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Cognitive and Behavioral Interventions in the Schools

Integrating Theory and Research into Practice

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To my parents, Angela and Patrick Flanagan,
you are missed everyday.

Rosemary Flanagan

To my wonderful children
Olivia and Charlie.

Korrie Allen

To my father, Norman, who guides me
through my memories of his wisdom,
kindness and friendship.

Eva Levine

Preface

Cognitive and Behavioral Interventions in the Schools is the product of our collective years of training and experience in clinical and school psychology. Although we are similarly trained, we have followed varied career paths as psychologists, serving in settings that include academia, the school system, independent practice, and pediatric mental health facilities. In our work with cognitive and behavioral approaches, we have successfully applied these methods with high functioning children needing specific assistance in one or two specific areas of difficulty, children with mild but more chronic difficulties, and children with severe and persistent mental health problems that significantly compromise functioning. We have designed this book to assist clinical and school psychologists working with a similarly diverse client base.

The training competencies of school psychologists are quite varied with regard to cognitive and behavioral treatment approaches. There are a number of reasons for this variability. Most importantly, as school psychologists can be trained at either a specialist (certificate) or doctoral level, there are significant differences in the amount of clinical-training school psychologists receive and the range of practice areas for which they obtain supervised experience. While those trained at the specialist level will typically have some training in cognitive and behavioral interventions, the certificate programs tend to place more emphasis on the areas of psychoeducational assessment (including social-emotional assessment), school consultation, academic interventions, childhood disorders, learning theory, counseling, research design, and psychometrics. Those trained at the doctoral level have more room in the curriculum for training in cognitive and behavioral interventions, and also have the benefit of a second internship, which often takes place in a more "clinically" focused setting with children exhibiting more complex and severe mental health presentations.

With regard to actual practice, the work of school psychologists ranges from a primarily "test and place" role, emphasizing the matching of children's learning and socio-emotional needs to services in the special education system, to more of a "response to intervention role," which gives more space for the implementation of individually tailored clinical protocols. Psychologists with a high level of testing/placement responsibilities will often have less time available to conduct clinically

based individual or group interventions. Importantly, as hospital clinic settings are increasingly being downsized, and more children with disabilities are being served locally, public schools have seen an increase in the numbers of youth with unaddressed and significant mental health and behavioral needs. Thus, the role and function of school psychologists continues to evolve, as we face ongoing changes in the health care delivery system and funding streams. As a notable case in point, school psychologists are among the providers named in the Affordable Care Act! We believe that school psychologists are in a unique position to provide much needed mental health support in this new environment. School psychologists are unique in the breadth and depth of their training, and they are well positioned to provide a wide array of services. Unfortunately, their diverse skill sets and knowledge bases are often underutilized, if not unutilized.

Indeed, school psychologists can theoretically be faced (and often are) with just about any problem facing children and families. Schools are one of the most diverse practice settings, and the school psychologist is often the first mental health professional to come in contact with a child and family in need of assistance. Being able to navigate such a broad range of presentations requires considerable knowledge and skill. This book is a resource that can provide school psychologists with specific practice guidelines and the research support for designing interventions within a cognitive and behavioral framework. Information is provided about techniques and strategies that may serve as a "tool kit" or resource to provide psychoeducation and assistance to children, parents, teachers, and other school professionals who interact with children facing mental health difficulties.

While a number of competing texts have focused on presentations of important empirically validated treatment packages, we have chosen to emphasize the component techniques and strategies that are incorporated into these packages, with the expectation that school psychologists may need to draw on these strategies in more idiosyncratic ways to meet the specific needs of their students and treatment settings. We acknowledge that it may often not be within the practice or job-description role for the school psychologist to directly deliver clinical services to children with identified mental health needs; however, in that scenario the school psychologist is often central in developing an appropriate treatment plan and in identifying adequate referral sources to provide children with the support they need. The knowledge this book provides will also be of guidance for school psychologists needing to make such referrals to community-based settings.

We are particularly excited to also have included in this text a segment on the use of technology in applying cognitive and behavioral interventions to school settings. While psychologists should not dismiss historically proven treatment modalities and treatment aids, there are a number of interesting developments in the interface between technology and mental health practice that school psychologists should start to become familiar with; it is our experience that students are also particularly interested in interventions that utilize these techniques.

