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Development and Validation of a Student Self-Report Screener of Social-Emotional Well-Being

By

Sarah Gates Wheeler

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in Education

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Development and Validation of a Student Self-Report Screener of Social-Emotional Well-Being  
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## Abstract

### Development and Validation of a Student Self-Report Screener of Social-Emotional Well-Being

by

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Doctor of Philosophy in Education

University of California, Berkeley

Professor Anne Cunningham, Chair

Many children in the United States suffer from mental health issues, and an even larger number have milder social-emotional difficulties that require support (Blanchard, Gurka, & Blackman, 2006; Child Mind Institute, 2011; Knopf, Park, & Mulye, 2008). Although school-based interventions to address these issues can be effective (Mills et al., 2006), the systems used to identify and treat children are lacking. Current research and trends in education, such as the Response to Intervention (RTI) model, support the use of broad screeners that are efficient and accessible, and that solicit young children's own reports of their well-being. In the current study, a self-survey of social-emotional problems, the How Am I Feeling Survey (HAIFS) was constructed, piloted, analyzed, and revised, with many promising results. The HAIFS was administered to students ( $N = 392$ ) in Grades 1 through 3, across 31 classrooms in 5 schools. Student responses on the HAIFS demonstrated high levels of internal consistency, structural integrity, and concurrent validity. Parent and teacher reports of child functioning had small positive correlations with child reports and small to moderate correlations with one another. Child self-reports on the HAIFS did not predict performance on standardized tests, which can be explained by a number of factors. Implications of these findings for practice and policy and areas for further research are also explored.

*Keywords:* social-emotional difficulties, screening, RTI

## Dedication

To Bert, who asks real questions, especially of children, and who actually listens to the answers.

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## **Development and Validation of a Student Self-Report Screener of Social-Emotional Well-Being**

Awareness of child and adolescent mental health has increased considerably over the past few decades, and with it, so has the percentage of the school-aged population in need of mental health support. Schools are well-positioned to address these issues, and a variety of school-based interventions have been found to be effective. However, children's mental health needs continue to be underserved in schools (Adelman & Taylor, 2006), and schools struggle to identify not just children with severe mental health issues, but also those with more mild *social-emotional difficulties* (SEDs) who present risk for developing further.

Because effective treatment begins with accurate identification, schools must improve their systems for recognizing early SEDs. Response to Intervention (RTI), one of the most important educational reforms of the last decade, provides an ideal structure and set of guidelines for such early identification procedures. Within this framework, areas for growth include utilizing screeners that cast a wide net for children who may be at-risk, ensuring that screenings are efficient and acceptable to school staff, moving beyond teacher referral to self-report, and screening at a younger age. Five areas of social-emotional development appear to have potential for use in screening: internalizing behaviors, externalizing behaviors, peer relationships, self-esteem/self-concept, and perceptions of school.

In the present study, I seek to improve procedures for schools to identify SEDs in children. I will examine the reliability and validity of the *How Am I Feeling Survey* (HAIFS), an original self-report screener of SEDs in children grades one through three. I will also answer questions about the connections between child self-report and reports from parents and teachers, as well as the predictive relationship between child self-report of SEDs and standardized test scores. Creating efficient, developmentally appropriate and comprehensive systems of identification for early risk will allow schools to detect SEDs early on and to address them before they become severe.

### **The State of Children's Mental-Health**

In the United States, a substantial number of children and adolescents suffer from mental health problems and the subsequent negative life outcomes that are associated with psychological and social difficulties. In the 2003 National Survey of Children's Health (NSCH), researchers reported finding a range of psychological, emotional, and behavioral issues, with a large, representative sample of parents (Blanchard, Gurka, & Blackman, 2006). For parents of children 6-17 years old, over 60% reported that they had been contacted more than once in the past year about their child's problems at school. Parents reported that a professional had diagnosed their child at rates of 8.8% for ADHD, 6.3% for behavior/conduct problems, 5.4% for depression/anxiety, and 19.6% for lower-level problems with emotions, concentration, behavior, or getting along with others.

More recently, the Child Mind Institute authored a study (CMI, 2011) in which researchers surveyed 1,000 parents of children and young adults ages 2-24. Over 20% of parents reported concerns about their child's mental health. Furthermore, the 20% represented by such parental report demonstrated more than *twice* as many problem behaviors (e.g., suicide attempts, suspension, drug and alcohol use) as the sample as a whole. By the time children reach adolescence, problems may be heightened. In a recent review of nationally representative data, Knopf, Park, and Mulye (2008) reported that one in five adolescents experience significant emotional distress, while almost one in ten have serious emotional impairments. A longitudinal study, tracking children ages 9-16 annually over a period of seven years found that by age 16,

almost 40% of the children had at some point met criteria for at least one psychiatric disorder (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003). This increase in rates of psychological distress between childhood and adolescence indicates that the process of developing into a young adult in our society can itself be a deterrent to well-being.

Concerns about child mental health are now being expressed at the national level. A 2007 estimate claims that mental, emotional, and behavioral issues in young people cost \$247 billion dollars annually (O'Connell, Boat, & Warner, 2009). Even the United States Secretary of Education, Arne Duncan, has begun referring to issues of mental health as barriers to learning and development for our nation's children. In recent remarks on the National School Discipline Guidance Package (January 8, 2014), the Secretary called for more supports in schools to "address underlying causes of misbehavior--like trauma, substance abuse, and mental health issues." He lauded grants that target the social and emotional needs of children in schools, highlighting the connection between such interventions and positive outcomes. As the authors of the Child Mind Institute report stress, "Not addressing mental health issues puts children at significant risk for...harmful behaviors...Parents, teachers, and pediatricians need better tools to identify these disorders in their early stages and help link these children to effective treatment" (CMI, 2011, p. 7).

In addition to children with clear or diagnosed mental health issues, policy-makers must also consider children with moderate social-emotional difficulties (SEDs), who are themselves a needy, neglected group. The national surveys noted above indicate that many children show mild symptoms of social-emotional distress that nonetheless require a response. For example, in the 2003 National Survey of Children's Health, almost 20% of children did not have a diagnosis but were experiencing social, emotional, or behavior distress (Blanchard et al., 2006). Other studies have found similar numbers of children with moderate problems or risk for developing issues (Stoep, et al., 2005). Fox, Carta, Dunlap, and Hemmeter (2010) describe this group as "Children who have social-emotional delays, who struggle with meeting developmentally appropriate social and behavioral expectations, or who have chronic but mild forms of problem behavior" and noted that these children "should be provided with systematic instruction focused on the development of targeted social-emotional skills" (p. 9). The Knopf et al. (2008) study also illustrates this need. Twice as many adolescents (one in five) displayed "significant emotional distress" than more extreme "serious emotional impairments" (Knopf et al., 2008, p. 9). Although policies and procedures shift to support this latter group, attention must also be paid to those children who are at-risk for developing severe issues, whose SEDs may be limiting their ability to learn, engage, and grow into high-functioning adults.

### **School-Based Intervention**

Despite the risk factors present for children with emotional needs, school-based mental health services can have a positive impact and minimize negative outcomes (Mills et al., 2006). Complications with insurance, appointment logistics, and financial resources can limit children's use of intervention in the community. However, schools provide daily access to children and families and frequent opportunities for observation and information gathering in both academic and social settings. In addition, schools have a stake in addressing mental health issues, as they impact student functioning and performance (Adelman & Taylor, 2006). Although a pediatrician may only see a child once a year, school personnel are able to develop deep, ongoing relationships with children. These relationships allow for a broader understanding of child issues and multiple viewpoints on child behavior. Because children often receive support or special attention for a variety of reasons (e.g., reading, math, speech) in schools, delivering social-



emotional interventions throughout the school day may be more acceptable to children and parents than other options.

In a review of almost 50 studies on the impact of mental-health programs in schools, Rones and Hoagwood (2000) found that programs had positive effects on a wide range of factors. For example, there is evidence that school based-mental health programs have the capacity to reduce special education and disciplinary referrals, suspensions, grade retention, aggressive and depressive symptoms, and stress. Programs not only reduced negative indicators, but also increased protective behaviors, such as positive social interactions. Programs represented a variety of approaches, such as individual and group counseling, home-school collaboration, and training to improve problem-solving and social skills.

In addition to the evidence supporting more structured mental-health interventions, studies have shown that less traditional and intensive supports, such as ensuring positive peer and adult relationships, can serve as protective influences for children (Ladd & Burgess, 2001). These interventions may be more appropriate for children classified as having SEDs who do not yet require extensive or individual programs. For example, a review of classroom-wide interventions showed that positive behavior support systems in the classroom reduced aggression and promoted prosocial skills in elementary-aged children (O'Connell et al., 2009). Similarly, changes in approaches to teaching, such as creating more learner-centered classrooms, can reduce stressful factors, such as peer rejection (Donohue, Perry, & Weinstein, 2003).

In one study, the effectiveness of the Check-In Check-Out (CICO) system in reducing behavior problems for at-risk students was examined (Filter et al., 2007). Nineteen elementary-aged children, referred by school staff, participated in a program where they *checked in* with a consistent adult each morning, received a point card and discussed what behaviors they were working on, received feedback on the card from each teacher throughout the day, and finally *checked out* with their key adult at the end of the day. Students received an agreed upon reward for meeting their daily goal, and brought their point card home for parents to initial. After beginning the program, two-thirds of the students showed a significant decrease in office discipline referrals. Furthermore, the intervention was implemented with fidelity and perceived as effective by staff. Another study of a similar program found that 67% percent of students in the intervention were identified as responders and over 50% experienced reductions in problem behaviors (Cheney, Flower, & Templeton, 2008). Like other positive behavior support systems, the CICO approach is thought of as a secondary prevention strategy, as it is low-cost, efficient, and appropriate for children who begin to show signs of SEDs.

Although the numbers of untreated children experiencing social-emotional and behavioral stress may seem daunting, school-based intervention is effective at multiple levels (Johnson, Pedro-Carroll, & Demanchick, 2005; Wiest et al., 2005) and the types of mental-health interventions being utilized continues to grow and widen. As discussed, school personnel play a key role in recognizing children's psychological difficulties and getting them help (Adams & Torchia, 1994). Schools must develop effective systems of support delivery and ensure timely and comprehensive prevention.

### **Issues with Service Delivery**

Unfortunately, although school-based mental health interventions show positive impacts, the data from national surveys indicate that not all children who need them receive these interventions. In the aforementioned NSCH study, 30% of parents reported having difficulty getting supports they needed for their children, including therapeutic services and counseling (Blanchard et al., 2006). In the Child Mind Institute report, of the one-fifth of parents surveyed

who reported mental-health issues in their children, 43% waited more than a year from the onset of symptoms and nearly a quarter (22%) waited more than two years to get treatment for their child (CMI, 2011). Another study of 700 children with severe emotional and behavioral needs found that only half of these children had received school-based supports (Mendenhall et al., 2011). An additional review of data from the 1990s showed that although one-fifth of children could have met criteria for a psychological disorder, only a very small percentage of these children ended up receiving intervention or treatment (Rones & Hoagwood, 2000). Although schools are considered an ideal setting for implementing mental health services (Mills et al., 2006), there is a disparity between the number of children who have emotional and psychological problems and the number of children who are actually treated in schools (Dvorsky, Girio-Herrera, & Owens, 2014).

Some critics point to problems with the current delivery of support services in schools. One pathway for mental health support is through special education, which can connect children with severe psychological and emotional needs, classified under the special education eligibility category of Emotionally Disturbed (ED), with supports such as psychotherapy individualized behavioral supports. However, even children with ED don't always receive the support they need; parents of these children report a gap of almost two years between the time the emotional disability was diagnosed and the time the child begins receiving services (Merrell & Walker, 2004). Once students show severe levels of social-emotional and behavioral problems and can be identified for special education services, there are very few effective treatments that schools can employ and the outcomes for treatment are poor.

In addition, severe emotional challenges are linked to academic failure, regardless of the student's aptitude. For example, children identified as ED often make little academic progress (Siperstein, Wiley, & Forness, 2011) and have the highest likelihood of any disability category to drop out of school, over 50% (US Department of Education, 2012). In a study of more than 2,000 children with ED, Wagner, Kutash, Duchnowski, Epstein, and Sumi (2005) found that, despite having average cognitive abilities, children with ED had substantial academic challenges, which were on par with children with cognitive impairments. They also found disproportionality in the distribution of children with ED, in that boys and Black students were highly overrepresented, whereas girls and Latino students were underrepresented (Wagner et al., 2005).

Finally, the ED population represents only a fraction of the high percentages of children with issues reported in the aforementioned studies, including children with lower-level SEDs. In 2009-2010, children identified as ED made up only .8% of the school-aged population (U.S. Department of Education, 2012). Clearly, special education is not a sufficient treatment avenue for children with mental health issues, and particularly for children with SEDs, who do not display severe enough behaviors to be classified as ED. Perhaps as a result of the required severity of symptoms, in addition to a specified duration of symptoms (longer than 6 months), the treatment outcomes for this population are poor. In fact, one could argue that waiting until children display ongoing and extreme symptoms of social-emotional distress is not an effective approach to identification and actually results in conditions that are more difficult to treat.

### **The Identification of Mental Health Issues**

The number of children experiencing mental health issues and lower-level SEDs illustrates the need not only to provide more and better interventions in schools, but also to assess issues in children as they arise so that they can be treated before the problems intensify (Knopf et al., 2008). Indeed, children with social-emotional and behavioral distress are not only underserved, but also underidentified (Merrell & Walker, 2004). In the CMI study, 40% of

parents who waited a year or two after the onset of symptoms to get their children support reported that they “didn't think it was a problem.” It is possible that parents do not always heed the advice of school personnel or specialists until symptoms become more extreme. However, it may also be that children are demonstrating distress visible to parents, but that schools fail to notice symptoms or call enough attention to student issues to make parents seek treatment. As mentioned, teachers and school staff, who view children daily and in the context of their peers, are in an ideal position to recognize delays in social-emotional development or SEDs. However, despite the potential of school referrals, the noted delays in and lack of services may be an indicator that schools are not doing enough to promote early identification. In the field of psychology in education, there is, in fact, an urgent outpouring of support for better systems of identification in schools (Dvorsky et al., 2014; Eklund, Vaillancourt, & Pedley, 2013; Kamphaus, 2012; Nese, Doerner, Romer, Kaye, & Merrell, 2012; Wagner et al., 2005; Wang, 2010).

It has been documented that social-emotional interventions are more effective when implemented earlier in child development (Hester, Baltodano, Gaber, & Tomnelson, 2004). Yet, research demonstrates that most children who are at risk of developing emotional and behavioral disorders are not actually identified until late elementary school (Hester et al., 2004). The Child Mind Institute articulated this issue well:

Since we know that early intervention leads to better outcomes, we should strive to close the gap between the onset of symptoms and the start of diagnosis and treatment, as well as encourage all concerned parents to seek treatment for mental health issues. Better education of parents, teachers, and pediatricians would enable them to recognize the signs and symptoms of mental health issues earlier, in addition to destigmatizing treatment and improving outcomes. (CMI, 2011, p. 7)

Indeed, systems of comprehensive and timely identification must be considered the foundation for intervention.

### **Social-Emotional Response to Intervention**

As opposed to the special education dichotomy of ED or not, Adelman and Taylor (2012) call for a “continuum of support” wherein schools promote healthy development, prevent mental-health problems, intervene early, and continue to support children with chronic or severe problems. Such systems would rely on and encourage early identification of issues, making this a cornerstone of the treatment process (Adelman & Taylor, 2012)

A new approach to identification and treatment of problems in students reflects this proposed continuum. Since the reauthorization of the Individuals with Disabilities Education Act (IDEA) in 2004, schools have advanced considerably in their capacity to identify and address student issues through the RTI framework (Brown-Chidsey & Steege, 2010; Fuchs & Fuchs, 2006; Kelly et al., 2010; Nese et al., 2012). RTI is informed by public health systems, which call for increasingly intensive interventions supplied in response to screening and monitoring of risk and ongoing issues (Merrell & Buchanan, 2006; Sabatino, 2009). In the educational setting, this process allows for students to maximize their learning potential through the prevention of academic failure and behavioral challenges (Fox et al., 2010).

