New Assessment Instruments

Psychological Services

Staff Meeting 11/06/13

Overview

We will be providing an overview of the following assessment instruments:

• CMOCS	• SAED-2
• ARES	• MASC-2
• CDI-2	• CARS-2
• ASRS	• CTOPP-2

Objectives

- To enhance the repertoire of our assessment instruments and strengthen our assessment skills

- To develop a cross battery approach in which multiple measures are used and shall be corroborated between home, school, and community

Guiding Principles

- All assessment procedures measure a limited sample of a person's total repertoire
- The selected measures should only be interpreted within the limits of their measured validity.
- No single measure shall be used as the sole criterion to make educational decisions

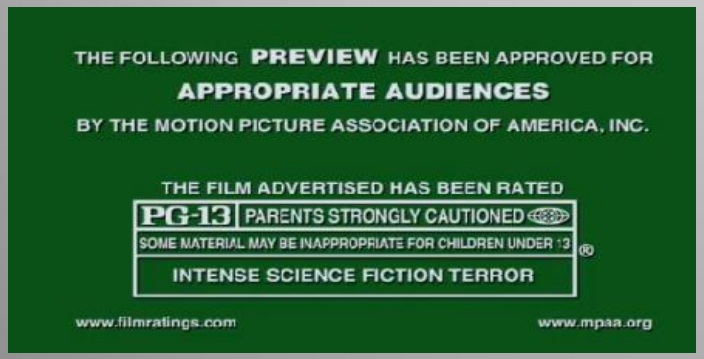
Children's Measure of Obsessive Compulsive Symptoms

Purpose of Assessment

- Designed to assess obsessive and compulsive behaviors and their impact on daily functioning

Video

- Here's a short video showing obsessive compulsive symptoms and their impact on daily life functioning and interpersonal relationships



Disclaimer
A Sense of Humor is Required!

Reliability

- Internal consistency estimate for Total score is .94 with retest reliability of .95

- For Impact score and Problem Area scores, internal consistency estimates range from .7 to .81 with retest reliability ranging from .78 to .94

Validity

- Internal consistency estimate for Total score is .94 with retest reliability of .95

- For Impact score and Problem Area scores, internal consistency estimates range from .7 to .81 with retest reliability ranging from .78 to .94

Demographics: Standardization Sample

The CMOCS is standardized on a subgroup (N= 1,644)that was randomly selected from a larger reference sample group

The subgroup was drawn to match the demographic composition of the US population in general

Age Ranges/ Protocol Types

- Designed for assessing children and adolescents between the ages of 8 and 19 years of age

- Auto-Score form

(Refer to CMOCS Hand-Out: Auto Score Form)

Administration

- 56- item self-report scale
- Requires 10-15 minutes to complete
- Can be administered individually or in a group setting
- Items are written to be understood easily by anyone with a second grade reading level

Scoring

- Items on a 0-4 Likert Scale (N, S, O, A)
- Auto Score Form
- T Scores (Mean of 50, SD=10)

Score range	Descriptor
70 and higher	Extremely high level of problems related to obsessions or compulsions
60-69	High level of problems related to obsessions and compulsions
41-59	Average level of problems
40- lower	Below average level of problems

(Refer to hand-out CMOCS Scoring Worksheet)

Type of Scores

- Total Score

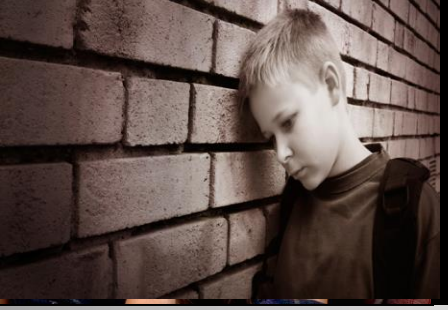
- Impact Score

  reflects the degree to which obsessions interfere with daily living resulting in functional impairment or distress

- Problem Area Scores

- Inconsistency Responding Index Score

(Refer to hand-out CMOCS Profile Sheet)



Interpretation

Assess the validity of responses

- Inconsistent Responding Index
- Defensiveness
- Omitted Items

Examine Summary Scores

- Total Score
- Impact Score

Interpretation

Examine Problem Areas

- Fear of Contamination (12 items)
- Rituals (11 items)
- Intrusive Thoughts (9 items)
- Checking (8 items)
- Fear of Mistakes and Harm (10 items)
- Picking/Slowing (6 items)

Interpretation

Item-level Interpretation

- As a general rule, formal interpretation of individual test items not recommended
- Individual items reflect a limited sample of behavior and have limited reliability
- Inquiry of certain items (i.e. “I want to be let alone when I eat”) may be useful when the presence of clinical problems other than OCD is suspected

Interpretation

- Consolidate Information from broad band and narrow band measures

- Recommendations for follow-up and /or interventions

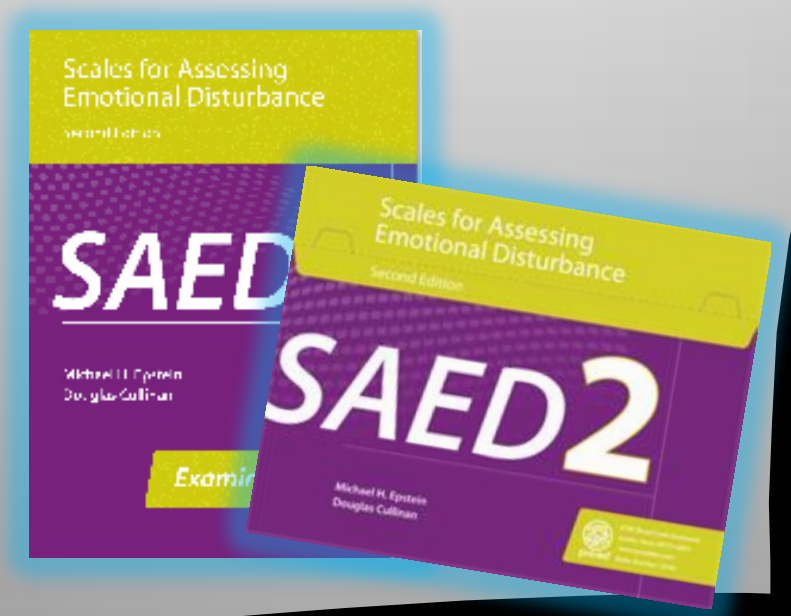
CMOCS- Case Study

Sample Write-Up: Christine, 14 year old

- Had been a conscientious, straight A student
- Avoids getting together with friends
- No longer likes to join in on family outings
- Unwilling to complete routine chores
- Has difficulty completing homework or class assignments

