

Evidence-based Assessment in Pediatric Psychology: Measures of Psychosocial Adjustment and Psychopathology

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Objective To provide an evidence-based review of measures of psychosocial adjustment and psychopathology, with a specific focus on their use in the field of pediatric psychology. **Methods** As part of a larger survey of pediatric psychologists from the Society of Pediatric Psychology e-mail listserv (American Psychological Association, APA, Division 54), 37 measures were selected for this psychometric review. Measures that qualified for the review fell into one of the following three categories: (a) internalizing or externalizing rating scales, (b) broad-band rating scales, and (c) self-related rating scales. **Results** Psychometric characteristics (i.e., three types of reliability, two types of validity) were strong for the majority of measures reviewed, with 34 of the 37 measures meeting “well-established” evidence-based assessment (EBA) criteria. Strengths and weaknesses of existing measures were noted. **Conclusions** Recommendations for future work in this area of assessment are presented, including suggestions that more fine-grained EBA criteria be developed and that evidence-based “profiles” be devised for each measure.

Key words adjustment; assessment; evidence-based; measurement; pediatric; psychometric; psychopathology.

As noted in the Introduction to this Special Series (Cohen et al., in press), scholars have sought to document the evidence-based status of psychological interventions in the fields of clinical child psychology and pediatric psychology (Chambless & Ollendick, 2001; Spirito, 1999). Interestingly, far less attention has been devoted to documenting the evidence-based status of our assessment instruments. One recent exception in the field of clinical child psychology is the special section of the *Journal of Clinical Child and Adolescent Psychology* (JCCAP) entitled “Developing Guidelines for the Evidence-Based Assessment of Child and Adolescent Disorders” (Mash & Hunsley, 2005), where authors reviewed current state-of-the-art assessment strategies across a wide variety

of disorders (e.g., anxiety, depression, ADHD, conduct problems) and methods (e.g., rating scales, observational techniques, and interview methodologies). Most importantly, the authors of these papers clearly demonstrated the importance of considering the evidence base for assessment techniques used in our clinical practices and research endeavors.

The purpose of this article is to provide an evidence-based review of measures of psychosocial adjustment and psychopathology, with a specific focus on their use in the field of pediatric psychology. Ultimately, the goal of this article is to aid researchers and clinicians in selecting appropriate measures for their work by providing detailed reports of psychometrics, clinical utility, and

Authors 3–5 are members of our APA Division 54 Evidence-Based Assessment Task Force Workgroup and are listed alphabetically by last name; their contributions were equivalent. Authors 6–13 are also listed alphabetically by last name; their contributions were equivalent.

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evidence-based support for each measure. This review of measures of psychosocial adjustment and psychopathology is one of eight papers in this special series. The other seven papers review assessment strategies from the following domains: quality of life, family functioning, social support and peer relations, adherence, pain, stress and coping, and cognitive functioning.

Assessment of Psychosocial Adjustment: Past Reviews

Although many of the measures discussed in the current article were also reviewed in JCCAP's special series (Mash & Hunsley, 2005), the current review diverges from this earlier set of papers in several respects. First, and most importantly, our review focuses on the use of these measures with pediatric populations. As will become clear later in this article, many unique assessment-related issues arise when attempting to use measurement techniques with children and youth with chronic medical conditions. Second, given that most children with chronic illnesses do not meet criteria for DSM diagnoses (Bennett, 1994), our focus was primarily on measures that tap symptomatology (rather than diagnostic criteria). Thus, we decided not to include diagnostic clinical interviews in this review. Third, unlike the JCCAP reviews, which focused on single psychopathologies, we reviewed measures across several psychosocial domains. In this way, comparisons can be made across symptom domains with respect to psychometric integrity and clinical utility. Finally, we emphasized psychosocial strengths (in addition to psychosocial liabilities) by including measures of perceived self-concept and self-esteem in our review.

With respect to pediatric psychology, reviews have been conducted of measures used by researchers in this field of study. Perhaps most relevant to the current article, Rodrigue, Geffken, and Streisand (2000) reviewed measures in the area of "child health assessment," including measures of adjustment, stress and coping, attitudes and beliefs, quality of life, and adherence. Most of the measures they reviewed in the area of adjustment were illness-related; thus, there is little overlap with measures examined in the current review [e.g., only the Children's Somatization Inventory (CSI) and the Pediatric Behavior Scale (PBS) are presented in both reviews]. Kelley, Reitman, and Noell's (2003) review of "empirically-based measures of school behavior" also overlaps with the current article (e.g., measures of externalizing symptoms were thoroughly reviewed),

except that the focus of their review was on the utility of assessment strategies in *school settings*.

Measurement Categories

In this article, we examined measures that fell into one of the following three categories: (a) internalizing or externalizing rating scales, (b) broad-band rating scales (i.e., measures with a broad coverage of psychological adjustment constructs), and (c) self-related rating scales (i.e., measures of perceived self-esteem or self-concept). We allowed this categorization to emerge during the measure selection process (described subsequently) rather than identify these domains a priori. Other categorizations were possible, of course. For example, we could have employed more specific domains, such as depression, anxiety, attention problems, etc. On the other hand, there was considerable item-overlap across some of these measures, even among those purporting to assess different constructs.

The Current Review

The first section of this review describes how measures were selected for further examination. Second, the criteria used to review the measures and determine their evidence-based status are outlined (Table I). We then review the measures (Table II and Appendix A) and provide a general critique of assessment strategies for psychosocial adjustment, as used in the field of pediatric psychology (including a discussion of strengths and limitations). Finally, we suggest future directions for this particular assessment domain and provide a set of recommendations for improving the evidence-base for this literature.

Measure Selection

As described in more detail in the Introductory paper (Cohen et al., in press), eight workgroups generated a list of all existing measures in their respective assessment domains. In total, 367 distinct measures were identified across the eight workgroups. On the 367 measures, 28 were identified by the Psychosocial Adjustment and Psychopathology workgroup. In 2003, the master list of measures was distributed to the APA Division 54 listserv (325 listserv members; not all members of Division 54 are members of this listserv) and respondents were asked to identify measures they "have used or have considered using for research or clinical purposes." They were also asked to list any additional measures they have

Table I. Criteria for Evidence-based Assessment

Category	Criteria
Well-established assessment	<ol style="list-style-type: none"> I. The measure must have been presented in at least two peer-reviewed articles by different investigators or investigatory teams. II. Sufficient detail about the measure to allow critical evaluation and replication (e.g., measure and manual provided or available upon request). III. Detailed (e.g., statistics presented) information indicating good validity and reliability in at least one peer-reviewed article.
Approaching well-established assessment	<ol style="list-style-type: none"> I. The measure must have been presented in at least two peer-reviewed articles, which might be by the same investigator or investigatory team. II. Sufficient detail about the measure to allow critical evaluation and replication (e.g., measure and manual provided or available upon request). III. Validity and reliability information either presented in vague terms (e.g., no statistics presented) or only moderate values presented.
Promising assessment	<ol style="list-style-type: none"> I. The measure must have been presented in at least one peer-reviewed article. II. Sufficient detail about the measure to allow critical evaluation and replication (e.g., measure and manual provided or available upon request). III. Validity and reliability information either presented in vague terms (e.g., no statistics presented) or moderate values presented.

found useful, but which were not included on the master list. Eighty-seven listserv members (27%) responded to the survey. The number of endorsements for the 28 psychosocial adjustment measures, specifically, ranged from 5 to 79 (median = 23.5 endorsements; see Table III for a list of endorsement frequencies). Seventeen additional measures were suggested by at least one respondent, and four additional measures (The ADHD Rating Scale-IV, the Coopersmith Self-Esteem Scale, the Social Adjustment Inventory for Children and Adolescents, and the Pediatric Behavior Scale) were suggested by members of our workgroup *after* the listserv survey was conducted. Thus, a total of 49 measures were considered by the Psychosocial Adjustment and Psychopathology workgroup.

Measures that received less than 25 endorsements were evaluated by the workgroup to determine whether they would be included in the more extensive review process. Of the 35 low-endorsement measures (which included the 17 scales that were added by the listserv respondents and the four scales that were added “post-hoc” by the workgroup), 12 were dropped from further consideration for at least one of the following reasons: (a) they were not perceived as relevant to the field of pediatric psychology, (b) they were overly redundant with other scales that received more endorsements, (c) they were diagnostic clinical interviews, and/or (d) they were older scales, in need of updating. Thus, 37 measures received a thorough review by members of our workgroup (Table II and Appendix A).

Assessment Criteria

One of the goals of this review was to provide an “evidence-based assessment” (EBA) classification for each of the measures reviewed. The three possible evidence-based categories were as follows (and the criteria for each are listed in Table I): (a) Well-established assessment, (b) Approaching well-established assessment, and (c) Promising assessment (see Cohen et al., in press for a more thorough discussion of the criteria for each of these three categories). Similar to the criteria for evidence-based interventions in the literature on psychological treatment, a measure must have been the focus of research by more than one investigative team to meet the criteria for “well-established.”

Review of Measures

Our workgroup was made up of four sub-workgroups who each reviewed a portion of the 37 target measures. (A copy of all comprehensive reviews, with separate reference sections—including all articles and manuals used to generate the psychometric data provided in this article—is available from the first author upon request.) The data from these reviews are summarized in Table II (which includes reliability and validity data) and Appendix A (which includes primary references for the measures, a statement of purpose for each measure, the applicable age range, the number of items, the address for obtaining the manual and measure, and the EBA classification for each measure).

