

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

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## 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)

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## Goals for Today

- 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.

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## I Had a Revelation in St. Augustine

The World Operates Along a Normal Curve!

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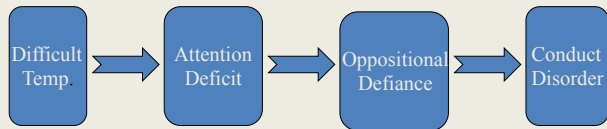
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### The Disruptive Continuum of Behavior



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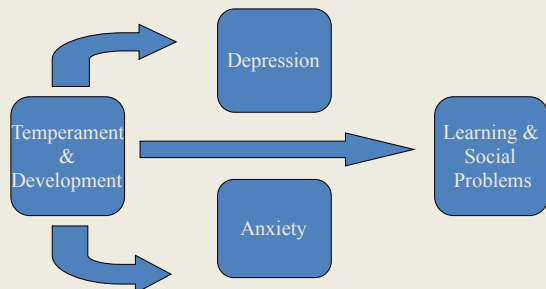
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### The Non-disruptive Continuum of Behavior



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

Diagnosis

Eligibility Determination

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Does diagnosis equal eligibility?

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How Shall We Understand, Define and Categorize Mental Illness and developmental Problems?

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

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## Diagnosis

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

the decision reached from such an  
examination.

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How distinct are these disorders  
from each other?

Much less so than makes me  
comfortable!

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## 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).

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## 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.

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## 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).

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## 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)

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## 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).

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## 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).

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## 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)
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## 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

- 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).
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## Depression

- 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 youth with SLD, Margari et al. (2013) found that 9% had a co-morbid mood disorder.
- 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

- 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 co-morbid ADHD.
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## 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

- 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.
- For individuals with ODD, researchers have found a lifetime prevalence of 62% for any anxiety disorder (Nock, Kazdin, Hiripi, & Kessler, 2007)
- 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).



## 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

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## 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

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## 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;

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### 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)

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### Eligibilities Under The School Psychologist's Indirect Consideration

- Other Health Impairment (e.g. diabetes)
- Orthopedics
- Hearing
- Vision
- Developmental Disability
- Multiply Handicapped

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## 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.

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## 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.

## Oregon

"Children with disabilities" or "students with disabilities" means children or students who require special education because of: autism; communication disorders; deafblindness; emotional disturbances; hearing impairments, including deafness; intellectual disability; orthopedic impairments; other health impairments; specific learning disabilities; traumatic brain injuries; or visual impairments, including blindness.

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

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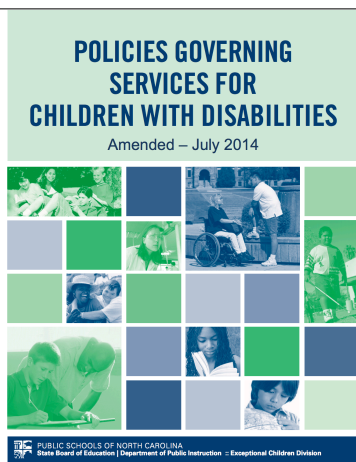
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Well Defined  
Guidelines



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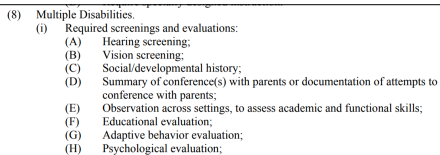
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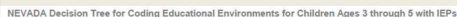


## July 2014

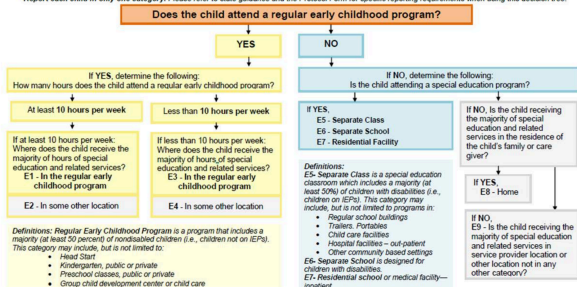
- (I) Speech/language evaluation;
  - (J) Medical evaluation; and
  - (K) Motor evaluation.
- (ii) To be determined eligible in the disability category of multiple disabilities, a child must demonstrate:
- (A) Two or more disabilities occurring together,
  - (B) The combination of which is so severe, complex, and interwoven that identification in a single category of disability cannot be determined.
- (iii) The disability must:
- (A) Have an adverse effect on educational performance, and
  - (B) Require specially designed instruction.