(Refer to Hand-out: CMOCS Sample Write-Up)

Scales for Assessing Emotional Disturbance 2nd Ed. (SAED-2)



Purpose of Assessment

Scales for Assessing Emotional Disturbance (SAED)

The Rating Scale was designed so that educational personnel could accurately and efficiently evaluate the emotional and behavioral problems of students in educational settings. Forty-five clearly stated items describing specific, observable, and measureable emotional and behavioral problems comprise six problem subscales corresponding to significant parts of the federal definition of ED

Subscales Include

Inability to Learn	Relationship Problems	Inappropriate Behavior
Unhappiness or Depression	Physical Symptoms or Fears	Socially Maladjusted

Validity and Reliability

- The scale was evaluated to determine the extent to which it discriminated between students with ED and those without

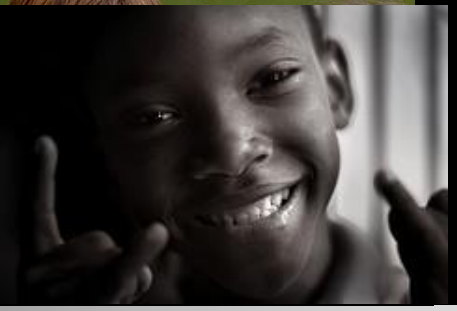
- Overall, students with ED scored about one SD higher than the group without ED on the behavior problem subscales and overall index score. T-test results indicated that this difference was statistically significant

Internal consistency reliability

- Non-ED group averaged from .80 to .96
- ED group averaged from .76 to .91

Inter-rater reliability (usually produce lower correlation coefficients than the conventional accepted levels)

- ED group averaged from .51 to .84



Demographics: Standardization Sample

The Rating Scale was normed on two samples of students:

1) A nationally representative sample of students **without** emotional disturbance (non-ED sample)
2) A national sample of students with an emotional disturbance (ED sample)

Demographics: Standardization Sample

Non-ED Sample

- 2,266 U.S. students
- Characteristics taken into consideration: geographic region, gender, ethnicity/race, family income, parent education attainment
- Sample was compared to the census for the school-age population and indicated that the sample was representative

ED Sample

- 1,371 students identified in school districts as qualifying under the ED category
- Same characteristics considered; resulted in different demographics than the non-ED group but was representative of students with ED nationwide

Age Ranges/ Protocol Types

The SAED-2 is appropriate for students ages 5-18

All three instruments (The Rating Scale, The Developmental/ Educational Questionnaire, and the Observation Form) are designed to provide objective information needed to help educators and psychologists make decisions regarding the identification of students with ED

The Socially Maladjusted subscale does not include norms for the 5-11 age group. This is because many of the items address behaviors in which young children would not typically engage (e.g., exhibits precocious sexual behavior)

Administration

SAED-2 Rating Scale

- The Rating Scale was designed so that educational personnel could accurately and efficiently evaluate the emotional and behavioral problems of students in educational settings. 45 clearly stated items describing specific, observable, and measureable emotional and behavioral problems comprise six problem subscales corresponding to significant parts of the federal definition of ED

- The rater may be the student's teacher but may also be another school adult who is knowledgeable about the student's behavior

Scoring

Section 2: Emotional Disturbance (ED) Characteristic Results

- Provides raw scores, %ile ranks, scaled scores and Descriptive Terms

Section 3: Descriptive Terms for ED Characteristics

Scaled score for ED Characteristics	***13 or lower***	***14-16***	***17 or higher***
Descriptive Term for ED Characteristics	Not indicative of ED	Indicative of ED	Highly indicative of ED

(Refer to Hand-out SAED-2: Rating Scale)

Scoring

Section 4: Rating Scale Index

- This index provides an overall score that indicates the severity of behavioral and emotional symptoms
- It is **not** recommended to use the Index scores for the purpose of identification as ED

Section 5: Socially Maladjusted Result

- A significantly high Socially Maladjusted score using the Non-ED norms is indicated by a scaled score above 13. This suggests a considerable problem involving the student's community antisocial and delinquent activity
- It is **not** recommended to use the Socially Maladjusted score for identification purposes

Scoring

Section 6: Emotional and Behavioral Ratings

- 45 items, preceded by directions for rating. The rater is to describe the student's functioning over the past 2 months

Section 7: Adversely Affects Educational Performance Rating

- The rater indicates the degree to which "educational performance" is impacted on a scale of 0 (not adversely affected) to 5 (affected to an extreme extent)

Section 8: Interpretive Observations and Recommendations

- Provides space for the examiner to write pertinent information about the student and about Rating Scale results

Administration

SAED-2 Developmental/Educational Questionnaire

- Supplemental assessment tool designed to gather information from the student's parents or other primary caregivers
- In-depth, semi-structured interview
- Content focuses on the history of the student's problems; present functioning; efforts attempted by the family, school, and community to address the problems; family resources and commitment to solve the problems; and other potentially significant topics

(Refer to Hand-out SAED-2: Developmental Questionnaire)