Working in school systems has many differences from the settings in which many clinical trials are designed and implemented. Thus, providing school psychologists with an understanding of the underlying principles of treatment and

the key issues for treatment fidelity can position them to make adjustments to interventions in a way that fits the school environment while minimizing threats to treatment integrity. Further, as the need for research on transportability of interventions and their sustainability is imperative, school psychologists with a greater knowledge of cognitive and behavioral interventions would be natural partners with the researchers wishing to conduct clinical trials in schools.

Finally, while clinical psychologists are well trained to deliver services in typical mental health outpatient settings, they are often less well trained in the logistics and challenges of working in school settings. This volume also specifically addresses aspects of navigating and entering school systems to provide clinical interventions. This is intended to assist psychologists first venturing into the school setting, as well as those working as independent practitioners who are treating youngsters whose problems are manifest in the school setting. We hope readers will find this book engaging and useful.

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Part I
Intervention Planning

Chapter 1
Introduction: The Future Is Now—Challenges in the New Age of Psychological Practice

Judith Kaufman

"*Do not confine your children to your own learning for they were born in another time.*"

Hebrew proverb

"*The real difficulty in changing any enterprise lies not in developing new ideas, but escaping old ones.*"

John Maynard Keynes

The Changing Landscape of School Psychology: Contributing Factors

Schools are microcosms of society at large, and as such, school personnel deal with the impact of social challenges and problems as they are reflected in the children they serve. Economic concerns, unemployment and underemployment, family and school violence, immigration, and acculturation have both direct and indirect impacts on learning and academic achievement. More and more children and adolescents are in need of mental health support, but are underserved (NAMI, 2013). While the current practice trend is directed at implementing a Public Health model of intervention in schools (Nastasi, 2004) (e.g., school-wide prevention programs, Response to Intervention (RTI) (Adelman & Taylor, 2010)), there are a large number of students who require individual and group intervention strategies.

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Contemporary Risk Factors

There are more than 73 million children under the age of 18 living in the United States. This is expected to increase to 80 million by the year 2020 (Federal Interagency Forum on Child and Family Statistics, 2007). There is a steady increase in the public school population, with over 49 million children now attending public schools (the private school sector has remained constant, accounting for 11 % of school-aged population). There has been a significant increase in the minority population in the public schools, which is currently at approximately 42 % and growing. These increases reflect greater demographic shifts in the general population, with the largest growth in the Hispanic population. A related increase in the free and reduced lunch program nationwide further indicates increased levels of poverty in our public school youth, with an estimated 12.5 million children living in poverty in the United States today. Importantly, higher poverty rates exist among minority groups (Annie E. Casey Foundation, 2007). The consequences of poverty and minority group membership together predict greater risk for school failure, lack of completion of high school, and mental and physical health issues (Borman & Rachuba, 2001; Larson, Russ, Crall, & Halfon, 2008).

Recent national reports of the educational progress in the public schools indicate that a growing number of children have not met national proficiency levels (Hemphill & Vanneman, 2011; Lee, Grigg, & Donahue, 2007). The achievement gap is particularly evident in comparing Hispanic students to White students. While scores in mathematics have generally increased, the performance gap has remained the same when measured in fourth and eighth grades. Similar trends in reading were found as well (Hemphill & Vanneman, 2011). Academic performance is typically assessed through standardized achievement tests often referred to as *high-stakes testing* (Kruger, Wandle, & Struzziero, 2007). High-stakes testing can be viewed as a critical stressor for school administrators, their teachers, and pupils. There may be sanctions imposed on underachieving schools including school restructuring and removal of staff (Nichols, Glass, & Berliner, 2006). There has been some research suggesting that high-stakes testing might be a considerable source of stress for students (Cornell, Krosnick, & Chang, 2006). Students who do not meet the test standards may be particularly vulnerable leading to feelings of depression and anxiety and potentially have a negative impact on mental health (Cornell et al., 2006). For those individuals where there is an existing achievement gap, the consequences may be even greater. Grant et al. (2004) report that multiple stressful life events predict psychological problems in adolescents.

Approximately 12 % of children between the ages of 3 and 21 receive special education services under IDEA (http://disabilitycompendium.org/compendium-statistics/special-education. No date). About 80 % of these students spend more than 40 % of their time in regular classroom settings. Of the youth exiting IDEA services, 20 % dropped out of school compared to the 7 % in regular education. Providing effective and evidence-based interventions to students with special needs is an additional challenge for mental health providers within the school setting.