## INFORMATION

Not Gender ID # <input type="text"/> SSN <input type="text"/> SSN <input type="text"/>  ALYON <input type="text"/>	<b>ELIGIBILITY CATEGORY</b> <input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> Deaf/Blind <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Emotional Disturbance <input type="checkbox"/> Health Impairment <input type="checkbox"/> Hearing Impairment/Deaf <input type="checkbox"/> Intellectual Disability <input type="checkbox"/> Multiple Impairment <input type="checkbox"/> Orthopedic Impairment <input type="checkbox"/> Specific Learning Disability <input type="checkbox"/> Speech/Language Impairment <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Visual Impairment/Blind	<b>MEETING INFORMATION</b> DATE OF MEETING: <input type="text"/> DATE OF LAST IEP MEETING: <input type="text"/> <b>PURPOSE OF MEETING</b> <input type="checkbox"/> Review IEP <input type="checkbox"/> Initial IEP <input type="checkbox"/> Annual IEP <input type="checkbox"/> IEP Following 5th Reevaluation <input type="checkbox"/> Revision To IEP Based On <input type="checkbox"/> New Student/Child <input type="checkbox"/> IEP Revision Without A Meeting At the request of <input type="text"/> Parent or <input type="text"/> School District <input type="checkbox"/> Other: <input type="text"/> IEP SERVICES WILL BEGIN: <input type="text"/> ANTICIPATED DURATION OF SERVICES: <input type="text"/> IEP REVIEW DATE: <input type="text"/> COMMENTS: <input type="text"/>
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Report each child in only one category. Please refer to state guidance and the Protocol Form for specific reporting requirements when using this decision tree.



**SPP/APR Indicator 6:** Percent of children 3 through 5 with IEPs attending:  
Indicator 6A: regular early childhood program and receiving the majority of  
special education and related services in the regular early childhood program.  
(E1+E3 divided by total number of children 3-5 with IEPs x 100)

↔ SPP/APR Indicator 6B: Separate special education class, separate school or residential facility.  $(E5+E6+E7 \text{ divided by total number of children 3-5 with IEPs} \times 100)$

### 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?

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### 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

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### Ability, Knowledge and Skill

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## 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

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## 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.

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## 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

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## 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.

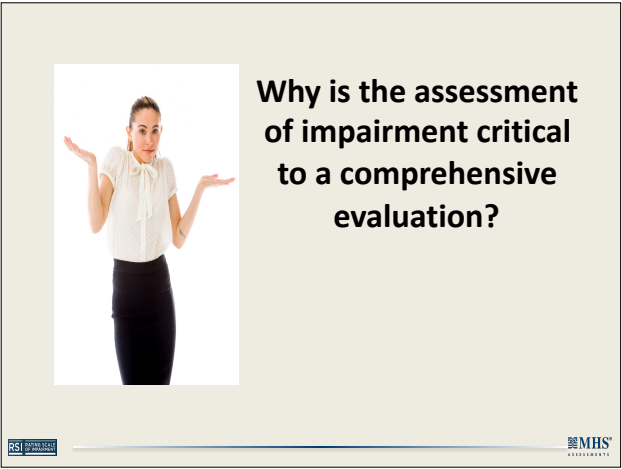
The pathways that lead to positive adaptation despite high risk and adversity are complex and greatly influenced by context therefore it is not likely that we will discover a magic (generic) bullet.

## 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



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.**



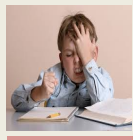
## SYMPTOMS VS. IMPAIRMENT

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)

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How does  
impairment differ  
from adaptive  
behavior?