Administration/Observation Form

SAED-2 Observation Form

- Supplemental assessment tool for direct observation of classroom behavior and emotional problems of students
- There is an option for the examiner to measure on-task behavior and one other examiner-designated behavior of significance for the student being assessed
  - Target behaviors are observed and recorded for 30 minutes per observation session
  - Target behaviors are recorded for both the student being evaluated and a comparison student

(Refer to Hand-out SAED-2: Observation Form)

Administration/Observation Form

Section 2: Observing and Recording Instructions

- There are 30 1-minute observe/record periods. The periods alternate between the target student and the comparison student. (15 observe/record periods for each student)

Section 3: Behavior Definitions (On task behavior and the 5 characteristics of ED)

- The protocol provides a list of observable, measurable behaviors by which these 6 characteristics are recognized

Section 4: Observation and Recording Grid

- Each interval (1-min) involves a 30s observe and a 30s record/wait period
- Observations for the target student are recorded in the upper half of the grid; comparison student, lower half of the grid

Administration/Observation Form

- The boxes that are not shaded in the “O” columns indicate 30s intervals where the student is to be observed but **not** recorded (These will always be blank)
  - During these “O” intervals, the observer will judge whether or not the student has engaged in the behavior

- The boxes that are not shaded in the “R” columns indicate 30s intervals during which the observer stops observing in order to record whether each of the target behaviors did or did not occur

- After completion of all (30) of the intervals, the observer sums the boxes marked with an “X” for each behavior for each student

Administration/Observation Form

Section 5: Recording Summaries

- Take sum of behaviors observed for target student and comparison student and record it in the appropriate columns in this section
- Percent of intervals is helpful in determining how discrepant the target student's behavior is from the comparison student

Section 6: Anecdotal Classroom Observations

- This section is used to record informal observations about key aspects of the target student's classroom (e.g. the physical layout of the classroom, the rules and routines of the classroom, and the teacher's behavioral management practices)

Interpretation and Sample Write-Up

Delvin, 3rd Grade, Age 9

- History of over-activity, disruptiveness, and learning problems
- Difficulties with peer relations due to bossy behavior and frequent arguments with peers
- At school, he demonstrates difficulties staying seated, attending to a task to completion, waiting his turn, and listening and looking appropriately
- Academically, he is well behind his peers
- In class, Delvin usually blurted out answers immediately and was ridiculed by classmates for his mistakes
- In class, he may have a tantrum, start an argument or fight with a classmate and remain noncompliant and impolite to the teacher

(Refer to Hand-out: SAED-2 Sample Write-Up)

Helpful Hints

Determining which norms to use: Non-ED sample vs. ED sample

- For decisions about initial or continued identification, many examiners will use the non-ED norms to answer the question, “How does this student function in comparison to students not identified with ED?”

- The ED norms are more appropriate for evaluating change as a result of educational interventions or other services for a student with ED

Helpful Hints

Use appropriate cautions: A single test/instrument does not diagnose or indicate a disability

- The results of the Rating Scale or any other instrument should never be the single source of information used to identify a student as ED
- Due to the sensitive nature of the disability being investigated, caution is recommended when providing the rating scale to teachers to complete
- Avoid overstating the meaning of assessment results, including Rating Scale scores. Alternate explanations for results should be considered and reported, when appropriate

Anger Regulation and Expression Scale

Purpose of Assessment

- Comprehensive assessment of the expression and regulation of anger in youth aged 10-17 years
- Broad profile of anger related experiences, thoughts and behavior patterns can be identified

Reliability and Validity

- Test-retest reliability range from .79 to .88

- Discriminant Validity: ARES could distinguish between clinical groups (CD and ODD) and the general population. The ARES scores also correlated with other measures of early childhood pathology

Demographics: Standardization Sample

The ARES normative sample includes 800 self-report ratings that are evenly proportioned in terms of age and gender

Data were collected from across the United States and closely matches the US Census race/ethnicity distribution

Age Ranges/ Protocol Types

- Students aged 10-17
- Self-Report Rating Scale

ARES : 75 Items

Reading level – 5.5

ARES (Short) 17 Items

Reading level- 5.2

(Refer to Hand-out ARES: Self-Report Short and Long Form)

ARES and ARES Short form Types of Scores

- Total Score

- Cluster Scores
  - Internalizing Anger
  - Externalizing Anger
  - Extent of Anger

Long Form Scales and Subscales

Internalizing Anger

- Arousal
  - Physiological Arousal
  - Cognitive Arousal
- Rejection
- Anger In
- Bitterness
    - Resentment
    - Suspiciousness

Long Form Scales and Subscales

Externalizing Anger

- Overt Aggression/Expression
  - Physical Aggression
  - Verbal Expression
- Covert Aggression
- Revenge
- Subversion
  - Relational Aggression
  - Passive Aggression
- Bullying
- Impulsivity

Long Form Scales

Extent of Anger

- Scope of Triggers
- Problem Duration
- Episode Duration

Administration

- Paper and pencil administration
- Individual
  - Long form takes 15 minutes
  - Short form takes 5 minutes
- If the student cannot read the ARES, it acceptable to read the instructions and items aloud. If possible, the student should be given a separate form to follow during reading, and mark his/her own responses

ARES Scoring

- Items are scored on a 1-5 Likert scale
  - 1- Never
  - 2- Hardly Ever
  - 3- Sometimes
  - 4- Often
  - 5- Always
- Assessor must enter the responses in ARES Scoring Software for scoring and report generation

Scoring

Omitted Responses

- Student skips an item or gives multiple responses to a single item
- Student gives an “in-between” response
- All scales and subscales have a maximum of 1 omitted item. A cluster score cannot be calculated if any of the scales within it cannot be calculated

Scoring

Inclusion of Validity Scales

- Positive Impression
  - ➢4 items from the Rejection Scale
  - ➢If the scores are equal to 4, consider that the scores may be artificially deflated

- Negative Impression
  - ➢8 items from different scales
  - ➢If the scores equal 5 or higher, consider that the scores might be artificially inflated