The implementation and critical features of RTI can differ from state to state (Berkeley, Bender, Peaster, & Saunders, 2009). However, RTI generally calls for universal screening to identify risk, ongoing progress monitoring to document growth and identify needs, and a continuum of increasingly intensive evidence-based interventions. RTI should be driven by data-based decision making and problem solving, and interventions and procedures should be implemented with fidelity (L. Fox et al., 2010). Kelly et al. (2010) also outlined four

overarching principles for the implementation of RTI. First, services should be capacity building, or allow for schools and personnel to develop skills and procedures that can be independently maintained. Second, as mentioned, practices should be of high-quality, evidence-based, and carried out with fidelity. Third, interventions should be delivered in a multi-tiered framework. Fourth, data should be used to identify responders and non-responders at each level of intervention.

The most commonly utilized multi-tiered framework for RTI requires three tiers of support for students (Berkeley et al., 2009; Kelly et al., 2010). First, in what is referred to as Tier 1, all students must be exposed to programs that are research-based and screened for low-level issues that may require further support. In the social-emotional realm, these would include school-wide positive behavior support and approaches to discipline that promote responsibility and community and encourage positive relationships between students, their peers, and school staff (Merrell & Walker, 2004). In addition, schools can provide Tier 1 social-emotional support by creating healthy and engaging school and classroom climates, and exposing all students to research-based social skills curricula.

At Tier 2, a small subset of children who show moderate-level risk are treated in more targeted ways, such as in small groups (Brown-Chidsey & Steege, 2010). These interventions can include group social skills training and group counseling, group or individual behavior support plans, and daily practices that build teacher-student relationships. Some schools intervene at Tier 2 by adding recess monitors to facilitate play or by providing alternative social activities, such as crafts, for children who struggle to engage in traditional recess games. At Tier 3, those students who do not show sufficient growth in Tier 2 receive individual support, such as psychological counseling or family therapy. Children with the most severe needs (such as those classified as ED) are sometimes served in separate classrooms with high adult-to-student ratios and an emphasis on therapeutic approaches to learning (Merrell & Walker, 2004). See Figure 1 for more detail.

As systems of academic RTI become more widely implemented and yield positive results, researchers and professional organizations are now demanding that schools engage in universal screening of emotional problems in children in order to treat the 5-15% of children who are at-risk for developing negative behavioral and emotional outcomes (Merrell & Walker, 2004), including those described here as having SEDs. RTI is most commonly viewed as a means of preventing academic failure and decreasing reliance on special education for the provision of targeted academic interventions (Berkeley, et al., 2009). However, more and more schools are expanding their use of RTI for the prevention of social-emotional delays and problem behaviors (L. Fox et al., 2010), addressing the shortcomings of using the ED classification. By 2009, most states had adopted some form of behavioral intervention into their implementation of RTI (Berkeley, et al., 2009). Multiple pyramid-like models that deal specifically with increasing positive behaviors and social skills, and decreasing emotional distress have been created (L. Fox et al., 2010; Merrell & Walker, 2004).

Once identified, these children can receive intensified Tier 1 support, such as changes to the classroom environment. Children who continue to show SEDs can then be treated through Tier 2 and 3 supports, such as, mentoring, small-group therapeutic interventions, social skills training, and, if needed, individualized treatment. Severson, Walker, Hope-Doolittle, Kratochwill, and Gresham (2007) commented on the promise of tiered systems of support for identifying and supporting children who are at-risk for emotional and behavioral problems, and recommend universal screening as the necessary means to this process (Severson et al., 2007).

However, there is more work to be done in creating effective systems of social-emotional RTI and documenting impact.

### **The Role of Screening for Social-Emotional Difficulties**

As with academic issues, screening for risk in school populations is an essential component of social-emotional RTI and allows for the provision of effective services and early intervention (Cohen, 2006; Davis, Young, Hardman, & Winters, 2011; Dvorsky et al., 2014; Glover & Albers, 2007). Screening gives equal attention to all students, provides a baseline for further monitoring, and leads to more cost-effective and efficient interventions (Dvorsky et al., 2014). As opposed to traditional psychological or psychiatric rating scales, which look for established symptoms and often examine one narrow area, screeners are designed to identify warning signs and risk for symptom development (Kamphaus, 2012). However, the research on social-emotional screening and systems-of-support is much more nascent than, for example, the parallel work on RTI for reading and math. In fact, one study found that just 2% of schools conduct universal screening for social-emotional problems (Romer & McIntosh, 2005).

In a review, Severson and colleagues (2007) outlined the history and current status of screening for issues in the social-behavioral development of children, often considered to be a secondary mandate to academic instruction. Although screeners for social-emotional and psychological issues have existed for decades, the idea of universal screening in this area is fairly new, following the theoretical shift from a medical model of screening toward screening for the prevention of psychological problems (Kamphaus, 2012). For RTI to address the current issues of underidentification and under-utilization of services, the screening process must be conducted effectively. However, several barriers to effective screening require attention.

**The need for screening broad issues.** Despite growing recognition that early social-emotional intervention in schools is highly beneficial for children (Adams & Torchia, 1994; Blanchard et al., 2006; Davis et al., 2011; Johnson et al., 2005; Northern California Training Academy, 2008; Rones & Hoagwood, 2000; Wiest et al., 2005; Zahn-Waxler, Shirtcliff, & Marceau, 2008), there are many problems with the ways in which screeners are selected and used. First, it is difficult to find screeners that assess a broad range of issues. This need is reflected in a recent report (O'Connell et al., 2009) that defined the concept of behavioral and emotional risk (BER) as issues that *could lead* to later behavioral/emotional problems and perhaps diagnosis. The report calls for screening with the goal of identifying risk factors, rather than surveying students for established psychological problems. Indeed, universal screeners should not be designed to diagnose disorders or disabilities, but to identify risk (Glover & Albers, 2007; Henderson & Strain, 2009). However, when screeners are too narrow, they can fail to achieve this purpose (Dvorsky et al., 2014).

**The need for usability.** An additional challenge with current universal screening systems is their failure to adequately reflect the logistical needs of school settings. Glover and Albers (2007) have noted that the usability of school-based universal screeners can be determined by examining cost, feasibility of administration, acceptability to various stakeholders, resources available for collecting and interpreting screening data, appropriateness of use, and utility in assisting with prevention and intervention. Kamphaus (2012) found that practicality of use remains a major issue in the field of school-based screening and is a major factor in schools' failures to adapt screening practices on a wider scale. He also noted that certain personnel, such as school psychologists, are well-suited to spearhead and manage screening practices, with help from other staff. Severson et al. (2007) also emphasized that educators are more accepting of

cost-effective, efficient screening tools that have a high likelihood of leading to positive outcomes.

**The need for self-report.** As opposed to sporadic, inconsistent referral systems, universal screenings completed by teachers are a positive step forward. However, teacher reports, even when streamlined, do not always provide the most accurate information. Referral patterns can be problematic, with bias resulting from differences in teacher expectations and documented delays in the identification of behavioral versus academic issues (Severson et al., 2007). Teachers can be guilty of underreferring and/or referring too late. Additionally, teachers are not trained to look for emerging mental health problems, as opposed to academic and more overt behavioral issues (Dvorsky et al., 2014). As a result, children who act out their difficulties through observable behaviors are more likely to be referred for mental health support than children with lower-level social-emotional challenges. More specifically, teachers do not always recognize internalizing problems (e.g., worry, sadness, withdrawal) in children, especially girls, who are indeed suffering from these issues (Costello et al., 2003; Davis et al., 2011; Frick, Silverthorn, & Evans, 1994; Zahn-Waxler et al., 2008). This imbalance in recognition is also reflected in the findings that boys and Black students are greatly over-identified as ED in schools (Wagner et al. 2005). In addition, even in community settings, children with anxiety are less likely to be identified and referred for treatment than are children with externalizing problems (Fox, Herzig, Colognori, Stewart, & Masia Warner, 2014). The links between different referral systems and the underreferral of certain groups (such as girls, Latino students, and children who internalize) and overreferral of other groups are not exactly clear, but the potential implications of inconsistent referrals are concerning.

Discrepancies in reports from different raters also support the argument for input from multiple sources. In a seminal meta-analysis of the correlations between cross-informant ratings of child and adolescent behavior, Achenbach, McConaughy, and Howell (1987) determined that parent, teachers, and children vary greatly in their perspectives. Across studies, the average correlation between informants with different roles, or those who see children in different conditions (e.g., parents and teachers), was just .28 with respect to a wide range of problem behaviors. The average correlation between self-report and the report of another informant (teacher or parent) was even lower, at .22. In addition, ratings were more strongly related for children with “undercontrolled” problems (externalizing) than they were for children with “overcontrolled” problems (internalizing). In other words, children with internalized issues were more likely to report symptoms that were not accurately identified in adult reports.

More recent studies have confirmed these patterns. For example, a study of clinical and community children ages 6 to 13 examined the relationships between child, parent, and teacher reports of internalizing, externalizing, and total behavior problems (Kolko & Kazdin, 1993). Overall, child and parent reports were significantly correlated for externalizing behaviors but not internalizing behaviors. Parent and teacher reports were significantly correlated for internalizing, externalizing, and behavior problems in the overall sample. However, for non-patients, or children who did not show severe psychological issues, parent and teacher reports of internalizing behaviors were not significantly correlated. In another study of 4<sup>th</sup> through 6<sup>th</sup> graders, parent report was more sensitive to behavioral problems but child report was more sensitive to mood disturbance and withdrawal (Wrobel & Lachar, 1998).

These patterns have also been found in studies of children’s social behaviors. Renk and Phares (2004) conducted a meta-analysis of cross-informant ratings of social competence in children and adolescents. They found small effect sizes (.21 – .30) for the correspondence

between child/adolescent reports of social competence and parent or teacher report. They also found only moderate effect sizes (.38 – .48) for the correspondence between external informants, such as parents and teachers. In another study of prosocial behavior, child and teacher reports of aggression were moderately correlated, but reports of prosocial behavior yielded only small correlations (Cole & Dodge, 1988). A study of cross-rater agreement on bullying and victimization in middle school found that students' ratings of their own bullying had only small correlations with their teachers' ratings (Wienke Totura, Green, Karver, & Gesten, 2009).

Because children's subjective interpretations of their experiences are not necessarily congruent with adults' views of their well-being (Achenbach et al., 1987; Kolko & Kazdin, 1993; Renk & Phares, 2004; Wrobel & Lachar, 1998), self-report can be extremely informative, especially for internalizing problems and covert antisocial behaviors. Kolko and Kazdin found that child self-reports can show higher rates of symptoms such as sadness and correlate with more in-depth methods of data collection, such as diagnostic interviews. Schools have the potential to recognize early warning signs and prevent patterns of disengagement and mental distress in students, and they must detect these signs from children themselves in order for such work to be comprehensive.

**The need to screen at a younger age.** Previous research has led to the understanding that earlier identification provides for more effective implementation of interventions (Hester et al., 2004). Studies show that young children can give reliable and valid reports of their own health related quality of life (Varni, Limbers, & Burwinkle, 2007), stress (Kassam-Adams, 2006), and anxiety and depression (Hodges, 1990). In the area of social-emotional well-being, self-report has been found to be a useful and accurate tool for identifying social-emotional distress and designing interventions for 6th graders (Stoep et al., 2005). However, self-reports that are designed for use with children in the early elementary grades are less common.

A recent literature review of mental health screening and assessment tools for children illustrated this need (Northern California Training Academy, 2008). The review identified a handful of teacher, parent, and self-report screeners designed for use with older children. However, there were no identified measures that allowed young children (first and second grade) to give self-reports of their well-being in an efficient manner. In another report that identified six of the most promising school-based screening tools (Severson et al., 2007), none involved a self-report component. For example, the Behavioral Assessment Scale for Children, Second Edition, Behavioral and Emotional Screening System (BESS; Kamphaus & Reynolds, 2007) and the Brief Problem Monitor (BPM; Achenbach, McConaughy, Ivanova, & Rescorla, 2011) have both been developed recently and are cited as commonly used screeners (Wright & Sulkowski, 2013). However, neither includes a self-report version for younger children. The BESS self-report can only be used for children in Grade 3 and higher, whereas the BPM self-report can only be used by children who are 11 and older. Other brief social-emotional screeners, such as the Social Emotional Assets and Resilience Scales (SEARS; Nese et al., 2012), also begin using self-report in the third grade.

Schools have a responsibility to ask children as young as first and second grade to reflect on their own well-being. Without this additional component, children who may benefit from non-intensive, deliverable interventions or who tend to internalize their social-emotional struggles may continue to suffer without treatment or develop more significant issues. These children require attention, and the field of school psychology must focus on empowering schools to identify these children and clarify the connections between early challenges and negative

outcomes. For the purposes of RTI, screeners must cast a wide net in order to further examine the needs of flagged students.

With all of these factors taken into account, few social-emotional screeners are considered highly practical. According to Dvorsky and colleagues (2014): “There remains a critical need for a brief, psychometrically strong tool that screens all children for a wide variety of problems that is free, requires no training or advanced degree, and allows for use by multiple raters” (p. 307). Screeners need to be broad, utilitarian, and allow younger children to provide first-hand information about their own experiences.

### **Developing a Screener**

When developing a screener to meet the abovementioned criteria, the issue of which areas to address is substantial. Overall, universal screeners for social-emotional and behavioral risk tend to cover similar areas. In a review of best practices in the development of screeners, Kamphaus (2012) emphasized that items from a variety of areas of concern should be present in screeners. Within the context of prevention and tiered intervention delivery, the need to reduce false negatives is more important than the need to reduce false positives. In other words, over-identification is more desirable than under-identification at the early stages of attempting to support children potentially at risk.

For the purpose of screening, items don't necessarily need to be linked to a particular diagnosis but can be informed by the psychological literature. Most often, screeners examine undercontrol (externalizing) and overcontrol (internalizing), but also include social skills, adaptive skills, and prosocial behaviors. Kamphaus (2012) recommended that any screener should include at least internalizing, externalizing, school problems/attention, and prosocial/adaptive behaviors. However, he also recognized that more research needs to be done to further substantiate the connections between these areas and the development of social-emotional and academic problems.

**Externalizing symptoms.** Externalizing symptoms refer to problematic behaviors that are directed outward, towards the social environment (Walker et al., 1990). Externalizing behaviors have been consistently connected to both the development of low-level risk and to more extreme negative outcomes. In a study of children in kindergarten through fifth grade, Jeuchter, Dever, and Kamphaus (2012) found that teacher ratings of externalizing behaviors were predictive of lower levels of both concurrent math and concurrent reading achievement. Ladd and Burgess (2001) followed 385 children from the beginning of kindergarten to the end of first grade. Not surprisingly, they found that higher levels of psychological maladjustment were correlated with lower levels of school adjustment. They also found that children who showed higher levels of confrontational aggression at the beginning of kindergarten became less well adjusted in many areas of psychological and school functioning by the end of first grade.