Table II. Summary of Reliability and Validity Information for Internalizing and Externalizing Rating Scales, Broad-Band Rating Scales, and Self-Related Rating Scales^a

Type of Measure	Measure	Reliability			Validity	
		Internal consistency	Test-Retest	Cross informant	Concurrent/predictive	Convergent
Internalizing or Externalizing Rating Scales	ADHD Rating Scale-IV	$\alpha = .92$ (parent, total), .86–.88 (parent, subscales); $\alpha = .94$ (teacher, total), .88–.96 (teacher, subscales)	$r = .85$ (parent, total, 4 weeks), .78–.86 (parent, subscales, 4 weeks); $r = .90$ (teacher, total, 4 weeks), .88–.89 (teacher, subscales, 4 weeks)	$r = .41$ (total), .30–.45 (subscales)	$r = .45$ –.81 (Conners' parent, learning difficulties, behavior problems); $r = .25$ –.88 (Conners' teacher, behavioral, emotional, and social problems) Subscales predictive of ADHD inattentive type and ADHD-combined type diagnosis 1 subscale differentiates ADHD-inattentive with ADHD combined types H/I subscale differentiates ADHD-combined with ADHD-Inattentive types	$r = .81$ (parent with Conners', parent, hyperactivity) $r = .76$ –.85 (teacher with Conners', teacher, attention and hyperactivity)
	Beck Anxiety Inventory (BAI)	$\alpha = .92$ –.94 (total, adults); $\alpha = .92$ (total, adol.)	$r = .75$ (adults, 1 week), .67 (adults, 2 weeks) $r = .71$ (adol., 1 week), .62 (adol., 2 weeks)	$r = .40$ (adolescents, clinician rating, HARS-R)	$r = .81$ (SCL-90-R Anxiety Subscale) Adol. in-patients endorse more symptoms of anxiety than high school students Differentiates anxious diagnostic groups from nonanxious groups	$r = .51$ –.54 (adults, HARS-R, anxiety diaries); $r = .58$ (adol., RCMAS)
	Beck Depression Inventory (BDI)	$\alpha = .76$ –.91 (total)	$r = .86$ –.98	Not reported	Score of 16 discriminates between adol. with and without MDD. 93% positive predictive power to detect MDD May differentiate MDD, minor depression, and nondepressive disorders	$r = .60$ –.62 (measures of adolescent adjustment), $r = .60$ (STAI), $r = .74$ (ATQ), $r = .55$ (CHS)
	Center for Epidemiologic Studies Depression Scale (CES-D)	$\alpha = .86$ –.90	$r = .19$ –.64	Not reported	$r = .76$ (RCMAS), $r = .54$ (MASC) Differentiates between adol. with MDD and dysthymia and adol. without depression 73% predictive power for MDD 17% of adol. with mild symptoms had mod/severe levels 1 year later, 46% had mild levels at 1 year. 44% with mod/severe levels stayed same at 1 year, 32% mild and 24% minimal at 1 year	$r = .41$ with the Children's Depression Rating Scale (CDRS)

(Continued)

Table II. Continued

Type of Measure	Measure	Reliability			Validity	
		Internal consistency	Test-Retest	Cross informant	Concurrent/predictive	Convergent
	Child and Adolescent Functional Assessment Scale (CAFAS)	$\alpha = .63-.78$	Correlations not reported, however, scores tend to decrease over time	$r = .84-.96$ (inter-rater reliability)	CAFAS predicted change in CBCL symptoms in 43% of cases Youth with higher scores more likely to have problems in social relationships (odds ratios 1.43–5.71), physically attack or threaten others (odds ratios 1.31–8.38), and have contact with juvenile justice (odds ratios 1.34–8.88)	$r = .22-.49$ (CBCL total), $r = .24$ (YSR total), $r = .52-.56$ (CAS)
	Childhood Anxiety Sensitivity Index (CASI)	$\alpha = .76-.87$ (nonclinical) $\alpha = .87-.88$ (clinical)	$r = .76$ (2 weeks, nonclinical); $r = .48$ (6 months, nonclinical) $r = .79$ for (1 week, clinical)	Not reported	Higher levels of anxiety sensitivity predicted more panic attacks symptoms, more symptoms of anxiety after anxiety-evoking challenge, and more internal catastrophic attributions about panic symptoms after simulated panic experience. Children with anxiety disorders and panic disorders displayed more anxiety sensitivity than those without psychiatric diagnosis.	$r = .50-.66$ (general anxiety), $r = .62-.64$ (trait anxiety), $r = .74-.76$ (fear), $r = .28-.61$ (panic attack symptoms), $r = .34-.43$ (# panic attack symptoms; non-clinical), $r = .64$ (general anxiety), $r = .62-.72$ (trait anxiety), $r = .59$ (fear; clinical)
	Children's Depression Inventory (CDI)	$\alpha = .71-.89$ (summary), $\alpha = .59-.68$ (factors)	$r = .38-.87$	$r = .40$ (child and parent versions)	Differences between psychiatric inpatient and normal samples; differences between depressed and nondepressed in-patients. Children with scores ≥ 13 had higher scores on RCMAS, and CBCL 4 years later; also received more counseling and had poorer grades. Distinguishes normal from clinical cases	$r = .46$ (CASQ attributional style questionnaire), $r = .60$ (anxiety), $r = .29$ (anger), $r = .20-.29$ (peer and teacher ratings of depression)
	Children's Somatization Inventory (CSI)	$\alpha = .90-.91$	$r = .14-.81$	$r = .17-.47$ (child and mother)	$r = .46-.63$ (CDI), $r = .53-.56$ (STAIC), $r = .26$ (CBCL, internalizing) Total score discriminates between healthy children and children with recurrent abdominal pain. Predicts school absence at 3 months.	$r = .65$ (FDI), $r = .42$ (CBCL, somatic complaints), $r = .76$ (PILL)
	Fear Survey Schedule for Children Revised (FSSC-R)	$\alpha = .92-.94$ (total), $\alpha = .57-.89$ (subscales)	$r = .82$ (1 week), $r = .85$ (2 weeks), $r = .62$ (3 months)	$r = .21$ (child and parent totals)	School phobic children endorse more fearfulness than matched controls. Discriminates types of phobias and specific anxiety d/os.	$r = .46-.51$ (trait anxiety)

Hospital Fears Questionnaire HFQ)	$\alpha = .60$ (pre-intervention), $\alpha = .58$ (post-intervention)	Not reported	Not reported	Not reported	$r = .48$ (CMFQ, frequency), $r = .95$ (CMFQ, intensity)
Multidimensional Anxiety Scale for Children (MASC)	$\alpha = .87-.93$ (total), $\alpha = .48-.90$ (across factors)	$r = .65-.78$ (idealized rater, 3 weeks), $r = .87$ (idealized rater, 3 months), $r = .78-.88$ (across raters, 3 weeks), $r = .93$ (across raters, 3 months)	$r = .39$ (mother and child) $r = .18$ (child and father) $r = .15$ (mother and father)	Not reported	$r = .63-.76$ (RCMAS), $r = .81$ (SCARED), $r = .71$ (SCAS), $r = .79$ (STAI, T-Anxiety), $r = .63$ (FSSC-R)
Positive and Negative Affect Schedule for Children (PANAS-C)	$\alpha = .80-.94$ (across subscales)	$r = .66-.74$ (across subscales)	Not reported	$r = .61$ (child emotionality), $r = .40$ (anger), $r = .49$ (fear), $r = -.22$ (sociability; negative affect) $r = -.23$ (child emotionality), $r = -.22$ (anger), $r = -.22$ (fear), $r = .33$ (activities), $r = .38$ (sociability; positive affect)	$r = .57-.66$ (CDI), $r = .51-.68$ (RCMAS), $r = .68$ (STAIC; negative affect) $r = -.55-.34$ (CDI), $r = -.34-.30$ (RCMAS), $r = -.30$ (STAIC, positive affect)
Revised Children's Manifest Anxiety Scale (RCMAS)	$\alpha = .79-.85$ (total), $\alpha = .56-.81$ (across subscales)	$r = .68$ (total, 9 months), $r = .98$ (total, 3 weeks), $r = .58$ (lie subscale, 9 months)	Not reported	Not reported	$r = .65-.88$ (STAIC), $r = .63$ (FSSC-R), $r = .76$ (MASC), $r = .85$ (SCARED), $r = .76$ (SCAS)
Reynolds Adolescent Depression Scale, 2 nd Ed (RADS-2)	$\alpha = .87-.96$	$r = .86$ (3 weeks), $r = .80$ (6 weeks), $r = .79$ (12 weeks)	Not reported	$r = .40-.75$ with measures of self-esteem, loneliness, suicidal ideation, hopelessness.	$r = .70-.89$ with other measures of depression
Screen for Child Anxiety Related Emotional Disorders (SCARED)	$\alpha = .90-.96$ (total), $\alpha = .55-.92$ (subscales)	$r = .70-.90$	$r = .33$ (parent & child, total), $r = .20-.47$ (parent & child, subscales)	Girls show higher total anxiety, GAD, separation anxiety, panic, and school phobia; rates of separation anxiety & panic decrease with age, while GAD increase. Differentiates children with diagnosed anxiety disorders and those with non-anxiety psychiatric disorders; discriminates between children with anxiety and depression.	$r = .85$ (SCAS), $r = .73$ (YSR anxiety/depression subscale), $r = .73$ (STAIC, trait), $r = .65$ (STAIC, state), $r = .86$ (RCMAS)

(Continued)