Scoring

T Score	Percentile Rank	Guideline
≥ 70	≥ 98	Very elevated Scores ; Many more concerns than are typically reported
65-69	93-97	Elevated Scores: More concerns than are typically reported
60-64	84-92	Slightly Elevated Score
40-59	16-83	Average Score; Typical level of concerns
< 40	<16	Low Score; Fewer concerns than typically reported

Interpretation

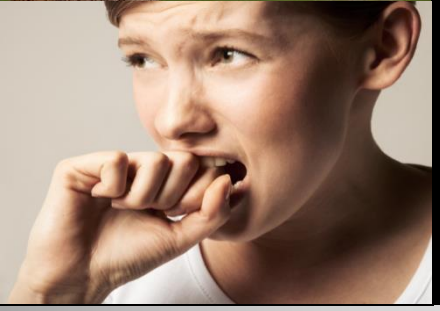
- Assess the validity of the results
- Interpret composite scores (Total/Cluster)
- Interpret the scale and subscale scores and examine item level responses
- Examine overall profile
- Integrate results from other sources of information

ARES- Case Study

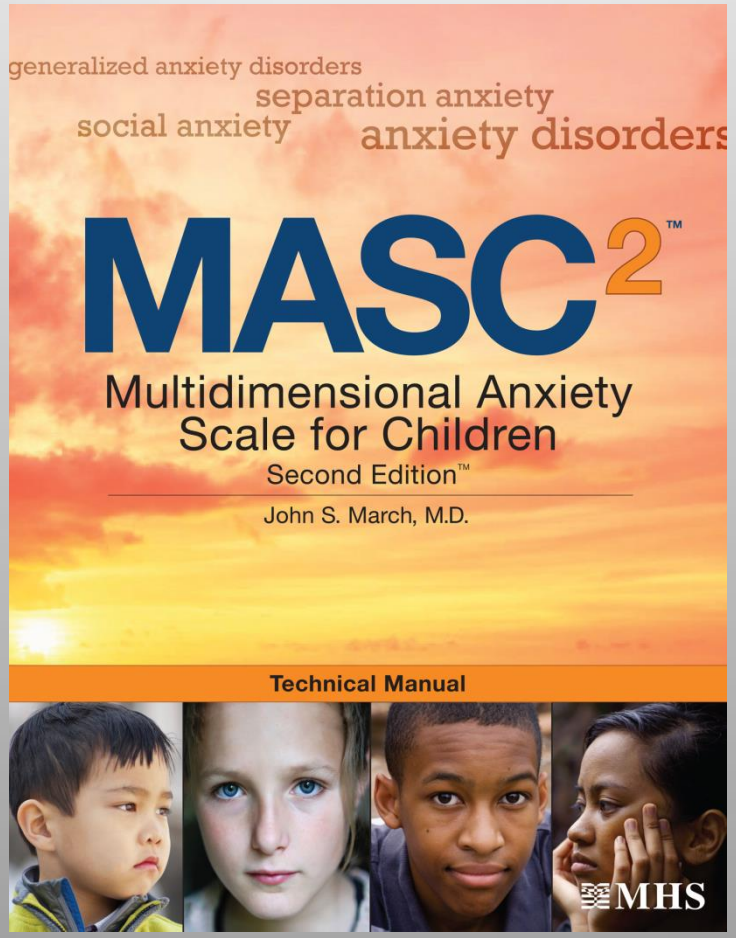
Sample Write Up: Kyle, age 15, only child

- Threatened mother with a knife during a fight
- Intense anger toward mother for about 6 months.
- Yells, curses and threatens mother whenever she sets limits on his behavior
- Father who Kyle was very close to died in the last year

(Refer to Hand-out: ARES sample write up “Kyle”)



Multidimensional Anxiety Scale for Children (MASC2)



Purpose of Assessment

- The MASC-2 is a comprehensive, multi-rater assessment of anxiety dimensions in children and adolescents

- Assesses a broad range of emotional, physical, cognitive and behavioral symptoms

Reliability

- For the parent report, internal consistency for the Total scores is .92 with retest reliability ranging from .80 to .93

- For the self report, internal consistency is .89 with test-retest reliability ranging from .80 to .94

Validity

- The MASC-2 was found to discriminate between relevant groups (general population vs. clinical groups), correlated meaningfully with scores form other measures of anxiety and was generalizable across rater type and racial/ethnic groups

Demographics: Standardization Sample

- The MASC-2 standardization sample was designed to match the US Census information (2009). Including demographic variables of age, gender, parental education level and race/ethnicity.

  Self Report N=1,800

  Parent Report N=1,600

Note: in the "Parent" sample, 79% were mothers, 10% were fathers, 5% were 'other' but described as primary caregivers (remaining this information was missing)

Age Ranges/ Protocol Types

- Designed for assessing children and adolescents ages 8 to 19 years old

- Two forms: Parent Report and Self Report

(Refer to Hand-out MASC-2: Self-Report and Parent Report)

Administration

Both Self Report and Parent Report have:

- 50 questions
- takes about 15 minutes to complete
- Items are written at about a 2nd grade reading level (can be read aloud)
- Scored by computer

Scoring

- Items on a 0-3 Likert Scale (Never, Rarely, Sometimes, Often). T-scores (mean=50, SD=10)
- Auto Score Form

T-Score	%ile	Classification
70+	98+	Very Elevated (Many more concerns than are typically reported)
65-69	93-97	Elevated (More concerns than are typically reported)
60-64	84-92	Slightly Elevated (Slightly more concerns than are typically reported)
55-59	66-83	High Average (Borderline levels of concern)
40-54	16-65	Average (Typical levels of concern)
<40	<16	Low (Fewer concerns than are typically reported)

Scoring

- Anxiety symptoms in children were found to vary by age and gender

- Generally, females tend to score higher than males and younger children tend to score higher than adolescents. To account for these effects in the interpretation process, T-cores conversions are reported by gender and age group. (age 8-11, 12-15, 16-19)

(combined gender norms are available)

Interpretation

- Determine Validity of Responses
  - Check inconsistency index
  - Check for over reporting/underreporting of symptoms
- Interpret Scale and Subscale Scores

Interpretation

- Subscales & common characteristics of individuals with elevated T-scores

MASC 2 Scale	Common Characteristics of Individuals with elevated Scores
MASC 2 Total Score	The youth may be experiencing an elevated number of anxiety sighs and symptoms. Further analysis of the scales will identify which components of anxiety are most problematic.
Separation Anxiety/Phobias	The youth may be anxious of being away from family or loved ones and fearful of certain places or things (e.g. the dark, being in a car).
GAD Index	The youth may be experiencing symptoms similar to youth diagnosed with Generalized anxiety Disorder, including elevated worry about future events and associated physical symptoms.

