I want to begin by thanking you, the membership of AACE, for a great year. I truly have enjoyed my time as your President and am looking forward to many years of continued involvement in the division. To my Executive Board, I extend my sincere appreciation for all that you have done to make this an active, fiscally solvent, and member-friendly division. I know many may not realize all the time, effort, and hard work that goes into serving as a board member but rest assured I recognize your contributions.

As I look back on this past year there have been many highlights for us as a division. In September we held a successful national conference in Memphis that was attended by over 90 registrants and guests. Now in its 8th year, the annual assessment and research conference has become a signature event of our division that is eagerly anticipated. Dr. Don W. Locke, ACA President-Elect, provided the keynote address and encouraged everyone to become actively involved in their profession. In addition, we offered for the first time a pre-conference workshop designed to provide members with an additional opportunity to earn CE credit in a concentration specific to assessment and evaluation.

This past year also saw the debut of our new division journal, Counseling Outcome Research and Evaluation. Under the leadership of its inaugural editor, Danica Hays, CORE’s first two issues were released in June and December of last year. By all accounts this journal has been well received. According to our representative at Sage Publishing, the number of people signing up for the free introductory subscription and requesting e-notification of future issue releases make this one of its most successful offerings ever. I truly am proud to see our division and its members continue to lead the way in producing top notch, scholarly work that is making a positive impact on the way we think about and conduct ourselves as professional counselors. If you would like to view the journal you can check out the CORE website at http://cor.sagepub.com for more information. You also will be able to sign up for a free online trial subscription.

Finally, I would like to recognize one of our members who brought pride and recognition to our division this year. As you most likely know, Brad Erford was recently elected President-Elect of the American Counseling Association. Brad has been a long time member of our division and has served in numerous capacity including Committee Chair, Treasurer, President, and most recently ACA Governing Council Representative. He is slated to assume the Association’s presidency on July 1, 2012. I have had a chance to work closely with Brad throughout my time associated with the division and I cannot think of an individual who better represents what our division stands for. We all can take heart in knowing that ACA is in good hands moving forward as it will be led by one of our own.

In closing, as I “pass the gavel” to our incoming President Danica Hays I do so with excitement for the coming year. I know Danica has many ideas for taking our division to new heights and I am eager to be a part of her team. I encourage all of you to consider taking on a more active role and shaping the future of our great division. It might turn out to be one of the best professional decisions you could make.

Best wishes to all and continue representing our profession well!
AACE PRESENTATIONS
AT ACA 2011

AACE Sponsored Presentations

Friday
11:30 am – 12:00 pm
ID #164, Assessing Adolescent Dating Violence
_Kelly Emelianchik-Key, Old Dominion University_

3:30 pm – 4:00 pm
ID #474, Initial Development of the Counseling Assessment Self-Efficacy Scale
_Joshua C. Watson, Mississippi State University – Meridian_

Saturday
10:30 am – 11:00 am
ID #352, Finding Your Place in AACE
_Joshua C. Watson, Mississippi State University – Meridian, & Eric D. Jett_

10:30 am – 12:00 pm
ID #372, Assessment Standards and Free Access Depression, Anxiety, Eating Disorder, Disruptive Behavior, and Substance Abuse Inventories
_Bradley T. Erford, Loyola University Maryland, & Stephanie Crockett_

Sunday
10:30 am – 1:30 am
ID #578, Diagnosis, Cultural Factors, and the Clinical Decision Making Process
_Elizabeth A. Prosek, Old Dominion University_

Thank you for representing AACE!

JOIN US IN Fort Worth!

AACE 2011 National Assessment and Research Conference
September 8-10, 2011

Currently accepting proposals!
Proposals due by July, 1 2011 to
Dr. Casey Barrio-Minton
Casey.Barrio@unt.edu

For more information, proposal and conference registration forms, please visit the AACE website

AACE COMMITTEE INFORMATION

Executive Council:
President: Joshua Watson, Mississippi State University - Meridian
JWatson@meridian.msstate.edu

President-Elect: Danica Hays, Old Dominion University
dhays@odu.edu

Past President: Marie Shoffner, University of Virginia
mfs2f@virginia.edu

Treasurer: Savita Abrahams, Argosy University - Dallas
savita_abrahams@hotmail.com

Secretary: Casey Barrio-Minton, University of North Texas—Denton
casey.bario@unt.edu