Table II. Continued

Type of Measure	Measure	Reliability			Validity	
		Internal consistency	Test-Retest	Cross informant	Concurrent/predictive	Convergent
	Social Anxiety Scale for Adolescents (SAS-A)	$\alpha = .76-.94$ (adol.), $\alpha = .78-.91$ (parent)	$r = .54-.78$ (across subscales, 2 months), $r = .47-.75$ (across subscales, 6 months)	Not reported	r (median) = $-.52$ (peer acceptance), r (median) = $-.37$ (close friendships) Not related to perceptions of support from parents and teachers; minimally related to self-perceptions in nonsocial areas. Discriminates between children with and without social phobia	$r = .58$ (RCMAS)
	Social Anxiety Scale for Children (SASC-R)	$\alpha = .60-.90$ (across subscales)	$r = .70$ (total), $r = .51-.63$ (across subscales)	Not reported	$r = -.47$ to $-.39$ (across subscales, SPPC, social acceptance), $r = -.37$ to $-.23$ (across subscales, SPPC, global self-worth) Children with social anxiety had significantly higher scores.	$r = .63-.81$ (SPAI-C), $r = .54$ (RCMAS), $r = .54$ (CASI), $r = .52$ (TASC)
	Social Phobia and Anxiety Inventory for Children (SPAI-C)	$\alpha = .92-.95$	$r = .86$ (2 weeks), $r = .63$ (10 months)	$r = .31$ (parent & child)	$r = .50$ (average # distressing social events/day), $r = .41$ (distress associated with event)	$r = .63-.81$ (SASC-R, total), $r = .50$ (STAIC, trait), $r = .13$ (STAIC, state), $r = .53$ (FSSC-R, failure and criticism), $r = .45$ (CBCL, internalizing)
	State-Trait Anxiety Inventory for Children (STAIC)	$\alpha = .65-.89$ (state), $\alpha = .44-.94$ (trait)	$r = .31-.71$ (across scales, 6 weeks)	Not reported	$r = .58$ (somatic complaints)	$r = .75$ (Children's Manifest Anxiety Scale), $r = .88$ (RCMAS), $r = .63$ (GASC), $r = .63$ (FSSC-R), $r = .79$ (MASC), $r = .87$ (SCARED), $r = .79$ (SCAS)
Broad-Band Rating Scales	Behavior Assessment System for Children (BASC)	$\alpha = .42-.97$ (across self-, parent-, and teacher-report, subscales)	$r = .41-.96$ (across self-, parent-, and teacher-report, subscales)	$r = .27-.97$ (parent- and teacher-report, subscales)	$r = .65-.92$ (parent, sensitivity); $r = .37-.82$ (parent, specificity) for distinguishing referred and nonreferred children. Comparable to CBCL in predicting ADHD (teacher-report better predictor of sub-threshold ADHD than CBCL).	$r = .31-.92$ (CBCL), $r = .12-.56$ (PIC-R), $r = .40-.71$ (CPRS-93), $r = .37-.76$ (MMPI), $r = .21-.65$ (CPQ)
	Child Behavior Checklist (CBCL/4-18, 1991)/Youth Self-Report (YSR, 1991)/Teacher Report Form (TRF, 1991)	$\alpha = .32-.64$ (competence and adaptive), $\alpha = .59-.97$ (problem/syndrome)	$r = .67-.93$ (competence and adaptive), $r = .47-.96$ (problem/syndrome)	$r = .36-.91$ (competence and adaptive), $r = .05-.86$ (problem/syndrome)	Discriminates between referred and non-referred children	$r = .03-.86$ (Conners' parent and teacher)

Child Behavior Checklist (CBCL/6-18, 2001)/Youth Self-Report (YSR,2001)/Teacher Report Form (TRF, 2001)	$\alpha = .55-.90$ (competence and adaptive), $\alpha = .71-.97$ (empirically based), $\alpha = .67-.94$ (DSM-oriented)	$r = .78-.93$ (competence and adaptive), $r = .60-.96$ (empirically based), $r = .62-.95$ (DSM-oriented)	$r = .37-.76$ (competence and adaptive), $r = .05-.85$ (empirically based), $r = .08-.88$ (DSM-oriented)	Discriminates between referred and non-referred children	$r = .32-.89$ (Conners' parent and teacher, DSM-IV, BASC, and ASEBA scales)
Children's Global Assessment Scale (CGAS)	Not applicable	$r = .85$	$r = .62-.84$	$r = .29$ (CBCL, school performance), $r = .43$ (Full Scale IQ), $r = .33$ (social readiness)	$r = -.25$ (Conners', parent); $r = .35$ (SAICA)
Conners' Rating Scales-Revised (CRS-R)	$\alpha = .73-.94$ (parent, long), $\alpha = .85-.94$ (parent, short), $\alpha = .88-.95$ (teacher, short), $\alpha = .74-.92$ (adol., long), $\alpha = .73-.85$ (adol., short)	$r = .47-.85$ (parent, long), $r = .62-.85$ (parent, short), $r = .47-.88$ (teacher, long), $r = .72-.92$ (teacher, short), $r = .73-.89$ (adol., long), $r = .68-.87$ (adol., short)	$r = .12-.55$ (parent & teacher, across subscales); agreement between parent & adol. and between teacher & adol. low or nonsignif for most subscales	Children diagnosed with ADHD scored higher on parent, teacher, and adol. short forms than non-ADHD children. Some indications that parent, teacher, and adol. short forms are able to classify ADHD and non-ADHD children (82.6- 93.4% accuracy)	$r = .33-.44$ (CPT, overall index); $r = .32-.89$ (CBCL)
Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A)	$\alpha = .35-.91$ (across clinical scales)	$r = .50-.84$ (across clinical scales)	Not reported	$r = -.65-.77$ (basic scales, sensitivity), $r = -.47-.65$ (basic scales, specificity), $r = -.86-.99$ (validity scales, sensitivity), $r = .73-.90$ (validity scales, specificity)	Not reported
Pediatric Behavior Scale (PBS)	$\alpha = .86-.95$ (across general factors), $\alpha = .45-.95$ (across specific scales)	Not reported	$r = .51-.79$ (across general factors)	Not reported	Not reported
Social Adjustment Inventory for Children and Adolescents (SAICA)	Not reported	Not reported	$r = .57$ (mother and child, total), $r = .30-.72$ (mother and child, across subscales)	$r = .22$ (child IQ), $r = .51$ (CBCL, problem behavior) Children with psychiatric disorders score higher than those without. Differences between those with any psychiatric history and those without.	$r = -.53$ to $-.33$ (CBCL, social competence), $r = .35$ (CGAS)
Social Adjustment Scale-Self Report (SAS-SR)	Not reported	Not reported	$r = .74$ (patient and close relative)	Depressed group had more problems in areas of social/leisure, family, and marital relationships than non-depressed group. Function significantly improved after treatment.	$r = .72$ (SAS, interview)

(Continued)

Table II. Continued

Type of Measure	Measure	Reliability			Validity	
		Internal consistency	Test-Retest	Cross informant	Concurrent/predictive	Convergent
	Social Adjustment Scale-Self Report (SAS-SR)	Not reported	Not reported	$r = .74$ (patient and close relative)	Depressed group had more problems in areas of social/leisure, family, and marital relationships than non-depressed group. Function significantly improved after treatment.	$r = .72$ (SAS, interview)
	Symptom Checklist-90-Revised (SCL-90-R)/Brief Symptoms Inventory (BSI)	$\alpha = .77-.90$ (across subscales)	$r = .68-.90$ (across subscales)	Not reported	$r = .88$ (sensitivity, diabetic sample), $r = .80$ (specificity, diabetic sample); $r = .76$ (sensitivity, bulimic sample), $r = .92$ (sensitivity, bulimic sample)	$r = .36-.75$ (across subscales), $r = .92$ (Global Severity Index)
Self-Related Rating Scales	Coopersmith Self-Esteem Inventory (CSEI)	$\alpha = .81-.92$	$r = .88$ (5 weeks), $r = .61$ (9 months), $r = .64$ (1 year), $r = .70$ (3 years)	Not reported	Not reported	$r = .55-.85$ with other self-esteem/self-concept scales
	Pictorial Scale of Perceived Competence and Social Acceptance for Young Children (PSPCSAYC)	$\alpha = .38-.93$ (across subscales)	$r = .48-.92$ (across subscales)	$r = .06-.37$ (child & teacher, across and subscales)	Not reported	$r = .08-.60$ (across subscales) with other self-esteem/self-concept scales
	Piers-Harris Children's Self-Concept Scale, 2nd edition (Piers-Harris 2)	$\alpha = .89-.93$ (total), $\alpha = .55-.84$ (across subscales)	$r = .65-.96$ (total)	Not reported	Not reported	$r = .32-.85$ (total), $r = .14-.62$ (across subscales) with other self-esteem/self-concept scales
	Rosenberg Self-Esteem Scale (RSES)	$\alpha = .72-.89$	$r = .63-.91$	Not reported	Predicts delinquent behavior, school failure and dropout, and substance abuse.	$r = .12-.76$ with other self-esteem/self-concept scales
	Self-Perception Profile for Adolescents (SPPA)	$\alpha = .56-.92$ (across subscales)	Not reported	Not reported	Not reported	$r = -.39-.59$ (across subscales) with other self-esteem/self-concept scales
	Self-Perception Profile for Children (SPPC)	$\alpha = .61-.86$ (across subscales)	$r = .72-.79$ (across subscales, 1 week), $r = .29-.61$ (across subscales, 3 years)	Not reported	Not reported	$r = .08-.60$ (across subscales) with other self-esteem/self-concept scales

Note: ATQ, Automatic Thoughts Questionnaire; CAS, Child Assessment Schedule; CCL-D, Cognitions Checklist Depression Subscale; CHS, Children's Hopelessness Scale; CMFQ, Children's Medical Fears Questionnaire; FDI, Functional Disability Inventory; GASC, General Anxiety Scale for Children; HAM-D, Hamilton Depression Rating Scales; HARS-R, Hamilton Anxiety Rating Scale-Revised; IAQ, Information Acquisition Questionnaire; PILL, Pennebaker Inventory for Limbic Languidness; SCAS, Spence Children's Anxiety Scale; STAI, State-Trait Anxiety Inventory; TASC, Test Anxiety Scale for Children.

*The table does not include an exhaustive review of measures or studies.

