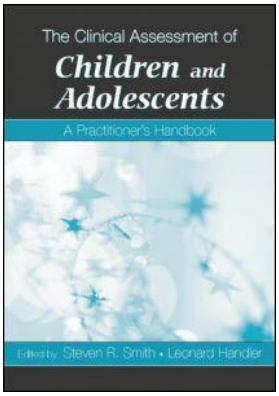

The Clinical Assessment of Children and Adolescents: A Practitioner's Handbook

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Personality Assessment in Schools

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PART

I

Issues and Concepts in Child and Adolescent Assessment

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CHAPTER

2

PERSONALITY ASSESSMENT IN SCHOOLS

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In this chapter, we present an overview of core issues that are associated with conducting personality assessments in schools. We recognize that most psychologists who work in schools have the education, training, and credentialing specific to the "school psychologist" title, but we also appreciate that there are psychologists whose primary employment and professional role identification are not with the school district. As such, we designated the interface between psychologists and schools as primary, secondary, or tertiary, depending on the degree to which employment and work activities are dedicated specifically to the school system. By "primary work activities" we refer to psychologists who are employed full-time either by a school district or by a private school. By "secondary work activities" we refer to psychologists who work as contracted or on a per diem basis in the schools. By "tertiary work activities" we refer to psychologists in non-school settings (e.g., private practice, residential-psychiatric, forensic) whose personality assessments of school-age children might bring them into contact with the school system.

The chapter proceeds as follows. First, we discuss Section 504 of the 1973 Civil Rights Act and the Individuals with Disabilities Education Act (Section 504, 1973 and IDEA 1997, as discussed in Miller & Newbill, 1998 and Jacob & Hartshorne, 2003, and referenced as a citation in Jacob & Hartshorne, 2003) because of their particular relevance to students with behavior, social-emotional, and ideational problems that warrant special education consideration. Both Section 504 and IDEA are very familiar to psychologists who work primarily in school districts, but are possibly less familiar to psychologists whose personality assessment work only occasionally overlaps with the educational system. Second, we present a framework for personality assessment and discuss different tests and measures that are useful in the identification of referral issues and for conducting personality assessments in schools that lead to decisions about eligibility for special education services. Third, we discuss some of the professional climate issues in school psychology that can affect personality assessment in schools. Fourth, we discuss school psychology training in personality assessment. Fifth, we present a case study.

SECTION 504 AND IDEA

Miller & Newbill (1998) and Jacob and Hartshorne (2003) provide information about Section 504 and IDEA and Section 504 of the 1973 Civil Rights Act. Section 504 is designed to protect the rights of individuals who participate in programs or activities that receive federal funding (Jacob & Hartshorne, 2003; Miller & Newbill, 1998). Included among individuals protected by Section 504 are school-age children who have been determined to have a handicapping condition. A student is defined as handicapped if he or she has "a physical or mental impairment which substantially limits one or more of a person's major life activities; has a record of such impairment, or is regarded as having such an impairment" (Miller & Newbill, 1998, pp. 2–3). Included among Section 504 handicapping conditions are ADD/ADHD, anxiety, dysthymia, dyslexia, eating disorders, emotional disorders, post-traumatic stress disorders, drug and alcohol dependency, learning disabilities, and suicidal tendencies (Jacob & Hartshorne, 2003; Miller & Newbill, 1998). Thus, Section 504 provides broad antidiscrimination protection for students whose mental health or learning needs have been determined to reflect a handicapping condition. A 504 Service/Accommodation Plan, coordinated by school personnel knowledgeable about a child or adolescent, can be implemented even when the handicap does not adversely affect the student's educational performance (e.g., an adolescent with bulimia who excels academically, but would benefit from school-based, group-oriented psycho-educational counseling led by a consulting psychologist who is hired and funded by the district).

IDEA is one subcategory of Section 504. Under IDEA, special education services are available to students whose disability adversely affects their performance (Miller & Newbill, 1998). There are 13 possible disabilities under IDEA: autism, deaf-blindness, deafness, emotional disturbance, hearing impairment, mental retardation, multiple disabilities, orthopedic impairment, other health impairment, specific learning disability, speech or language impairment, traumatic brain injury, and visual impairment. If a student is designated as having a disability under IDEA, then an Individualized Educational Program (IEP) is required and developed in order to provide the student with an individually designed instructional program (e.g., specialized reading program, supplemental math support, extended school year, extended testing time, behavioral intervention, individual counseling, group counseling). The IEP is a written plan of intervention, short-term objectives, and measurable, annual goals that emerge from an evaluation by a multidisciplinary team (i.e., qualified professionals and the parent[s]) and reflects district compliance with the law (Jacob & Hartshorne, 2003; Miller & Newbill, 1998).