**Internalizing symptoms.** Internalizing symptoms refer to behavior problems that are directed *inwards*, towards the self, such as worry, anxiety, depression, or psychosomatic distress (Walker et al., 1990). For young children, anxiety is particularly prevalent and detrimental to development. Anywhere from 2% to 27% of children and adolescents have been found to have an anxiety disorder. Furthermore, a much higher number suffer from lower level anxiety issues that are nonetheless harmful to their well-being (Wright & Sulkowski, 2013). Even children with anxiety issues who do not go on to develop serious psychological disorders are at much higher risk for a number of negative outcomes, both socially and academically. As such, research supports the treatment of anxiety in a multi-tiered fashion, and interventions delivered at the group level have been found to be effective (Wright & Sulkowski, 2013). The inclusion of



internalizing-related questions on screeners is supported by the finding that girls tend to demonstrate many more of these symptoms than they do more overt externalizing symptoms, particularly as they progress from childhood to adolescence (Walker et al., 1990). A focus on internalizing concerns is important in order to avoid the underidentification of risk in female students.

**Peer relationships.** Problems with peer relations have long been documented as predictors of later risk and maladjustment in children (Hymel, Rubin, Rowden, & LeMar, 1990; Ladd, 1990; Parker & Asher, 1987). For example, in a study of 122 low-income boys, Trentacosta and Shaw (2009) found peer rejection in middle childhood (ages 8-10) predicted antisocial behavior in adolescence. Laird, Jordan, Dodge, Perrit, and Bates (2001) found that peer rejection in middle childhood predicted externalizing behaviors in adolescence (Laird et al, 2001). Although some argue a causal connection between early peer rejection and negative trajectories, others claim that both are caused by an underlying psychological or interpersonal problem. Still, even controlling for initial levels of behavioral or emotional problems, peer rejection independently predicts negative outcomes. In a review of longitudinal studies connecting peer relationship problems with negative outcomes, Parker and Asher found that anywhere from 28% to 70% of disordered adults had had problematic peer relationships. However, data on peer relationships has been collected primarily through teacher and peer ratings, and not by self-report. In addition, most of the data involved children aged 10 to 14, and only a handful of children in the early elementary years. Both peer and teacher-related peer acceptance in children (mostly 10-14) predicted dropping out of school.

Ladd and Burgess (2001) suggested that early contributors to maladjustment in children are additive. In studying the mediating role of relationships in the trajectory of children with early aggressive behaviors, they found that both peer rejection and teacher-child conflict contributed unique variance to the prediction of later adjustment, and relationship risks contributed greatly to higher levels of maladjustment. They also pushed for understanding of these relationships in younger children, rather than simply focusing on middle and high school students. Although well-created sociometric tools do exist, these measures do not provide information about other factors that might interact with negative relationships to create higher risk, such as anxiety or low self-esteem. Sociometric tools answer the question, “Is the child liked?”; but the question, “Does the child *feel* liked” may be equally important. If various risk factors do interact to create more significant problems, then it would be most informative to assess child perceptions of aggression, relationships, and additional factors in one comprehensive tool.

**Self-esteem/self-concept.** Children’s self-perceptions are a critical part of how they experience social, academic, and emotional situations. Self-esteem is often related to psychological well-being (Rosenberg, Schooler, Schoenbach, & Rosenberg, 1995). Although some research shows an absence of negative outcomes for children with low self-esteem, other research connects low self-esteem to teen pregnancy, poor social relationships, and other undesirable risk factors (Butler & Gasson, 2005). Self-esteem in childhood has been found to predict academic success, anxiety, the development of eating disorders in girls, and even adult job satisfaction (Mann, Hosman, & Schaalma, 2004). In addition, studies of self-esteem in children with learning disabilities have also connected low self-esteem with academic failure (Black, 1974), indicating that self-esteem may interact with other risk factors (such as learning challenges).

Self-beliefs, defined broadly and often interchangeably with self-esteem and self-concept,

have been found to have small but positive predictive relationships with academic success. When children are asked specifically about self-beliefs as they pertain to the academic domain, this predictive relation increases (Valentine, DuBois, & Cooper, 2004). Because self-esteem and self-concept are best measured through self-report (Butler & Gasson, 2005), these constructs appear particularly promising for exploratory investigation.

**Perceptions of school.** Kamphaus (2012) argued that scale items focused on academic attitudes, beliefs, and behaviors are valid for inclusion in risk screening for several reasons. Academic achievement is a huge concern of those working with children, and such items can identify the beginnings of academic failure or even disability. In addition, they add to the power of the screener to predict later problems. Kamphaus noted that in some screeners, questions about academic problems load onto attention factors, indicating that they may also serve as a proxy for revealing attention problems.

Students' perceptions of school climate variables, such as school and teacher support, have been linked to outcomes such as support-seeking behaviors (Eliot, Cornell, Gregory, & Fan, 2010) and behavior problems (Wang & Dishion, 2011), and GPA (Stewart, 2008). Self-perceived climate factors have been demonstrated to be subjective and to vary despite objective school and classroom characteristics (Mitchell, Bradshaw, & Leaf, 2010). Although the literature linking perceptions of school to negative outcomes is not as substantial as in other areas, it is reasonable that questions on this topic would add meaningful information to an experimental study.

### **Pilot Study**

A pilot version of the How Am I Feeling Survey (HAIFS) was created and administered in order to gather self-reported information about a range of social-emotional issues and to explore validity and reliability of the instrument (see Appendix A for sample survey). Using a three-point Likert scale (*Not True, A Little True, Very True*), children gave their endorsements of a variety of items that centered on mental health issues. Items fell into one of four categories: relationships/perceptions of others, self-concept, emotions, and other signs of stress. The instrument included a mix of positive items (e.g., "I have good friends") and negative items (e.g., "I worry a lot"). Items were adapted from the BASC-2 Behavioral and Emotional Screening System (BESS; Kamphaus & Reynolds, 2007) and from the author's experience with children in mental health and educational settings. Items were written with the goal of being concise and accessible to young children, and questions that seemed too abstract for this age group were not included. Initially, a larger group of items was created, but these items were poorly balanced amongst the four key categories, and as a result some items were deleted.

Next, an expert panel was consulted about survey content and format. The panel included including one educational researcher, one former teacher, one school psychologist trainee, one measurement expert, and one child. The panel commented on imbalances in the number of questions asked about home and school in the different areas, and panel members raised questions about which aspects of mental health items were being tapped by each question. They also wondered if the survey was too long and if certain questions were worded clearly. After this feedback, the number of items was reduced from 28 to 24 to make the survey less time-consuming, and questions were reworded so they were easier to understand and answer. Several questions were also rewritten so that they clearly corresponded with one of the four key areas, and the order of questions was revised to create more balance. Increased examples were given before the test items to ensure student comprehension of the response process.

After a second item panel, the initial four-point Likert scale was reworked to include only three points, and clearer descriptions of each level were added. Certain items were reworded again or deleted. Finally, the instrument was given to five children ages six through eight. These children gave further feedback about confusing wording on a few items, which were revised. They appeared to understand the instructions and the purpose of the Likert scale after completing the examples.

**Procedure.** The measure was piloted in a public elementary school in a suburb of San Francisco. The school is located in an upper-middle class area and has strong API (Academic Performance Index Scores; 918) and STAR test results (79% English Language Arts, 86% Math, 90% Science). Seventy-three percent of students are White, with smaller numbers of Asian (10%), Latino (9%), Filipino (1%) and multi-racial children (7%). The administration was conducted with a total of 75 students over four classrooms (two first-grade and two second-grade). Overall, the sample was 40% male ( $n = 30$ ), and 60% female ( $n = 45$ ). Forty-nine percent were first-graders ( $n = 37$ ) and 51% were second-graders ( $n = 38$ ).

The survey was given during the school day. The author visited each classroom at a previously scheduled time and explained the survey to the children. They were told that the school wanted to make sure that all students were feeling “safe and comfortable” so that anyone who was not could get some support. Surveys were distributed and children were able to move to other places in the room or put up cardboard folders for privacy. The survey was projected on a screen in each classroom, and children completed and discussed each of the two example items, so that they understood the Likert scale and that they were providing their opinion, not a right or wrong answer. Once all children appeared to understand how to complete the survey, each question was read aloud and both the author and the classroom teacher circulated to answer questions. After all children had responded, the next question was read aloud.

For the first several questions and for some more complicated questions, examples of the meaning of each possible response were given. For example, for “I worry a lot” children were told that circling *not true* would mean that they do not worry a lot, circling *a little true* would mean that they sometimes worry a lot, and circling *very true* would mean that they worry a lot of the time. At the completion of the survey, children were reminded that their surveys were going to be “private” and that there were many people who they could talk to (e.g., school counselor, teacher, parents) if they had a sad or bad feeling during the survey that they wanted to share. All children who participated had parent permission, as per school policy. Children who did not have parent permission were able to read or draw quietly under the supervision of their teacher.

**Results.** In general, Wright Mapping revealed that the items were more sensitive in measuring respondents with higher levels of need than those with lower levels. In other words, the item thresholds extended beyond the respondent locations at the top of the scale, though not at the bottom. Given that the purpose of this instrument was to identify children who are in greatest need of intervention, it is possible that further sensitivity at the lower levels is not necessary. More accuracy for respondents at the highest levels may actually be the goal of this instrument.

Two measures of internal consistency were calculated. The first, Cronbach’s alpha, was moderately high ( $\alpha = .78$ ,  $N = 73$ ). This measures the extent to which the items as a whole produce similar responses. The second statistic, which measures separation reliability, was .77. This statistic determines how well the measure discriminates between levels. These statistics showed that internal consistency was substantial, but not excellent. The standard error of measurement (SEM) graph showed that there were no respondents in the upper range of

proficiency, which in this case meant children with severe social-emotional challenges. It may be that, given a sample of children with more social-emotional problems, a greater number of respondents would appear at the upper ranges and create a symmetrical inverse curve of standard errors.

Five approaches to validity were explored. The first level, instrument content validity, was supported through a creation of a construct map, the items design, and the fit of the model employed. Although the construct and items were designed with extensive research and feedback, the fit of the model was not ideal. For example, in looking at individual respondents, 37 (49%) showed good fit (infit *ms* between .75 and 1.33), while 22 respondents (29%) had a fit that was less random than expected (below .75) and 16 (21%) had a fit that was more random than expected (above 1.33). Less than half of the respondents showed a good fit, and especially that 21% had more random responses than would be predicted. To gain more knowledge about the validity of the instrument content, the proficiencies of students who were already receiving some form of mental health service at school were examined in order to determine whether these students had higher proficiencies, which would be expected if the content of the measure were valid. These children were mostly clustered towards the middle range of proficiencies, with one child showing a very high proficiency. Although one might expect to see these children obtaining higher proficiencies, most of them were receiving interventions for social skills. Such children are not necessarily always aware of their issues with social interactions and do not always have negative emotions that correspond with outside concern for their social abilities. In fact, the highest proficiency score in this group was achieved by the only student who was actually receiving individual counseling for emotional issues.

Another approach to validity, response processes validity, was achieved by conducting exit interviews with teachers and children after the survey was completed. From these interviews, it was clear that some questions, such as “I get a lot of stomachaches” had to be further explained for children to understand the implications of endorsing each level of the Likert scale. In general, children understood the use of the Likert response after doing the sample problems. They demonstrated understanding not only in their comments (“I don’t like vegetables but I do eat them a lot so I will say ‘very true’”) and by the fact that they did not seem to be answering items by just circling the same choice every time. Teachers said they felt that students generally understood the questions and their own responses.

In terms of group differences, the correlation between the construct and gender was  $r = .046$  and the correlation between the construct and grade was  $r = .026$ , which are both negligible and non-significant. These results imply that responses on the items did not differ significantly along the lines of grade or gender. External validity was explored through the relation between the construct and other similar measures. Two teacher-rated scales were used: the Prosocial Behavior scale and the Motivation to Learn scale, both taken from the AIMS Web behavior monitoring and intervention program. Teachers rated each child on a scale of 1 to 5, with five indicating the highest level of functioning. It was predicted that there would be a negative correlation between children’s scores on these two teacher-rated scales and their need for mental health intervention, as measured by the current survey. The correlation coefficients were  $r = -.238$  (with Prosocial) and  $r = -.261$  (with Motivation), indicating that there was a low negative correlation between the scale and these external measures. These values likely indicate a discrepancy between teachers’ ratings of children’s behavior and children’s reports of their own subjective experience that is found in the literature. In fact, during the administration of the

survey, a few teachers commented that they were surprised to see some of the responses their students gave to items.

In addition, exploratory factor analysis (EFA) was conducted with principal axis extraction. As explained by Floyd and Widaman (1995), this procedure is appropriate for exploring the commonalities between questions on proposed scales within an instrument. EFA is useful for determining which items load significantly on more than one factor, which items should be eliminated, and generally preparing for subsequent confirmatory factor analyses (CFA). In this type of analysis, it is ideal for at least three items to load onto each factor. Orthogonal rotation using the varimax procedure was also used. Both three and four-factor structures were examined.

For both the three-and-four factor solutions, Kaiser–Meyer–Olkin values met minimum criteria (.64), and Bartlett’s test of Sphericity was significant at the .001 level. In the three-factor solution, the three factors accounted for 34% of the variance in the scale. All three factors had five items with coefficients greater than .4, for a total of 15 items. The four-factor solution accounted for 39% of the variance. As in the three-factor model, three of the four factors contained five items with coefficients greater than .40. However, the fourth factor also contained two additional items with strong loadings (.687 and .825). As a result, the four-factor solution was chosen, and the fourth “composite” factor was expanded in the second iteration of the scale. Two items (“I have trouble going to sleep” and “I like being at home”) did not load onto any factor at higher than .350 and were dropped from the scale. For items that had particularly strong loadings, such as “I feel lonely” (.748), additional, similar items were created in order to strengthen factors.

### **The Current Study**

The current study expanded upon the pilot study by further developing the HAIFS and administering it to a larger and more varied sample of children. In addition, the current study involved the collection of data from multiple sources, such as parent and teacher reports, in order to explore the connections between the scale and information from other informants. The HAIFS was also compared to existing self-report measures. The study explored the following questions:

1. Does the *How Am I Feeling Survey* yield reliable and valid ratings of child functioning?
2. How well do student self-reports correlate with parent and teacher reports, both globally and across different domains? Do teachers accurately identify difficulties that are self-reported by students?
3. How predictive are student, parent, and teacher reports of external measures of child functioning (i.e., test scores)?

I hypothesized that the five-factor structure of the HAIFS would be confirmed and that subscales and the overall scale would yield moderate to large reliability scores. I also hypothesized that overall scores on the HAIFS would have moderate to large correlations with scores on the BESS (for 2<sup>nd</sup> and 3<sup>rd</sup> graders). Based on the extant literature, I also hypothesized that girls would demonstrate higher levels of Internalizing symptoms and that boys would demonstrate higher levels of Externalizing Symptoms.

I hypothesized that overall scores on student surveys (HAIFS and BESS) would have small but significant correlations with parent and teacher ratings of child behavior, similar to those found in the literature (Achenbach et al., 1987; Kolko & Kazdin, 1993; Renk & Phares, 2004; Wrobel & Lachar, 1998). In addition, overall parent and teacher ratings would yield small

to moderate correlations with one another. For teacher rankings of students' internalizing and externalizing issues, I hypothesized that children whom teachers identified as High Externalizers would also have higher self-reported Externalizing symptoms, but that the same effect would not be seen for Internalizing.

