2013 DIVISION 16 AWARDS

Catching Students Before They Fall

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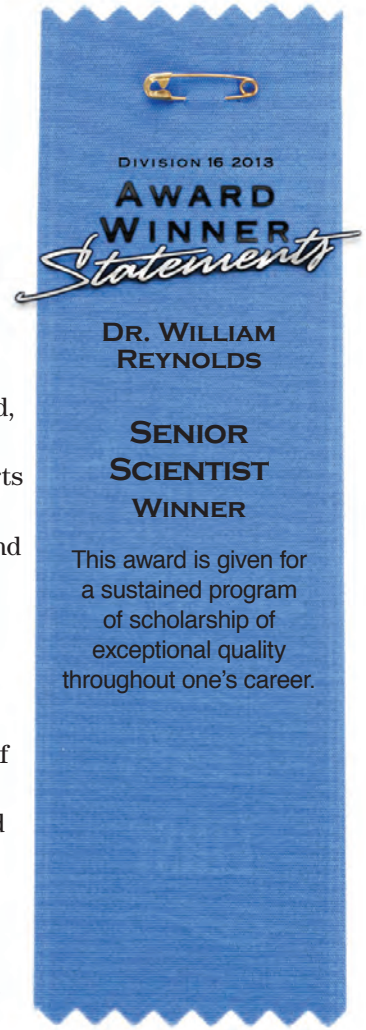

I am deeply honored by the APA Division 16 award committee in their consideration of my scholarly contributions to the field of school psychology, and to those individuals who nominated and wrote letters of support. In response to this award I would like to share some insights into one of my research areas as well as how school psychology impacted my educational experience.

For the past 32 years, one of my research interests and programmatic lines of scientific inquiry has been the development of methods and procedures to assist school psychologists in catching students before they fall in life-threatening ways. When I started work in this area in 1980 there was very little published empirical psychological research on depression in children and adolescents, and even less on suicidality. I should note that my doctoral degree was in school psychology, but I also took minors in clinical psychology and in special education at the University of Oregon – Eugene. My minor advisor was Norman Sundberg, with whom I shared a particular interest in assessment (e.g. Reynolds & Sundberg, 1976). As a graduate student, Norm invited me to become a coauthor on a chapter for the prestigious *Annual Review of Psychology*. The topic was to be the assessment of psychopathology, but after much discussion, we modified the chapter to focus on the assessment of competence and incompetence of persons (Sundberg, Snowden, & Reynolds, 1978). Writing this chapter stimulated my interest in the affective competence of children and adolescents, and led to my study of depression in young people. The early evolution of my work in this area follows.

In 1982 several students and I presented a research paper at the American Educational Research Association on a multimethod study of depression in elementary school children (Reynolds, Anderson, & Bartell, 1982), which was published several years later (Reynolds, Anderson, & Bartell, 1985). This study found low relationships between child, parent, and teacher reports of children's depression and highlighted the problem inherent in the multi-informant assessment of internalizing disorders and the issue of informant variance (Kazdin, 1996). In July 1982, Kevin Coats and I presented a paper at the International Congress of the International Association for Child and Adolescent Psychiatry and Allied

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Professions in Dublin, Ireland. The study reported on a sample of over 700 adolescents, examining prevalence and correlates of depression. The conference was illuminating, with a number of papers on depression in children and adolescents presented by emerging scholars in the field such as Kim Puig-Antich, Maria Kovacs, Michael Strober, Javad Kashani, and others. There was also an interesting presentation by an older individual by the name of John Bowlby. At this conference I first heard depression in children characterized as one of "subjective misery", reinforcing the notion that, because of the subjective nature of symptom severity, the best reporter of depression (and internalizing disorders in general) is typically the child. Subsequently we have found that children are reliable reporters of their depressive symptomatology (Reynolds & Graves, 1989).

To introduce school psychologists to this topic, I wrote a review paper on the nature, evaluation, and treatment of depression in children and adolescents in a school psychology journal (Reynolds, 1984) which I updated in 1990 (Reynolds, 1990a, 1990b) in a special issue on internalizing disorders in children. Around this time I wrote a comprehensive chapter on depression for the then annually published book: *Advances in School Psychology* (Reynolds, 1985).