The one IDEA category that has particular relevance to the personality assessor is emotional disturbance (ED). ED is defined by the Federal Code of Regulations, Title 34, Section 300.7 (Jacob & Hartshorne, 2003) as follows:

> (i) The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance. (A) An inability to learn that cannot be explained by intellectual, sensory, or other health factors. (B) An inability to build on or maintain satisfactory interpersonal relationships with peers and teachers. (C) Inappropriate types of behavior or feelings under normal circumstances. (D) A general or pervasive mood of unhappiness or depression. (E) A tendency to develop physical symptoms or fears associated with personal or school problems. (ii) The term includes schizophrenia. The term does not apply to children who are socially maladjusted unless it is determined that they have an emotional disturbance. (pp. 128–129)

In the next section, we offer a brief framework for conceptualizing and organizing the school psychological evaluation that includes personality assessment and offers an overview of the

range of tests and measures that are useful when one is considering how to respond conscientiously to a referral concern.

A FRAMEWORK FOR PERSONALITY ASSESSMENT

The school psychologist makes decisions about assessment strategies based on referral information within the context of constraint or latitude provided by the school district. Districts vary in the flexibility they afford psychologists to select measures. There may be some school districts, for example, where there is a preference for certain types of achievement tests, certain types of behavior ratings, and/or a very cautious attitude toward such tests as the Rorschach because of concerns that may range from fear of misuse, invasion of privacy (e.g., Jacob & Hartshorne, 2003), and relevance to school-related problems. Within this framework of flexibility or constraint, the tests that the psychologist uses will vary, depending on the child/adolescent referral information. School reports, case history, previous evaluations, and treatment/intervention information need to be considered when the test battery is being designed.

Understanding the referral question helps to determine the choice of methods and the areas to be assessed. During the referral, it is important to obtain information about the child's context from an ecological point of view (home, family, community, culture, classroom, peers, teachers, school). It is necessary to clarify whether the child/adolescent is a language minority student and determine his or her level of acculturation if the child/adolescent or parent/guardian is from another country. It is important for school psychologists to understand the risk factors for the development of mental problems for culturally different children. These risk factors include immigration, family role changes, and the experience of racism and prejudice (Gopaul-McNicol & Thomas-Presswood, 1998). Prereferral intervention responses serve as pivotal information in understanding what methods may be chosen to further delineate a child/adolescent's needs. Strengths and weaknesses from prior assessments also serve as baseline information for the determination of progress, change, and the child's outcome. Learning about research on the variability of different raters in different settings and ways to integrate discrepant data is an important preliminary step prior to obtaining data from rating scales (Prevatt, 1999). Familiarity with educational laws and terms (e.g., Jacob & Hartshorne, 2003) that are used to define eligibility for services is also important for understanding how conclusions from test data will address the referral issues. Following the collection of referral information, the evaluator obtains a developmental, medical, and educational history and conducts observations of the child within the school setting and interviews with the child/adolescent, parents, and teachers.

We appreciate the evolving nature of available tests from which psychologists can select when coordinating an assessment battery. Given the many available tests from which to choose, we offer a categorical matrix of selected assessment instruments (Appendix). Our decision to include these particular tests is based mainly on direct clinical and/or teaching experience with the instrument and is not meant as a negative evaluation of other tests and measures we have excluded. There are single as well as multiple domain measures represented. The list is not exhaustive and will only represent a sampling of those tests that may be beneficial in clarifying some of the more common child/adolescent problematic areas. The choice of tests should coincide with the referral questions. As can be seen from this matrix, there are many different areas that a psychologist who conducts personality assessments in schools needs to consider when prioritizing test selection relative to referral information. In

addition, there are other issues that carry weight and influence the assessment process in schools. We have identified several such issues and discuss them in the next section.

PROFESSIONAL CLIMATE ISSUES AND SCHOOL PSYCHOLOGY PERSONALITY ASSESSMENT

Lehr and Christenson (2002) provide a description of a positive school climate, focusing on the importance of an interpersonal ambience generated by the quality of school community, personnel, and spirit that permeates the learning environment. They discuss the school's ecology (e.g., cleanliness, equipment), milieu (e.g., teacher and student morale), social system (e.g., administrative organization, community school relations), and culture (e.g., norms, values, and belief systems of different groups within the school) as variables that shape school climate. The school psychologist has to consider not only climate issues that affect the particular school in which he or she works (or is testing for), but also broader, more general issues that are part of the professional climate in school psychology.

Building on the description of "school climate" offered by Lehr and Christenson (2002), several professional climate issues that affect personality testing in schools are highlighted: (1) The overrepresentation of minorities in special education. (2) The relationship between ED, social maladjustment (SM), conduct disorders (CD), internalizing-externalizing disorders, and comorbidity. (3) The relevance of the *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition [DSM-IV-TR] (American Psychiatric Association, 2000) to school psychology practice. (4) Paradigm shift from classification to early identification and intervention. These issues are discussed below.