In terms of specific domains of functioning, I hypothesized that the Internalizing and Self-Esteem/Self-Concept, and Perceptions of School on the HAIFS would correlate poorly with overall scores and emotional symptoms (internalizing) on parent and teacher reports. I hypothesized that Externalizing and Peer Relationships would correlate more strongly with corresponding domains (conduct problems/externalizing, hyperactivity-inattention, peer problems, and prosocial behavior) on the parent and teacher SDQ. In addition, student ratings of Externalizing Symptoms would be positively related to teacher-rated peer rejection (on the Dishion Social Acceptance Scale) and negatively related to teacher-rated peer acceptance, whereas student ratings of internalizing symptoms would be positively related to teacher rated peer ignoring but not other domains of Social Acceptance. I also hypothesized that there would be differences in associations depending on gender, such that parents and teachers would report a higher level of social-emotional and behavioral problems in boys, regardless of whether boys demonstrated higher levels of issues on self-reports. I hypothesized that reports of child functioning (HAIFS and BESS) would provide added value to the predictive nature of parent and teacher reports on child test scores.

## **Method**

### **Participants**

A total of 31 teachers participated, including 10 first-grade teachers, 10 second-grade teachers, and 11 third-grade teachers. A total of 392 students participated, with 96 first-graders, 127 second-graders, and 160 third-graders. Fourteen students (3.6%) were in special education. Students were 80% White, 14% Asian, 3% Hispanic/Latino and 3% Other/Unreported. Students were 48% male, 50.5% female, and 1.5% did not indicate gender.

### **Measures**

**Child ratings.** The HAIFS was administered to all children in the study. A description of the construction and analysis of the first version of the survey can be found in the Pilot Study section of this paper. Exploratory factor analysis revealed four factors that are included in the second version: Externalizing Symptoms (five items), Internalizing Symptoms (five items), Peer Relationships (two items), and Self-Esteem/Self-Concept (six items). In addition, a fifth subscale, Perceptions of School, was added after further literature review. Additional questions were created after the initial factor analysis, a review of relevant developmental literature, and examples from other, validated assessments for older children, such as the BESS. In addition, an expert panel including school psychologists, parents, elementary school teachers, and elementary-aged children reviewed the second version of the HAIFS and provided feedback, after which questions were reworded and rearranged.

One item from the Externalizing Symptoms factor "I like being in school" was moved to the proposed Perceptions of School factor. I hypothesized that this item would be more closely related to the new Perceptions of School factor, as it was conceptually relevant. Two items ("I get in trouble a lot" and "I get in lots of fights") were added to the Externalizing Symptoms factor. These items were added to increase the range of externalizing symptoms being measured; questions specifically referring to school perceptions would better fit into their own subscale. One item, "Many things scare me" was added to the Internalizing Symptoms factor. Four items, ("Other children pick on me," "I would rather be alone than with other children," "No one wants

to play with me,” and “I like my classmates”) were added to the Peer Relationships subscale, as the pilot version of this subscale had few questions and more were needed. In addition, one item with a low loading, “I have good friends” was changed to “I have many friends.” For the Perceptions of School subscale, five items (“My teacher cares about me,” “My teacher thinks I’m smart,” “School is boring,” “My teacher listens to me,” and “My school is a friendly place.”) were added based on the literature and existing scales of child views on school and teacher relationships.

The final survey consisted of a total of 30 questions, with six questions on each factor. As in the first version, students were asked to respond to each question by circling a glass that is empty (*Not True*), half-full (*A Little True*) or almost full (*Very True*). For the majority of items, an answer of *not true* was scored as a 1 (lowest risk), an answer of *a little true* was scored as a 2 (medium risk), and an answer of *very true* was scored as a 3 (most risk). However, for 12 items, circling *not true* indicated the highest level of risk, and scores on these items were reversed in order to consistently match higher risk with greater numerical responses. See Appendix B for the revised version.

Children in Grades 2 and 3 were also administered the BESS, Student Form (Kamphaus & Reynolds, 2007). This survey consists of 30 questions, with a four-point Likert scale response (Never, Sometimes, Often, Almost Always). Like the HAIFS, it is given to students as a whole class and can be completed in roughly 15 minutes (AIMSweb Behavior Administration and Technical Manual, 2010). The form is intended for students in Grades 3 through 12, and is written at a second grade reading level. Thus, although it provides norms only for students in the third grade, it was determined that second-grade students would be able to complete the survey with the questions read aloud. The BESS can be scored with up to four missing items. Standardized *T*-scores are available for third grade students, and indicate whether students demonstrate Normal Risk, Elevated Risk, or Extremely Elevated Risk. For children ages 8-9, scores on the BESS Student Form were found to have an internal consistency of .92 and test-retest reliability of .80 (Kamphaus & Reynolds, 2007). The BESS also has high content validity, and adjusted correlations between the Student Form and the BASC-2 Student Report range from .69 – .86. Adjusted correlations with the Achenbach System of Empirically Based Assessment (ASEBA) Youth Self-Report Form range from .66 – .77 (King, Reschly, & Appleton, 2012).

**Teacher ratings.** Teachers completed three observational measures. The first measure, the *Strengths and Difficulties Questionnaire* (SDQ), is a 25-item rating scale designed to be completed by teachers of children aged 4 - 17 in about five minutes. Teachers use a three-point Likert scale to report how much each item applies to the child, based on five areas: emotional symptoms (internalizing), conduct problems (externalizing), hyperactivity-inattention, peer problems, and prosocial behavior (Goodman, 2001). The SDQ is used for screening and assessment in both practical and research settings and has been translated into over 40 languages and has both satisfactory reliability and validity scores. The SDQ has also been found to be highly correlated with the *Child Behavior Checklist* (CBCL), and equally able to discriminate high from low-risk cases (Goodman & Scott, 1999). It has been suggested that the SDQ is more appropriate for work with community samples where acceptability of measures is particularly important, whereas the CBCL might be better for determining pathology, which is not the goal in this study.

The second measure given to teachers to evaluate students consisted of Stage 1 of the *Systematic Screening for Behavior Disorders* (SSBD; Walker & Severson, 1992). The SSBD is

a three-stage screening system that uses teacher report and direct observations to identify children at risk for emotional problems in the areas of both internalizing and externalizing. In Stage 1 of the SSBD, teachers are given descriptions of internalizing and externalizing behaviors and then asked to list the ten students in their class who exhibit the most internalizing behaviors and the ten who exhibit the most externalizing behaviors. Teachers then rank-order these two lists of students in terms of intensity of behaviors. This stage is estimated to take 10 minutes to complete. In Stages 2 and 3, which were not used in this study, teachers complete more detailed behavior checklists for these nominated students and students who meet a certain threshold are then observed. The psychometric characteristics of each stage of the SSBD have been demonstrated to be adequate across multiple studies (Walker, Severson, Kehle, Jenson, & Clark, 1994; Walker et al., 1990). Like the SDQ, teachers and other stakeholders have demonstrated preference for the SSBD as an efficient and cost-effective measure (Walker et al., 1994).

Teachers also completed the *Dishion Social Acceptance Scale* (DSAS; Dishion, 1990). For each child, teachers rated the percentage of classmates who “like and accept” and who “dislike and reject” them along a five-point scale: 1 (*almost none*, less than 25%); 2 (*a few*, 25–50%); 3 (*about half*, 50%); 4 (*most*, 50–75%); 5 (*nearly all*, over 75%). Moderate correlations have been found between the DSAS and peer sociometric nominations (Dishion, 1990; Dishion & Kavanagh, 2003).

### **Procedure**

All study procedures were approved by the Committee for the Protection of Human Subjects at the University of California, Berkeley. Teachers were recruited from three different school districts in the San Francisco Bay Area: Reed Union School District, San Ramon Valley Unified School District, and Piedmont Unified School District. First, contact was initiated with principals of elementary schools in each district, and information was given about the risks and benefits of the study, as well as principal and teacher responsibilities. Overall, principals from five elementary schools agreed to participate, two each in Reed Union and San Ramon Valley, and one in Piedmont.

Information about the study was presented to teachers at a staff meeting, and informational fliers were distributed. Once teacher consents were signed, teachers were given parental consent and parent survey packets to send home to all students, with a letter explaining the study. Once parent permissions were signed and parent surveys were completed, teachers were given two weeks to complete the three surveys regarding participating children. In the following two weeks, each classroom was visited by the researcher. Before administering surveys, children who had parent permission to participate were read a child assent script. All but one child agreed to participate.

Participating children were administered surveys, as a group, either in their classroom (with the teacher taking non-participating children to another location for quiet reading) or in a separate room on campus. The directions for each survey were carefully explained and modeled with practice questions, and children were encouraged to ask questions of the researcher during administration. Children were also spaced throughout the room and/or given dividers so that they could not view each other’s responses. No teachers were present during survey administration, although some schools required the presence of an instructional aide, who sat quietly in the back of the classroom and did not engage with children or the researcher. For second and third-graders only, a second visit was conducted, with similar procedures, to administer a second survey. Child survey administration order was randomly alternated so that half of the second and third-grade classrooms completed the BESS first and then the HAIFS, and



half completed the HAIFS first and then the BESS. The amount of time between taking the two surveys ranged from two to ten days. Data kept by the school, such as test scores and special education status, were obtained with help from school principals and online and paper student databases.

### **Data Analysis**

Data analysis was conducted in parallel with the three core research questions of the study. To determine the validity and reliability of the *How Am I Feeling Survey*, EFA was used. Internal consistency reliability of both subscales and the overall scale was assessed using average inter-item correlations. In addition, the association between the HAIFS and the BESS was examined using correlational analyses. Correlational analyses were also used to determine the relations between student self-reports and parent and teacher reports, both globally and across specific domains. For the HAIFS, surveys that were missing more than three items were excluded. For the BESS, surveys that were missing more than four items were excluded, as per the administration guidelines.

Independent samples *t*-tests were conducted to examine mean differences between children who were rated highly as externalizers or internalizers on the SSBD. Cohen's *d* (Cohen, 1992) was calculated for each analysis to establish whether differences were practically significant. This process was repeated for students by grade level and gender. Hierarchical regression analyses were used to determine the predictive power of student, parent, and teacher reports on student test scores. All analyses were conducted using the Statistical Package for Social Sciences (SPSS) version 20.0 (IBM Corporation, 2011).

## **Results**

### **Research Question One**

**Preliminary analyses.** In order to further evaluate the HAIFS, EFA (principal axis extraction) was used to examine structural validity. A total of 369 students had complete scores on the HAIFS. First, reliability estimates (Cronbach's alpha) were calculated for scores on each of the five proposed subscales. Items that were found to reduce the reliability of the subscale and that seemed to be theoretically disconnected from core subscale themes were deleted. One item ("I hate making mistakes") was deleted from the proposed Externalizing subscale and one item ("I like going out to recess") was deleted from the proposed Internalizing subscale.

**Structures of individual factors.** Single-factor EFAs (principal axis extraction) were run for each of the five subscales with the two deleted items excluded. Item salience was set at .40. All Kaiser–Meyer–Olkin values (Kaiser, 1974) were high (above .64) and for each subscale, Bartlett's Test of Sphericity was significant. For all five subscales, the decision rules supported a one-factor solution, and the single factors that were extracted were robust, with four of the scales having at least three items with coefficients greater than .50, and the fifth subscale having two items with coefficients greater than .50.

**Structure of overall scale.** The number of factors to extract was determined by theory and parallel analysis as recommended (see Tabachnick & Fidell, 2007; Thompson, 2004) and factors were expected to have a minimum of three salient items. Parallel analysis indicated a five-factor solution. In the five-factor solution, three items had coefficients less than .400, and eight additional items had coefficients under .500. No item with a coefficient of .400 or greater on one factor cross-loaded onto another factor. However, one factor did not meet the minimum of three salient items (it had two). As a result, a four-factor solution was attempted, to determine whether it was, in fact, superior to the five-factor solution. In the four-factor solution, four items had coefficients less than .400, and nine additional items had coefficients under .500. One item

that had a coefficient of .400 or greater on one factor cross-loaded onto another factor. The five-factor solution was in keeping with theory and represented a better fit in terms of strength of coefficients and cross-loading of items. Thus, it was accepted. The oblique rotation (direct oblimin) was used. In the five-factor principal axis analysis, neither “I hate making mistakes” nor “I like going out to recess” loaded onto any factor at greater than .300, and these items were dropped from the scale.

Factor One (*Internalizing*) consisted of 10 items that were interpreted as indicators of Internalizing, including five of the originally proposed Internalizing items (the sixth item was deleted from the scale in the first step of factor analysis). These items examined students’ negative thoughts towards themselves, as well as worry, sadness, and psychosomatic symptoms. One item, “I’d rather be by myself than with other people” was deleted from the factor because it did not meet the threshold of .400. Factor Two (*Relationships*) consisted of seven items that tapped into a child’s perceptions of peers, family, and teachers. It included three items from the proposed Peer Relationships scale, three items from the proposed Perceptions of School scale, and one item from the proposed Self-Esteem scale. Factor Three (*Self-Confidence*) consisted of four items, three of which came from the proposed Self-Esteem scale. These items tapped into a student’s perceptions of his/her intelligence and abilities, as well as how these were perceived by others. Factor Four (*Externalizing*) consisted of four items, all from the proposed Externalizing scale, which asked about a student’s anger and related consequences. The fifth factor consisted only of two items, which both asked about attitudes towards school. These items were both on the proposed *Perceptions of School* scale, which had not been previously tested. Because this factor did not meet the three-item criteria, it was instead considered a promising “composite” and these items were included in further analyses. A detailed breakdown of the final HAIFS can be found in Appendix C.

**Descriptive statistics.** Because of missing items, the number of valid respondents differed slightly for each subscale. For each subscale and the total scale of 27-items used for analyses, the number of valid respondents, number of items, subscale mean scores and standard deviations and reliability estimates of scores are presented in Table 1. Alpha coefficients for scores on the four subscales and the total score ranged from .68 to .87. The coefficient for the total scale is above the internal consistency reliability recommendations of .75 - .80 for screening instruments (Glover & Albers, 2007). Internal consistency scores of the overall scale varied only slightly across grade levels, with  $\alpha = .86$  for first grade,  $\alpha = .89$  for second grade, and  $\alpha = .86$  for third grade.

Correlations among subscale scores are presented in Table 2. The strongest positive correlation was between scores on the *Internalizing* and *Externalizing* scales, which shared 27% of their variance. Scores on the *Relationships* scale were also positively correlated with scores on the *Internalizing* and *Self-Confidence* scales, sharing 19% of their variance.

**Gender differences.** Girls reported significantly higher levels of *Internalizing* symptoms,  $t(368) = -3.53, p < .001, d = .37$ , and *Self-Confidence* problems,  $t(370) = -2.18, p < .05, d = .23$ , than boys on the HAIFS. Their *Perceptions of School* were significantly more positive,  $t(373) = 3.21, p < .001, d = .33$ .

**Concurrent validity of full scale.** A total of 266 students completed both the BESS and HAIFS, with a Pearson correlation of .77, significant at the .001 level. Full scale scores on the HAIFS appear to be highly correlated with a previously validated measure of social-emotional and behavioral functioning.

### Research Question Two

Correlations between different informant ratings of child behavior were generally similar to those found in the extant literature (see Table 3). Child ratings of overall behavior on the BESS had small but significant correlations with parent ratings and, to a lesser extent, with teacher ratings on the SDQ. For the overall HAIFS, correlations with teacher ratings on the SDQ were similar and also small but significant, but correlations with overall parent ratings on the SDQ were much smaller, although positive. Parent and teacher ratings were moderately correlated.

Tables 4 and 5 show correlations between subscales on the HAIFS and subscales on parent and teacher ratings, respectively. As predicted, basic domains of internalizing and externalizing were significantly correlated between child and parent ratings, although these correlations were small, and slightly stronger for externalizing than for internalizing. Children's perceptions of relationships were also significantly positively correlated with parent perceptions of emotional symptoms, and child-rated attitudes towards school were significantly positively related to parent-rated conduct problems, and negatively related to parent-rated prosocial skills. All correlations were small. Correlations between teacher ratings of social acceptance and overall child ratings on the HAIFS and BESS were not meaningful (see Table 6).

