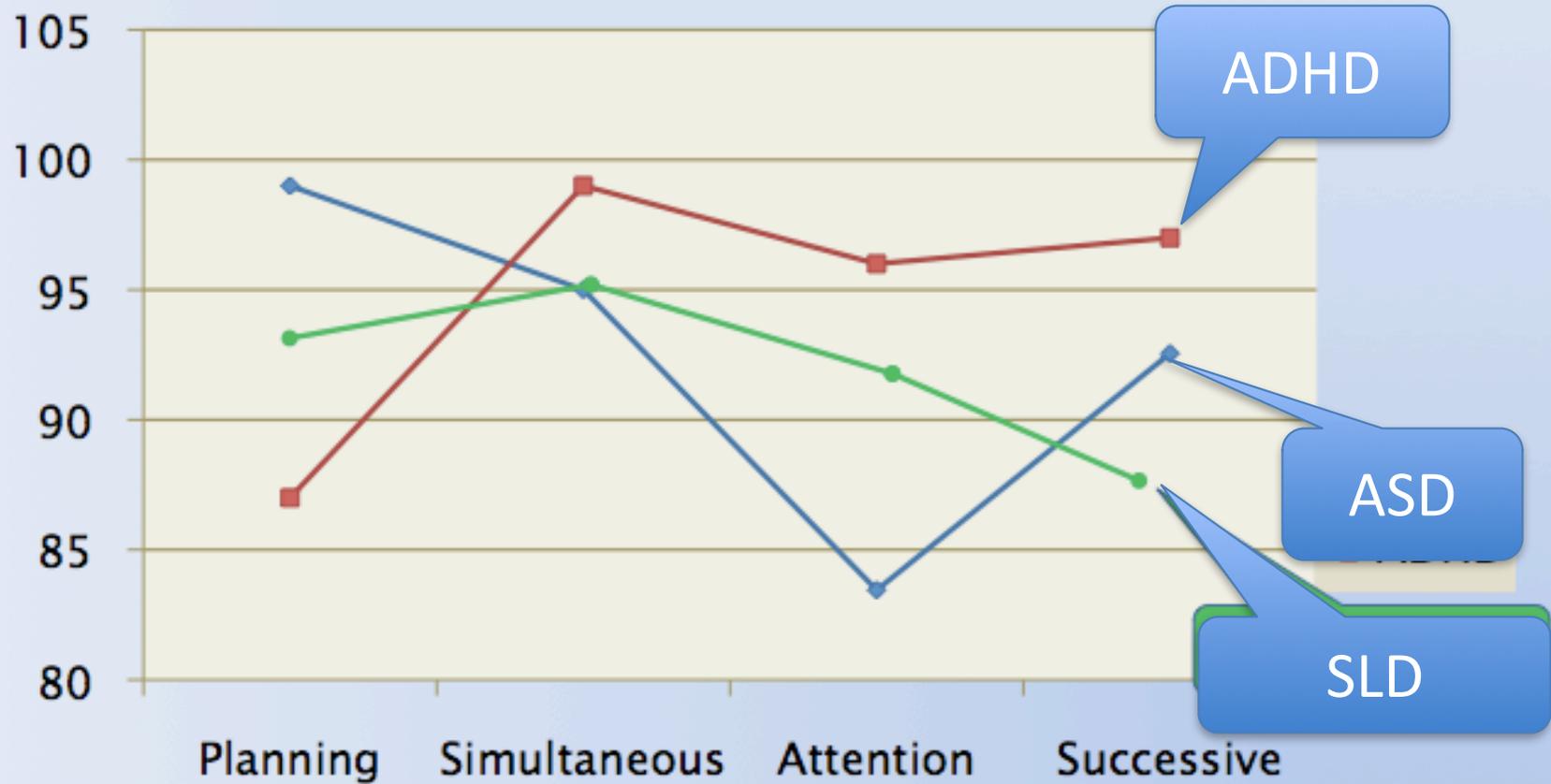
Knowledge and Planning Learning Curves

- Learning depends upon instruction and intelligence (PASS)
- At first, PASS plays a major role in learning
- When a new task is learned and practiced it becomes a skill and execution requires less PASS



Ability Profiles

PASS Processing Scores



Organizing the Data

- A day in the life.
- Ability/Knowledge/Skill
- Risk and Protective factors
- Determining eligibility
- Suggesting possible diagnoses
- Recommending needs
- Considering continuum of services

Multiple Handicap or Primary/Secondary?

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TEDx

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The Power Of Resilience

https://www.youtube.com/watch?v=isfw8JJ-eWM&feature=youtube_gdata