Table III. Number of Times Each Measure was Cited in JPP and the Number of Division 54 Listserv Members who Reported using Each Measure

Type of measure	Measure	Number of JPP citations ^a	Number of Div 54 listserv endorsements ^b
Internalizing or externalizing rating scales	ADHD Rating Scale-IV	0	**
	Beck Anxiety Inventory	3	26
	Beck Depression Inventory	44	*
	Center for Epidemiologic Studies Depression Scale	24	22
	Child and Adolescent Functional Assessment Scale	1	21
	Childhood Anxiety Sensitivity Index	3	*
	Children's Depression Inventory	69	66
	Children's Somatization Inventory	14	21
	Fear Survey Schedule for Children Revised	1	*
	Hospital Fears Questionnaire	4	*
	Multidimensional Anxiety Scale for Children	7	13
	Positive and Negative Affect Schedule for Children	2	10
	Revised Children's Manifest Anxiety Scale	28	60
	Reynolds Adolescent Depression Scale, 2nd Ed	1	39
	Screen for Child Anxiety Related Emotional Disorders	3	*
	Social Anxiety Scale for Adolescents	1	*
	Social Anxiety Scale for Children	6	*
	Social Phobia and Anxiety Inventory for Children	1	6
	State-Trait Anxiety Inventory for Children	37	56
	Broad-band rating scales	Behavior Assessment System for Children	7
Child Behavior Checklist (4–18, 1991 and 6–18, 2001)		247	79
Youth Self-Report (1991, 2001)		23	67
Teacher Report Form (1991, 2001)		21	73
Children's Global Assessment Scale		2	19
Conners' Rating Scales-Revised		2	66
Minnesota Multiphasic Personality Inventory-Adolescent		2	*
Pediatric Behavior Scale		4	**
Social Adjustment Inventory for Children and Adolescents		0	**
Social Adjustment Scale-Self Report		0	5
Symptom Checklist-90-Revised		35	*
Brief Symptom Inventory		46	*
Self-related rating scales	Coopersmith Self-Esteem Inventory	7	**
	Pictorial Scale of Perceived Competence and Social Acceptance for Young Children	6	25
	Piers-Harris Children's Self-Concept Scale, 2nd Ed	28	50
	Rosenberg Self-Esteem Scale	10	14
	Self-Perception Profile for Adolescents	11	33
	Self-Perception Profile for Children	37	43

^aThe number of times each measure was cited in articles within the *Journal of Pediatric Psychology* between January 1976 and December 2006.

^bThe number of Division 54 listserv members who reported using each measure on a preliminary survey to determine commonly used measures in pediatric research.

*Additional scales suggested by the listserv respondents.

**Additional scales suggested by the taskforce workgroup after collection of listserv data.

The measures are listed by category in Tables II and III and alphabetically in Appendix A.

Three types of reliability data were evaluated for each measure: internal consistency (usually Cronbach's α),

test-retest, and cross-informant. Also, two types of validity data were summarized: concurrent/predictive validity (or criterion-related validity, which includes reported correlations between the measure and outcomes

that the measure was expected to predict, including differentiation between diagnostic categories) and convergent validity (which includes correlations between the target measure and other measures that are purported to assess the same construct). The more extensive complete reviews (available upon request from the first author) contain other psychometric data that may be of interest to the reader, including psychometric data for subscales, a review of data relevant to other forms of construct validity, an assessment of clinical utility, the strengths and limitations of each measure, and a discussion of applicability with various linguistic minorities.

Internalizing/Externalizing Symptom Rating Scales

In the “Internalizing or Externalizing Rating Scales” category, 19 measures are listed in Table II. Interestingly, all but one of the scales (i.e., the ADHD Rating Scale-IV) target internalizing symptoms exclusively (i.e., depression, anxiety, fears, somatization, positive and negative affect). The least reported index in Table II for this category was cross-informant reliability (reported for only 9 of the 19 measures), presumably because there are not multiple reporter versions for many of these measures. Only the Hospital Fears Questionnaire (HFQ) is missing key reliability and validity data across several of the dimensions assessed. As such, it received the EBA rating of “promising assessment.” All other measures in the “Internalizing or Externalizing Rating Scales” category received EBA ratings of “well-established.”

With respect to the more specific indices of reliability for measures in the “internalizing or externalizing rating scales” category, the psychometrics tended to be strong. Measures of internal consistency ranged from .44 to .96 (median = .88). When alphas fell below .60, it was for subscales of measures rather than for total scores (e.g., Children’s Depression Inventory, CDI; Fear Survey Schedule for Children-Revised, FSSC-R; Multidimensional Anxiety Scale for Children, MASC; Revised Children’s Manifest Anxiety Scale, RCMAS; Screen for Child Anxiety Related Emotional Disorders, SCARED; State-Trait Anxiety Inventory for Children, STAIC). Test–retest correlations ranged from .14 to .98 (median = .74). Lower correlations tended to occur for longer time lags (e.g., 6 months; Childhood Anxiety Sensitivity Index, CASI; Social Anxiety Scale for Adolescents; SAS-A) or subscales (Social Anxiety Scale for Children, SASC; STAIC). Cross-informant correlations tended to be lower than internal consistency or test–retest reliability correlations, with r ’s ranging from .15 to .47 (median = .32). With respect to validity (Table II), many

of the measures reviewed in this category demonstrated the ability to differentiate between diagnosed and undiagnosed groups or between differently diagnosed groups. With respect to convergent validity, most measures demonstrated high correlations with other measures that were purported to assess similar constructs (range = .13–.88; median = .63).

Broad-Band Rating Scales

In the Broad-Band Rating Scales category (Table II), 10 measures are listed (although the CBCL scales are listed twice, once for the 1991 version and once for the 2001 version). All of the measures in this category received “well-established” EBA classifications, except for two: the PBS (“promising”) and the Social Adjustment Inventory for Children and Adolescents (SAICA; “promising”), both of which have received little empirical attention in the literature. Both of these measures also lack adequate normative data. With respect to more specific psychometric data, most internal consistencies were high, with an overall range from .32 to .97 (median = .85). As was the case with the internalizing and externalizing measures, some of the subscales for some measures had low alpha coefficients [Behavior Assessment System for Children, BASC; the 1991 version of the CBCL; certain subscales of the Minnesota Multiphasic Personality Inventory-Adolescent version (MMPI-A)]. Test–retest correlations were high across most scales, ranging from .41 to .96 (median = .84). Finally, cross-informant correlations were more modest, ranging from .05 to .97 (median = .59). As was the case with the internalizing/externalizing scales, many of these broad-band measures have successfully discriminated between different diagnostic groups (concurrent/predictive validity) and they tend to be significantly associated with other measures purported to be measuring the same constructs (i.e., convergent validity; range = .03–.92; median = .42).

Self-Related Rating Scales

In the Self-Related Rating Scales category (Table II), six measures are listed and all of them received “well-established” EBA classifications. On the other hand, there was less psychometric data available for the six “self-related” scales than for the psychopathology scales, although internal consistencies for these scales were uniformly high (with the exception of some subscales for the Pictorial Scale of Perceived Competence and Social Acceptance for Young Children; PSPCSAYC). The overall range for the alphas was .38–.93 (median = .85). Test–retest correlations were more modest (.29–.96; median = .67), but this was due to the very long test–

retest interval used for some scales (e.g., 3 years for the Self-Perception Profile for Children, SPPC). Cross-informant and concurrent validity data were not available for most measures in this category, but most convergent validities for these scales were acceptable (although correlations were low for some of the subscales; range = .08–.85; median = .57).

In summary, the reliability and validity data reported for the measures examined in this review are quite impressive, with two exceptions: (a) the quality of the psychometric data is poor for the subscales of some measures, and (b) there is little concurrent or predictive validity for most measures of perceived self-concept and self-esteem. We now turn to a discussion of the strengths and limitations of the measures reviewed, with an emphasis on recommendations for future work.

Strengths of the Measures Reviewed

At the most general level, the measures reviewed demonstrated strong psychometric characteristics, with 34 of 37 measures receiving EBA classifications of “well-established.” More specifically, the measures tended to demonstrate significant strengths across the three types of reliability (i.e., internal consistency, test–retest, and cross-informant associations) and the two types of validity (i.e., concurrent/predictive and convergent). Also, some form of normative data is provided for most measures and authors of some measures provide normative data for pediatric populations (e.g., CSI). The factor structure for several measures has been replicated across studies with different populations (e.g., FSSC-R; MASC; RCMAS; and Harter’s series of self-perception scales). Moreover, nearly half the measures have been used in treatment outcome studies and nearly all of the measures (33 of 37) have been translated into languages other than English (with Spanish versions being the most common). Some measures also have norms for different countries (e.g., ADHD-Rating Scale IV). Moreover, many of the scales are available in multiple administration formats, such as audiotape (e.g., MMPI-A; Symptom Checklist-90, Revised, SCL-90-R; Brief Symptom Inventory, BSI), computerized (e.g., BASC, Rosenberg Self-Esteem Scale, RSES), and online (BASC, SCL-90-R, BSI) versions.

Although most of the scales reviewed focus on “deficits,” some also focus on strengths [e.g., BASC, CBCL, Children’s Global Assessment Scale (CGAS)]. Additionally, three of the measures reviewed include “lie” scales and other validity scales (BASC; MMPI-A; RCMAS). Although most of the measures were not

designed with developmental or theoretical issues in mind, there were some exceptions. The MMPI-A and the Harter self-perception scales were designed to be sensitive to developmental issues and the Positive and Negative Affect Schedule for Children (PANAS-C) is based on a rigorous theoretical framework.