Member-at-Large Membership: Amy McLeod, Argosy University - Atlanta

Member-at-Large Publications: Dale Pietrzak, University of South Dakota

Member-at-Large Awards: Susan Eaves, Weems Mental Health Center

ACA Governing Council Representative: Brad Erford, Loyola University Maryland

Graduate Student Representative: Eric Jett

Committees:
Standards and Statements Chair: Janet Wall
Diversity Issues Chair: Michael Becerra
Bylaws and Ethics Chair: Rick Balkin
Conference Committee Chair: Casey Barrio-Minton
Newsletter Committee Chair: Amanda Healey
Annual Conference Announcement

I am pleased to announce that the 2011 AACE Conference will be held September 8-10 in Fort Worth, Texas! Fort Worth is a unique city with a character and charm all its own. Fall is a wonderful time to visit North Texas, and I hope you will come early or stay late so you can experience the historic stockyards, take advantage of cultural offerings, or enjoy some of the many entertainment offerings in the DFW Metroplex.

During this year's conference, we will be focusing on how professional counselors can use assessment and evaluation to advocate for services and resources, create knowledge for the profession, and empower clients and communities. In addition to offering 1.5 days of educational sessions, our conference will include two plenary sessions by recognized leaders, a luncheon keynote by ACA President-Elect-Elect, a preconference workshop on our theme, and plenty of opportunities for networking. Whether you are a practitioner, graduate student, or counselor educator, I trust you will find our program will include something meaningful for you.

We are accepting program proposals and earlybird registrations through 6/1/2011, and participants must make hotel reservations by 8/7/2011 to qualify for the $89 conference rate. Please visit www.theaaceonline.com/conference today so you can access the program proposal portal, register, and learn more about travel arrangements.

I look forward to welcoming you to Fort Worth this fall!

Casey A. Barrio Minton
Casey.Barrio@unt.edu

AACE Election Results

Congratulations to the newly elected officers of AACE

President-Elect

Carl J. Sheperis

Treasurer

Stephanie A. Crockett
At the Texas Counseling Association Professional Growth Conference in Austin in November, the Texas AACE division offered a program session titled Demystifying Assessment Tools. This program was in response to requests that more sessions be offered for counselors in private practice and community counseling settings. Dr. Chi-Sing Li and I presented on assessment tools that may be useful for counselors and clients in settings other than schools.

The program began, in fact, with the attendees taking a test – a brief true/false test to guide our discussion.

How would you respond to the following statements?

1. Testing and assessment are interchangeable terms.
2. Achievement test, aptitude test, personality test, and intelligence test are all ways of referring to the same concept.
3. Counselors can give any test as long as they have had the appropriate coursework and training.
4. There are no clear professional guidelines to help counselors make decisions about assessment tools.
5. With appropriate methods of test construction, we can insure that a test is culture-free.
6. Every assessment tool is only as good as the examiner.

One of the objectives of this program was to help counselors see that while most of us rely on I & I (Intake and Intuition) in making assessments of our clients, there are valuable, more objective instruments available that can help us in working with client issues and in writing treatment plans. These instruments are not for our benefit, but for our clients who often appreciate having results from standardized instruments that help them further explore their own issues, thoughts, feelings, values, and needs. Assessment instruments can help externalize important information that clients can explore for self-enhancement and decision-making.

During the program, we discussed various instruments and issues associated with using assessment tools. PowerPoints were made available to attendees in electronic format so that embedded websites of each assessment tool could be easily accessed. Some of the tools addressed included intelligence instruments (Wechsler instruments, the Kaufman Assessment Batteries, and the Test of Nonverbal Intelligence-3); achievement instruments (Wechsler Individual Achievement Test III and the Developmental Assessment of Young Children); clinical instruments (Beck Depression Inventory, Substance Abuse Subtle Screening Inventory, and the Myers-Briggs Type Indicator); rating scales (Behavior Assessment System for Children), family assessments (Prepare and Enrich and Family Adaptability and Cohesion Evaluation Scales) and career instruments (Strong Vocational Interest Inventory and the Self-Directed Search).

The answers to the true/false activity above were indicated through the presentation. Compare your answers to the following discussion:

**Testing and assessment are interchangeable terms.**

False. Assessment refers to a wide variety of evaluation procedures, while tests yield scores on specific instruments.