In addition to the study of depression in regular education school students, my students and I were conducting research with special populations, including adolescents with intellectual disabilities (Reynolds & Miller, 1985) and intellectually gifted children (Bartell & Reynolds, 1986). During the 1980's I typically had eight to ten depression and suicidality studies going on at the same time, with a substantial effort directed at training graduate students in clinical interview procedures, traveling to schools to collect data, interviewing hundreds of children and adolescents, managing extensive data bases that were collected, and presenting research at national and international conferences, as well as writing manuscripts for publication. Luckily, I had excellent graduate students who collaborated with me on many of these studies. I was also fortunate to receive grant support from various granting agencies, including several Wisconsin Alumni Research Foundation Grants and NIH Biomedical Research Support Grants, and a Spencer Foundation Grant.

As is the unfortunate case for many researchers, a large number of studies that my students and I conducted were never submitted for publication. Of note has been research conducted with many hard working graduate students, including Dr. Jean Baker's MA thesis (1986) on the efficacy of training teachers to identify depressed students (no difference between trained and untrained teachers – a finding replicated by Kalista Hickman's MA thesis in 2002). Dr. Karla Downey's dissertation (1984) focused on loneliness and depression in a large sample of adolescent using a three month retest period to examine stability. Dr. Gail Anderson (1986) did a substantial investigation of multiple causal models of stress, coping, social support and depression using path analysis with a large sample of adolescents. Dr. Nancy Lopez (1985) conducted the first cross-cultural study of depression in children. Dr. Thomas Evert (1987) evaluated the efficacy of the three stage depression screening model with a large sample of adolescents, which included structured diagnostic clinical interviews at the later stage of the model. Dr. Karen Ott-VandeKamp (2001) conducted a comparison study of depression, stress, and social support in adolescents with and without intellectual disabilities for her MA thesis. Erin Moors' (1999) MA thesis examined gender differences in social problem-solving in depressed and non-depressed adolescents. Diana Misic (1999) examined the relationship of adolescents' violence exposure and their ratings of depression, PTSD, and suicidal ideation. Jolene M. Rothrauff (2004) examined social support as a moderator

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of stress and depression in alternative school students. A number of master's students conducted research on self-harm in children and adolescents, including Jessica Pickens (2005) and Patricia Sorci (2003). All of these studies, as well as others not listed, I consider noteworthy in their scope and impact. My regret is the relatively large number of research studies I have completed individually as well as those with students, were not submitted for publication due to time and other considerations. This is not to say that my students did not substantially add to the literature on this topic (e.g., Bartell & Reynolds, 1986; Mazza & Reynolds, 1998, 1999, 2001, 2007; Reynolds & Coats, 1986; Reynolds & Mazza, 1994; 1998, 1999; Reynolds & Miller, 1985; Reynolds & Stark, 1987; Stark, Reynolds, & Kaslow, 1987).

Measures for the Assessment of Depression in Children and Adolescents

At the start of my research on depression in school children and adolescents, there was a need for reliable and valid age appropriate measures. My initial efforts focused on the development of a measure for children, which after it proved effective, was revised for use with adolescents. By 1981, both the Child Depression Scale (later named the Reynolds Child Depression Scale, Reynolds, 1989a) and the Reynolds Adolescent Depression Scale (1987) were being used in my research studies, and soon by other researchers.

My primary motivation for developing measures of depression for children and adolescents was for the identification of students who manifested clinically significant depressive symptomatology. In this manner schools could quickly screen students (you can screen 2,000 students in 10 minutes of class time) and identify student who require targeted interventions and/or referral. A paper describing the logic and procedure for this multi-gate school-based screening for depression was published in the APA Division 16 journal (*Professional Psychology*, later renamed *School Psychology Quarterly*) (Reynolds, 1986), as well as in other publications (Reynolds, 1991a; 1994; 1998). Much of the research for the development, testing, and efficacy of this screening procedure was conducted over a six-year period at the Beloit, WI school district and facilitated by one of my students who at the time was director of student services (Evert & Reynolds, 1987). Much of this initial research with the RADS and RCDS was published in the manuals for these measures, as well as in several book chapters (Reynolds, 1989b; 1992, 1994). Since their publication, the RADS and RCDS have been used by hundreds of researchers and practitioners in this and other countries. Unfortunately, it is my impression that few schools are using these measures for proactive identification of depressed children and adolescents, i.e., screening students. This is not to say that these measures are not used for individual cases, they are used extensively in schools and clinical settings. However, the lack of screening of children and adolescents means that many students go unidentified and suffer the *subjective misery* of depression, with accompanying low quality of life and other perturbations.