Limitations of the Measures Reviewed

Many of the scales demonstrated weak psychometrics in at least one of the following ways: (a) lack of psychometric data [i.e., reliability and/or validity; e.g., HFQ, MASC, PBS, Social Adjustment Scale-Self-Report (SAS-SR) and all perceived self-esteem and self-concept scales], (b) items that fall on more than one subscale (e.g., CBCL-1991 version), (c) low alpha coefficients (e.g., below .60) for some subscales, which calls into question the utility of using these subscales in research and clinical work (e.g., HFQ, MMPI-A, CBCL-1991 version, BASC, PSPCSAYC), (d) high correlations between subscales (e.g., PANAS-C), (e) lack of clarity regarding clinically-relevant cut-off scores, yielding high false positive and false negative rates (e.g., CES-D, CDI) and an inability to distinguish between minor (i.e., subclinical) and major (i.e., clinical) “cases” of a disorder (e.g., depression; CDI, BDI), (f) lack of correspondence between items and DSM criteria (e.g., CBCL-1991 version, CDI, BDI, CES-D), (g) a factor structure that lacks clarity across studies (e.g., PSPCSAYC, CASI; although the factor structure is often difficult to assess in studies of pediatric populations, given the small sample sizes), (h) low inter-rater reliability for interview and observational methods (e.g., CGAS), (i) low correlations between respondents such as child, parent, teacher [e.g., BASC, PSPCSAYC, CSI, FSSC-R, SCARED, Connors Ratings Scales-Revised (CRS-R)], (j) the inclusion of somatic or physical symptom items on mental health subscales (e.g., CBCL), which is a problem when conducting studies of children with pediatric physical conditions because physical symptoms may be a feature of the condition rather than an indicator of a mental health problem, (k) high correlations with measures of social desirability, which is particularly problematic for the self-related rating scales and for child-report scales more generally, and (l) content validity problems (e.g., the RCMAS is a measure of anxiety, but contains items that tap mood, attention, peer interactions, and impulsivity).

Several of the measures lack adequate normative data on pediatric populations, clinical populations, different age groups, and/or different ethnic groups.

Without such data, the ability to evaluate treatment effectiveness or make treatment decisions is compromised, because it is unclear where a particular child stands in relation to a relevant comparison sample. With respect to use of measures across different cultural contexts, the majority of measures have been translated into other languages. On the other hand, there has been virtually no attention paid to whether scale items show “meaning” equivalence or psychometric equivalence across different language versions of the measures. Relatedly, there is a paucity of data on the utility of these measures in minority versus majority populations.

Several of the measures have not been used extensively in research with pediatric populations. For example, the HFQ has received little attention in studies of children with chronic illnesses or in children with hospital experiences. To examine the degree to which each of the 37 measures has been used in research, we conducted a search of all issues of *JPP* from January 1976 to December 2006 for references to each measure. The citation frequencies are included in Table III (first column). The findings of this review suggest that there is considerable variability in the degree to which the measures have been used in research studies. For example, the CBCL appears in 247 articles, but many measures (22 of the 37 measures) appear in fewer than 10 papers published in *JPP*. Interestingly, most measures that have received frequent citations in *JPP* were also endorsed with greater frequency by the respondents to the Division 54 survey (see column 2 of Table III), but there were some exceptions. For example, the Beck Anxiety Inventory (BAI), the Reynolds Adolescent Depression Scale-2 (RADS-2), the BASC, and the CRS-R were rarely cited in *JPP*, but received 26 to 66 endorsements from respondents to the survey. Such discrepancies may have occurred because these measures are more often used in clinical settings rather than in research settings and, therefore, have received little attention in the pediatric psychology research literature.

Some of the measures reviewed here are quite lengthy, which can be a problem for clinic-based studies where time with family members is limited (e.g., the MMPI-A, the Piers–Harris Children’s Self-Concept Scale, PHCSCS; and the PBS). Some measures that are useful with young children or with adolescents can only be administered to respondents within fairly narrow age ranges [e.g., the MMPI-A, RADS-2; PSPCSAYC; the Self-Perception Profile for Adolescents (SPPA)], thereby making these measures less useful within the

context of longitudinal investigations. A difficulty with the “self-related rating scales” is that they typically require the respondent to compare oneself (or the target) to a social reference group; unfortunately, the nature of this social reference group is not always specified (e.g., should a teacher compare a child to other children in his/her class or to other children with similar chronic physical conditions?). Some of these scales also have response formats that may be difficult for cognitively-compromised children (e.g., the SAICA includes items with varying time frames).

A more general concern with self-report scales is that children tend to under-report psychopathology, compared with the reports of parents and teachers. Indeed, in their review of ADHD assessment strategies, Pelham, Fabiano, and Massetti (2005) recommended that parent and teacher rating scales be employed since there is no evidence for the validity of child report of ADHD symptoms. Such a lack of validity for child report, however, may be less true for measures of internalizing symptoms (Holmbeck, Li, Schurman, Friedman, & Coakley, 2002; Silverman & Ollendick, 2005).

Recommendations

Given the findings of this review and the discussion of limitations of existing measures, we provide a set of recommendations for future work in this assessment area:

- (1) As noted by Kazdin (2005), we already have a large number of measures. Thus, it may be useful to “take a step back” and determine which measures are useful for what purposes and think critically about what types of measures are still needed and which measures could be “retired.”
- (2) It is recommended that we develop more fine-grained criteria for EBA classifications. As noted earlier, 34 of the 37 measures reviewed met “well-established” criteria, but most of these 34 measures also have at least one major psychometric problem or lack certain types of psychometric data. As suggested by Mash and Hunsley (2005, p. 372), we may want to devise EBA “profiles” that indicate the evidence base for each of several assessment characteristics (e.g., norms, internal consistency, test–retest reliability, content validity, incremental validity,

- diagnostic utility, treatment utility, etc.). It would be helpful to have specific evidence-based criteria for each of these characteristics (Kazdin, 2005).
- (3) We recommend that more effort be directed to demonstrating the research and clinical utility of these measures for: (a) specific pediatric populations, (b) specific minority populations (including non-US populations), and (c) children from different age groups, developmental levels, stages of illness, and with different cognitive abilities. We also recommend that more normative data be provided for specific pediatric populations. Finally, more work needs to be done to demonstrate the differential utility of measures for different assessment-related purposes (e.g., evaluations of interventions vs. diagnostic evaluations vs. research endeavors).
- (4) We need more studies of pediatric populations that compare different measures of the same constructs. Specifically, because no “gold standard” exists for assessments in most areas of inquiry (Kazdin, 2005), such studies could compute the differential incremental validity of the measures being compared (e.g., Does measure X or measure Y have more incremental validity above and beyond an existing standard battery?). Similarly, does the addition of an extra respondent or an extra method add to the predictive utility or diagnostic accuracy of the assessment protocol? Which measure is most clinically meaningful with respect to clinical decision making and/or which measure demonstrates the most sensitivity to change following therapeutic interventions? Such comparisons across measures rarely have been done in any field, including pediatric psychology. Finally, and particularly for measures originally developed for typically developing populations, we need more information on whether pediatric populations interpret an instrument’s items similarly to typically developing populations (e.g., an item from an anxiety scale may be interpreted in relation to specific medical procedures in children with a chronic health condition but may be interpreted as tapping cross-situational anxiety in typically developing children).
- (5) Although scholars often maintain that multi-informant, multi-method data are preferred over single-source, single-method data (Holmbeck et al., 2002), we need more research on how best to integrate conflicting assessment data because there often is little agreement across respondents and methods (Silverman & Ollendick, 2005).
- (6) Longitudinal data collection is becoming more common in pediatric psychology (Holmbeck, Bruno, & Jandasek, 2006), but we know little about which measures can be used repeatedly across developmental periods.
- (7) It is recommended that pediatric psychologists begin to take a more rigorous look at externalizing symptomatology. It appears that we tend to rely exclusively on broad-band rating scales to assess such symptoms, when studying children with chronic conditions. An alternative and potentially fruitful strategy would be to assess multiple relevant domains of externalizing symptoms in our research and clinical endeavors (e.g., aggression, conduct problems, high risk behaviors, substance use, and risky sexual behaviors).
- (8) For clinicians and researchers who are faced with decisions regarding whether or not to use a specific measure for a particular purpose, we suggest that the following issues be considered: (a) the fit of a given measure with its intended use, (b) the length of the measure, (c) the salience of specific strengths and weaknesses of a given measure, depending on its intended use, (d) the psychometric quality of the measure (including the EBA classification), and (e) the utility of the measure as determined by past research and clinical work. Of course, readers may find themselves weighing the various strengths and weaknesses of certain measures and having to decide between two scales. For example, in comparing the BASC and the CBCL, one will observe several strengths for each measure. The BASC has a “developmental history” component, a “student observation system,” several subscales that are not included in the CBCL series (e.g., self-esteem, self-reliance, locus of control, sense of inadequacy, study skills), and a set of validity indices. The CBCL measures now include scoring options for DSM subscales as well as a very sophisticated cross-informant program, where several indices of informant agreement are computed. Thus, the decision regarding which to use depends largely on which

features of the scales will be most useful to the investigator or clinician.

Conclusions

The current review showed that pediatric psychologists clearly have a number of excellent measures to choose from when attempting to assess psychosocial adjustment and psychopathology for either research or clinical purposes. Indeed, 92% of the measures reviewed met the “well-established” criteria for EBA. Of course, the available measures are not without flaws, and some measures have not yet been adequately tested with pediatric populations. As noted by Kazdin (2005), we may need to identify the different purposes of assessment in the field of pediatric psychology including diagnosis, prognosis, assessing treatment outcome, case management, and basic research (Pelham et al., 2005) and then develop evidence-based criteria for each of these purposes. It also may be beneficial to devise fine-grained, multi-faceted evidence-based criteria (a “profile”) that can help to document the psychometric status of a measure across numerous domains (Mash & Hunsley, 2005). More generally, we are hopeful that the recommendations provided in this review will be helpful in increasing the clinical and research utility of assessment strategies employed by pediatric psychologists.