Increased Incidence of Minority Representation in Special Education

In 2000, Black children made up 22% of all children in public school with one of three disabilities (specific learning disability [LD], ED, and mental retardation [MR]), even though they were only 17% of the total public school population (National Center for Education Statistics [NCES], 2001). In addition, Black children disproportionately represented 27% of all children with an emotional disturbance. Interestingly, 5% of all students have serious emotional disturbance; however, in 2001 under IDEA, less than 1% qualified for services (Koyanagi, 2003). Not only are minority children, particularly Black children, overidentified as ED, but many children with disabilities are not identified or perhaps are misidentified. As suggested by the Elementary and Middle School Technical Assistance Center (EMSTAC) (2005), the overidentification of Black children may be viewed as racial segregation, leading to removal of these children from mainstream classrooms, lower teacher expectations, and less challenging instruction. On the other hand, children not identified or misidentified may be mislabeled as LD, seen as exhibiting disruptive behaviors, and considered to be SM, and therefore not ED. These children are at increased risk for being expelled as opposed to being identified as ED (Koppelman, 2004; Olympia et al., 2004).

Wagner (1995) noted that African American youths, particularly males, were overdiagnosed with social emotional disturbance (SED), along with two other disabilities, deafness and visual impairment. He hypothesized that poverty contributed significantly to these impairments. Wagner also speculated that poverty was an important variable that needed additional attention when the high rates of ED classification among minority youth are being considered.

Several authors have addressed issues related to overidentification and increased incidence of minority representation in special education (Cullinan, Epstein, & Sabornie, 1992; Harry, 1994; Hughes & Bray, 2004; Kehle et al., 2004; Reddy, 2001; Shaafombabi, 2005; Wagner, 1995). Yet, despite their overidentification for SED in schools, minority children are less likely to receive mental health services (Surgeon General, 1999), and culturally diverse children are often underserved and are at high risk for psychosocial problems, welfare dependency, and low job productivity (Cross, Bazron, Dennis, & Isaacs, 1989; Pumariega & Cross, 1997). School psychologists must keep abreast of the statistical findings regarding educational outcomes for minority youth, acquire competence in cultural assessment issues, understand the current advantages and disadvantages of classification problems, and, as Wagner (1995) highlighted, search for more appropriate assessment tools and methods for identifying children with SED.

Kehle et al. (2004) offered an "alternative nonenvironmental" genetic reason, "heterosis," for the increase in prevalence of ED/SM characteristics. *Heterosis* is a genetic term used to explain that "secular changes in several cognitive, physical, and psychological characteristics may have the same nonenvironmental etiology" (p. 861). This explanation unfortunately forecloses causality, promoting a polarized view with regard to the dichotomous genetics vs. environmental argument and lowers expectations for those identified as ED/SM. The position of Kehle and colleagues (2004) also contradicts a more current view of understanding psychological problems that are multidimensional and examines multiple vulnerabilities that are environmentally and biologically based (i.e., neurological factors and temperament) (Ingram & Price, 2001).

Relationship Between ED, SM, Internalizing-Externalizing Disorder, and Comorbidity

There are several classification issues that affect personality assessment in schools. For instance, ED, as described above, accounted for less than 1% of all students qualified under IDEA in 2001, even though 5% of all children actually have a serious emotional disturbance (Koyanagi, 2003). Thus, there are more students in need of emotional support than receive it, and there are issues that might complicate this problem. For example, the internalizing (e.g., depression, anxiety)–externalizing (e.g., conduct) dichotomy is popular and has empirical support at the level of factor analysis (Knoff, 2002) but may contribute to overidentification of youngsters with conduct problems and possibly underestimate the presence of comorbid disorders.

Price and Lento (2001) reviewed the prevalence studies on diagnostic categories of disorders and found rates of comorbidity to be in the 50% range, even within the internalizing and externalizing clusters. They emphasized the importance of examining the "constellation of comorbid conditions" with less focus on just problematic behaviors.

Olympia and colleagues (2004) appeared to address this point by noting that the federal interpretation of ED at state and local levels, and the choice and interpretation of tests used to measure internalizing or externalizing disorders can affect classification of SM as well as ED. Olympia and colleagues (2004) also noted some SM/ED definition misconceptions about youngsters with externalizing disorders that might eliminate them from special educational consideration. Examples of these misconceptions are that externalizing disorders do not have high comorbidity, behaviors of those that are disruptive are intentional and can be controlled (whereas ED's are unable to regulate and control behaviors), and children with externalizing behaviors do not have guilt, in contrast to the ED child, who is thought

to have guilt. Skiba and Grizzle (1991) addressed concerns about inadequate measures to differentiate SM from ED, including lack of operationally defined definitions of ED and SM, overrepresentation of conduct disorders (CD) in special education, language inconsistencies between IDEA and DSM, misuse of scales identifying students as externalizers vs. internalizers, lack of understanding and training about coexisting disorders, and limited resources related to classification. Other authors indicate that minority children with SED tend to be diagnosed as having an externalizing disorder and conduct disorder, perhaps to the neglect of recognizing internalizing disorders (Carron & Rutter, 1991; Kilgus, Pumariega, & Cuffe, 1995). Difficulties and challenges associated with identifying ED in a school setting have been noted (Skiba & Grizzle, 1991; Skenkovich, 1992; Skiba & Grizzle, 1992; Forness, 1992).