Interpretation

- Continued….

MASC 2 Scale	Common Characteristics of Individuals with Elevated Scores
Social Anxiety Total	The youth may be experience anxiety symptoms related to humiliation/rejection, reflecting anticipation of embarrassment and performance fears, reflecting anticipatory anxiety about being “on stage” in a public or interpersonal context. Further analysis of the subscale scores will identify which kids of social anxiety problems are most evident.
Humiliation/Rejection	The youth may be anxious about being humiliated, embarrassed or rejected by others in a social setting.
Performance Fears	The youth may be anxious about performing (e.g. public speaking, answering a teachers questions in calls) in public settings.

Interpretation

- Continued….

MASC 2 Scale	Common Characteristics of Individuals with Elevated Scores
Obsessions & Compulsions	The youth may be experiencing obsessive thoughts and/or engaging in compulsive behaviors that are consistent with a diagnosis of Obsessive-Compulsive Disorder, including thought of harm about others, excessive checking, fear of contamination, ritualistic cleaning and scrupulosity.
Physical Symptoms: Total	The youth may be experiencing physical symptoms, including those related to panic and feelings of being tense or restless. Although physical symptoms alone are not predictive of anxiety disorders at the diagnosis level, they are often targets for treatment intervention. Further analysis of the subscale scores will identify which kinds of physical symptoms are most problematic.

Interpretation

- Continued….

MASC 2	Common Characteristics of Individuals with Elevated Scores
Panic	The youth may be experiencing the following panic symptoms: chest pain, sweaty or cold hands, feeling sick to the stomach, breathlessness, dizziness, irregular heartbeats, feeling strange, weird or unreal.
Tense/Restless	The youth may be tense, shaky, jumpy, restless or on edge.
Harm Avoidance	The youth may tend to engage in harm and avoidant behaviors to avoid negative outcomes, wrong-doings and/or dangers. (These items often targets for exposure based treatments.)

Case Study

Sample Case Study Write-up "Isabel"

- 16 yrs. old
- 9TH Grade
- Declining academic performance
- Negative and defiant attitude toward teachers
- One hospitalization

(Refer to Hand-out MASC-2: Case Study Write-up "Isabel")

Break

U.S. Statistics on Childhood Depression

- About 11 percent of adolescents have a depressive disorder by age 18
- Girls are more likely than boys to experience depression
- The risk for depression increases as a child gets older
- Youth who have depression show signs different from the typical adult symptoms
- Children who are depressed may complain of feeling sick, refuse to go to school, cling to a parent or caregiver, or worry excessively that a parent may die
- Older children and teens may sulk, get into trouble at school, be negative or grouchy, or feel misunderstood

(National Institute of Mental Health, *October 2013*)

Children's Depression Inventory 2 (CDI2)

Purpose of Assessment

- Comprehensive multi-rater assessment of depressive symptoms in children aged 7 to 17 years
- To identify children and adolescents currently suffering from depressive symptoms

Reliability

- Internal consistency for the self report (for total score) is .91
- Internal consistency for the teacher rated form is .89 and parent rated form is .88
- Test-Retest data indicated strong reliability ranging from .76 to .92 (self report data only)

Validity

- The CDI 2 was found to discriminate between children with a diagnosis of Major Depressive Disorder and those without
- It also correlated with scores from other assessments that measure depression
- The CDI 2 was found to be usable with youth from various backgrounds

Demographics: Standardization Sample

- The CDI 2 was standardized on a subgroup (N=1,100) that was designed to math gender, race/ethnic distribution and geographic regions based on the 2000 US Census

- Additional rater sets were constructed for Parent raters (N=800) and Teacher raters (N=600)

Age Range/Protocol Types

- For students 7-17
- Self Report (long and short)
- Parent (caregiver) Report
- Teacher Report

Administration

Forms now available:

	Self Report CDI 2:SR	**Self Report (short) CDI 2:SR [S]**	**Parent Report CDI 2:P**	**Teacher Report CDI 2:T**
Number of items	28	12	17	14
Reading grade level	1.7	1.5	2	2.2
Administration time	15 minutes	5 minutes	10 minutes	5 minutes

*can be read aloud if necessary

Scoring

The self report of the CDI 2 (like the original CDI) has three choices per item. Items reflect developmentally appropriate manifestations of depressive symptoms using the context of school and peer group

The 3 items of the items sets mirror the severity of the target symptoms from 0 (none) to 2 (definite)

Example:

- **I am sad once in awhile.**
- **I am sad many times.**
- **I am sad all the time.**

(Refer to Hand-out CDI-2: Self-Report and Self-Report Short Form)

Scoring

Both the CDI 2 parent and teacher forms have single items reflecting observable aspects of depression with each item rated on a 4 point Likert scale from 0 (not at all) to 3 (much of most of the time)

On all forms, the higher the score, the more symptomatic the child is.