**Gender differences.** On the SDQ, boys were rated as having more overall social-emotional and behavioral problems than girls by both parents,  $t(370) = 2.01, p < .05, d = .21$ , and teachers,  $t(362) = 3.34, p = .001, d = .35$ .

**Teacher rankings.** Independent samples *t*-tests were conducted to examine the relationship between child perceptions and teacher rankings of child internalizing and externalizing on the SSBD. These tests did not reveal significant differences between scores on the HAIFS among children who were rated by teachers as most at-risk (top three Internalizers or Externalizers in each class, (84 children overall), and those who were not, with a few exceptions. Significant differences were found for scores on the Internalizing scale of the HAIFS between top three Internalizers and children who were not rated as top three Internalizers,  $t(367) = 2.44, p = .015, d = .25$ . Children who were rated by teachers as a top three Internalizer had slightly higher scores on the Internalizing domain of the HAIFS. For top-three Externalizers, significant differences were found on the Externalizing scale ( $t(371) = 3.50, p = .001, d = .36$ ) and the Self-Confidence scale of the HAIFS ( $t(369) = 2.17, p = .03, d = .23$ ). Children who were rated by teachers as top three Externalizers reported more externalizing problems on the HAIFS and *fewer* issues with self-esteem and self-confidence.

### Research Question Three

Multiple regression analyses were conducted in order to answer the question of whether child reports as a whole, and the HAIFS in particular, provided predictive value to child outcomes beyond parent and teacher report. Because California State Standardized Testing and Reporting (STAR) scores are only available for current third graders (from the previous Spring), only third graders were used in these analyses. In the first regression, dummy variables for gender and ethnicity were entered in Model 1, followed by total parent and teacher rating scores on the SDQ in Model 2, and finally, student BESS scores in Model 3. In the second regression, these models were repeated using the total HAIFS score instead of the BESS in Model 3. In all regression analyses, total STAR scores (English-Language Arts scores plus Mathematics scores) were used as the dependent variable.

Results of the regression analyses did not support the research hypothesis. In the first regression analysis (Table 8) gender, ethnicity, and parent reports were not predictive of test

scores for the final model. Teacher reports did significantly improve prediction; however, this effect was small. The addition of the BESS report scores did not improve prediction.

In the second regression analysis (Table 9), beta coefficients for gender, ethnicity, and parent report were not predictive of test scores for the final model. Teacher report did significantly improve prediction, again to a small extent. The addition of the HAIFS report scores did not improve prediction.

### **Discussion**

The current study examined the utility and theoretical structure of a screening tool for early social-emotional difficulties (SEDs). This approach highlighted the importance of (a) screening for a broad range of risk factors, (b) creating screening tools that are practical for use in schools, (c) soliciting children's own perspectives on their well-being, and (d) engaging younger children in screening. The following discussion addresses the research questions this study sought to answer, as well as the implications of the current study for policy and practice and the study's limitations. Directions for further research are also discussed.

In today's complex world, the demands placed on children can be grueling. Academic success, time-management, and even career preparation often take precedence over healthy social-emotional development. In what David Elkind (2007) referred to as a "hurried childhood," parents and schools, among others, are seeking to maximize each moment and accelerate growth, in a process that inevitably leads to stress for young children. Elkind argued that over the past several decades, changes in economics, popular science trends, and the culture of testing have exacerbated these effects to the point where children are being denied the space and time needed for healthy development. Self-esteem, self-regulation, and social-emotional competence are not only beneficial for children, but are fundamental to their abilities to learn and grow into successful adults.

As a nation, we have seen increasing concerns about child mental health, from this perspective and elsewhere, but the best ways to identify and ameliorate child stress are not always clear. For schools, the goals of fostering child development and meeting academic standards can sometimes appear to be in competition with one another. However, recent trends in education, which emphasize universal screening for early signs of risk and prevention of mounting issues, provide guidance. On the one hand, increased use of screening, monitoring, testing, and intervention seems to be just another symptom of an education system that overwhelms and stresses students. On the other hand, such approaches may be the answer to the growing cry for greater attention to the inner experience of students. It now seems possible that accountability and assessment, often seen as anathema to emotionally sensitive schooling, can be used to promote rather than endanger mental health.

As noted, strong systems of prevention and intervention begin with comprehensive methods of identification. When early social-emotional problems go unnoticed, children are not only at greater risk of school failure, but are more likely to develop aggressive and illegal behaviors and severe mental health issues (Dvorsky et al., 2014). Traditional approaches to identification fail to provide children with equal opportunities for support. Children with certain issues and from certain demographics are less likely to be referred by teachers, and problems in younger children can persist unnoticed. For schools to achieve success with supporting the social-emotional welfare of their students, changes to screening practices must be made.

#### **The HAIFS as a Screener for Social-Emotional Well-Being**

The first research question addressed the effectiveness of the HAIFS as a tool for identifying student difficulties. It was hypothesized that the HAIFS would maintain the

proposed five-factor structure and that subscales and the overall scales would yield moderate to large reliability scores and correlate strongly with additional measures of similar issues. The screener, did, in fact, coalesce as a five-factor instrument, with general alignment between proposed and final factors, with some exceptions. Interestingly, there seemed to be an overlap between two factors, the Relationships with Others factor and the Perceptions of School composite. Three proposed items from the Perceptions of School factor (“My teacher cares about me,” “My teacher listens to me,” and “My school is a friendly place”) loaded on to the Relationships with Others factor in the final version of the screener. Additionally, only two items were preserved as the Perceptions of School composite. For children in the first through third grades, it may be that *relationships*, more than academics or activities, play a significant role in how positively they view school. It may also be that screeners should include broader definitions of school elements and activities. For example, the academic attitudes and beliefs that Kamphaus (2012) recommended for inclusion in screeners may not, in fact, have been reflected in the questions on the HAIFS, which were more related to general positive feelings at school and connections with others.

The subscales of the HAIFS and the overall scale demonstrated strong internal consistency, and seemingly measured unified constructs. For the purposes of screening, overall internal consistency is most essential, as fine discrimination between subscales is not expected, as it would be in a scale used for more diagnostic purposes. It is important to note that internal consistency was similar across first, second, and third grades. This finding indicates that the HAIFS measures a cohesive well-being concept not only in third graders, who are more often the target of such screeners, but also in children one and even two grades lower.

The analyses also confirmed the external validity of the HAIFS, which shares 50% of its variance with an established screener, the BESS, for second and third graders. As discussed, the BESS is part of an expensive system of screening, presented to children in a standardized test format, rather than in a manner that is readily understandable and familiar to them. It is only standardized for third grade and above and the questions must be read silently by children. The HAIFS also includes more questions about internalizing than the BESS, which may have led to slightly less overlap, but also indicates that the HAIFS may be more effective at identifying children with these issues, who represent a chronically under-identified population. As a no-cost, developmentally appropriate alternative to the BESS, the HAIFS appears to have potential to be as psychometrically strong and perhaps to tap into even more of the types of problems not readily recognized by adults.

### **Relationships Among Ratings of Child Well-Being**

The second research question addressed the relationship between perspectives of different raters: children, their parents, and their teachers. Based on previous research, it was hypothesized that correlations between child and adult (teacher and parent) ratings would be small but significant, and that parent and teacher ratings would have small to moderate correlations with one another. In general, the interrater relationships found in this study were similar to those found in previous research (Achenbach et al., 1987; Kolko & Kazdin, 1993). Parent and teacher ratings of behavior were moderately correlated. Relationships between parent and teacher report and child self-report, on the both the BESS and the HAIFS, were positive and significant, but so small that they were uninterpretable. Although other studies have confirmed a pattern of small relationships between child and adult ratings, the relationships found here were even weaker. Some would argue that young children keep little to themselves and that worry, sadness, and other issues may be more visible in young children who have less self-control and

awareness than older children, but it may also be that some of these issues are truly less perceptible to adults at this age.

Achenbach (1987), along with other more recent researchers (Kolko & Kazden, 1993; Wrobel & Lachar, 1998), found that the relation between adult reports and child reports is stronger for externalizing than internalizing issues. In the current study, the associations between child and adult report were somewhat stronger for the externalizing domain, supporting the ideas discussed in this paper regarding the more observable nature of child externalizing versus internalizing behavior. Further analyses indicated similar trends. On independent samples *t*-tests, teachers were better at identifying externalizers than internalizers, again indicating that outwardly-directed signs of distress in children are more readily perceived by adults.

In addition to failing to consistently identify children with different symptomatic profiles, teachers in this study lacked accuracy in their ability to identify students with the highest self-rated SEDs. Of the 36 students who identified themselves as High Internalizers (in the highest 10% for Internalizing Symptoms on the HAIFS), teachers only identified 11 as High Internalizers on the SSBD class rankings (within the top three ranked students, or more than top 10% of class). In other words, teachers only identified 31% of the children who self-identified as being in greatest need of support for internalizing problems. Interestingly, this pattern was also observed for externalizing. Of the 41 children who identified themselves as High Externalizers, only 15 (37%) were identified by teachers as High Externalizers. Thus teachers identified a greater percentage of these students compared to internalizers. This disparity indicates the presence of a group of children with poor perceived social-emotional well-being who are not considered relatively severe by teacher observations. This effect has been found in previous research: King et al. (2012) found that a student self report identified a greater number of children at risk (32%) than parent or teacher report.

In addition, children rated by teachers as High Externalizers had significantly fewer issues with self-confidence than their peers. It may be that children who visibly act out their emotions are more outgoing and sure of themselves than those who keep them to themselves. However, children who teachers rated as High Internalizers *or* High Externalizers did not differ in their self-ratings on either the HAIFS or the BESS, indicating a disconnect between teacher perception of problems and child perception. This pattern was also seen for the children who were rated as the single highest internalizer or externalizer in each class.

Finally, it was also hypothesized that children's ratings of their own social-emotional well-being would be related in various ways to teacher ratings of their social acceptance. However, no meaningful correlations were discovered. This finding may have been due to a real lack of theoretical and practical connection, to a lack of accurate teacher perception of child social status, or to a potential phenomenon wherein, at a young age, moderate internal emotional problems do not yet relate to social acceptance.

### **Social-Emotional Well-Being as a Predictor of Outcomes**

The final research question examined the predictive nature of parent, teacher, and child-rated well-being on child test scores. It was hypothesized that child self-reports would add value to the predictive power of parent and teacher reports. As noted earlier, test scores were available only for children in the third grade, as state testing in California does not begin until Spring of the second grade. Although the HAIFS was found to be structurally and theoretically sound, child responses did not significantly predict test scores for third graders. It should be noted that child ratings on the BESS were also not predictive of test scores.

This area of analysis was limited by the fact that standardized test scores were the only streamlined outcome variable available, available for only a third of the subjects. In older populations, outcomes such as GPA or office referrals are easier to obtain and often reflect some level of objectivity. However, for children in elementary school, grades and other commonly collected data are often unclear, subjective, and variable across schools and even classrooms.

Although teacher-reported social-emotional well-being has been found to be predictive of academic outcomes (Jeuchter et al., 2012; Ladd & Burgess, 2001), there is little research on the relation between self-reported social-emotional functioning and academics in the early elementary years. In a study of the predictive power of seventh grade behavioral issues on 10<sup>th</sup> grade academic achievement, Fleming et al. (2005) found that some child self-report measures, such as relational aggression and contact with negative peers, were related to grades and/or test scores. In some areas, such as commitment to school, attention, and depression, child reports were significantly related to academics but the relationship was small (< .3). These varied findings illustrate the complexity of the predictive relationship self-reported social-emotional functioning and school outcomes.

In related areas of child functioning, such as social skills, studies have shown that for elementary-aged children, child ratings have few correlations (not predictive power) with test scores and weaker correlations than teacher ratings (Malecki & Elliot, 2002). It may be that at this young age, the impact of social-emotional stress on academics has not yet been realized. Children are still engaged in school, know one teacher fairly well, and spend more time on social or non-academic activities. The cycle of having negative feelings towards school, disengaging from classroom activities, not completing homework, performing poorly, and then experiencing increased negative feelings has not yet been cemented. As children get older, the impact of emotional well-being on academics may shift. Indeed, Breslau et al. (2009) reported that teacher-rated issues in elementary school predicted high school academics, but did not predict academics in elementary school. As such, it may take time for the negative transaction of SEDs and success in school to take shape.

Although parent reports were also not predictive of child test scores, teacher reports had a small predictive relationship with test scores. In the early grades, teachers may be more aware of issues that relate to academics than parents, who see less of their child's academic skills and do not yet receive very detailed or objective report cards. In other studies, teacher ratings of child social-emotional behavior have also been found to be predictive of child academic outcomes. For example, Wentzel (1993) found that teacher (and peer) ratings of prosocial and antisocial behavior in middle-schoolers significantly predicted child GPAs and that prosocial behavior predicted child test scores.

Ultimately, when designing a screener for the early elementary years, identifying predictive power tied to academics may not in fact be necessary. In line with the aforementioned concept of behavioral and emotional risk, a screener can be effective when it identifies risk and informs intervention. In comparison with rating scales, screeners are not simply used to identify established, significant mental health problems, which have been found to connect more solidly with poor academic outcomes (Fox et al., 2014). The fact that screeners may not predict academic issues is not an argument for or against their effectiveness in this context: young children at-risk have not yet been separated into those who will be resilient and those who will fail, and the ethics of prevention mandate that we treat all at-risk children with the assumption that without treatment, they could become the latter. Based on what we know about the

*development* of factors that do predict poor outcomes, screening is a cautionary, no-harm process, even in the absence of a clear connection to academic failure.

### **Limitations and Future Directions**

Like so many other initial studies, the current was limited by its subject population. The majority of participants, both teachers and children, were from White, middle- and upper-class backgrounds. The student population in this country varies considerably, and it will be important to examine the HAIFS in a more ethnic and socio-economic diverse population. Such work would speak not only to the possibilities of generalizing the findings of this study to a broader population, but it would also shed light on the practical utility of the HAIFS in schools that have fewer resources and different structures. In addition, as one of the goals of early self-report screening is to reduce bias in identification, the HAIFS must be used with populations that have been historically overidentified for mental health services and special education, such as Black students.

Further revisions of the HAIFS must include the addition of more items to the Perceptions of School composite. Additional clarification about the unique nature of this composite will also help in creating new questions and restating current questions that were hypothesized as capturing Perceptions of School but in fact loaded on other factors. Research has found connections between children's feelings of safety, support, and community at school and their life satisfaction (Danielsen, Samdal, Hetland, & Wold, 2009), academic achievement (Battistich, Solomon, Kim, Watson, & Schaps, 1995; Nichols & Nichols, 2012), and even overall school-wide achievement (MacNeil et al., 2009). Although attitudes towards school are not necessarily a mental health issue, they contribute greatly towards a child's sense of engagement and competence at school and should not be excluded from screeners.

In terms of usability, the delivery of the HAIFS should also be made as attractive and consistent as possible. For example, an audio recording of the directions and questions may lead to consistency of administration and greater ease and efficiency. Criteria for scoring the HAIFS must also be articulated in a manner that is clear and brief for teachers, RTI leaders, or school psychologists to complete. The question of whether students should have to meet a certain cut-off threshold to be referred for intervention, or whether the highest quartile or quintile of students should be considered for intervention, must also be explored.

In a more broad sense, although the RTI system appears to be promising, more information is needed about how RTI can reduce mental health problems. Currently, some research indicates reductions in academic problems and special education referrals when RTI is implemented (Fox et al., 2010), but less is known about the impacts of RTI as a system of consistent identification and early intervention on reducing risk for social-emotional problems. For example, Kelly et al. (2010) discussed the need to clarify the role of school social workers in the RTI process. Most school social workers report spending a disproportionate amount of time on Tier 2 and 3 interventions, and a desire to spend more time on Tier 1 prevention. Social workers, like psychologists, should be involved in universal screening and school wide primary prevention. It may be that greater alignment between school personnel, such as social workers and psychologists, at each level of social-emotional and behavioral RTI, is needed before the full effects of these programs can be examined.