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## 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)

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## 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)

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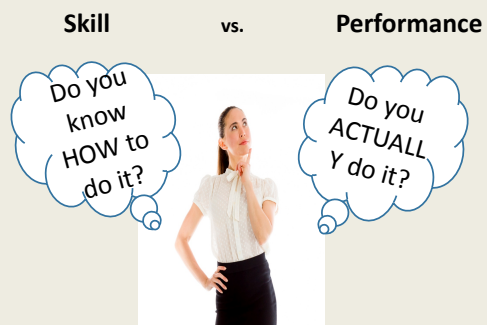
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## Adaptive Behavior vs. Impairment



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## Adaptive Behavior vs. Impairment



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**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




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## Relationship Between The RSI And Other Measures

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

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

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## Content: Scales & Subscales



**Emotional Distress** → *Upsetting Thoughts*<sup>1</sup>;  
*Worrying*<sup>1</sup>; *Upsetting Thoughts/Physical  
Symptoms*<sup>2</sup>; *Social Anxiety*<sup>2</sup>

**Separation Fears**<sup>2</sup>

**Defiant/Aggressive Behaviors**

**Hyperactivity**<sup>5</sup>/Impulsivity

**Academic Difficulties**

**Perfectionist &  
Compulsive Behaviors**<sup>4</sup>

**Social Problems**<sup>1</sup>

**Physical Symptoms**

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

## DSM Scales



ADHD Inattentive

Major Depressive  
Disorder

Generalized  
Anxiety Disorder

ADHD Hyperactive-  
Impulsive

Manic Episode

Separation  
Anxiety Disorder

ADHD Combined

Mixed Episode

Social Phobia

Conduct Disorder

Oppositional Defiant  
Disorder

Autism Spectrum  
Disorder

Obsessive-Compulsive  
Disorder

<sup>1</sup> Scale on Conners CBRS-P & CBRS-T forms only.

## Other Clinical Indicators



Bullying Perpetration

Pica<sup>2</sup>

Bullying Victimization

Post-Traumatic Stress Disorder

Enuresis/Encopresis<sup>1</sup>

Specific Phobia

Panic Attack

Tics

Pervasive Developmental  
Disorder<sup>3</sup>

Trichotillomania

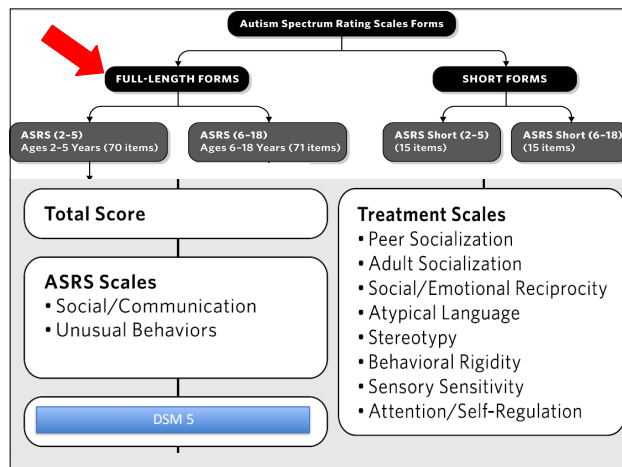
<sup>1</sup> Scale Conners CBRS-P & CBRS-T forms only; <sup>2</sup> Scales on Conners CBRS-P & CBRS-SR forms only; <sup>3</sup> Scales on Conners CBRS-SR form only.