In summary, there is a need for more attention to the comorbidity of disorders and the externalizing/internalizing dichotomy and understanding the overlap of disorders and patterns of adaptation. Assessors' knowledge of overlapping conditions when identifying children for special education may contribute to more accurate decisions about classification, effective prevention strategies, intervention planning, and successful outcomes. There are youngsters who are not readily classified as ED and therefore are unable to access special education because of SM/CD problems that do not meet the ED threshold. The psychologist who evaluates youngsters with ED/SM/CD would benefit the child by obtaining increased training in coexisting disorders and including specific measures of emotional disturbance that highlight primary affect states (e.g., anger, depression, anxiety) and personality characteristics (Lounsbury, 2003) when ruling out ED.

DSM-IV in Schools

DSM-IV-TR represents standard diagnostic language in mental health, but not in school psychology. Despite exposure to DSM in classes (Culross & Nelson, 1997), school psychologists are dedicated primarily to the classification schemas of IDEA. Yet students who qualify under Section 504 for educational accommodations because of an identified disability may be diagnosed as such with the use of DSM-IV, as might be the case when dysthymia or attention deficit disorder is diagnosed. However, Knoff (2002) has questioned the value of using DSM-IV as it pertains to school psychology personality assessment. Knoff identifies five problems with DSM-IV: reliance on the medical model of pathology and disease classification; emphasis on signs, symptoms, and syndromes compared with functional assessment of why a problem occurs; too many diagnostic categories; psychometric issues; and problems in the application of definitions of some diagnosis across settings and their lack of fit with ED as described in IDEA.

An alternative position has been offered by Sattler (1983), who stated over 20 years ago that knowledge of the DSM would help a school psychologist understand mental disorders and communicate with community resources such as psychiatrists and community service centers. Power and DuPaul (1996) also support the importance of having knowledge of the DSM, given the recognition by the National Association of School Psychology (NASP) that school psychologists need to become involved in mental health problems in the schools. Similarly, McBurnett (1996) reviewed the relevance of DSM-IV and found this version to be very useful to psychologists working in schools. Atkins et al. (1996), for example, indicated that the DSM-IV was more empirically sound than other versions and was helpful in the attempt to operationalize the definitions of conduct disorder and ODD.

Moving from Classification to Early Identification and Intervention

Koppelman, in the *National Health Policy Forum* (2004), highlights the need for early intervention to improve the chances for a successful educational outcome. However, the emphasis placed on early identification, proposed by the President's Commission on Excellence in Special Education (PCESE) (2002), recommended screening for learning and/or behavioral problems. Limiting the focus of early identification to behavioral problems without also considering and incorporating emotionality into the matrix of assessment promotes the premise that behaviors can operate independently of other personality features, including the affective domain. School psychologists in practice are frequently required to negotiate this tendency to focus on behaviors to the exclusion of the other components of a functioning child, but it is critical to consider the child holistically (i.e., thought, affect, behavior, culture, race/ethnicity, spirituality) during personality assessments to minimize potential slights to the totality of the child's experience.

Child assessments that give consideration to as many aspects of the child's life as possible, or which use this model as an ideal for which to strive, create opportunities for expanding or evolving the potential for beneficial interventions that are responsive to the assessment process. Sattler (2002) has supported this view by noting that measures of behavioral, social, and the emotional competencies are beneficial for school assessment, recommendations, and evaluation of interventions. The term "evolving context" has been used by Truscott, Catanese, and Abrams (2005) to describe the changes in the special education classification system as these changes pertain to service delivery. Concern regarding lack of coordination among mental health providers and current assessment practices (Hatzichristou, 2002) is central to an understanding of the terminology of Truscott et al. because of the increased attention paid to the importance of dovetailing assessment with interventions that are pragmatic, titrated, and in the child's best interest relative to referral concerns.

Hughes and Bray (2004) support focusing on empirically based treatment as opposed to the continuing focus on classification. This position reflects an earlier recommendation by Ysseldyke and Christenson (1988) for a paradigm shift from viewing assessment as classification to linking assessment to effective interventions. Likewise, current supporters of this thinking (Reschly & Ysseldyke, 1995, 2002) recommended that assessment be linked to outcome so that children could be more effectively understood across treatment and educational settings. Likewise, Truscott et al. (2005) recommended a focus on interventions across contexts. This recommended intervention focus also represents the positions of NASP (2004) and PCESE (2002) on program effectiveness.

TRAINING ISSUES IN SCHOOL PSYCHOLOGY AND PERSONALITY ASSESSMENT

In this section we present a sampling of surveys to show some of the trends that have evolved over the years with respect to school psychology training and practice in the area of personality assessment. Application of personality assessment to school psychology practice and intervention covers the range of exceptionalities, including gifted students (e.g., Pfeiffer, 2001), students with a neuropsychologically based disability (Domingos & Yalof, 2002; Rothstein, Benjamin, Crosby, & Eistenstadt, 1988), emotional disorders that are comorbid with ADHD (e.g., Demaray, Schaefer, & Delong, 2003), and students with learning disabilities (e.g., Martinez & Semrud-Clikeman, 2004). A summary of key survey research is pre-

sented to illustrate the evolving trend among school psychologists toward the application of emotional and behavior rating measures in the identification social-emotional adjustment.