### **Implications for Policy and Practice**

The findings from the current study offer guidance for school practices and policies in many areas. Ultimately, the goal of studies such as this is to initiate shifts in systems that are currently inadequate or ineffective. In this case, schools and how they approach the social-



emotional well-being of their students is the target of change. Certainly, multiple priorities vie for time, attention, and funding in schools, with each domain arguing its utmost importance. However, it does a disservice to children to consider social-emotional well-being as simply another subject for focused instruction, such as reading or math. In fact, social-emotional well-being is the foundation with which children enter school, interact with others, and exercise their potential to learn and grow (Cohen, 2006). Without attending to children's psychological development, educators run the risk of building on shaky scaffolding, of attempting to impart knowledge to children who are not ready to receive it, as their more basic social-emotional needs have not been met. Recently, it seems that educational interest groups have drawn their attention to the impact that social-emotional challenges can have on learning. It is my hope that some of the findings of this study will steer this attention towards certain key issues.

**The inclusion of self-report in the screening process.** First, the current study adds weight to the argument that schools must include self-reports when screening for social-emotional distress. As Rohbeck, Azar, and Wagner (1991) explained, self-reports tell us about a child's functioning across many different situations (as opposed to just at home or in the classroom). In this study, as in others (Achenbach et al., 1987; Kolko & Kazdin, 1993; Renk & Phares, 2004; Wrobel & Lachar, 1998), parent and teacher ratings did not correlate strongly with child self-reports. Some may take this as an indicator that children are not reliable sources of information about their own functioning, but it is just as likely that children's perspectives encompass different elements than the perspectives of adults.

In addition, especially in the case of screening for risk, the exclusion of self-report "may unnecessarily narrow the focus of interventions to observable behaviors and external contingencies" (Rohbeck et al., 1991, p. 179). When teachers are the sole reporters of student SEDs, certain groups of children can be under and over identified, and those who direct behaviors inwards can be at risk for going undetected (Costello et al., 2003; Davis et al., 2011; Frick, Silverthorn, & Evans, 1994; Zahn-Waxler et al., 2008). Despite the danger of under-identification, self-reports are sorely lacking from available social-emotional screeners (Severson et al., 2002). For example, the Systematic Screening for Behavior Disorders (SSBD), often referred to as the "gold standard" in social-emotional screening, includes three stages of screening, none of which includes a self-report component (Lane et al., 2008). Although the SSBD claims to effectively identify internalizers as well as externalizers, the very nature of internalizing behaviors calls into question the validity of relying solely on adult opinion to define such issues. The SSBD has been correlated with indicators such as peer social behavior and behavioral referrals (Walker et al., 1994) and academic tests (Walker et al., 1990), but the overlap with or added value of self-reports has not been examined. Although systems like the SSBD have contributed to universal, efficient screening in schools, such efforts are insufficient when they fail to include self-report measures. The findings of the current study indicate that the HAIFS may be an appropriate example of one such measure.

**Screening younger populations of students.** Second, the outcomes of this study also suggest that screening should be conducted with children younger than third grade. Student responses on the HAIFS showed similar internal consistency, regardless of grade level. In addition, students in Grades 1 and 2 demonstrated understanding of and interest in completing the screener, despite their younger age. Previous studies support the idea that young children are valid reporters of various factors related to their well-being (Hodges, 1990; Kassam-Adams, 2006; Varni et al., 2007). Despite this contention, self-reports for children younger than Grade 3 are scarce. In the spirit of RTI, which emphasizes prevention first, schools must consider that

children as young as 6 and 7 can communicate information about their own social-emotional well-being when given the right tools. This present study provides some evidence that these children are just as reliable as their older counterparts in their self-identification of risk.

Indeed, the period referred to as “middle childhood,” which spans ages 6 to 10 (Eccles, 1999, p. 31), is one that involves dramatic development of the self. Eccles (1999, p. 33) explained,

“Children who do not see themselves as competent in academic, social, or other domains...during their elementary school years report depression and social isolation more often than their peers, as well as anger and aggression. Frequent feelings of frustration and incompetence early in a child’s school career may coalesce into a negative pattern of adaptation towards schooling.”

There are few compelling arguments for waiting until children are 8 or 9 to administer self-reported screeners. Issues that can be easily treated with low-level interventions can and must be identified as early as possible in order to reflect the self-awareness that young children do possess and support them in creating positive identities.

**Screening for a wide range of risk-factors.** Third, this study provides further evidence for the established idea that screeners must be broad, rather than narrow. As discussed, the HAIFS, though it included some elements not typically found in mental-health screeners, had high internal consistency across grade levels.

Broadening the content of social-emotional screeners may also help to counteract the pattern of underidentification of girls in mental health treatment (Wagner et al., 2005) and to curtail the rise in negative outcomes for our nation’s female population. It is estimated that more than one-fourth of adolescent girls in this country suffer from one or more serious social-emotional issues, including self-mutilation, eating disorders, depression, or serious consideration of suicide (Hinshaw & Kranz, 2009). Some of these challenges, such as depression, are being observed earlier and earlier in girls, adding to the severity of issues and the extent of impact. Although the teacher and parent screeners used in this study identified significantly more problems in boys than girls, the HAIFS, on the other hand, identified more issues with internalizing and self-confidence in girls. These are exactly the kinds of issues that need to be quantified, recognized, and treated to prevent poor outcomes. In the process of screening, adults must pay careful attention to the development of self-directed issues and poor self-esteem in young girls.

The examination of the HAIFS also demonstrated that broader screeners do not necessarily require more time. The survey was administered to whole classes within 15 minutes, a negligible amount of time in the context of annual screening. In California, to be exact, that amounts to .03% of the instructional minutes required each year for students in Grades 1 through 3 (California Department of Education (CDE), 2014). In comparison, screeners that rely solely on teacher report can take 1-2 hours of teacher time to complete (AIMSweb Behavior Administration and Technical Manual, 2010; Walker et al., 1990). The HAIFS is designed so that it can be analyzed by school psychologists, social workers, and other personnel. In this way, teachers, who are constantly strapped for time and energy, can focus their attention on delivering social-emotional supports post-screening.

**Pathways to more interventions.** Although screening is a critical first step in mental-health prevention, stronger screening processes will require that schools also increase the quality and range of interventions available to students who are identified as at-risk. The call for improving and expanding school mental health services (Mills et al., 2006; Rones & Hoagwood,

2000) has been growing louder, but attention must be given not only to high-level treatments for existing issues (Tier 3) but to the prevention and administration of low-cost, low-intensity interventions to ameliorate developing SEDs (Tier 1 and 2). A number of primary and secondary treatments have been found to be effective for treating mild to moderate levels of anxiety (J. K. Fox et al., 2014), depression (Patel, Stark, Metz, & Banneyer, 2014), aggressive behaviors (Swearer, Wang, Collins, Strawhun, & Fluke, 2014), and attention problems (Storer, Evan, & Langberg, 2014) in schools.

For example, the Cool Kids intervention program (Misfud & Rapee, 2005) has been implemented and evaluated in schools in Australia, with promising results. The program uses cognitive-behavioral therapy techniques to treat children ages 7 to 12 who demonstrate risk for anxiety disorders. The treatment is at the group level (designed for groups of eight to 12 students), brief (eight weekly sessions), and low-cost. In a study of the effectiveness of the Cool Kids program as a school-based intervention, Misfud and Rapee examined differences between waitlist controls and children who participated in the program. Children were referred after meeting criteria on a school-wide screener. Post-intervention, the treatment group displayed fewer anxiety symptoms than the control on both teacher and self-ratings. This effect persisted at a 4-month follow-up.

With increased access to practical, reliable tools for screening, both researchers and school personnel can increase their focus on developing and implementing interventions such as this one. The ultimate goal of creating effective screeners is to move children towards treatment more quickly and accurately. The purpose of this study and future studies is that they lead to an increased urgency in the development of primary and secondary interventions to reduce the risk identified by screeners.

### **Conclusion**

The goal of this study was to create and examine a low-cost, reliable, and efficient screening tool to aide in social-emotional RTI, with the aim of helping all children learn and develop into happy, well-balanced individuals. Children at risk for social-emotional problems can and must be identified early in schools. Although not all at-risk children develop significant mental health problems as adolescents and adults, the more prevalent incidence of maladjustment, low self-esteem, and lack of connection keep children from reaching their academic and social potentials and keeps schools from effectively supporting all students. In addition, children who do go on to develop more severe SEDs will benefit from early intervention. Our understanding of how to identify children with overt behavioral manifestations of poor psychological well-being is somewhat established. However, we know less about identifying and supporting children who internalize their social-emotional challenges. In the current study, I sought to develop a measure for the purpose of recognizing a broad range of risk factors in young children, and also to strengthen our knowledge of the links between self-rated well-being and other risk-related factors in young children. By further exploring this issue, schools should become more effective at maximizing each child's potential to learn, grow, and succeed.

### References

- Achenbach, T. M., McConaughy, S. H., & Howell, C. T. (1987). Child/adolescent behavioral and emotional problems: Implications of cross-informant correlations for situational specificity. *Psychological Bulletin, 101*, 213–232. doi:10.1037/0033-2909.101.2.213
- Achenbach, T. M., McConaughy, S. H., Ivanova, M. Y., & Rescorla, L. A. (2011). *Manual for the ASEBA Brief Problems Monitor*. Burlington, VT: ASEBA.
- Adams, G. B., & Torchia, M. (1998). *School personnel: A critical link in the identification, treatment, and management of OCD in children and adolescents*. Milford, CT: OC Foundation.
- Adelman, H. S., & Taylor, L. (2006). Mental health in schools and public health. *Public Health Reports, 121*, 294.
- Adelman, H. S., & Taylor, L. (2012). Mental health in schools: Moving in new directions. *Contemporary School Psychology, 16*, 9–18.
- AIMSweb Behavior Administration and Technical Manual*. (2010). Bloomington, MN: Pearson.
- Battistich, V., Solomon, D., Kim, D., Watson, M., & Schaps, E. (1995). Schools as communities, poverty levels of student populations, and students' attitudes, motives, and performance: A multi-level analysis. *American Educational Research Journal, 32*, 627–658. doi:10.3102/00028312032003627
- Berkeley, S., Bender, W. N., Peaster, L. G., & Saunders, L. (2009). Implementation of response to intervention: A snapshot of progress. *Journal of Learning Disabilities, 42*, 85–95. doi:10.1177/0022219408326214
- Black, F. W. (1974). Self-concept as related to achievement and age in learning-disabled children. *Child Development, 45*, 1137–1140. doi:10.2307/1128109
- Blanchard, L. T., Gurka, M. J., & Blackman, J. A. (2006). Emotional, developmental, and behavioral health of American children and their families: A report from the 2003 National Survey of Children's Health. *Pediatrics, 117*, 1202–1212. doi:10.1542/peds.2005-2606
- Breslau, J., Miller, E., Breslau, N., Bohnert, K., Lucia, V., & Schweitzer, J. (2009). The impact of early behavior disturbances on academic achievement in high school. *Pediatrics, 123*, 1472–1476. doi:10.1542/peds.2008-1406
- Brown-Chidsey, R., & Steege, M. W. (2010). *Response to Intervention: Principles and strategies for effective practice*. New York, NY: Guilford Press.
- Butler, R. J., & Gasson, S. L. (2005). Self-esteem/self-concept scales for children and adolescents: A review. *Child and Adolescent Mental Health, 10*, 190–201. doi:10.1111/j.1475-3588.2005.00368.x
- California Department of Education (2014). *Reducing instructional time*. Retrieved August 31 from <http://www.cde.ca.gov/fg/au/ag/reducingit.asp>.
- Cheney, D., Flower, A., & Templeton, T. (2008). Applying response to intervention metrics in the social domain for students at risk of developing emotional or behavioral disorders. *The Journal of Special Education, 42*, 108–126. doi:10.1177/0022466907313349
- Child Mind Institute. (2011). *National children's mental health report card 2011*. New York, NY: D. Thomsen.
- Cohen, J. (1992). A power primer. *Psychological Bulletin, 112*, 155–159. doi:10.1037/0033-2909.112.1.155

- Cohen, J. (2006). Social, emotional, ethical, and academic education: Creating a climate for learning, participation in democracy, and well-being. *Harvard Educational Review*, *76*, 201–237.
- Cole, J. D., & Dodge, K. A. (1988). Multiple sources of data on social behavior and social status in the school: A cross-age comparison. *Child Development*, *59*, 815–829. doi:10.1111/j.1467-8624.1988.tb03237.x
- Costello, E. J., Mustillo, S., Erkanli, A., Keeler, G., & Angold, A. (2003). Prevalence and development of psychiatric disorders in childhood and adolescence. *Archives of General Psychiatry*, *60*, 837–844. doi:10.1001/archpsyc.60.8.837
- Danielsen, A. G., Samdal, O., Hetland, J., & Wold, B. (2009). School-related social support and students' perceived life satisfaction. *The Journal of Educational Research*, *102*, 303–320. doi:10.3200/joer.102.4.303-320
- Davis, S. D., Young, E. L., Hardman, S., & Winters, R. (2011). Screening for emotional and behavioral disorders. *Principal Leadership*, *11*, 12–17.
- Dishion, T. J. (1990). The family ecology of boys' peer relations in middle childhood. *Child Development*, *61*, 874–892. doi:10.1111/j.1467-8624.1990.tb02829.x
- Dishion, T. J., & Kavanagh, K. (2003). *Intervening in adolescent problem behavior: A family-centered approach*. New York, NY: Guilford Press.
- Donohue, K. M., Perry, K. E., & Weinstein, R. S. (2003). Teachers' classroom practices and children's rejection by their peers. *Applied Developmental Psychology*, *24*, 91–118. doi:10.1016/S0193-3973(03)00026-1
- Dvorsky, M. R., Girio-Herrera, E., & Owens, J. (2014). School-based screening for mental health in early childhood. In M. D. Weist (Ed.), *Handbook of school mental health: Research, training, practice, and policy* (pp. 297–310). New York, NY: Springer Science and Business Media.
- Eccles, J. S. (1999). The development of children ages 6 to 14. *The Future of Children*, *9*(2), 30–44. doi:10.2307/1602703
- Eklund, K., Vaillancourt, K., & Pedley, T. (2013). Expanding the role of the school psychologist in the delivery of school-based mental health services. *National Association of School Psychologists Communiqué*, *41*(5), 28.
- Elkind, D. (2007). *The hurried child: Growing up too fast too soon*. Cambridge, MA: Da Capo Press.
- Eliot, M., Cornell, D., Gregory, A., & Fan, X. (2010). Supportive school climate and student willingness to seek help for bullying and threats of violence. *Journal of School Psychology*, *48*, 533–553. doi:10.1016/j.jsp.2010.07.001
- Fleming, C. B., Haggerty, K. P., Catalano, R. F., Harachi, T. W., Mazza, J. J., & Gruman, D. H. (2005). Do social and behavioral characteristics targeted by preventive interventions predict standardized test scores and grades? *Journal of School Health*, *75*, 342–349. doi:10.1111/j.1746-1561.2005.00048.x
- Filter, K. J., McKenna, M. K., Benedict, E. A., Horner, R. H., Todd, A., & Watson, J. (2007). Check in/check out: A post-hoc evaluation of an efficient, secondary-level targeted intervention for reducing problem behaviors in schools. *Education and Treatment of Children*, *30*(1), 69–84. doi:10.1353/etc.2007.0000
- Floyd, F. J., & Widaman, K. F. (1995). Factor analysis in the development and refinement of clinical instruments. *Psychological Assessment*, *7*, 286–299. doi:10.1037//1040-3590.7.3.286