Negative school climate has been demonstrated to be a potential risk factor and can potentially contribute to the increase in bullying and victimization (Wilson, 2004). National data suggest that one in four children are either face-to-face or cyber bullied on a regular basis (http://www.bullyingstatistics.org/content/school-bullying-statis. No date). The long-term mental health consequences of being bullied have been well documented (Rigby, 2007). The confluence of changing demographics and poor academic and behavioral outcomes along with increased environmental stressors provide a strong argument for the need for quality psychological services in the schools, both within the regular education and special education frameworks.

Children and Mental Illness: Schools and Mental Health

Over four million children and adolescents, or 12–20 %, suffer from serious mental disorders (SED) that cause significant impairment at home, at school, and with peers (NAMI, 2011). The lifetime prevalence of mental disorders is 46 %, with no significant difference between males and females. The estimated cost of providing services is approximately $247 billion per year, although only 40 % of children and youth suffering with mental illness receive mental health services (NAMI, 2011).

About half of all lifetime cases of mental disorders begin by age 14. Approximately 50 % of students age 14 and older living with serious mental illness drop out of high school, the highest rate of any disability group (US Department of Education, 2006). While already alarming, these numbers and the magnitude of the problems keep increasing without a parallel increase in available services (Center for Disease Control and Prevention, 2013; US Department of Health and Human Services, 1999).

Gender differences exist when examining prevalence rates of mental disorders (Eaton et al., 2012). ADHD is the most prevalent diagnosis in children between the ages of 3 and 17, with males impacted at a higher prevalence rate than females (see Reddy et al. 2015). With the exception of autistic spectrum disorder (ASD), the number of children with mental health diagnoses increases with age (NAMI, 2013). Females present with internalizing disorders, while males exhibit more externalizing disorders (Eaton et al., 2012). By the age of 15, two times more girls than boys demonstrate symptoms of depression, generalized anxiety disorders, and eating disorders (NAMI, 2013). Boys demonstrate a greater percentage of antisocial behavior, aggression, and substance abuse (Eaton et al., 2012).

School is a natural environment for mental health service delivery. The majority of youth receiving such services do so within the school setting (Rones & Hoagwood, 2000). It has been noted that 96 % of families who were offered school-based mental health services followed through, while only 13 % referred to community-based clinics availed themselves of services (Mennuti & Christner, 2010). School-based health centers which encompass mental and behavioral health care are often operated in partnership with the community and have proven to be successful in addressing both the physical and mental health needs of children and youth (HRSA.gov retrieved, 1/27/14). School-based mental health services have received empirical

support in demonstrating not only an increase in emotional well-being but also directly impacting on increased academic achievement (Research and Training Center for Children's Mental Health, retrieved 1/29/14). There is an increasing emphasis on a tiered model of school-based mental health services, with the primary entry point being universal or systemic prevention/intervention (Nastasi, 2004), followed by targeted interventions addressing particularly at-risk populations. However, although prevention efforts have proven to be successful, there are significant numbers of children who require more intensive interventions (Mennuti & Christner, 2010). Such interventions are typically provided on an individual or small group basis and involve symptom reduction, enhancement of coping skills, building resiliency, and risk reduction (Compas et al., 2005; Smallwood, Christner, & Brill, 2007). Although it is essential to consider the broader role of the school psychologist in systems-level interventions, expanding the intensive intervention skill set is likewise imperative, as research supports the relationship between improved mental health and children's academic competencies in the school context (Adelman & Taylor, 2010).

Impact of the Affordable Care Act (ACA)

The Affordable Care Act of 2010 (ACA) provides a major focal point for the change in the delivery of health services, particularly for children and youth. Children, in particular, will benefit as a result of ACA, as almost double the number (from about 7 million to 11 million) will be eligible to receive both physical and mental health care because of expanded coverage (Kaiser Family Foundation, 2010). Provisions of ACA encompass the funding for school-based health clinics (SBHC), expanding services, and the identification of new treatment sites. The ACA appropriated $50 million in competitive grant funds for each fiscal year from 2010 to 2013 to develop SBHCs (Section 4101a, The Patient Protection Act of 2010). SBHCs are typically located in schools or on school grounds and cooperate with the school and community to meet the unique needs of the community population. Currently, there are about 2,000 SBHCs in 46 states and the District of Columbia serving about two million children and youth (Strozer, Juszczak, & Ammerman, 2010).