Example:

My child…	Not at all	Some of the time	Often	Much or most of the time
1. Looks sad	0	1	2	3

(Refer to Hand-out CDI-2: Teacher and Parent Protocol)

Scoring

- CDI 2 computer scoring yields the following classifications:

T-Score	%ile	Classification
70+	98+	Very Elevated (Many more concerns than are typically reported)
65-69	93-97	Elevated (More concerns than are typically reported)
60-64	84-92	High Average (Somewhat more concerns than are typically reported)
40-59	61-83	Average (Typical levels of concern)
<40	<16	Low (Fewer concerns than are typically reported)

Interpretation

- Review the overall profile
- Examine item level responses
- Probe if necessary

  For example…. *“So, for this group of sentences, you checked the answer that says….can you tell me more about that…”*

  *Pay attention to critical items (“I want to kill myself)

  *Integrate results from multiple sources

Interpretation

Scales/Subscales & common characteristics associated with elevated scores:

Total Score	**The child may be experiencing an elevated number of depressive symptoms. Further analysis of the scale scores will identify which components of depression are most problematic.**
Emotional Problems	The child may be experiencing negative mood, sleep problems, and negative self-esteem. The child may appear sad, irritable or lonely.
Functional Problems	The child may be experiencing issues with ineffectiveness and interpersonal problems. Specifically, the child may have problems interacting with peers and maintaining school performance. The child may also have an impaired capacity to be cooperative and to enjoy school activities.

Interpretation

- Continued….

Negative mood/Physical Symptoms	The child may have depression symptoms that manifest as sadness or irritability, as well as physical symptoms related to sleep, appetite, fatigue and aches/pains.
Negative Self-Esteem	The child may have low self-esteem, self-dislike, and feelings of being unloved.
Ineffectiveness	The child may be evaluating his/her abilities and school performance negatively and may be experiencing an impaired capacity to enjoy school or other activities.
Interpersonal Problems	The child may have problems interacting with peers, and may have feelings of being lonely and unimportant to his or her own family.

- *Self-Report Subscales

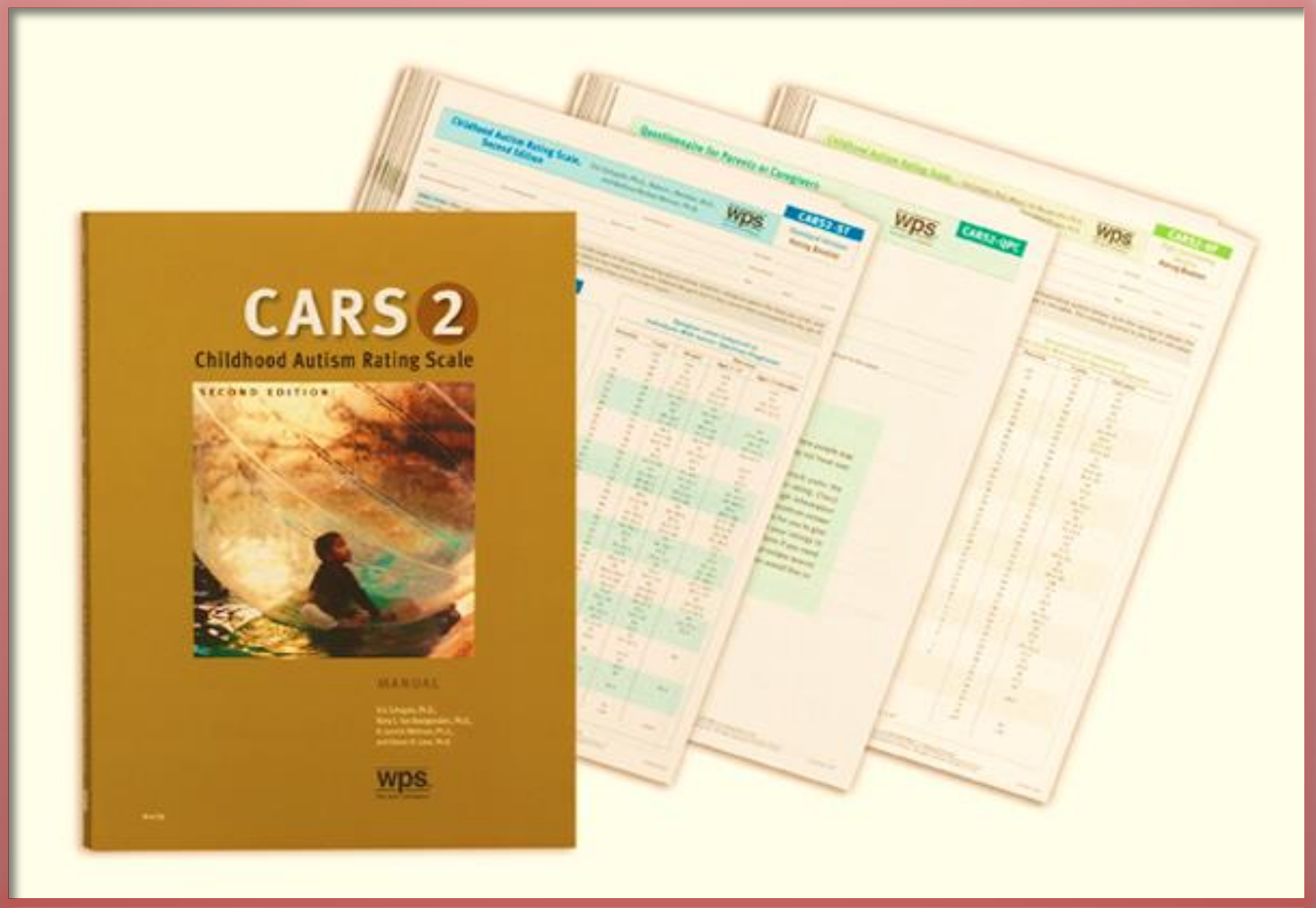
Case Study

Sample Write Up: Sally, age 14, grade 9

- Declining academic performance
- Defiant towards teachers
- Putting her head down in class
- One hospitalization

(Refer to Hand-out CDI-2: Case Study “Sally”

Childhood Autism Rating Scales 2nd Edition (CARS-2)



Purpose of Assessment

CARS-2: Childhood Autism Rating Scale, 2nd Edition

The CARS-2 (ST, HF) are not intended for use with the general population. Their primary value lies in their providing brief, quantitatively specific and reliable yet comprehensively based summary information that can be used to help develop diagnostic hypotheses among referred individuals of all ages and functional levels.