- Fox, J. K., Herzig, K., Colognori, D., Stewart, C. E., & Warner, C. M. (2014). School-based treatment for anxiety in children and adolescents: New developments in transportability and dissemination. In M. D. Weist (Ed.), *Handbook of school mental health* (pp. 355–368). New York, NY: Springer Science and Business Media. doi:10.1007/978-1-4614-7624-5\_26
- Fox, L., Carta, J. S., Dunlap, G., & Hemmeter, L. M. (2010). Response to Intervention and the pyramid model. *Infants & Young Children, 23*, 3–13. doi:10.1097/iy.0b013e3181c816e2
- Frick, P. J., Silverthorn, P., & Evans, C. (1994). Assessment of childhood anxiety using structured interviews: Patterns of agreement among informants and association with maternal anxiety. *Psychological Assessment, 6*, 372–379. doi:10.1037/1040-3590.6.4.372
- Fuchs, D., & Fuchs, L. S. (2006). Introduction to Response to Intervention: What, why, and how valid is it? *Reading Research Quarterly, 41*, 93–99. doi:10.1598/rrq.41.1.4
- Glover, T. A., & Albers, C. A. (2007). Considerations for evaluating universal screening assessments. *Journal of School Psychology, 45*, 117–135. doi:10.1016/j.jsp.2006.05.005
- Goodman, R. (2001). Psychometric properties of the Strengths and Difficulties Questionnaire. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*, 1337–1345. doi:10.1097/00004583-200111000-00015
- Goodman, R., & Scott, S. (1999). Comparing the Strengths and Difficulties Questionnaire and the Child Behavior Checklist: Is small beautiful? *Journal of Abnormal Child Psychology, 27*, 17–24. doi:10.1023/a:1022658222914
- Henderson, J., & Strain, P. (2009). *Screening for delays and problem behavior (Roadmap to effective intervention practices)*. Tampa, FL: University of South Florida, Technical Assistance Center on Social Emotional Intervention for Young Children.
- Hinshaw, S., & Kranz, R. (2009). *The triple bind: Saving our teenage girls from today's pressures*. New York, NY: Random House LLC.
- Hodges, K. (1990). Depression and anxiety in children: A comparison of self-report questionnaires to clinical interview. *Psychological Assessment: A Journal of Consulting and Clinical Psychology, 2*, 376–381. doi:10.1037//1040-3590.2.4.376
- Hester, P. P., Baltodano, H. M., Hendrickson, J. M., Tonelson, S. W., Conroy, M. A., & Gable, R. A. (2004). Lessons learned from research on early intervention: What teachers can do to prevent children's behavior problems. *Preventing School Failure: Alternative Education for Children and Youth, 49*, 5–10. doi:10.3200/psfl.49.1.5-10
- Hymel, S., Rubin, K. H., Rowden, L., & LeMare, L. (1990). Children's peer relationships: longitudinal prediction of internalizing and externalizing problems from middle to late childhood. *Child Development, 61*, 2004–2021. doi:10.1111/j.1467-8624.1990.tb03582.x
- IBM Corporation.. (2011). *IBM SPSS Statistics for Windows, Version 20.0*. Armonk, NY: IBM Corp.
- Jeuchter, J. I., Dever, B. V., & Kamphaus, R. W. (2012). Mental health screening and academic outcomes in elementary school. *School Psychology Forum: Research in Practice, 6*, 137–147.
- Johnson, D. B., Pedro-Carroll, & Demanchick, S. P. (2005). The primary mental health project: A play intervention for school-age children. In L. A. Reddy, T. M. Files-Hall, & C. E. Schaeffer (Eds.), *Empirically-based play interventions for children* (pp. 13–30). Washington, D.C.: American Psychological Association. doi:10.1037/11086-002

- Kamphaus, R. W. (2012). Screening for behavioral and emotional risk: Constructs and practicalities. *NASP School Psychology Forum: Research in Practice*, 6, 89–97. doi:10.1037/e615622013-001
- Kamphaus, R. W., & Reynolds, C. R. (2007). *BASC-2 Behavioral and Emotional Screening System (BESS) manual*. Circle Pines, MN: Pearson.
- Kassam-Adams, N. (2006). The Acute Stress Checklist for Children (ASC-Kids): Development of a child self-report measure. *Journal of Traumatic Stress*, 19, 129–139. doi:10.1002/jts.20090
- Kelly, M. S., Frey, A. J., Alvarez, M., Berzin, S. C., Shaffer, G., & O'Brien, K. (2010). School social work practice and Response to Intervention. *Children & Schools*, 32, 201–209. doi:10.1093/cs/32.4.201
- King, K., Reschly, A. L., & Appleton, J. J. (2012). An examination of the validity of the Behavioral and Emotional Screening System in a rural elementary school: Validity of the BESS. *Journal of Psychoeducational Assessment*, 30, 527–538. doi:10.1177/0734282912440673
- Knopf, D., Park, M. J., & Mulye, T. P. (2008). *The mental health of adolescents: A national profile*. National Adolescent Health Information Center. San Francisco, CA: University of California.
- Kolko, D. J., & Kazdin, A. E. (1993). Emotional/behavioral problems in clinic and nonclinic children: Correspondence among child, parent, and teacher reports. *Journal of Child Psychology and Psychiatry*, 34, 991–1006. doi:10.1111/j.1469-7610.1993.tb01103.x
- Ladd, G. W. (1990). Having friends, keeping friends, making friends, and being liked by peers in the classroom: Predictors of children's early school adjustment? *Child Development*, 61, 1081–1100. doi:10.1111/j.1467-8624.1990.tb02843.x
- Ladd, G. W., & Burgess, K. B. (2001). Do relational risks and protective factors moderate the linkages between childhood aggression and early psychological and school adjustment? *Child Development*, 72, 1579–1601. doi:10.1111/1467-8624.00366
- Laird, R. D., Jordan, K. Y., Dodge, K. A., Pettit, G. S., & Bates, J. E. (2001). Peer rejection in childhood, involvement with antisocial peers in early adolescence, and the development of externalizing behavior problems. *Development and Psychopathology*, 13, 337–354. doi:10.1017/s0954579401002085
- Lane, K. L., Little, M. A., Casey, A. M., Lambert, W., Wehby, J., Weisenbach, J. L., & Phillips, A. (2008). A comparison of systematic screening tools for emotional and behavioral disorders. *Journal of Emotional and Behavioral Disorders*, 17, 93–105. doi:10.1177/1063426608326203
- MacNeil, A. J., Prater, D. L., & Busch, S. (2009). The effects of school culture and climate on student achievement. *International Journal of Leadership in Education: Theory and Practice*, 12(1), 73–84. doi:10.1080/13603120701576241
- Malecki, C. K., & Elliot, S. N. (2002). Children's social behaviors as predictors of academic achievement: A longitudinal analysis. *School Psychology Quarterly*, 17, 1–23. doi:10.1521/scpq.17.1.1.19902
- Mann, M., Hosman, C. M., & Schaalma, H. P. (2004). Self-esteem in a broad-spectrum approach for mental health promotion. *Health Education Research: Theory and Practice*, 19, 357–372. doi:10.1093/her/cyg041
- Mendenhall, A. N., Demeter, C., Findling, R. L., Frazier, T. W., Fristad, M. A., Youngstrom, E. A., ... Horowitz, S. M. (2011). Mental health service use by children with serious

- emotional disturbance: Results from the LAMS study. *Psychiatric Services*, 62, 650–658. doi:10.1176/appi.ps.62.6.650
- Merrell, K. M., & Buchanan, R. (2006). Intervention selection in school-based practice: Using public health models to enhance systems capacity of schools. *School Psychology Review*, 35, 167–180.
- Merrell, K. M., & Walker, H. M. (2004). Deconstructing a definition: Social maladjustment versus emotional disturbance and moving the EBD field forward. *Psychology in the Schools*, 41, 899–910. doi:10.1002/pits.20046
- Mills, C., Stephan, S. H., Moore, E., Weist, M. D., Daly, B. P., & Edwards, M. (2006). The President's New Freedom Commission: Capitalizing on opportunities to advance school-based mental health services. *Clinical Child and Family Psychology Review*, 9, 149–161. doi:10.1007/s10567-006-0003-3
- Mifsud, C., & Rapee, R. M. (2005). Early intervention for childhood anxiety in a school setting: Outcomes for an economically disadvantaged population. *Journal of the American Academy of Child and Adolescent Psychiatry*, 44, 996–1004. doi:10.1097/01.chi.0000173294.13441.87
- Mitchell, M. M., Bradshaw, C. P., & Leaf, P. J. (2010). Student and teacher perceptions of school climate: A multilevel exploration of patterns of discrepancy. *Journal of School Health*, 80 (6), 271–279. doi:10.1111/j.1746-1561.2010.00501.x
- O'Connell, M. E., Boat, T., & Warner, K. E. (Eds.). (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. Washington, DC: National Research Council and Institute of Medicine of the National Academies. National Academies Press.
- Nese, R. N., Doerner, E., Romer, N., Kaye, N. C., & Merrell, K. W. (2012). Social Emotional Assets and Resilience Scales: Development of a strength-based short-form behavior rating scale system. *Journal for Educational Research Online*, 4, 124–139.
- Nichols, G. W., & Nichols, J. D. (2012). An analysis of student and parent perceptions: School climate surveys for the public good. *Scholarly Partnership Edu*, 6(1), 13–24. Retrieved from <http://opus.ipfw.edu/cgi/viewcontent.cgi?article=1067&context=spe>
- Nickerson, A. B., Brosco, A. M., & Shapiro, V. B. (2004). Predicting positive outcomes for students with emotional disturbance. *The California School Psychologist*, 9(1), 39–49. doi:10.1007/bf03340906
- Northern California Training Academy. (2008). Mental health screening and assessment tools for children: Literature review. Retrieved from <http://humanservices.ucdavis.edu/academy/pdf/final2mentalhealthlitreview.pdf>
- Patel, P. G., Stark, K. D., Metz, K. L., & Banneyer, K. N. (2014). School-based interventions for depression. In M. D. Weist (Ed.), *Handbook of school mental health* (pp. 369–383). New York, NY: Springer Science and Business Media. doi:10.1007/978-1-4614-7624-5\_27
- Parker, J. G., & Asher, S. R. (1987). Peer relations and later personal adjustment: Are low-accepted children at risk?. *Psychological Bulletin*, 102, 357–389. doi:10.1037//0033-2909.102.3.357
- The President's New Freedom Commission on Mental Health Report. (2003). *Achieving the promise: Transforming mental health care in America*. Retrieved from <http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/downloads.html>



- Renk, K., & Phares, V. (2004). Cross-informant ratings of social competence in children and adolescents. *Clinical Psychology Review, 24*, 239–254. doi:10.1016/j.cpr.2004.01.004
- Rorhbeck, C. A., Azar, S. T., & Wagner, P. E. (1991). Child Self-Control Rating Scale: Validation of a child self-report measure. *Journal of Clinical Child and Adolescent Psychology, 20*, 179–183. doi:10.1207/s15374424jccp2002\_9
- Romer, D., & McIntosh, M. The roles and perspectives of school mental health professionals in promoting adolescent mental health. In D. L. Evans, E. B. Foa, R. E. Gur, H. E. Hendin, & M. E. Seligman (Eds.), *Treating and preventing adolescent mental health disorders: What we know and what we don't know*. (pp. 598–615). New York, NY: Oxford University Press. doi:10.1093/9780195173642.003.0032
- Rones, M., & Hoagwood, K. (2000). School-based mental health services: A research review. *Clinical Child and Family Psychology Review, 3*, 223–241.
- Rosenberg, M., Schooler, C., Schoenbach, C., & Rosenberg, F. (1995). Global self-esteem and specific self-esteem: Different concepts, different outcomes. *American Sociological Review, 60*, 141–156. doi:10.2307/2096350
- Sabatino, C. (2009). School social work consultation models and Response to Intervention: A perfect match. *Children & Schools, 31*, 197–206. doi:10.1093/cs/31.4.197
- Severson, H. H., Walker, H. M., Hope-Doolittle, J., Kratochwill, T., & Gresham, F. M. (2007). Proactive, early screening to detect behaviorally at-risk students: Issues, approaches, emerging innovations, and professional practices. *Journal of School Psychology, 45*, 193–223. doi:10.1016/j.jsp.2006.11.003
- Siperstein, G., Wiley, A. L., & Forness, S. R. (2011). School context and the academic and behavioral progress of students with emotional disturbance. *Behavioral Disorders, 36*, 172–184.
- Stewart, E. B. (2008). School structural characteristics, student effort, peer associations, and parental involvement: The influence of school-and individual level factors on academic achievement. *Education and Urban Society, 40*, 179–204. doi:10.1177/0013124507304167
- Stoep, A. V., McCauley, E., Thompson, K. A., Herting, J. R., Kuo, E. S., Stewart, D. G., ... Kushner, S. (2005). Universal emotional health screening at the middle school transition. *Journal of Emotional and Behavioral Disorders, 13*, 213–222. doi:10.1177/10634266050130040301
- Storer, J. L., Evans, S. W., & Langberg, J. M. (2014). Organization interventions for children and adolescents with Attention-Deficit/Hyperactivity Disorder (ADHD). In M. D. Weist (Ed.), *Handbook of school mental health* (pp. 385–398). New York, NY: Springer Science and Business Media. doi:10.1007/978-1-4614-7624-5\_28
- Swearer, S. M., Wang, C., Collins, A., Strawhun, J., & Fluke, S. (2014). Bullying: A school mental health perspective. In M. D. Weist (Ed.), *Handbook of school mental health* (pp. 341–354). New York, NY: Springer Science and Business Media. doi:10.1007/978-1-4614-7624-5\_25
- Tabachnick, B.G. and Fidell, L.S. (2007). *Using multivariate statistics* (5th ed.). New York, NY: Allyn and Bacon.
- Thompson, B. (2004). *Exploratory and confirmatory factor analysis: Understanding concepts and applications*. Washington, D.C.: American Psychological Association.