**Achievement test, aptitude test, personality test, and intelligence test are all ways of referring to the same concept.**

False. Each of these kinds of instruments measures different constructs and are distinguishable from one another.
Counselors can give any test as long as they have had the appropriate coursework and training.
False. While counselors must have appropriate training before administering any instrument, counselors do not give projective instruments.

There are no clear professional guidelines to help counselors make decisions about assessment tools.
False. The American Counseling Association, the Association for Assessment in Counseling and Education, the Joint Commission on Testing Practices, the American School Counseling Association, the American Educational Research Association, and the American Psychological Association all offer standards and guidelines for assessment practices.

With appropriate methods of test construction, we can insure that a test is culture-free.
False. While test constructors seek to improve instruments to minimize cultural bias, no instrument is totally culture-free. Examiners must interpret results in light of cultural context and with use of appropriate normative samples.

Every assessment tool is only as good as the examiner.
True. Even the best and most widely-used instruments do not yield valid and reliable results if the examiner does not follow standardized procedures, is inadequately trained to use and interpret the scores, or fails to use ethical and appropriate procedures.

It was our hope that offering this divisional program would benefit all counselors by increasing their knowledge base about the many assessment instruments available for use in assisting clients. Dr. Li and I would like to thank the 28 participants who attended our program.

2011 AACE Emerging Scholars Program

AACE strives to facilitate the professional growth and excellence of graduate students and new professionals in counseling and education. The AACE Emerging Scholars Program has been developed to (a) promote future leaders in assessment and research; (b) allow scholars to participate in AACE activities; (c) facilitate presentation opportunities at a national conference; and (d) provide mentorship and networking opportunities. Emerging scholars will be featured in NewsNotes and recognized at the AACE business luncheon at the 2011 AACE National Research and Assessment Conference in Fort Worth, TX.

Two Emerging Scholars will be selected for 2011 and will receive a complimentary AACE Conference registration and an invitation to participate in board meeting activities. Recipients must be an AACE member at the time of nomination.
Kaufman Brief Intelligence Test – Second Edition

Gabriel I. Lomas, Ph.D., Western Connecticut State University

General Information
Title: Kaufman Brief Intelligence Test – Second Edition (KBIT-2)
Authors: Alan S. Kaufman and Nadeen L. Kaufman
Publisher: American Guidance Services, 4201 Woodland Road, Circle Pines, MN, 55014-1796. Telephone: 800-328-2560. Internet: www.agsnet.com

Forms: There is one version, designed for individuals aged 4 – 90.

General Type: Brief, individually administered measure of verbal and nonverbal intelligence.

Practical Features: The KBIT-2 offers two Verbal subtests (Verbal Knowledge and Riddles) that combine to offer a Verbal standard score. To measure non-verbal aspects of intelligence, it uses a single subtest (Matrices). Examiners sum the two standard scores to formulate a Composite IQ. Thus, the instrument offers users three different scores. The KBIT-2 can be administered in 15 – 30 minutes, in most cases. There are no time limits for responses.

The instrument uses the popular and convenient easel format. The easel is designed quite well, though some questions, particularly many on the Riddles subtest, do not incorporate use of the easel. Whether or not the easel is used, administration is uncomplicated and follows the test protocol nicely. Additionally, with large, color graphics, the pages of the easel are attractive and easily seen by examinees, including many with mild to moderate visual impairments. However, examinees with color-blindness may be at a disadvantage as many of the graphics on the Matrices subtest require examinees to use color to identify logical patterns.

The basil is easily established, as the examinee must pass three consecutive items at the age-based entry point correctly. If the examinee fails one of the first three items at the age-based entry point, the examiner drops back to the prior age-based entry point, which is clearly marked on the test protocol. Likewise, the ceiling is easily established on all three subtests. The ceiling for the KBIT-2 is set at four consecutive incorrect answers for each of the three subtests.

Cost: The complete kit costs $239.00 and includes the easel, manual, 25 test protocols, and a bag.

Purpose and Nature of Instrument

Stated Purpose: The KBIT-2 offers a brief assessment of Verbal and Nonverbal intelligence in individuals from ages 4 – 90. The publisher reports it can be used for screening, giftedness identification, employment decisions, periodic reassessments, vocational rehabilitation decisions, and determining cognition in psychiatric patients when cognition is of secondary consideration. The publisher also indicated the instrument can be used in special education and the identification of learning disabilities when a comprehensive measure is either not included or an unnecessary part of the assessment battery.