If the potential of the ACA is realized, there are opportunities to significantly change mental health service delivery models. As an outgrowth of and in conjunction with ACA, Healthy People (2020) has as one of its primary goals to improve mental health through prevention and by ensuring access to appropriate quality mental health services (healthypeople.gov, retrieved 10/2013). A broader range of services and new approaches to treating complex problems can be offered to underserved populations (School Psychology in Illinois, 2013). With the expansion of mental health services to a broader population, mental health professionals will be compelled to expand their skill sets incorporating prevention and integrated primary care (Rozensky, 2012).

In order for school psychology to take advantage of ACA provisions, a reframing of role, and function is essential. A shift from primarily providing assessment and

placement services to delivering intervention services is required (Mennuti & Christner, 2010). Included in this change of role would be the exploration of specific questions—for example, what are the competencies that would be required to offer integrated care in a school setting? What evidence-based services need to be available? How do we develop collaborative interdisciplinary working relationships?

The Ethics of Change: Professional Considerations

The practice of school psychology has undergone significant changes as a result of evolving social trends, federal legislation, and societal challenges. There has been increased attention to issues of social responsibility and the protection of the rights of children (McNamara, 2011). The prevailing influence of technology, security of records, and personal information, as well as storage and access to information, provide additional challenges in the protection of patient confidentiality.

New challenges raise new ethical considerations. School psychologists express concerns as to what appropriate services are to be provided in a school setting and what competencies are necessary to provide such services (Dailor, 2007). A critical ethical principle is that of "responsible caring," requiring professionals "to attain and maintain competence in the delivery of professional services, and to guard against practices that may result in harmful or damaging consequences" (McNamara, 2011, pg 768). Among the conditions of responsible caring are that school psychologists must continually assess and maintain competency in their areas of professional practice, monitor their own practices and decisions, and assist in the identification and execution of evidence-based practices. Further, the school psychologist must consider the integrity or fidelity by which these practices are executed. An additional ethical consideration is how to protect confidentiality within the school system (Dailor, 2007). The National Association of School Psychologists in the *Blueprint for Training and Practice* (Ysseldyke et al., 2006) and the Ethical Principles and Code of Conduct of the American Psychological Association (2010) specify that psychologists must work within the bounds of their professional competence. With the critical need for evidence-based mental health services, it is essential that school psychologists have the necessary training to be effective therapists.

The "half-life" of specialty training is a concept used to indicate the amount of time that the acquired information can be considered current and relevant. Thus, the half-life of a doctorate degree in psychology is considered to be 10–12 years. The estimated half-life of knowledge in school psychology is 9 years and, with the proliferation of research and information, is moving to 8 years. In clinical child psychology, the half-life is 8 years with movement toward 6.75 years (Rozensky, 2012). Rozensky, a 2013 APA award winner for Distinguished Career Contributions to Education and Training in Psychology, states that "education and training in, and the practice of, professional psychology must adopt and adapt to changes in accountability and quality expectations in the evolving health care system brought about by the implementation of the Patient Protection and Affordable Care Act"

(Rozensky, 2013 pg 703). "The ultimate contract is between society and the profession…a mature, autonomous self- regulating profession" (Belar, 2012 pg 548). While there is great importance in understanding the foundations of knowledge, it is critical to remain informed of contemporary issues and changing cultural and clinical concerns.

With the impetus of ACA, the potential for role expansion for school psychologists is evident. While school psychologists are ideally positioned to provide mental health services, are they prepared to meet the challenge of providing counseling and mental health services? (http://csmh.umaryland.edu/Resources/Briefs/HealthCareReformBrief.html). School Psychologists have always been seen as the mental health providers in the schools. However, there is great variation in the emphasis in training programs across the United States as well as local differences in job priorities and demands. Therefore, there are many practitioners in the field requiring further training and knowledge.

Research Supported Treatment

In response to the concerns about the efficacy of mental health treatment and the results of such treatment, the American Psychological Association created the Task Force on the Promotion and Dissemination of Psychological Procedures (1993). The Task Force developed a model with three levels to evaluate empirically supported treatments (EST):

1. W*ell-established* treatments that require two or more studies using between group research designs done by different investigators which demonstrated the superiority of the treatment to a placebo or different treatment or its equivalence to another empirically supported treatment. The treatment must be manualized to permit replication of treatment.
2. *Probably* efficacious treatment that require at least two studies with superior outcomes compared to untreated control groups or two studies by the same investigators yielding superior results or series of single case studies with withdrawal designs and multiple replications.
3. *Experimental* treatment that is newly developed and awaiting study.
4. All other treatments that lack empirical verification without research support (APA Presidential Task Force on Evidence-based Practice, 2006).