CARS-ST and CARS-HF ratings are based not only on the frequency of behaviors, but also on their intensity, peculiarity, and duration. This allows for flexibility in integrating comprehensive information about a case, and at the same time yields consistent quantitative results. Professionals can also use CARS2 results to help in giving diagnostic feedback to parents, characterizing functional profiles, and guiding intervention planning.

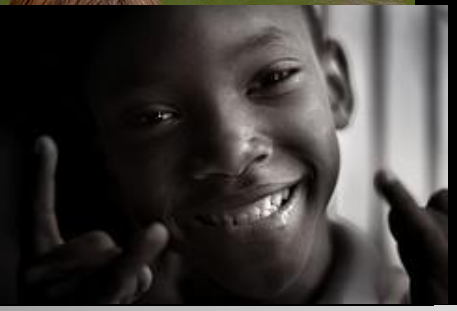
Validity and Reliability

Internal Consistency Reliability

- CARS2-ST- .93
- CARS2-HF- .96

Inter-rater Reliability

- CARS2-HF- .95



Demographics: Standardization Sample

- CARS2-ST
  - 1,034 individuals in the sample
  - 2/3rd of the cases were male (consistent with the demographics of individuals with Autism)
  - Age range: 2-36 years (30% 2-5; 43% 6-10; 20% 11-15; 7% over 15)
  - IQ: 85 or lower
- CARS2-HF
  - 994 individuals in the sample (variety of clinical diagnoses, including Asperger's, PDD-NOS, ADHD, Learning Disorder and other internalizing/externalizing disorders)
  - 2/3rd of the cases were male (consistent with the demographics of individuals with Autism)
  - Age range: 6-57 years (35% 6-10; 41% 11-15; 24% over 16)
  - IQ: 80 or higher

Age Ranges/ Protocol Types

- CARS2-ST

This version is for students under the age of 6 or students older than 6 who have less than Average intelligence or notable communication difficulties.

- CARS2-HF

This version is for students, 6 years of age and older, with an IQ greater than 80 (presumed Average functioning)

- CARS2-QPC

The Questionnaire for Parents of Caregivers is an unscored form designed to assist in gathering information from a parent or caregiver about behaviors related to Autism. Information from the CARS2-QPC can be integrated with other evaluation information when completing the other rating scales.

(Refer to Hand-out CARS-2: All Protocols)

Administration

- The CARS2-ST and CARS2-HF each include 15 items that ask respondents to rate an individual on a scale from 1 to 4 in key areas related to autism diagnosis

- In each booklet, comprehensive descriptions are provided of each of the 15 functional areas to be rated. Detailed item-specific rating anchors are provided that give specific examples of the kinds of behavior represented at each rating level.

- The rating values given for the 15 areas are summed to produce a Total score. For each form, Total score cutoff values are provided that help to determine whether further comprehensive evaluation for the presence of autism is warranted.

Scoring

1. Transfer the ratings for all 15 categories from the inside pages of the booklet to the corresponding spaces provided in the Summary section on the front page of the booklet.
2. Sum the ratings to obtain the Total raw score.
3. Indicate the Severity Group that corresponds with the Total raw score by making a check mark in the appropriate box.
4. To obtain a standard score in the form of a T-score, circle the value that corresponds to the Total raw score in the table provided on the right side of the Summary section. The number printed to the left of the value that you circled is the T-score. The number printed to the left of the T-score is the percentile rank.

Integrating the QPC

- The CARS2-QPC provides information relevant to each of the 15 CARS2-ST or HF rating areas
- Parent and caregiver information should be summarized and reviewed by a professional familiar with autism to be effectively integrated into CARS2 ratings.
- One way to facilitate this integration is to use the QPC as a framework for a follow-up interview to clarify responses.

Integrating the QPC

Four main considerations when interpreting the QPC:

1. Be aware of the overall pattern of strengths and weaknesses
2. Review and evaluate any examples the parent/caregiver may provide
3. The consistency of the information given by the caregiver with regard to all other information obtained during the assessment process should be taken into consideration
4. Since ASD is a developmental disorder, these reports must indicate that the symptoms of autism were present early in life, that is, prior to the age of 4 or 5

Interpretation and Sample Write-Up

Daniel, Age 8

- Nonverbal and verbal intellectual abilities fall in the average range
- Significant impairment in social-communicative development and imaginative play
- He has developed strong and focused interests that are unusual for his age
- He has a thinking pattern that is detail focused
- Repetitive motor excesses such as flapping arms
- Characteristics are reported across settings and informants
- His parents report early developmental difficulties around his language development, social interactions, and pretend play

(Refer to Hand-out CARS-2: Sample Write-up “Daniel”)

Helpful Hints

- In order to complete ratings on the CARS2-HF, one must have information from multiple sources. For example, to complete the CARS2-HF, **it is necessary** to have information from a direct observation of the person being rated as well as an interview with someone who knows of that person's behavior in different settings.

- The CARS2-ST can be completed based on information from a single source, such as a parent interview or a direct observation. Although information from multiple sources is needed to make a diagnosis of autism, care should be taken when basing CARS2-ST ratings on information from multiple sources. Direct observation should generally be given more weight than the reports of others.

Helpful Hints

- In making ratings, you should compare the individual's behavior with that of a typically developing individual of the same age. When behaviors are observed that are not typical for an individual of the same age, the peculiarity, frequency, intensity, and duration of these behaviors should be considered. All behavior should be rated without recourse to causal explanations.