Description of Test Items and Scoring: Two subtests (Verbal Knowledge and Riddles) comprise the Verbal portion of the KBIT-2. A single subtest (Matrices) allows users to identify a Nonverbal score. The Verbal and Nonverbal scores can be summed as part of the identification of a Composite IQ. The Verbal subtests necessitate the examinee to have a strong receptive vocabulary. However, examinees are able to answer most or all of the test items by pointing to the easel or offering single-word answers. Thus, the instrument may be suitable for use with individuals with communication disorders, particularly expressive language disorders. Furthermore, examinees who speak English as a second language are likely to be able to respond to test questions. However, many of the questions on the Verbal scale are designed to be answered by individuals who grew up in the United States and were educated in our school system. Examiners should use the KBIT-2 with caution when testing recent immigrants. The instrument indicates responses can be given in Spanish. In fact, the test protocol and easel have Spanish responses printed directly onto these documents. However, the manual indicated the exclusion of Spanish speakers in the normative sample.
The test protocol is a tri-fold 8 ½ by 11” document that is printed in color, is well-designed, and easy to use. The protocol includes two teaching items on the Verbal Knowledge and Matrices subtests to ensure understanding when errors are made early in administration. The front page has adequate space for marking all major results including standard scores, confidence intervals (90%), percentile ranks, descriptive categories, and age-equivalents. The Average standard score is 100 with standard deviations of 15 points. Thus, Average scores range from 85 to 115, with 15 point intervals on subsequent descriptive categories.

The KBIT-2 is designed to be hand-scored. Locating the scoring and conversion tables in the manual can be done quickly and easily. The test protocol has table numbers, which correspond with tables in the test manual, clearly identified on the forms.

**Practical Evaluation**

**Adequacy of Directions:** The directions provided by the publisher are clear and easy to follow. The publisher did a nice job reducing ambiguity in explanations of administration and scoring of the KBIT-2.

**Training Required to Administer:** The publisher indicated the test may be given by individuals trained to administer psychological tests, including but not limited to psychologists and counselors. Additionally, professionals in related fields such as nurses, educators, diagnosticians, speech-language pathologists, and other professionals should be able to administer the instrument with some training and supervision. Finally, the publisher reported that technicians without advanced coursework in assessment may be trained to administer the KBIT-2. However, the publisher warned that administration and interpretation are quite different, and stressed that test interpretation should be done only by individuals formally trained in interpretation.

**Technical Considerations**

**Norms:** The KBIT-2 was standardized with a sample of 2,120 individuals at 113 sites in 34 states and the District of Columbia. The publisher reported a stratified sample with regard to gender, race/ethnicity, geographic region, and educational level using population data from 2001. It’s important to note that the publisher excluded individuals who were not fluent speakers of English, and those with physical, perceptual, or psychological impairments.

The 23 normative age groups were generally equally divided by male and female participants. The largest group was the 5 – 10 year-olds (n = 125). Most of the other age groups had 50 to 100 participants in each group. The publisher reported race/ethnicity for these groups: African-American, Hispanic, White, and Other. The race/ethnic composition of the normative sample greatly mirrored population estimates from 2001.

**Adequacy of Norms:** Although the test developer could have been more generous with the normative sample, the current sample appears to be adequate to assess many examinees. While Asian-Americans as a group have grown significantly in our general population, they were not included in normative samples. Regarding disability and psychological impairments, the publisher reported demographic characteristics of individuals in the “special population” of the normative sample. This category included: Learning Disability, Speech/Language, ADHD, Mental Retardation, Gifted/Talented, Traumatic Brain Injury, and Dementia. While the inclusion of some disability categories is helpful, the publisher indicated the test can be used with deaf people, but did not include deaf people in the normative sample. Likewise, the instrument indicates applications with Spanish speakers, but did not include Spanish speakers in the normative sample. Although it’s likely to be appropriate for use with some individuals with vision impairments, none were included in the normative sample.

Examiners may find it interesting to note that the KBIT-2 was normed concurrently with the Kaufman Assessment Battery for Children – Second Edition (KABC-2). Users of both instruments will notice that all three subtests from the KBIT-2 are represented on the KABC-2. However, it’s important to be aware that all test items from the three scales are different, eliminating concern about the two having overlapping questions.