Evidence-based treatment (EBT), a categorization similar to EST, upholding similar criteria, however, is less specific in the standards and does not necessarily require manualized treatment in order to be considered to be "well established" and permits a wider range of treatments to be acceptable (Kazdin, 2008; Steele et al., 2008). Recent research has indicated that not every patient benefits from every treatment component in an indicated protocol. Thus, a modular treatment approach has been introduced (Comer & Barlow, 2014). Protocols are structured as freestanding

modules, rather than a linear approach as seen in manualized treatment. Clinicians can select modules and design a sequencing that is most appropriate to the specific concern or patient, while preserving the authenticity of an evidence-based approach (Comer & Barlow, 2014).

While data-based decision making is critical (Ysseldyke et al., 2006), along with the need for developing an evidence base to support a form of treatment, there are questions which remain unanswered when solely applying a data driven approach. Of primary concern is *how* (emphasis added) the treatment works or what factors other than the treatment itself are important sources of the treatment effectiveness. These factors include the client/therapist relationship, the cultural relevance of the treatment, and the setting where the treatment occurs. In a close examination of the evidence-based studies, the population diversity is often not reflected. Further, much evidence is gathered in "clean" settings as contrasted to implementation in a school context and with adult rather than child populations, where treatments are often downward extensions of interventions without regard to the developmental implications. It is important to remember that clinical practice with children and adolescents may bear little resemblance to treatments evaluated in efficacy research (Messer, 2004).

The evaluation of what works by examining the process of successful treatments in contrast to the specific content is referred to as the "common factors" approach (Messer, 2004; Norcross, Pfund, & Prochaska, 2013). There is a trend in the literature to more closely examine the process and mechanisms of change across evidence-based treatments and not necessarily on the specific treatment (Krueger & Glass, 2013). The issue of efficacy of treatment vs. effectiveness of a particular treatment has been a primary issue for discussion and debate (Kazdin, 2008). Integrative approaches are becoming more common among clinicians treating children and adolescents, with more than 50 % of therapists reporting the use of a mixture of techniques (Fonagy, Target, Cottrell, Phillips, & Kurz, 2002; Stricker, 2010). The integrative approach focuses on taking techniques from a variety of models and applying them to treatment while examining the relationship between practice and theory (Stricker, 2010). However, there is little empirical research on the application of integrative therapy for children.

Irrespective of the model of treatment provided, and in consideration of both NASP (2010) and APA (2010) guidelines particularly with the diversity of the populations, we need to respect the dignity and rights of all persons. This includes fostering autonomy and self-determination, protection of privacy and confidentiality, and assuring fairness and justice. *Informed* consent and assent for the minor receiving treatment are essential and include sharing of the reasons for treatment, goals, the frequency and duration, the format and methods, anticipated benefits, potential risks, and alternatives to the methods proposed. For self-referred minors, one or several meetings to assess the need for services and the extent the minor may be in danger may be engaged in within the school system without parental consent. Subscribing to the professional codes of ethics first and foremost protects the individual and secondarily the practitioner.

New Roles, New Functions

The confluence of the aforementioned factors is evolving to redefine the role and function of psychology in the schools. No longer is a "test and place" model adequate for the practice of school psychology. Today's role and function is more varied and may include consideration of universal prevention strategies and the integration of a public health model; the impact of data-based decision making and multi-tiered problem solving encompassing Response to Intervention (RTI) has shifted assessment and intervention paradigms (Eckert, 2011). These shifts suggest that with a greater emphasis on prevention and early intervention, those identified as requiring intervention at an individual level may present with the more challenging issues and potentially require more in-depth and extensive services. School psychologists need to consider the knowledge necessary to support expanding roles in a multicultural and global society. Examining the impact of technology on communication and practice is essential. For example, the ethics of cyber-counseling and the role of social media and electronic communication are just being examined and potentially could have significant impact on training and practice (DeAngelis, 2012).

Schools are unique practice settings, reflecting a diversity of gender, race, ethnicity, religion, and ability level and may, in fact, be the most diverse environment (Flanagan & Miller, 2010). There are opportunities to work systemically, introducing prevention programs as well on an individual level. School psychologists have the advantage of observing and intervening with children in their ecological environment. Treatment can be provided on a consistent basis without depending on family members bringing children to the proscribed services. However, ethical challenges often concern the provision of appropriate treatment within the legal and legislative constraints of the educational system (see Mychailyszyn, 2015). How then do we prepare for the future which is now?