Goh and Fuller (1983) surveyed 274 practicing school psychologists about their personality assessment practices. Their results indicated that a majority of school psychologists used projective techniques. The percentages of school psychologists using individual personality tests were reported as follows: 88% used the Bender-Gestalt, which was classified as a projective technique; 87% used the Sentence Completion; 73% used the House-Tree-Person; 65% used the Thematic Apperception Test (TAT); 59% used the Children's Apperception Test (CAT); 45% used the Draw-A-Person and Rorschach; 16% used the Hand Test; 11% used Kinetic Family Drawing Scales; and 5% used the Rosenzweig Picture Frustration Study. Among self-report measures, the two most commonly used instruments were self-concept scales (44%) and the Minnesota Multiphasic Personality Inventory (MMPI) (25%). For the individual behavior rating scales, the most commonly used measures were informal ratings (59%) and the Devereux Behavior Rating Scales (33%). The authors noted that school psychologists did not view personality and behavior ratings as incompatible with each other and were likely to use both measures in their work.

Prout (1983) surveyed school psychology practitioners and directors of school psychology training programs to learn about their training and assessment practices. Results showed that a very high percentage of respondents (94.1%) used a combination of assessment techniques. Over one half of the assessments school psychologists conducted included an evaluation of social-emotional functioning. Social-emotional assessment techniques were rank-ordered, with clinical interview, informational classroom observation, human figure drawings, Bender-Gestalt (emotional indicators), and Incomplete Sentences, respectively, as the top five measures. Behavior rating scales were ranked ninth on the list. Other tests and measures, including the TAT, CAT, Rorschach, and MMPI, were ranked below tenth on the list. Practitioners ranked behavioral observation, clinical interview, projective tests, behavior rating scales, and objective tests, respectively, as the top five measures in terms of their importance and utilization. Practitioners reported that the TAT received the most attention in terms of their professional training, followed by human figure drawings, the Bender-Gestalt, clinical interviewing, and the CAT. Trainers ranked clinical interviewing, followed by informal classroom observation, human figure drawings, Bender-Gestalt, and structured classroom observation, as the top five assessment techniques in terms of training emphasis.

Stinnett, Havey, and Oehler-Stinnett (1994) surveyed 400 randomly selected members from NASP about their typical assessment practice techniques. They found that interviews were more popular than projective tests and self-report measures. Overall, results indicated that respondents spent approximately 50% of their practice hours doing assessments. Interview and behavioral observation were considered the most important techniques. The authors emphasized the identified preferences among school psychologists for informal assessment techniques compared with formal assessment techniques.

Wilson and Reschly (1996) surveyed 251 school psychology practitioners and found that the Draw-A-Person technique was the most frequently used projective measure. The authors reported that "at least two-thirds" (p. 16) of respondents were giving the Draw-A-Person, House-Tree-Person, or Kinetic-Family-Drawing "every month" (p. 16). The TAT was the fourth most common measure. The Achenbach-Edelbrock Child Behavior Checklist (CBCL) was the most popular behavior rating scale.

Culross and Nelson (1997) surveyed NASP programs offering specialist level training and asked faculty who taught personality assessment courses to respond to questions about how students were trained. Results indicated that 71% of programs offered a course in personality assessment and 30% offered more than one course in this area. The majority of

programs taught both child and adult assessment but focused primarily on child assessment. The six most commonly taught measures were clinical interviewing, behavioral assessment, Bender-Gestalt, classroom observation, and the TAT. Over 80% of the programs offered clinical training (e.g., administration, scoring, interpretation) compared with a smaller percentage of programs whose instruction was primarily didactic versus clinical. The Rorschach was taught by only 38% of the programs that offered clinical training. The authors noted, however, that "practitioners routinely use tests with questionable validity and reliability" (p. 123), noting in particular the limitation of the Bender-Gestalt and figure drawings. The three topics most commonly taught in personality assessment classes were report writing (68%), ethical and professional issues (44%), and diagnostic classification systems (32%). More recently, Brown, Kissell, and Bolen (2003) surveyed 61 APPIC internship directors in order to better understand internship training in school psychology in non-school settings. They found that school psychology interns devoted most of their time to individual and group counseling, with the next highest percentage of time devoted to psychological assessment. The potential value of additional coursework in personality assessment was identified as being important for students who seek pre-doctoral internships in non-school settings.

Shapiro and Heick (2004) surveyed 684 NASP members, focusing on their recent and evolving assessment experiences, and found that 89.6% used rating scales (teacher and/or parent) and 75.3% used student self-ratings in 4 of their last 10 assessments. Ratings were more popular than projective tests, supporting the trend identified by Kamphaus, Petoskey, and Rowe (2000), who summarized research on test practices among child psychologists and indicated that behavior ratings scales would continue to grow in popularity over time.