**Reliability:** The publisher reported an internal consistency coefficient of .93 across ages (.89 - .96) for the Composite IQ, which is considered quite strong. Although the Verbal (.91) and Nonverbal (.88) coefficients are slightly lower, they are also acceptable. Test-retest reliability for the Composite IQ was .90, with mean intervals of 22.5 to 30 days between examinations. The mean performance increase in the test-retest studies was 4 points. Likewise, the Verbal (r = .91) and Nonverbal (r = .83) scales showed increases that were analogous.
Validity: The publisher reported a number of validity studies on the KBIT-2. Considering this is a second edition, published in 2004, it makes sense that the publisher reported concurrent validity with other measures. For example, KBIT-2 scaled scores were found to be about 2 points lower than this instrument’s predecessor, the KBIT. After adjustment, correlations for the Composite IQ ranged from .80 to .86. Unfortunately, the Nonverbal scale was found to have a meager correlation of .47 for children aged 4 to 7. Composite score correlations with the Wechsler Abbreviated Scale of Intelligence (WASI) were in the acceptable range from .77 to .90. Further studies with the Wechsler Intelligence Test for Children, 3rd and 4th editions were at .76 and .77 for composite scores, respectively.

Cross-cultural Fairness: Although the KBIT-2 appears to address cross-cultural considerations, the normative sample was not inclusive of a number of large American groups including Asian-Americans, Spanish speakers, speakers of English as a second language, and many individuals with disabilities including those who are deaf. Examiners should use caution when interpreting the results of clients from diverse populations, especially those overlooked in the normative sample.

Evaluation

Practicality: Generally, the KBIT-2 appears to have strong psychometric properties, making it a well-designed instrument for cognitive screening. Overall statistics indicate the instrument is both reliable and valid. Furthermore, it is likely to be affordable for most examiners. It offers users a quick cognitive screening of individuals ranging in age from 4 to 90, covering the majority of people that may need this type of testing. The current instrument represents few changes from the previous edition. The KBIT-2 is popular due to its many positive features, several of which are outlined above. It is accepted in numerous settings such as clinics and the criminal justice system. As such, it can be a valuable tool for many examiners.

Aids to User: This is an essential tool for examiners who perform cognitive screenings as a part of larger assessment batteries. Be cautious when using the KBIT-2 with some individuals with disabilities and some minorities. The instrument is easy to administer, but requires training and supervision with regard to interpretation.

Reference

Review of the Carroll Depression Scale

By Kimberly LaFragola, Walden University

General Information

Title: Carroll Depression Scale
Author: Bernard Carroll
Publisher: Multi-Health Systems, North Tonawanda, NY
Date of publication: 1998
Forms, groups to which applicable: There are three versions of the CDS available: CDS, CDS-Revised, and Brief CDS. Each inventory is an instrument in measuring the severity of depression in adults ages 18 and up. The CDS-Revised includes DSM-IV criteria for depressive disorders not included in the first version (Swearer, 2001).

General Type: Provides a measurement of level and severity of depression in adults.

Practical features: The CDS provides a simple “Yes-No” response format that measures four diagnostic features that correspond to the DSM-IV’s depressive disorders diagnoses.

Cost: The complete CDS kit includes the professional manual, 25 CDS-R forms, and 25 Scoring forms for $161.00. The manual is available for $82.00, 50 CDS-R forms for $4.00, 25 Scoring forms for $58.00, and 50 computer data entry sheets for $32.00. There is a French-Canadian version of all forms available (MHS, 2010).

Time required to administer: It takes approximately 20 minutes for clients to complete the CDS-R.

Purpose and Nature of the Instrument:

Stated Purpose: To provide a measure of depression in adults for the purpose of diagnosis (Swearer, 1998).

Description of test items and scoring: It is a 61-item ‘yes-no’ response measure that assesses depressive symptoms per DSM-IV standards. The CDS includes four indices that allow for diagnostic tools to diagnose for depression subtypes as well as the severity. There are six scores that can be obtained from the CDS: total, diagnostic for Major Depression, diagnostic for atypical features of Major Depression, diagnostic for melancholic features of Major Depression, diagnostic for Dysthymic Disorder, and scores from the Hamilton Depression Rating Scales (HDRS). Scores range from 0-52, higher scores indicative of depression (Swearer, 1998).
Practical Evaluation:

**Adequacy of directions, training required to administer:** Qualifications of examiners: CDS requires a qualification level of B. Level B requires the examiners to have a Master’s in Psychology, Counseling, or a closely related field, and “relevant training or coursework in the interpretation of psychological tests and measurement at an accredited college or university” (Platt, 2007, p. 2); membership in a professional organization where part of the ethical code requires that practitioners practice within the scope of their competence; person’s with a Master’s degree education or a related field with relevant training in assessment (Pearson Education, 2010).