- Trentacosta, C. J., & Shaw, D. S. (2009). Emotional self-regulation, peer rejection, and antisocial behavior: Developmental associations from early childhood to early adolescence. *Journal of Applied Developmental Psychology, 3*, 356–365. doi:10.1016/j.appdev.2008.12.016
- United States Department of Education, National Center for Education Statistics. (2012). *Digest of education statistics, 2011*. Retrieved from <http://nces.ed.gov/pubsearch/pubsinfo.asp?pubid=2012001>
- Valentine, J. C., DuBois, D. L., & Cooper, H. (2004). The relation between self-beliefs and academic achievement: A meta-analytic review. *Educational Psychologist, 39*, 111–133. doi:10.1207/s15326985ep3902\_3
- Varni, J. W., Limbers, C. A., & Burwinkle, T. M. (2007). How young can children reliably and validly self-report their health-related quality of life? An analysis of 8,591 children across age subgroups with the PedsQL™ 4.0 Generic Core Scales. *Health and Quality of Life Outcomes, 5*, 1. doi:10.1186/1477-7525-5-1
- Wagner, M., Kutash, K., Duchnowski, A. J., Epstein, M. H., & Sumi, W. C. (2005). The children and youth we serve: A national picture of the characteristics of students with emotional disturbances receiving special education. *Journal of Emotional and Behavioral Disorders, 13*, 79–96. doi:10.1177/10634266050130020201
- Walker, H. M., & Severson, H. H. (1992). *Systematic Screening for Behavioral Disorders (SSBD). Second edition*. Longmont, CO: Sopris West.
- Walker, H. M., Severson, H. H., Kehle, T., Jenson, W. R., & Clark, E. (1994). Replication of the Systematic Screening for Behavior Disorders (SSBD) procedure for the identification of at-risk children. *Journal of Emotional and Behavioral Disorders, 2*, 66–77. doi:10.1177/106342669400200201
- Walker, H. M., Severson, H. H., Todis, B. J., Block-Pedego, A. E., Williams, G. J., Haring, N. G., & Barckley, M. (1990). Systematic Screening for Behavior Disorders (SSBD): Further validation, replication, and normative data. *Remedial and Special Education, 11*, 32–46. doi:10.1177/074193259001100206
- Wang, M., & Dishion, T. J. (2011). The trajectories of adolescents' perceptions of school climate, deviant peer affiliation, and behavioral problems during the middle school years. *Journal of Research on Adolescence, 22*, 40–53. doi:10.1111/j.1532-7795.2011.00763.x
- Wang, S. S. (2010, June). Call for kids' mental-health checks. *The Wall Street Journal*. Retrieved from <http://online.wsj.com>
- Wentzel, K. R. (1993). Does being good make the grade? Social behavior and academic competence in middle school. *Journal of Educational Psychology, 85*, 357–364. doi:10.1037/0022-0663.85.2.357
- Wienke Tatura, C. M., Green, A. E., Karver, M. S., & Gesten, E. G. (2009). Multiple informants in the assessment of psychological, behavioral, and academic correlates of bullying and victimization in middle school. *Journal of Adolescence, 32*, 193–211. doi:10.1016/j.adolescence.2008.04.005
- Wiest, M. D., Sander, M. A., Walrath, C., Link, B., Nabors, L., Adelsheim, S., ... Carrillo, K. (2005). Developing principles for best practice in expanded school mental health. *Journal of Youth and Adolescence, 34*, 7-13. doi:10.1007/s10964-005-1331-1
- Wright, S., & Sulkowski, M. L. (2013, June). Assessing and treating childhood anxiety in school settings. *NASP Communiqué*. Retrieved from <http://www.nasponline.org/publications/cq/41/8/anxiety.aspx>

- Wrobel, N. H., & Lachar, D. (1998). Validity of self-and parent-report scales in screening for behavioral and emotional problems in elementary school. *Psychology in the Schools, 35*, 17–27.
- Zahn-Waxler, C., Shirtcliff, E. A., & Marceau, K. (2008). Disorders of childhood and adolescence: Gender and psychopathology. *Annual Review of Clinical Psychology, 275–303*. doi:10.1146/annurev.clinpsy.3.022806.091358

Table 1  
*Descriptive Statistics*

	N	Items	Mean	SD	Skew	Kurtosis	Alpha (95% CI)
HAIFS-IN	373	10	15.85	4.29	.92	.67	.84 (.82, .86)
HAIFS-RL	377	7	8.92	2.17	1.47	2.56	.73 (.69, .77)
HAIFS-EX	377	4	6.03	1.82	.72	-.18	.68 (.63, .73)
HAIFS-SC	375	4	5.42	1.55	1.18	1.34	.72 (.67, .76)
HAIFS-PSC	378	2	3.02	1.20	.96	.00	.77 (.71, .81)
HAIFS-Total	369	27	39.30	7.78	.86	.99	.87 (.85, .89)
BESS	278	30	24.28	11.44	.82	.76	.88 (.86, .90)
Parent SDQ	359	33	21.04	11.85	1.12	.96	.90 (.89, .92)
Teacher SDQ	353	25	12.87	4.99	.90	.15	.73 (.69, .77)

*Note.* *IN* = Internalizing; *RL* = Relationships; *EX* = Externalizing; *SC* = Self-Confidence; *PSC* = Perceptions of School Composite.

Table 2  
*Correlations Between Scales on the How Am I Feeling Survey*

	<i>IN</i>	<i>RL</i>	<i>Ex</i>	<i>SC</i>	<i>PC</i>	<i>Total</i>
<i>IN</i>	--	.44**	.52**	.30**	.06	.87**
<i>RL</i>	--	--	.31**	.44**	.21**	.71**
<i>EX</i>	--	--	--	.23**	.19**	.67**
<i>SC</i>	--	--	--	--	.18**	.57**
<i>PSC</i>	--	--	--	--	--	.33**
<i>Total</i>	--	--	--	--	--	--

*Note.* *IN* = Internalizing; *RL* = Relationships; *EX* = Externalizing; *SC* = Self-Confidence; *PSC* = Perceptions of School Composite.

\*\**p* < .001.

Table 3  
*Correlations Between Child, Parent, and Teacher Ratings*

	HAIFS	BESS	Parent SDQ	Teacher SDQ
HAIFS	--	.77**	.15**	.17**
BESS	.77**	--	.27**	.18**
Parent SDQ	.15**	.27**	--	.46**
Teacher SDQ	.17**	.18**	.46**	--

\*\* $p < .001$ .

Table 4  
*Correlations Between HAIFS and Parent Ratings*

Child Ratings	Parent SDQ Ratings				
	Emotional Symptoms	Conduct Problems	Hyperactivity	Peer Problems	Prosocial
<i>IN</i>	.15**	.10	.06	.04	.10
<i>RL</i>	-.04	.17**	.10	-.02	-.06
<i>EX</i>	.09	.030	.03	-.02	-.02
<i>SC</i>	.11*	.09	.08	.10	-.10
<i>PSC</i>	.08	.15**	.04	.01	-.18**

*Note.* *IN* = Internalizing; *RL* = Relationships; *EX* = Externalizing; *SC* = Self-Confidence; *PSC* = Perceptions of School Composite.

\* =  $p < .05$ . \*\* =  $p < .01$ .

Table 5  
*Correlations Between HAIFS and Teacher Ratings*

Child Ratings	Teacher SDQ Ratings				
	Emotional Symptoms	Conduct Problems	Hyperactivity	Peer Problems	Prosocial
<i>IN</i>	.19**	.13*	.05	.11*	-.08
<i>RL</i>	.00	.18**	.12*	.13*	-.15**
<i>EX</i>	.02	-.06	.03	.06	-.08
<i>SC</i>	.00	.08	.05	.09	-.16*
<i>PSC</i>	.08	.16**	.13*	.14**	-.25**

*Note.* *IN* = Internalizing; *RL* = Relationships; *EX* = Externalizing; *SC* = Self-Confidence; *PSC* = Perceptions of School Composite.

\* =  $p < .05$ . \*\* =  $p < .01$ .



Table 6  
*Correlations Between Social Acceptance Scores and Child Ratings*

	Accept	Reject	Ignore
<i>IN</i>	-.09	.15**	.05
<i>RL</i>	-.12*	.04	.11*
<i>EX</i>	-.17**	.11*	.13*
<i>SC</i>	-.11*	-.04	.11*
<i>PSC</i>	-.09	.06	.07
<i>HAIFS Total</i>	-.17**	.12*	.13*
<i>BESS Total</i>	-.18**	.16**	.07

\* =  $p < .05$ . \*\* =  $p < .01$ .

Table 7  
*Correlations Between Predictor Variables for Third Graders (N = 132)*

	Child HAIFS	Child BESS	Parent SDQ	Teacher SDQ
Child HAIFS	--	.78**	.13	.14
Child BESS	.78**	--	.19*	.15
Parent SDQ	.13	.19*	--	.49**
Teacher SDQ	.14	.15	.49**	--

\* $p < .05$ . \*\* $p < .01$ .

Table 8  
*Summary of Hierarchical Regression Analysis for Parent, Teacher and Student BESS Scores  
 Predicting Test Scores (N = 132)*

Variable	Model 1			Model 2			Model 3		
	<i>B</i>	<i>SE B</i>	$\beta$	<i>B</i>	<i>SE B</i>	$\beta$	<i>B</i>	<i>SE B</i>	$\beta$
Gender	18.10	18.54	.09	33.04	18.03	.16	32.75	18.17	.15
Ethnicity	15.69	24.92	.06	-3.01	24.25	-.01	-3.04	24.35	-.01
Parent SDQ				-2.54	1.91	-.13	-2.50	1.93	-.13
Teacher SDQ				-4.57	1.70	-.26**	-4.53	1.72	-.26*
Child BESS							-.16	.88	-.02
$R^2$		.01			.12			.12	
<i>F</i> for change in $R^2$		.66			4.32**			3.44**	

\* $p < .05$ . \*\* $p < .01$ .

Table 9  
*Summary of Hierarchical Regression Analysis for Parent, Teacher and Student HAIFS Scores Predicting Test Scores (N = 132)*

Variable	Model 1			Model 2			Model 3		
	B	SE B	$\beta$	B	SE B	$\beta$	B	SE B	$\beta$
Gender	13.51	18.80	.06	28.33	18.10	.13	32.21	18.37	.15
Ethnicity	19.87	25.59	.07	.20	24.73	.00	.19	24.69	.00
Parent SDQ				-2.79	1.92	-.14	-2.94	1.92	-.15
Teacher SDQ				-5.02	1.76	-.28**	-5.27	1.77	-.29**
Child HAIFS							1.44	1.24	.10
$R^2$		.01			.13			.14	
$F$ for change in $R^2$		.54			4.72**			4.06**	

\* $p < .05$ . \*\* $p < .01$ .

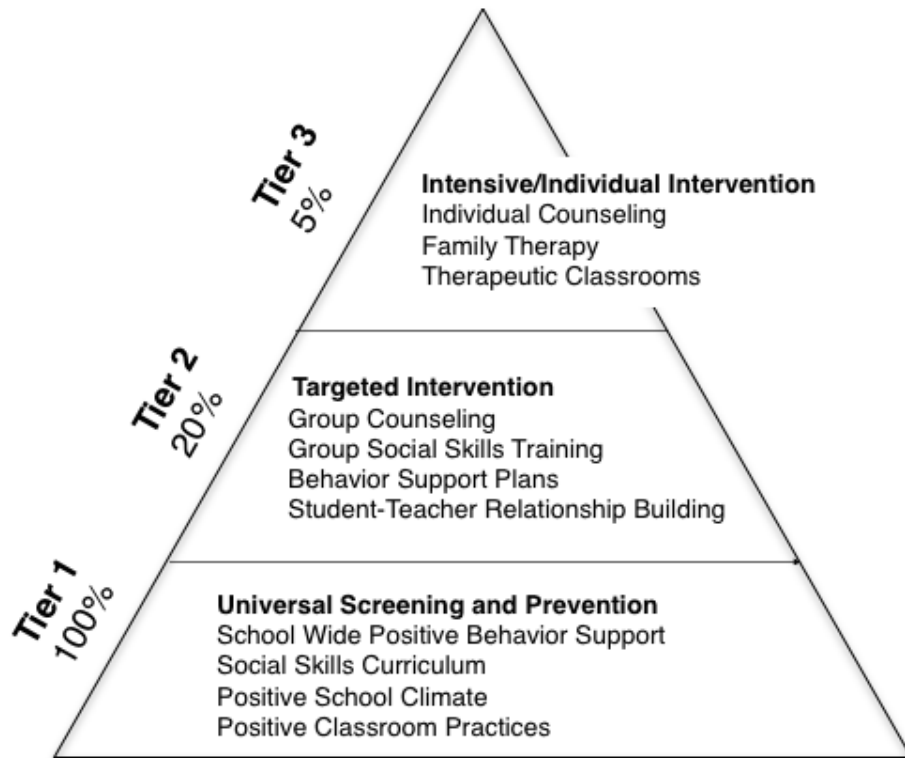


Figure 1. Social-emotional and behavioral response to intervention.

## Appendix A

*Pilot Version of the How Am I Feeling Survey (HAIFS).*

## ***How Am I Feeling?***

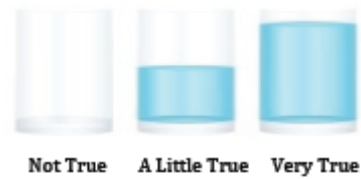
**Example:** *I like big dogs.*



**Example:** *I eat a lot of vegetables.*



1. My family is proud of me.



2. I have trouble going to sleep.



3. I worry a lot.



4. I like being in school.



Not True    A Little True    Very True

---

5. I get angry a lot.



Not True    A Little True    Very True

---

6. I am left out of things.



Not True    A Little True    Very True

---

7. I am smart.



Not True    A Little True    Very True

---

8. No one listens to me.



Not True    A Little True    Very True

---

9. I like going out to recess.



Not True    A Little True    Very True

---

10. I am good at lots of things.



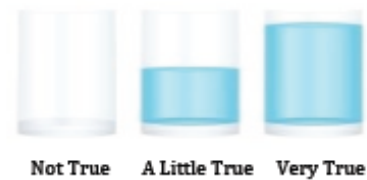
---

11. I feel sad a lot.



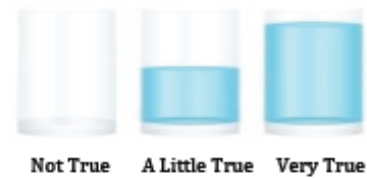
---

12. I have good friends.



---

13. People get mad at me a lot.



---

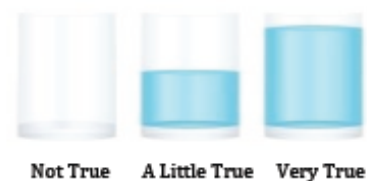
14. I get lots of stomachaches.



---

15. Other kids like me.

---





16. I feel lonely.



17. I am good at solving problems.



18. I hate making mistakes.



19. I like being at home.



20. Even when I try hard I fail.



## Appendix B

Revised Version of the How Am I Feeling Survey (HAIFS).

## How Am I Feeling?

**Example:** *I like big dogs.*



**Example:** *I eat a lot of vegetables.*



1. My family is proud of me.



2. I like being in school.



3. I get in trouble a lot.



4. I worry a lot.



5. I am smart.



6. My teacher cares about me.



7. I am left out of things.



8. No one listens to me.



9. I like going out to recess.



10. I am good at lots of things.



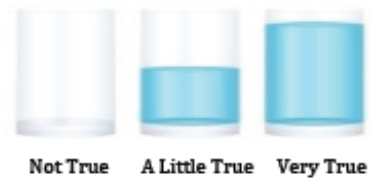
11. My school is a friendly place.



12. I get lots of stomachaches.



13. People get mad at me a lot.



14. I feel sad a lot.



15. Other kids like me.



16. I feel lonely.



17. I like my classmates.



18. Even when I try hard I mess up.



19. Many things scare me.



20. No one wants to play with me



21. My teacher thinks I'm smart.



22. Other children pick on me.



23. I am good at solving problems.



24. I would rather be by myself  
than with other people.



25. I hate making mistakes.



26. I get angry a lot



27. I have many friends.



28. School is boring.

---



29. I get in a lot of fights.

---



30. My teacher listens to me.

---



## Appendix C

### *How Am I Feeling Survey (HAIFS) Items After Factor Analysis.*

#### **Factor One (Internalizing)**

I feel lonely  
I am left out of things  
I feel sad a lot  
No one listens to me  
Many things scare me  
I get lots of stomachaches  
Other children pick on me  
No one wants to play with me  
I worry a lot  
Even when I try hard I mess up

#### **Factor Two (Relationships)**

Other kids like me  
My teacher cares about me  
My teacher listens to me  
I like my classmates  
My school is a friendly place  
I have many friends  
My family is proud of me

#### **Factor Three (Self-Confidence)**

I am good at lots of things  
I am smart  
I am good at solving problems  
My teacher thinks I'm smart

#### **Factor Four (Externalizing)**

I get angry a lot  
People get mad at me a lot  
I get in trouble a lot  
I get in a lot of fights

#### **Perceptions of School Composite**

I like being in school  
School is boring