Appendix A. Measures Reviewed

ADHD Rating Scale-IV

Central reference. DuPaul, G. J., Power, T. J., Anastopoulos, A. D., & Reid, R. (1998). *ADHD rating scale-IV: Checklists, norms, and clinical interpretation*. New York: Guilford.

Purpose of measure. The ADHD Rating Scale-IV (18 items) is a parent and/or teacher rated measure of symptoms of ADHD in children aged 5–18 years. The measure includes two subscales: Inattention and Hyperactivity–Impulsivity.

Address for manual and measure. The Guilford Publications, 72 Spring Street, New York, NY 10012, USA; www.guilford.com.

EBA classification. The ADHD Rating Scale-IV is a well-established assessment.

Beck Anxiety Inventory (BAI)

Central reference. Beck, A. T., Epstein, N., Brown, G., & Steer, R. A. (1988). An inventory for measuring clinical

anxiety: Psychometric properties. *Journal of Consulting and Clinical Psychology*, 56, 893–897.

Purpose of measure. The BAI (21 items) is a self-report measure of anxiety in adolescents and adults aged 17–80 years. Factor analyses reveal four subscales: Subjective, Neurophysiological, Panic, and Autonomic.

Address for manual and measure. The Psychological Corporation, 19500 Bulverde Road, San Antonio, TX 78259, USA; www.PsychCorp.com

EBA classification. The BAI is a well-established assessment for use with older adolescents and adults; it has not been established for use with children.

Beck Depression Inventory (BDI)

Central reference. Beck, A. T., Ward, C. H., Mendelson, M., Mock, J. E., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, 4, 561–571.

Purpose of measure. The BDI (21 items) is a self-report measure of depressive symptoms originally designed to be used with adults, although it has been used with adolescents as well. See also Children’s Depression Inventory (CDI).

Address for manual and measure. The Psychological Corporation, 19500 Bulverde Road, San Antonio, TX 78259, USA; www.PsychCorp.com

EBA classification. The BDI is a well-established assessment.

Behavior Assessment System for Children (BASC)

Central References. Reynolds, C. R., & Kamphaus, R. W. (1992). *Behavioral assessment system for children manual*. Circle Pines, MN: American Guidance Service.

Reynolds, C. R., & Kamphaus, R. W. (1998). *Behavioral assessment system for children manual*. Circle Pines, MN: American Guidance Service.

Purpose of measure. The BASC (109–148 items, depending on the version) is a multi-method, integrated approach (completed as a self-report, parent report, and/or teacher report) to the evaluation of the behavior and perceptions of children ages 2½–18 years. It also can be used to gather historical information (via the Structured Developmental History), and can be used as an observational tool (via the Student Observation System). The parent and teacher reports include four composite indices (Externalizing Problems, Internalizing Problems, Adaptive Skills, and Behavioral Symptoms), and the teacher report has one additional index (School Problems). The self-report includes four composite indices as well: School Maladjustment, Clinical

Maladjustment, Personal Adjustment, and Emotional Symptoms.

Address for manual and measure. American Guidance Service, Inc., 4201 Woodland Road, Circle Pines, MN 55014-1796, USA; www.agsnet.com

EBA classification. The BASC is a well-established assessment.

Brief Symptom Inventory (BSI)

Central references. Derogatis, L. R. (1993). *Brief symptom inventory: Administration, scoring, and procedures manual.* Minneapolis, MN: National Computer Systems.

Derogatis, L. R. (2000). *BSI-18: Administration, scoring and procedures manual.* Minneapolis, MN: National Computer Systems.

Purpose of measure. The BSI (53 items) is the short form of the Symptom Checklist-90-Revised (SCL-90-R) which screens for a broad range of psychological problems and symptoms of psychopathology with individuals 13 years of age and older. The measure taps nine primary symptom dimensions: Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism. See also Symptom Checklist-90-Revised (SCL-90-R).

Address for manual and measure. NCS Pearson, Inc., PO Box 1416, Minneapolis, MN 55440, USA; www.pearsonassessments.com

EBA classification. The BSI is a well-established assessment.

Center for Epidemiologic Studies Depression Scale (CES-D)

Central references. Radloff, L. S. (1977). A CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement*, 1, 385–401.

Roberts, R. E., Andrews, J. A., Lewinsohn, P. M., & Hops, H. (1990). Assessment of depression in adolescents using the Center for Epidemiological Studies - Depression Scale. *Psychological Assessment: Journal of Consulting and Clinical Psychology*, 2, 122–128.

Purpose of measure. The CES-D (20 items) was originally designed to measure self-reported depressive symptoms in large scale surveys among adults, but it is used with adolescents as well.

Address for manual and measure. The CES-D is available from the central reference.

EBA classification. The CES-D is a well-established assessment.

Child and Adolescent Functional Assessment Scale (CAFAS)

Central reference. Hodges, K. (1989). *Child and adolescent functional assessment scale.* Ypsilanti, MI: Department of Psychology, Eastern Michigan University.

Purpose of measure. The CAFAS (18 scales) is a clinician rated measure of youth functioning and impairment for children referred for problems with emotions, behavior, substance use, or psychological problems. The CAFAS is designed for use with children and adolescents in the first through twelfth grades. The measure includes eight scales that measure different aspects of functioning: School or Work Role, Home Role, Community Role, Behavior towards Others, Self-Harm, Moods and Emotions, Substance Use, and Thinking.

Address for manual and measure. Functional Assessment Systems, LLC, 2140 Old Earhart Road, Ann Arbor, MI 48105, USA.

EBA classification. The CAFAS is a well-established assessment.

Child Behavior Checklist (CBCL/4-18, 1991; CBCL/6-18, 2001)

Central references. Achenbach, T. M. (1991a). *Manual for the child behavior checklist/4-18 and 1991 profile.* Burlington, VT: University of Vermont, Department of Psychiatry.

Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA school-age forms and profiles.* Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.

Purpose of measure. The CBCL (105–120 items, depending on the version) is a parent (or parent-surrogate) completed rating scales for assessing competencies, adaptive functioning and problems for a target child ages 4–18 years (CBCL/4-18, 1991) or ages 6–18 years (CBCL/6-18, 2001). Items on the CBCL make up eight statistically derived scales of co-occurring problems: Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Rule-Breaking Behavior, Aggressive Behavior, Social Problems, Thought Problems, and Attention Problems. See also Teacher Report Form (TRF) and Youth Self-Report (YSR).

Address for manual and measure. ASEBA, 1 South Prospect Street Burlington, VT 05401, USA; www.ASEBA.org

EBA classification. The CBCL is a well-established assessment.

Childhood Anxiety Sensitivity Index (CASI)

Central reference. Silverman, W. K., Fleisig, W., Rabian, B., & Peterson, R. A. (1991). Childhood anxiety sensitivity index. *Behaviour Research and Therapy*, 37, 903–917.

Purpose of measure. The CASI (18 items) is a self-report measure of anxiety sensitivity in children ages 6–17 years.

Address for manual and measure. Wendy K. Silverman, PhD, Child and Family Psychosocial Research Center, Child Anxiety and Phobia Program, Department of Psychology, Florida International University, Miami, FL 33199, USA.

EBA classification. The CASI is a well-established assessment.

Children's Depression Inventory (CDI)

Central reference. Kovacs, M. (1985). The children's depression inventory (CDI). *Psychopharmacology Bulletin*, 21, 995–998.

Purpose of measure. The CDI (27 items) is a self-report measure designed to assess depressive symptoms in children ages 7–13 years, and is a downward extension of the Beck Depression Inventory. See also Beck Depression Inventory (BDI).

Address for manual and measure. Multi-Health Systems, Inc., PO Box 950, North Tonawanda, NY 14120, USA; www.mhs.com

EBA classification. The CDI is a well-established assessment.

Children's Global Assessment Scale (CGAS)

Central reference. Shaffer, D., Gould, M. S., Brasic, J., Ambrosini, P., Fisher, P., Bird, H., et al. (1983). A children's global assessment scale. *Archives of General Psychiatry*, 40, 1228–1231.

Purpose of measure. The CGAS (1 scale) is a clinician rated assessment of social and psychological functioning in children ages 7–16 years, and is a downward extension of the Global Assessment Scale.

Address for manual and measure. The CGAS is available from the central reference

EBA classification. The CGAS is an approaching well-established assessment.

Children's Somatization Inventory (CSI)

Central references. Walker, L. S., Garber, J., & Greene, J. W. (1991). Somatization symptoms in pediatric abdominal pain patients: Relation to chronicity of abdominal

pain and parent somatization. *Journal of Abnormal Child Psychology*, 19, 379–394.

Garber, J., Walker, L. S., & Zeman, J. (1991). Somatization symptoms in a community sample of children and adolescents: Further validation of the children's somatization inventory. *Psychological Assessment*, 3, 588–595.

Purpose of measure. The CSI (32 items) is a self-report measure of nonspecific somatic symptoms in children ages 8–17 years.

Address for manual and measure. Lynn Walker, PhD, Division of Adolescent Medicine, Vanderbilt Children's Hospital, 11128 Doctors' Office Tower, Nashville, TN 37232-9060, USA. *EBA classification.* The CSI is a well-established assessment.

Conners' Rating Scales-Revised (CRS-R)

Central reference. Conners, C. K. (2001). *Conners' rating scales-revised: Technical manual*. North Tonawanda, NY: Multi-Health System.

Purpose of measure. The CRS-R (27–87 items, depending on the version; long and short versions are available) includes parent, teacher, and adolescent self-report behavioral ratings scales used to evaluate problem behavior experienced by children and adolescents. The parent and teacher rating scales are appropriate for youth ages 3–17 years, and the self-report measure is completed by adolescents of ages 12–17 years. The parent and teacher rating scales include the following subscales: Oppositional, Cognitive-Problems/Inattention, Hyperactivity, Anxiety-Shy, Perfectionism, Social Problems, Psychosomatic Concerns (parent scale only), Conners' Global Index (including Restless-Impulsive and Emotional Liability), ADHD index, and DSM-IV Symptoms (including Inattentive, Hyperactive-Impulsive). The adolescent self-report has includes the following subscales: Conduct, Cognitive, Family, Anger Control, Emotional Problems and Hyperactivity, ADHD index, and DSM-IV Symptoms.