This Volume

Despite the fact that intervention is an important domain of training within the National Association of School Psychologist Standards, historically school psychologists have not been extensively involved in school-based interventions (Ball, Pierson, & McIntosh, 2011). In contrast, demographics and contemporary issues suggest an important role that school psychologists can play in the direct provision of therapy services. School psychologists are well positioned to deliver quality interventions. Their understanding of the educational process, the relationship between mental health and academic health, and knowledge of the sociocultural school environment provide a critical basis to determine the most effective interventions (see Flanagan, 2015).

To address the challenges of providing effective intervention services to diverse populations, psychologists working in schools need to evaluate their knowledge base and repertoire of intervention strategies. To meet professional and ethical responsibility, it is essential to build upon already existing skills and to develop

more in-depth and sophisticated skill sets, particularly within the cognitive behavioral framework. Cognitive behavioral therapy (CBT) has consistently achieved research support, particularly with children and adolescents. CBT has proven to be flexible with fidelity, allowing the practitioner to tailor interventions to the individual, problem, or setting (Kendall, 2006). The emphasis on problem-solving approaches, cognitive information processing, coping skills, and interpersonal relationships while remaining performance-based fits naturally in a school environment (Kendall, 2006). The focus on "learning" provides ample opportunity for the transfer of skills to the classroom and to the home. Techniques are applicable for both individual and group interventions.

This volume is divided into five sections that provide a systematic approach to treatment planning, examining the trajectory from clinical assessment to intervention strategies for specific clinical disorders. Difficulties in implementation of these strategies in school settings are addressed and comprehensively discussed (see Mychailyszyn, Chap. 14). Maintaining integrity and fidelity to treatment may be difficult given the daily scheduling and the time for treatment balanced with academic demands. Engaging parental participation may present an additional challenge.

The treatment approaches presented in this book are helpful for all mental health professionals working with children, particularly for psychologists working in the schools who are often on the frontlines of intervention planning. Each chapter presents a comprehensive review of the disorder and the evidence-based CBT interventions supported by case examples highlighting important aspects of assessment and intervention planning. The variety of chapters in this volume provides a wide range of information on contemporary evidence-based treatment and offers the knowledge to expand treatment options. The chapters answer important questions such as the following: what state-of-the-art, evidence-based treatment interventions are available that could be tailored to a school setting? How do we treat internalizing and externalizing disorders with the most efficacious approaches? What techniques and strategies can be imported to assist the psychologists in the school setting? How do we overcome obstacles and barriers in school-based treatment? We are ethically bound to provide the best evidence-based treatment to a particular patient given the sociocultural context, with respect for diversity and special needs. The focus of this book provides us with knowledge to meet our commitment to the populations we serve.

The mental health profession is changing. ACA provides opportunities to provide a wider range of services to underserved populations. There is a greater emphasis on implementing evidence-based treatment and evaluating the outcomes of that treatment. Cyber treatment and enhanced technology present both practice and ethical concerns. Children with severe disabilities and chronic illnesses formerly excluded from public education are now included in the mainstream and more often in inclusionary environment. This volume responds to the need to meet contemporary practice challenges, to continue to develop professional competencies, and to be responsive to the ethical commitment for responsible caring. CBT interventions have demonstrated efficacy in facilitating change with school-age populations; this volume is an important step in making these interventions accessible to professional working in the school setting.

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Chapter 2
Behavioral Assessment in School Settings

Eva Feindler and Matthew Liebman

Introduction to Behavioral Assessment

Assessment is an indispensable component in the treatment of child behavior disorders and can be a complex and lengthy process. Assessment results are often the basis for diagnosis and classification as well as for the selection of targets for intervention. Further, data from various assessment methods can assist in the design and evaluation of intervention efforts. The assessment process also helps to draw inferences about causal variables and assist in the functional analysis of problem behavior patterns. Behavioral assessment encompasses methods and concepts derived from behavioral construct systems and is most frequently identified with an emphasis on quantification of observable and minimally inferential constructs. The methods of assessment differ from traditional assessment methods in their structure, focus, specificity, level of interest, and underlying assumptions. A recent comprehensive volume, *Diagnostic and Behavioral Assessment in Children and Adolescents* by McLeod, Jensen-Doss, and Ollendick (2013), attests to the developments in the field and can be consulted for greater theoretical and methodological information.

This chapter is an overview of behavioral assessment methods that might be useful in the development and evaluation of interventions for children in the school setting. As such, the authors will review a number of methods, namely, interviewing, screening measures, other paper–pencil inventories, behavioral observation, analogue

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