Autism Spectrum Rating Scales (ASRS):

Purpose of Assessment

- Measures behaviors associated with Autism Spectrum Disorder (ASD) in children and youth age 2-18 yrs
- To help guide Ed Code eligibility for special education determinations for students suspected of Autism
- To guide diagnostic decisions regarding treatment planning, services, and on-going progress monitoring of RTI

Validity and Reliability

Content Validity

ASRS items are conceptually consistent with key symptomatic areas of the ASDs according to multiple sources (e.g., DSM IV-TR, ICD-10, ADOS, ADIR)

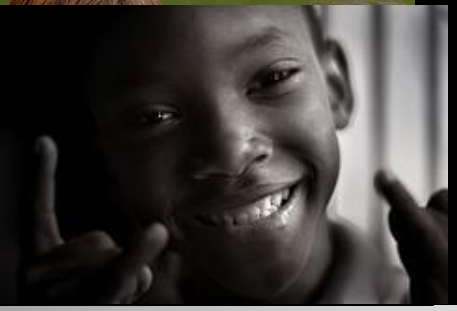
Questions are aligned to the key content areas:

Socialization	Social and emotional reciprocity	Language	Stereotypies
Behavioral rigidity	Sensory sensitivity	Attention	Self-Regulation

Validity and Reliability

Inter-Rater Reliability

Strong levels of rater agreement were found across all scales for *parent* raters (.87 to .89) and moderate correlations for *teacher* raters (.60)



Demographics: Standardization Sample

- The normative sample includes 1,280 parent and 1,280 teacher ratings across the 2-5 and 6-18 yr. age range

- All of the Teacher or Childcare providers had known the students for **at least 1 month** (the minimum time requirement to complete the ASRS)

- The sample characteristics are very similar to the U.S. population (based on the 2,000 U.S. Census) on race/ ethnicity and geographic region

Age Ranges/ Protocol Types

There are *three* basic forms:

- Teacher/Parent or Childcare Provider 2-5 yrs. (70 items)
- Teacher/Parent 6-18 yrs. (71 items)
- There is also a “short form” version for each, containing 15 items
- All protocols come in English/Spanish

(Refer to Hand-out: Sample ASRS protocols)

Administration

- Using a 0-4 Likert scale, parents and teachers are asked to evaluate how often they observe specific behaviors in the child or adolescent

0-Never	1-Rarely	2-Occasionally	3-Frequently	4-Very Frequently

- Key Areas Measured by the ASRS:

Social/ Communication	Unusual Behaviors	Self-Regulation	Peer Socialization
Adult Socialization	Atypical Language	Stereotypy	

Administration

- The full length ASRS can be completed in 15 minutes, while the Short Form can be completed in 5 minutes
- Appropriate Raters: Parents, teachers, childcare providers, nannies, daycare teachers, and early childhood educators
- If a rater cannot read or has poor eyesight, reading the questions aloud is an option (the rater should be given a separate form to follow during the reading and should mark his/her own responses)

Scoring

- QuikScore form yields the following Classifications:

Description	T-Score	Percentile Rank
Very Elevated	70-85	98-99%ile
Elevated	65-69	93-97%ile
Slightly Elevated	60-64	84-92%ile
Average	40-59	16-82%ile
Low	25-39	1-14%ile

(Refer to Hand-out: Sample ASRS QuikScore Form)

Scoring

There is also a computerized Scoring method to be used with the ASRS USB Drive- Scoring Key

- Two scoring options are available:

(a) a standard version

(b) scoring method for individuals who do **not** speak or speak infrequently

- Immediate generation of reports once responses are entered
- Reports can be saved as .pdf or .rtf format (for using copy/paste functions) and transferring information directly onto the assessment report
- Portable program can be easily transferred from one computer to another

Interpretation

The manual provides a step-by-step sequence for interpreting the ASRS:

- Analyzing the scale scores
- Analyzing item-level responses
- Comparing results across raters, and
- Reporting results

Interpretation

Analyzing the scale scores

- The ASRS Total Score is the most inclusive scale, and the most reliable indicator of the extent to which an individual exhibits behaviors associated with ASD

- However, a high Total Scale Score could result from high scores in *all* areas of functioning, or from a very high score in one or two areas

- Thus, each ASRS Scale must be examined separately to obtain a more complete view of the youth

Interpretation

Analyzing item-level responses

- Each scale can be better understood by determining which items from each scale contributed to a low or high score

Comparing results across raters

- Comparison of ASRS scores obtained from different combinations of parent and teacher raters can be useful in obtaining a multi-rater perspective of the youth's problems

Reporting of Results

- After carefully examining the ASRS results, assessors should be able to describe elevated scores and areas of concern, performance of the youth across settings by multiple raters, and communicate level of severity on any particular item or domain

ASRS- Case Study

Sample Write-Up “Joey”

- 10 Year old boy
- History of ADHD, described as extremely literal often missing social cues, socially isolated, referred by Pediatrician

(Refer to Hand-out ASRS: Sample Write-up “Joey”)

Comprehensive Test of Phonological Processing-2 (CTOPP-2)

Major Changes to the original CTOPP

- All new normative data were collected in 2008 and 2009
- The test was normed on 1,900 individuals ranging in age from 6- 24 yrs
- The demographic characteristics are representative of the United States
- The lower version of the CTOPP-2 now covers the

  4-6 year-old range
- A new phonological awareness subtest called Phoneme Isolation was added

CTOPP-2 Cont.

The CTOPP-2 has four principal uses:

(1) to identify individuals who are significantly below their peers in important phonological abilities

(2) to determine strengths and weaknesses among developed phonological processes

(3) to document individuals' progress in phonological processing as a consequence of special intervention programs

(4) to serve as a measurement device in research studies investigating phonological processing

Final Comments

- Identify those instruments that will enhance your assessment, strengthen your recommendations, and drive appropriate educational supports
- The goal of our assessments should be to increase student functioning and the likelihood of academic, social/emotional and behavioral success

Our Assessments Should Work Toward