Address for manual and measure. Psychological Assessment Resources, Inc., 16204 North Florida Avenue, Lutz, FL 33549, USA; www.parinc.com

EBA classification. The CRS-R is a well-established assessment.

Coopersmith Self-Esteem Inventory (CSEI)

Central reference. Coopersmith, S. (1967). *The antecedents of self-esteem*. San Francisco: W. H. Freeman.

Purpose of measure. The CSEI (58 items) is a self-report measure of children's multidimensional self-regard,

which includes the following four self domains: General Self, Social Self–Peers, Home–Parents, and School–Academic. While items were originally worded for use with children ages 8–10 years, the CSEI has been used with children and adolescents of a wide age-range.

Address for manual and measure. The CSEI is available from the central reference

EBA classification. The CSEI is a well-established assessment.

Fear Survey Schedule for Children Revised (FSSC-R)

Central references. Scherer, M. W., & Nakamura, C. Y. (1968). A fear survey schedule for children (FSS-FC): A factor analytic comparison with manifest anxiety (CMAS). *Behaviour Research and Therapy*, 6, 173–182.

Ollendick, T. H. (1983). Reliability and validity of the revised fear survey schedule for children (FSSC-R). *Behaviour Research and Therapy*, 21, 685–692.

Purpose of measure. The FSSC-R (80 items) is a self-report measure of fears and fearfulness in children ages 7–16 years. Factor analyses reveal the following five subscales: Fear of the Unknown, Fear of Minor Injury and Small Animals, Fear of Danger and Death, Medical Fear, and Fear of Failure and Criticism.

Address for manual and measure. Thomas H. Ollendick, PhD, Child Study Center, Department of Psychology, Virginia Polytechnic Institute & State University, Blacksburg, VA 24061, USA.

EBA classification. The FSSC-R is a well-established assessment.

Hospital Fears Questionnaire (HFQ)

Central reference. Roberts, M. C., Wurtele, S. K., Boone, R. R., Ginther, L. J., & Elkins, P. D. (1981). Reduction of medical fears by use of modeling: A preventive application in a general population of children. *Journal of Pediatric Psychology*, 6, 293–300.

Purpose of measure. The HFQ (5 items) is a self-report measure of children's situational anxiety aroused by the hospital setting, procedures, and personnel, intended for use with children ages 6–12 years.

Address for manual and measure. Michael C. Roberts, PhD, Clinical Child Psychology Program, 2009 Dole Human Development Center, University of Kansas, 1000 Sunnyside Avenue, Lawrence, KS 66045, USA.

EBA classification. The HFQ is a promising assessment.

Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A)

Central reference. Butcher, J. N., Williams, C. L., Graham, J. R., Archer, R. P., Tellegan, A., Ben-Porath, Y. S., et al. (1992). *Manual for administration, scoring, and interpretation of the minnesota multiphasic personality inventory-adolescent*. Minneapolis, MN: University of Minnesota Press.

Purpose of measure. The MMPI-A (478 items) is self-report measure of psychopathology, specifically used to identify personal, social, and behavioral problems in adolescents of ages 14–18 years. The MMPI has eight validity scales (Variable Response Inconsistency, True Response Inconsistency, Infrequency, Infrequency 1, Infrequency 2, Lie Correction, Defensiveness, and Cannot Say) and 10 clinical scales (Hypochondriasis, Depression, Hysteria, Psychopathic Deviate, Masculinity-Femininity, Paranoia, Psychasthenia, Schizophrenia, Hypomania, and Social Introversion).

Address for manual and measure. NCS Pearson, Inc., PO Box 1416, Minneapolis, MN 55440, USA; www.pearsonassessments.com

EBA classification. The MMPI-A is a well-established assessment.

The Multidimensional Anxiety Scale for Children (MASC)

Central reference. March, J. (1998). *Manual for the multidimensional anxiety scale for children (MASC)*. Toronto: Multi-Health Systems, Inc.

Purpose of measure. The MASC (39 items) is a self-report measure which assesses a wide spectrum of common anxiety disorders across children and adolescents ages 8–18 years. This measure includes four major factors: Physical Symptoms, Harm Avoidance, Social Anxiety, and Separation Anxiety.

Address for manual and measure. Multi-Health Systems, Inc., PO Box 950, North Tonawanda, NY 14120, USA; www.mhs.com

EBA classification. The MASC is a well-established assessment.

Pediatric Behavior Scale (PBS)

Central reference. Lindgren, S. D., & Koepl, G. K. (1987). Assessing child behavior problems in a medical setting: Development of the Pediatric Behavior Scale. In R. J. Prinz (Ed.), *Advances in behavioral assessment of children and families* (Vol. 3, pp. 57–90). Greenwich, CT: JAI Press Inc.

Purpose of measure. The PBS (165 items) is a parent completed measure designed to evaluate child behavior problems in a medical setting. The basic scale is for use with children ages 6–16 years, and the preschool scale is for use with children ages 3–5 years. The PBS has six subscales: Conduct, Attention Deficits, Depression–Anxiety, Deviation, Health, and Cognition.

Address for manual and measure. The PBS is available from the central reference

EBA classification. The PBS is a promising assessment.

The Pictorial Scale of Perceived Competence and Social Acceptance for Young Children (PSPCSAYC)

Central references. Harter, S. (1983). *Manual for the pictorial scale of perceived competence and social acceptance for young children*. Unpublished manuscript, University of Denver.

Harter, S., & Pike, R. (1984). The Pictorial scale of perceived competence and social acceptance for young children. *Child Development*, 55, 1969–1982.

Purpose of measure. The PSPCSAYC (PSPCSA; 24 items) uses picture plates to assess a multidimensional self-concept of children ages 4–7 years, and was designed as a downward extension of the Self-Perception Profile for Children. Four domains of self-concept are assessed: Cognitive Competence, Physical Competence, Peer Acceptance, and Maternal Acceptance. See also Self-Perception Profile for Children (SPPC) and Self-Perception Profile for Adolescents (SPPA).

Address for manual and measure. Susan Harter, PhD, University of Denver, Department of Psychology, 2155 South Race Street, Denver, CO 80208, USA.

EBA classification. The PSPCSAYC is a well-established assessment.

Piers–Harris Children’s Self-Concept Scale, Second Edition (Piers–Harris 2)

Central reference. Piers, E. V. & Herzberg, D. S. (2002). *Piers-Harris children’s self-concept scale, second edition: manual*. Los Angeles: Western Psychological Services.

Purpose of measure. The Piers–Harris 2 (60 items) is a self-report, multidimensional measure of self-concept designed for children ages 7–18 years. The measure includes six subscales: Physical Appearance and Attributes, Intellectual and School Status, Happiness and Satisfaction, Freedom from Anxiety, Behavioral Adjustment, and Popularity.

Address for manual and measure. Western Psychological Services, 12031 Wilshire Boulevard, Los Angeles, CA 90025, USA; www.wpspublish.com

EBA classification. The Piers–Harris 2 is a well-established assessment.

Positive and Negative Affect Schedule for Children (PANAS-C)

Central reference. Laurent, J., Catanzaro, S. J., Joiner, T. E. J., Jr., Rudolph, K. D., Potter, K. I., Lambert, S., et al. (1999). A measure of positive and negative affect for children: Scale development and preliminary validation. *Psychological Assessment*, 11, 326–338.

Purpose of measure. The PANAS-C (30 items) is a self-report measure which attempts to differentiate positive and negative affect in children in the third through eighth grades, and is a downward adaptation of the adult version of the PANAS.

Address for manual and measure. The PANAS-C is available from the central reference.

EBA classification. The PANAS-C is a well-established assessment.

Revised Children’s Manifest Anxiety Scale (RCMAS)

Central reference. Reynolds, C. R., & Richmond, B. O. (1985). *Revised children’s manifest anxiety scale (RCMAS) manual*. Western Psychological Services: Los Angeles, CA.

Purpose of measure. The RCMAS (37 items) is a self-report measure of generalized, nonspecific, nonsituational anxiety in children ages 6–19 years. This measure includes four subscales that can be used in addition to the total score: Physiological, Worry/Oversensitivity, Social Concerns/Concentration, and a Lie subscale.

Address for manual and measure. Western Psychological Services, 12031 Wilshire Boulevard, Los Angeles, CA 90025, USA; www.wpspublish.com

EBA classification. The RCMAS is a well-established assessment.

Reynolds Adolescent Depression Scale-2nd Edition (RADS-2)

Central reference. Reynolds, W. M. (2002). *Reynolds adolescent depression scale: Professional manual* (2nd ed.). Lutz, FL: Psychological Assessment Resources.

Purpose of measure. The RADS-2 (30 items) is a self-report measure used to assess the current severity of depressive symptoms in adolescents of ages 11–20 years. Four domains of depressive symptomatology are

assessed: Dysphoric Mood, Anhedonia/Negative Affect, Negative Self-Evaluation, and Somatic Complaints.

Address for manual and measure. Psychological Assessment Resources, Inc., 16204 North Florida Avenue, Lutz, FL 33549, USA; www.parinc.com

EBA classification. The RADS-2 is a well-established assessment.

Rosenberg Self-Esteem Scale (SES)

Central reference. Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton, NJ: Princeton University Press.

Purpose of measure. The Rosenberg SES (10 items) is a self-report unidimensional assessment of global self-esteem, normed on high school juniors and seniors, and intended for use with adolescents.