In summary, a preference appears to have emerged in the education and training of school psychologists for the use of objective scales in identifying social-emotional disturbances.

CASE STUDY

The following case material is a composite case designed to illustrate the value of personality assessment during evaluation of a child for school and clinical purposes. The case highlights the impact of cognitive deficits on personality functioning while also providing insights about the child's inner life that are hard to extrapolate from self-report and observer rating scales. The overlapping nature of internalizing and externalizing disorders, for example, is often overlooked when rating scales are unidimensional.

B.J. (a pseudonym), a teenager, was referred for an assessment by his foster parents because of problems in school (e.g., fighting, impulsivity, disrespect toward teachers, poor academic performance) and at home (acting out against parental limits) and because his therapist requested a comprehensive assessment to assist with treatment interventions. B.J.'s natural mother (father's whereabouts were unknown) abandoned him at an early age, and he has been with his foster parents, who adopted him, since he was two years old. B.J. was diagnosed with attention deficit hyperactive–impulsive disorder (ADHD) combined type, in preschool. He was also diagnosed with a reading disability. There were many disciplinary issues in school and at home, and recently both school and B.J.'s parents had been considering an alternative, out-of-state school placement. School focus has been on supporting B.J.'s academic needs and providing teacher recommendations for classroom management through his IEP. B.J. had been unsuccessful with private therapists, but his most recent therapist felt that he was struggling with issues that went beyond the externalizing behaviors noted in school reports, and requested both cognitive and personality testing. On interview B.J. reported repetitive dreams of being harmed, some ritualistic behaviors, anxiety, and sleep difficulty.

Cognitive assessment revealed low average intelligence (WISC IV), with significant deficiencies in working memory and processing speed. Academic achievement testing (WIAT II) supported the presence of both reading and arithmetic disabilities. There were consistent deficits in both executive functioning (Category Test; Trail Making Test) and sustained attention (Conners Continuous Performance; Seashore Rhythm Test), as well as several below average scores on tests of visual and verbal learning and memory (Wide Range Assessment of Memory and Learning; California Verbal Learning Test; Rey Complex Figure Design and Recognition Trial). Thus, B.J.'s cognitive needs interfaced clearly with his behavior problems, but what was missing from the overall picture was a thorough understanding of B.J.'s personality beyond rating scales (BASC, Conners' Rating Scale) highlighting problems with conduct, attention, impulsivity, and externalizing behavior. On a depression self-report scale (Children's Depression Inventory), he scored above average for negative mood. On an anxiety self-report scale (Multidimensional Anxiety Scale for Children), he scored above average for tense-restless behavior.

B.J. was administered the Roberts Apperception Test and Rorschach to further understand his personality. Several of his stories to the Roberts stimuli were indicative of self-blame, vulnerability to making mistakes, and a desire to receive help. These inferences provided an appreciation for B.J.'s internal, personal struggle in a way that was neither verbalized nor observed during history taking and interview. Rather than casting him only as a poorly controlled ADHD youngster with language-based learning needs, B.J.'s stories suggested a more dynamic internal process in which he was possibly feeling a sense of remorse for bad behavior, experienced anxiety about decreased self-control, and had an underlying desire to receive help. These story themes, combined with B.J.'s difficulty interacting and communicating, could motivate him to subvert the helping efforts of others as a way of avoiding a repetition of the early abandonment trauma. His distancing behavior was evidenced at home as well as in therapy and school.

B.J.'s Rorschach (Exner, 2003) results are abstracted here to further illustrate the importance of conducting a comprehensive personality assessment when there are significant and overlapping disorders that manifest behaviorally with symptoms affecting full access to the curriculum. We emphasize the structural response variables in the following analysis. For example, although B.J. was characterized as an impulsive, externalizing student on rating scales, his Rorschach revealed that he tried very hard to minimize stimulation as a way of keeping himself controlled (Lambda = 3.0). Efforts at internal control were rigid, designed to minimize distressing or anxiety-provoking thoughts (FM = 0) that could contribute to nightmares. B.J. was very self-protective of his personal space (HVI positive). However, he did not have an adaptive coping style (EB = 2.0:2.0). As a result, he was vulnerable to strong emotions (Pure C = 1), confusion, and anger, resulting in judgment errors ($S - 3$; $X - \% = .35$). B.J.'s self-image was lower than expected ($3r + 2/R = .25$), and he was not comfortable initiating contact with other people in a positive way ($T = 0$). His interpersonal perceptions indicated that while he expected negative outcomes, he also hoped for positive outcomes (GHR:PHR = 7:5).