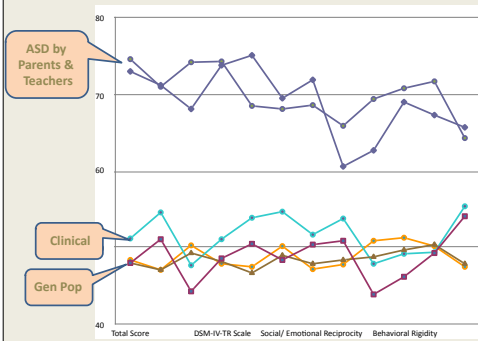
## Decide on Narrow Spectrum Questionnaires

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

## Autism Spectrum

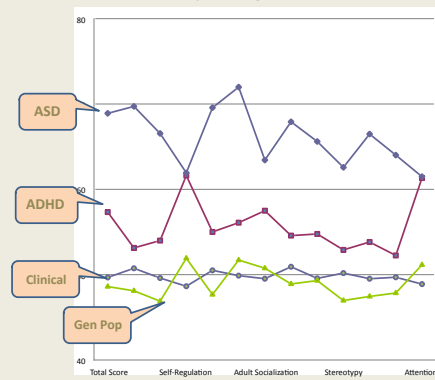


## ASRS Validity for ages 2-5 Parents



76

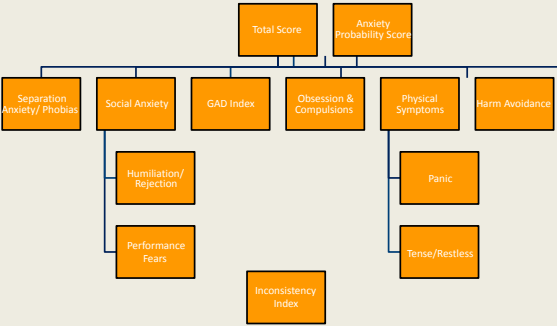
## ASRS Validity: Ages 6-18 Parents



77

Anxiety

MASC-2 Scales



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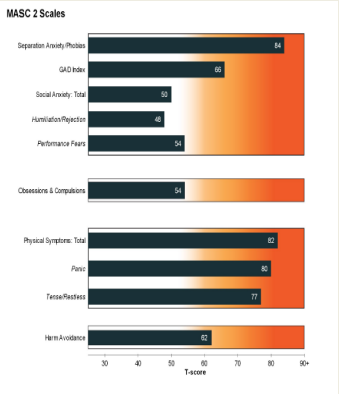
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MASC 2 Scales



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Depression

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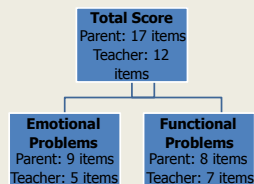
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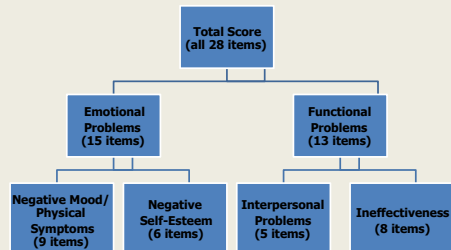
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## Scale Structure: Parent and Teacher



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

## Scale Structure: Self-Report (Full Length)

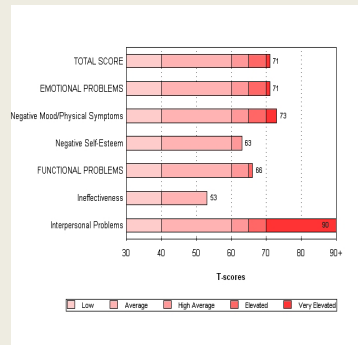


The image shows a sample of the CDI-2 Self-Report form. It includes a header with the CDI-2 logo and 'SELF-REPORT' text. Below the header, there are instructions for the child to pick the sentence that describes them best in the past two weeks. The form is divided into two columns of items, each with a checkbox. Item 1, 'I am sad once in a while', is circled in blue. The form also includes a section for the child to write their name and date.