Address for manual and measure. The most updated version of the Rosenberg SES can be found on the University of Maryland, College Park website: www.bsos.umd.edu/soc/grad/socpsy_rosenberg.html

EBA classification. The Rosenberg SES is a well-established assessment.

The Screen for Child Anxiety Related Emotional Disorders (SCARED)

Central reference. Birmaher, B., Khetarpai, S., Brent, D., Cully, M., Balach, L., Kaufman, J., et al. (1997). The Screen for child anxiety related emotional disorders (SCARED): Scale construction and psychometric characteristics. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 545–553.

Purpose of measure. The SCARED (85 items) is a self-report measure developed to screen and diagnose anxiety disorders (including generalized anxiety disorder, separation anxiety disorder, panic disorder, social phobia, and school phobia) in children ages 9–18 years.

Address for manual and measure. The SCARED can be found on the University of Pittsburgh Medical Center website: www.wpic.pitt.edu/research/city

EBA classification. The SCARED is a well-established assessment.

Self-Perception Profile for Adolescents (SPPA)

Central reference. Harter, S. (1988). *Manual for the self-perception profile for adolescents*. Unpublished manuscript, University of Denver.

Purpose of measure. The SPPA (45 items) is a self-report, multidimensional measure of self-concept in adolescents of ages 13–20 years, and was designed as an upward extension of the Self-Perception Profile

for Children. This measure taps five domain specific subscales (Scholastic Competence, Social Acceptance, Athletic Competence, Physical Appearance, and Behavioral Conduct) and one Global-Self Worth subscale. See also Pictorial Scale of Perceived Competence and Social Acceptance for Young Children (PSPCSA) and Self-Perception Profile for Children (SPPC).

Address for manual and measure. Susan Harter, PhD, University of Denver, Department of Psychology, 2155 South Race Street, Denver, CO 80208, USA.

EBA classification. The SPPA is a well-established assessment.

Self-Perception Profile for Children (SPPC)

Central reference. Harter, S. (1985). *Manual for the self-perception profile for children. Revision of the perceived competence scale for children*. Unpublished manuscript, University of Denver.

Purpose of measure. The SPPC (16 items) is a self-report, multidimensional measure of self-concept in children ages 8–13 years. This measure taps five domain specific subscales (Scholastic Competence, Social Acceptance, Athletic Competence, Physical Appearance, and Behavioral Conduct) and one Global-Self Worth subscale. See also Pictorial Scale of Perceived Competence and Social Acceptance for Young Children (PSPCSA) and Self-Perception Profile for Adolescents (SPPA).

Address for manual and measure. Susan Harter, PhD, University of Denver, Department of Psychology, 2155 South Race Street, Denver, CO 80208, USA.

EBA classification. The SPPC is a well-established assessment.

Social Adjustment Inventory for Children and Adolescents (SAICA)

Central reference. John, K., Gammon, G., Prusoff, B., & Warner, V. (1987). The Social adjustment schedule for children and adolescents (SAICA): Testing of a new semi-structured interview. *Journal of the American Academy of Child and Adolescent Psychiatry*, 26, 898–911.

Purpose of measure. The SAICA (77 items) is a semi-structured clinical interview developed to evaluate the social functioning of children ages 6–18 years. The SAICA is organized into the following areas: School Functioning, Spare Time Activities, Peer Relationships, and Home Adjustment.

Address for manual and measure. Myrna Weissman, Columbia University, New York State Psychiatric

Institute, 1051 Riverside Drive, Unit 24, New York, NY 10032, USA.

EBA classification. The SAICA is a promising assessment.

Social Adjustment Scale-Self Report (SAS-SR)

Central reference. Weissman, M. M., & Bothwell, S. (1976). Assessment of social adjustment by patient self-report. *Archives of General Psychiatry*, 33, 1111–1115.

Purpose of measure. The SAS-SR (54 items) is a self-report measure a respondent's level of social adjustment, and was adapted from the Social Adjustment Scale original interview format. The measure examines seven areas of functioning: Work, Social and Leisure, Extended Family, Marital, Parental, Family Unit, and Economic. The SAS-SR was designed for use with adults, although it has been adapted for use with adolescents (by replacing "work" items with "school" items).

Address for manual and measure. Multi-Health Systems, Inc., PO Box 950, North Tonawanda, NY 14120, USA; www.mhs.com

EBA classification. The SAS-SR is a well-established assessment.

Social Anxiety Scale for Adolescents (SAS-A)

Central reference. La Greca, A. M. (1999). *Manual for the social anxiety scales for children and adolescents*. Miami, FL: Author.

Purpose of measure. The SAS-A (22 items) is a self-report measure of adolescents' feelings of social anxiety in the context of their peer relations. The SAS-A includes the following three subscales: fear of negative evaluation from peers, social avoidance, and distress specific to new situations or unfamiliar peers, and social avoidance and distress experienced more generally in the company of peers. See also Social Anxiety Scale for Children (SASC-R).

Address for manual and measure. Annette La Greca, PhD, University of Miami, Department of Psychology, PO Box 249229, Coral Gables, FL 33124, USA.

EBA classification. The SAS-A is a well-established assessment.

Social Anxiety Scale for Children (SASC-R)

Central reference. La Greca, A. M. (1999). *Manual for the social anxiety scales for children and adolescents*. Miami, FL: Author.

Purpose of measure. The SASC-R (22 items) is a self-report measure of children's feelings of social anxiety in the context of their peer relations. The SASC-R

includes the following three subscales: fear of negative evaluation from peers, social avoidance and distress specific to new situations or unfamiliar peers, and social avoidance and distress experienced more generally in the company of peers. See also Social Anxiety Scale for Adolescents (SAS-A).

Address for manual and measure. Annette La Greca, PhD, University of Miami, Department of Psychology, PO Box 249229, Coral Gables, FL 33124, USA.

EBA classification. The SASC-R is a well-established assessment.

The Social Phobia and Anxiety Inventory for Children (SPAI-C)

Central reference. Beidel, D. C., Turner, S. M., & Morris, T. L. (1995). A new inventory to assess childhood social anxiety and phobia: The social phobia and anxiety inventory for children. *Psychological Assessment*, 7, 73–79.

Purpose of measure. The SPAI-C (26 items) is a self-report measure of somatic, cognitive, and behavioral aspects of social phobia and anxiety in children ages 8–14 years.

Address for manual and measure. Multi-Health Systems, Inc., PO Box 950, North Tonawanda, NY 14120, USA; www.mhs.com

EBA classification. The SPAI-C is a well-established assessment.

The State-Trait Anxiety Inventory for Children (STAIC)

Central reference. Spielberger, C. D. (1973). *Manual for the state-trait anxiety inventory for children*. Palo Alto, CA: Consulting Psychologists Press.

Purpose of measure. The STAIC (40 items) is a self-report assessment for both chronic and acute anxiety in children ages 9–12 years, although the measure has been used with adolescents. The STAIC is comprised of two scales: the T-Anxiety (trait; chronic, pervasive anxiety) scale and the S-Anxiety (state; acute-transitory anxiety) scale.

Address for manual and measure. Mind Garden, Inc., 1690 Woodside Road, Suite 202, Redwood City, CA 94061, USA; www.mindgarden.com

EBA classification. The STAIC is a well-established assessment.

Symptom Checklist-90-Revised (SCL-90-R)

Central references. Derogatis, L. (1983). *The SCL-90 administration, scoring and procedures manual*. Towson, MD: Clinical Psychometric Research.

Derogatis, L. R. (1994). *Symptom checklist-90-revised administration, scoring, and procedures manual* (3rd ed.). Minneapolis, MN: National Computer Systems.

Purpose of measure. The Symptom Checklist-90-Revised (SCL-90-R; 90 items) screens for a broad range of psychological problems and symptoms of psychopathology with individuals 13 years of age and older. The measure taps nine primary symptom dimensions: Somatization, Obsessive–Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism. See also Brief Symptoms Inventory (BSI).

Address for manual and measure. NCS Pearson, Inc., PO Box 1416, Minneapolis, MN 55440, USA; www.pearsonassessments.com

EBA classification. The SCL-90-R is a well-established assessment.

Teacher Report Form (TRF)

Central references. Achenbach, T. M. (1991c). *Manual for the teacher's report form and 1991 profile*. Burlington, VT: University of Vermont, Department of Psychiatry.

Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA school-age forms & profiles*. Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.

Purpose of measure. The TRF (105–120 items, depending on the version) is a teacher (or school staff) completed rating scale for assessing competencies, adaptive functioning and problems of a target child. Items on the TRF make up eight statistically derived scales of co-occurring problems: Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Rule-Breaking Behavior, Aggressive Behavior, Social Problems, Thought Problems, and Attention Problems. See also Child Behavior Checklist (CBCL) and Youth Self-Report (YSR).

Address for manual and measure. ASEBA, 1 South Prospect Street Burlington, VT 05401, USA; www.ASEBA.org

EBA classification. The TRF is a well-established assessment.

Youth Self-Report (YSR)

Central references. Achenbach, T. M. (1991b). *Manual for the youth self-report and 1991 profile*. Burlington, VT: University of Vermont, Department of Psychiatry.

Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA school-age forms & profiles*. Burlington,

VT: University of Vermont, Research Center for Children, Youth, & Families.

Purpose of measure. The YSR (105–120 items, depending on the version) is a self-completed rating scale for assessing competencies, adaptive functioning and problems for a target child, ages 11–18 years. Items on the YSR make up eight statistically derived scales of co-occurring problems: Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Rule-Breaking Behavior, Aggressive Behavior, Social Problems, Thought Problems, and Attention Problems. See also Child Behavior Checklist (CBCL) and Teacher Report Form (TRF).

Address for manual and measure. ASEBA, 1 South Prospect Street Burlington, VT 05401, USA; www.ASEBA.org

EBA classification. The YSR is a well-established assessment.

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