In summary, B.J. has features of an anxiety disorder as well as ADHD and a learning disability. It is the overlap between B.J.'s externalizing (i.e., ADHD; Combined Type) and internalizing (i.e., anxiety) problems, rather than just his externalizing issue, that contributes to a broader understanding of his problems. His cognitive deficits interfere with his ability to fully anticipate, attend, manage, and respond thoughtfully to potential conflict situations. These deficits placed B.J. at a coping disadvantage. His ADHD is an externalizing disorder and represents the focus of the school but does not explain the full diagnostic picture. He is

anxious, fearful, and angry, with lowered self-image and a desire for positive relationships, even though manifest behaviors are distancing. These insights from personality assessment can be useful to parents, therapist, and teachers as they develop strategies for helping B.J. improve his cognitive, social-emotional, and behavioral adjustment.

CONCLUSION

The practice of personality assessment in school psychology requires an appreciation of points of convergence and divergence with traditional clinical psychology personality assessment practices. Psychologists who work in private settings and whose work products are used by school districts have to be familiar not only with DSM nomenclature, but with IDEA, Section 504, and the prevailing climate of personality assessment in the particular school setting. There are a multitude of referral issues that present either in isolation or comorbidly with other disorders. Assessment requires skillful application and integration of interview, observation, history, and tests and measures with an eye toward functional interventions that serve the student's programmatic goals in relation to the curriculum. Attention to examining dimensions of personality as manifested through cognition, behavior, affect, and social experiences may better determine problematic areas identified for prevention and intervention as well as high rates of comorbidity.

APPENDIX

Referral domain	*Test/measure & source*	*Ages/range**
Observation/interview	Behavioral Assessment System for Children-Student Observation System (BASC-SOS; Reynolds & Kamphaus, 1992). AGS.	School-aged children
	Direct Observation Form (CBC-DOF). Achenbach System of Empirically based Assessment (ASEBA) Research Center for Children, Youth, & Families.	5–14
	Structured Observation of Academic & Play Settings (Milich, Loney, & Landau, 1982)	Children
	Semistructured Interview for Children & Adolescents (SCICA.) ASEBA Research Center for Children, Youth & Families.	6–18
School climate/ ecological	Reynolds Bully Victimization Scales for Schools (RBVS; Reynolds 2003); Includes: Bully-Victimization Scale (BVS), Bully Victimization Distress Scale (BVDS), & School Violence Anxiety Scale (SVAS). PsychCorp.	BVS: Grades 3–12; BVDS: Grades 3–12; SVAS: Grades 5–12
	Social Experience Questionnaire Self-Report (SEQ-S; Crick & Bigbee, 1998) & the Social Experience Questionnaire Peer Report (SEQ-P; Crick & Bigbee, 1998). See http://vinst.umdnj.edu/VAID/TestReport.asp?Code=SEQP	9–11

(*continued*)

Referral domain	*Test/measure & source*	*Ages/range**
Personality	Student Styles Questionnaire (SSQ;) Oakland, Glutting, & Horton, 1996). PsychCorp.	8–17
	The Kid's Coolidge Axis II Inventory (KCAT) (Coolidge et al., 1990)	5–11
	Personality Inventory for Children, Second Edition (PIC-2; Lachar & Gruber)	5–19 4th–12th grades
	Personality Inventory for Youth (PIY; Lachar & Gruber, 1995). Western Psychological Services.	
	Student Behavior Survey (SBS; Lachar, Wingenfeld, Kline, & Gruber). Western Psychological Services.	5–18
	Minnesota Multiphasic Personality Inventory–Adolescent (MMPI-A; Butcher, Williams, Graham, Archer, Tellegen, Ben-Porath & Kaermmer, 1992). Pearson Assessments.	14–18
	Millon Adolescent Personality Inventory (MAPI; Millon, Green, & Meagher, 1982). Pearson Assessments.	13–19
	BarOn Emotional Quotient-Inventory: Youth Version (BarOn EQ-i:YV; Bar-On & Parker). Multi-Health Systems, Inc.	7–18
Self-concept	Piers Harris Self-Concept Scale, Second Edition (Piers, Harig, & Herzberg). Western Psychological Services.	7–18
Trauma	Trauma Symptom Checklist for Children (TSCC; Briere, 1996). Psychological Assessment Resources, Inc.	8–16
	Clinician Administered PTSD for Children and Adolescents (CAPS-CA; Newman, Weathers, Nadar, Kaloupek, Pynoos, Blake, & Kraiegler). Western Psychological Services.	8–15
	Children's PTSD Inventory (ChPTSD; Saigh). PsychCorp.	6–18
Depression	Children's Depression Inventory (CDI; Kovacs, 1992). Multi-Health Systems, Inc.	7–17
	Reynold's Adolescent Depression Scale Second Addition (RADS-2; Reynolds). Psychological Assessment Resources, Inc.	11–20
	Beck Depression Inventory–II (BDI–II; Beck, Steer, & Brown, 1996). PsychCorp.	13–18
Anxiety	Multidimensional Anxiety Scale for Children (MASC; March, 1997). Multi-Health Systems, Inc.	8–19
	Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds, & Richmond, 1985). Western Psychological Services.	6–19
	State-Trait Anxiety Inventory for Children (STAIC; Spielberger, 1973). MindGarden, Inc.	6–14
	The Fear Survey Schedule for Children–Revised, (FSSC-R) (Ollendick, 1983)	Children & adolescents