Screening for Suicidality

After conducting research on screening for depression with several thousand adolescents, including hundreds of follow-up clinical interviews with depressed and nondepressed students, it became clear that a substantial number of nondepressed students reported significant suicidality. Of students who reported such suicidality, approximately 25% were not depressed (Reynolds, 1989b). Based on clinical interviews, these students present a range of problems and psychopathology, from extreme anger to thought disorders. I considered this very problematic as the screening procedure, although designed for depression, was also meant to identify

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students at risk for suicidal behaviors. It was apparent that the screen (as in a net) was not sufficient refined to catch at-risk students. Toward this goal, I developed the Suicidal Ideation Questionnaire (SIQ) to assess suicidal cognitions of adolescents, with a 30-item for high school students, and a 15-item version (SIQ-JR) for junior high and middle school students.

The screening procedure for suicidal ideation with the SIQ works quite well and typically identifies 10 to 12% of students as above the cutoff who require additional evaluation and possible intervention. There have been hundreds of published research studies using the SIQ in clinical as well as regular education settings. Gould and her colleagues (2005) examined the use of the SIQ for screening in a large sample of adolescents and reported in the Journal of the American Medical Association, that "No evidence of iatrogenic effects of suicide screening emerged. Screening in high schools is a safe component of youth suicide prevention efforts". Other researcher also found screening with the SIQ to have substantial predictive validity in adolescents who subsequently attempted suicide (Keane, Dick, Bechtold, & Manson, 1996). To increase the increase the application of screening for suicidality in schools, a semi-structured clinical interview, the Suicidal Behaviors Interview (Reynolds, 1990b, 1991b) was developed. Similar to the use of the depression scales, there is little evidence that schools are actively screening for the identification of suicidal students, even with evidence that this is a viable and safe procedure.

My Debt to the Field of School Psychology

My connection with school psychology started at an early age. I am the oldest of four children and grew up with English as a second language. My parents, both of whom had eighth-grade education levels, immigrated to the United States from Vienna, Austria several years before I was born. Their lives had been substantially impacted during the War by years in concentration camps including Auschwitz and Dachau and the loss of their families. In my early elementary school classes I was considered a *slow learner*, a general label in California (Moskowitz, 1948) similar to the "borderline mental retardation" classification of that time. As a child I spoke with an accent and used odd words in school and did not understand others. For a while, the school had a speech pathologist work with me, although this did not last long. At a teacher-parent meeting, the teacher told my mother that she should try to speak English with me at home. Subsequently, in the third grade I was tested by a school psychologist. I did not know it at the time – but I still recall that a man with a bow tie and a brief case took me to the school library and had me do some tasks. In hindsight, it is probable that the evaluation was for special class placement. Several months after the assessment, my parents received a letter from the State Department of Education informing them that the State of California had classified me as a "mentally gifted minor." This was in the days of active tracking of students, and beginning in the fourth grade I was placed in the upper ability track, moving with a cohort of students in grades four through eight. In fourth grade they allowed me to work in math at my own pace and I was soon working at the sixth grade level. I still brought a note from my mother the first day of school asking the teacher to seat me at the front of the class so I could see the black board – my eyesight was not that great. I finally received my first pair of glasses when I was in the seventh grade. It was not until I was 24 years old, had completed my Ph.D. in school psychology and accepted my first academic position as an assistant professor at SUNY Albany, did I fully recognized the impact that the school psychologist who tested me in third grade (without expectancy effects) had made in my life.

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As is the case for many academic school psychologists, a major impetus for my research is to help children and adolescents. I started graduate school with the goal of becoming a master's level school psychologist. As research and methods courses stimulated my scientific interests, and a half-time research appointment in Research and Training Center in Mental Retardation at the University of Oregon allowed me to continue my graduate education, a career as a university professor emerged as a goal. My work on the development of measures to identify students at-risk is, is in large part, based on the combination of my desire to help children and adolescents and my interest in research in mental health domains.

For over 30 years, the study of depression and suicidality has been one of the most meaningful areas of my research. From the early research briefly described above, I have continued to work in this area, including updates of depression measures (Reynolds, 2002; 2008, 2010), collaborative research with scholars in other countries (e.g., Hyun, Nam, Kang, & Reynolds, 2009), and the study of suicidality in adolescents with developmental disabilities (Ludi, Ballard, Greenbaum, Pao, Bridge, Reynolds, & Horowitz, 2012). My research in this area has been assisted by many colleagues, including graduate students, researchers at other universities, school teachers, school psychologists, school administrators and fellow faculty members. The latter is especially true of my colleagues in the Educational Psychology Department at the University of Wisconsin-Madison, and in particular Maribeth Gettinger and Tom Kratochwill, who provided support and put up with my professorial moods. The memories of the frequent freezing journeys walking from my office at night through the ice and snow to the UW Computing Center with one or more large box of computer cards to conduct data analyses continue to linger, yet reinforce the sense of a program of research that has been worth the effort.

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