## CDI-2 Self-Report

Each sentence is given either 0,1, or 2 points

## 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)

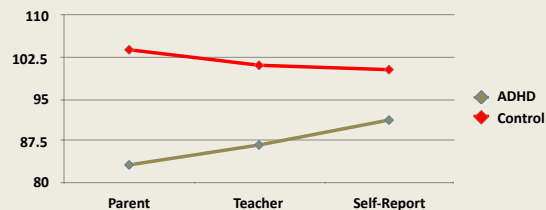


Table 8.19 Differences Between ADHD and Matched General Population Samples: CEFI Full Scale

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

# Group Differences: ASD

(Naglieri & Goldstein, 2013)

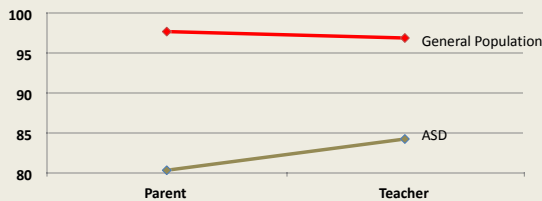


Table 8.20 Differences Between ASD and Matched General Population Samples: CEFI Full Scale

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

# Group Differences: Learning Disabilities

(Naglieri & Goldstein, 2013)

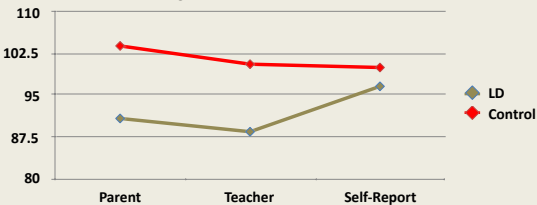


Table 8.22 Differences Between LD and Matched General Population Samples: CEFI Full Scale

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

## Group Differences: Mood Disorders

(Naglieri & Goldstein, 2013)

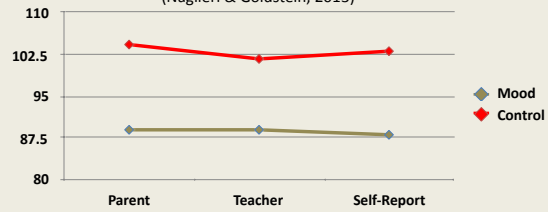


Table 8.21 Differences Between Mood Disorder and Matched General Population Samples: CEFI Full Scale

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

- Risk Behaviors
- Strength Behaviors
- Risk Behaviors
  - Bullying
  - Delinquency
  - Health
  - Sexual
  - Substance Abuse
  - Suicide

## Ability and Achievement

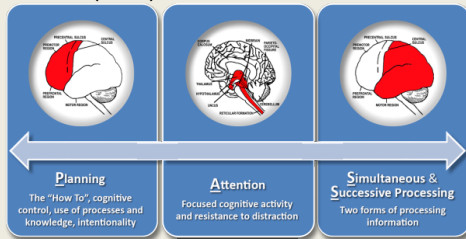
## PASS Theory

- **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)



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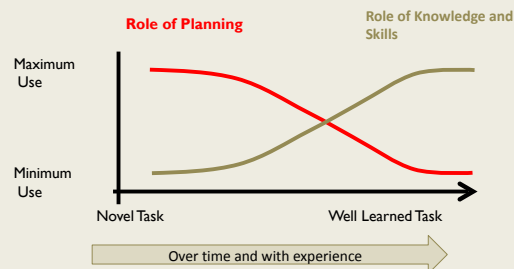
## PASS Theory: Planning

- **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

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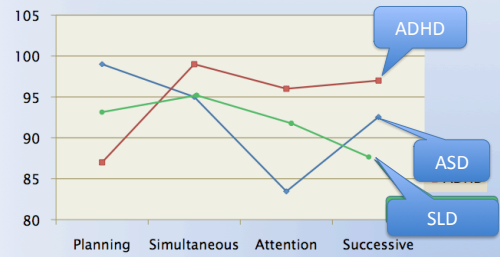
## Knowledge and Planning Learning Curves

- 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?

ADOPT A LEARNING TO RIDE A BICYCLE  
MINDSET!

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[www.MHS.com](http://www.MHS.com)  
<https://tinyurl.com/assessmentgoldstein>

**TEDx**

**Sam Goldstein, Ph.D.**  
[sam@samgoldstein.com](mailto:sam@samgoldstein.com)

**The Power Of Resilience**

[https://www.youtube.com/watch?v=isfw8JJ-eWM&feature=youtube\\_gdata](https://www.youtube.com/watch?v=isfw8JJ-eWM&feature=youtube_gdata)

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