(*continued*)

Referral domain	*Test/measure & source*	*Ages/range**
	Multidimensional Anxiety Scale for Children, (MASC; March, 1996). Multi-Health Systems, Inc.	8–19
	Beck Youth Inventories of Emotional & Social Impairment (BYI; Beck, Beck, & Jolly, 2001). PsychCorp.	7–14
	Adolescent Anger Rating Scale (AARS; Burney). Western Psychological Services.	11–19
	Children's Inventory of Anger (ChIA; Nelson & Finch). Western Psychological Services.	6–16
	Navaco Anger Scale & Provocation Inventory (NAS-PI; Novaco). Western Psychological Services.	9+
Anger	State-Trait Anger Expression Inventory-II (STAXI-II; Spielberger & Vagg, 2002). Psychological Assessment Resources, Inc.	16 and older
OCD	Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS; Goodman, 1986) In *OCD in children & adolescents: Cognitive-Behavioral Treatment Manual* (1998) by J. March & K. Mulle.	6–17
	Leyton Obsessional Inventory (Williams & Wilkins, 1988) In *OCD in children & adolescents: Cognitive-Behavioral Treatment Manual* (1998) by J. March & K. Mulle	Children & adolescents
	Clark-Beck Obsessive-Compulsive Inventory (CBOCI; Clark & Beck). PsychCorp.	17 and older
Eating	Eating Disorder Inventory–3 (EDI-3; Garner, Olstead, & Polivy, 2004). Psychological Assessment Resources, Inc.	13–53
	Overeating Questionnaire (OQ; O'Donnell & Warren, 2004). Western Psychological Services.	9 years +
Psychopathology	Children's Interview for Psychiatric Syndromes (ChIPS; Rooney, & Fristad, Weller, & Weller). American Psychiatric Publishing, Inc.	6–18
	Adolescent Psychopathology Scale (APS; Reynolds, 1998) and Adolescent Psychopathology Scale–Short Form (APS-SF; Reynolds, 2000). Psychological Assessment Resources, Inc.	APS 12–19 APS-SF 12–19
	Devereux Scales of Mental Disorder (DSMD; Naglieri, LeBuffe, & Pfeiffer, 1994). PsychCorp.	Child: 5–12 Adolescent: 13–18
	Behavior and Emotional Rating Scale-2 (BERS; Epstein & Sharma, 1998). pro-ed.	5–18.11
Social skills	Social Rating System (SSRS; Gresham & Elliot, 1990). AGS.	3–18
Substance abuse	Substance Abuse Subtle Screening Inventory (SASSI-3; Miller, Roberts, Brooks, Lazowski, & the SASSI Institutes, 1997). SASSI Institute.	12–18

(*continued*)

Referral domain	*Test/measure & source*	*Ages/range**
Parent information	Parent Stress Index–Third Edition (PSI-3; Abidin, 1995). Psychological Assessment Resources, Inc.	Parents of children 1 month–12 years
Sentence completion	Rotter Incomplete Sentences Blank, Second Edition (RISB; Rotter, Lah, & Rafferty, 1992). PsychCorp.	High school to adult
Behavior	The Behavior Assessment System for Children, Second Edition (Reynolds & Kamphaus); Parent Rating Scales Preschool (PRS-P), child (PRS-C), & Adolescent (PRS-A); Teacher Rating Scales Preschool (TRS-P), child (TRS-C), & adolescent (TRS-A); self report-child (SRP-C) & self report adolescent (SRP-A). AGS.	PRS-P = 2–5 PRS-C = 6–11 PRS-A = 12–21; TRS-P = 2–5, TRS-C = 6–11 & TRS-A = 12–21; SRP-C = 8–11 & SRP-A = 12–21
	Child Behavior Checklist (CBCL), Teacher's Report Form (TRF), and Youth Self-Report (YSR). ASEBA Research Center for Children, Youth & Families.	CBCL/11/2–5 & C-TRF = 2–5 CBCL & TRF = 6–18; YSR: 11–18
	Conners' Rating Scales–Revised (CRS-R; Conners, 1997); Parent/teacher rating forms and self report. Multi-Health Systems, Inc.	3–17 self-report 12–17
Apperception & thematic methods	Rorschach Technique (Rorschach, 1921). PsychCorp.	5–adult
	Roberts–2 (Roberts). Western Psychological Services.	6–18
	TEMAS (Tell-Me-A-Story) (Costantino, Malgady, & Rogler, 1988). Western Psychological Services.	5–18
	Thematic Apperception Test (TAT: Murray, 1943). PsychCorp.	Children & adolescents
	Children's Apperception Test (C.A.T.; Bellak & Bellak, 1949). PsychCorp.	5–12

* The population is defined as designated in the test manual or primary source.

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