Technical Considerations:

**Norms and Scoring:** Field trials of the CDS were completed at the University of Michigan in the 1970s and at Duke Medical Center. The two samples were combined to provide a sample of 959 depressed participants and 248 nondepressed participants. The results have been used to determine the reliability and validity of the CDS (Swearer, 1998). The CDS is hand scorable and takes approximately 5-10 minutes to score (Swearer, 2001). There is also software available which produces a profile report which presents scores graphically and numerically to summarize the results and any possible diagnosis as well as the specific criteria met and responses as they relate to each diagnosis. The report includes further information, such as response validation, global severity score, and graphs which illustrate the distribution of the responses (MHS, 2002).

**Adequacy of norms:** The CDS does not report adequate descriptions of the demographic characteristics of the normative samples.

**Reliability:** The split-half reliability for even and odd items is .87, while the Cronbach’s coefficient alpha is .95. Furthermore, the test-retest reliability estimates performed on 16 participants yielded a Pearson correlation coefficient of .96; though the manual suggests that this may be an inflated estimate (Swearer, 1998).

**Validity:** The primary indication of face validity of the CDS is the correlation of .80 to the HDRS. The convergent validity is the correlations of the CDS and various other depression assessments: the Montgomery-Asberg Depression Rating Scale (MADRS) at .71; the Clinical Global Rating of Depression (CGRD) at .63, the Beck Depression Inventory (BDI) at .86, the Center for Epidemiological Studies of Depression Scale (CES-D) at .67, and the Visual Analog Scale (VAS) at -.71. The discriminant validity is good due to the ability to differentiate between depressed and anxious participants; meanwhile, the correlation between the CDS and the State-Trait Anxiety Inventory is .26 (Swearer, 1998). The revised CDS (CDS-R) does not provide any information regarding validity or reliability; therefore, the reported findings are specifically for the original CDS.

**Cross-cultural fairness:** The CDS does not report adequate descriptions of the demographic characteristics of the samples used with the exception that all of the participants were Caucasian. While the CDS has been translated in many other languages (e.g. Spanish, French, German, Japanese, Chinese, Greek and American Sign Language); there is little evidence supporting its effectiveness in its original form for various cultures. While there is the potential for the CDS to be useful multiculturally, the efficacy across cultures is unknown (Swearer, 1998).
Evaluation

Practicality: The full CDS has had extensive research throughout its history; while the Brief CDS and the CDS-R have had less research performed. However, because of its high correlation to the Hamilton Depression Scale (Yesavage, 1986), it is considered to be a valid and reliable tool as an observer-rated depression scale. As Jallade, et al. (2004) illustrate, the CDS “prevents subjects from being influenced by the clinician’s questions” (Sec. 2.3); thereby limiting the subjective perspective of the clinician. Clinicians should use caution when using the CDS as it contains some items that may lead to false positives in the elderly (Yesavage, 1986). The CDS is designed to inform diagnosis as it provides “diagnostic support indices that summarize the symptom pattern for corresponding DSM-IV depressive disorder diagnoses” (Swearer, 2001, para. 3) and is useful in allowing clinicians guidance in providing a clear counseling plan.

Aids to user: The CDS is a useful instrument in providing clinicians the self-reported measurement of depression. It is an easy-to-use, fast, and efficient method to gather information to inform diagnosis in a clinical environment. While there are some concerns that the elderly population is underrepresented in research of the CDS; it is predominantly well versed through a variety of cultures and provides an abundance of tools to be used with different populations. Studies of the CDS indicate excellent convergent and discriminant validity as well as split-half and test-retest reliability, as well as extensive research in utilizing this instrument with other tests and populations to measure the self-reported symptoms of depression. Further research should be undertaken to gain further understanding and insight into the cohesiveness of the CDS in analyzing depression in all populations and determining the best possible care for those who suffer from depression.

References


Student Perspectives: Get Involved!

Rebekah J. Byrd, Student Perspectives Editor

Student Perspectives is a column developed for the AACE Newsletter developed in response to a recommendation from the AACE executive council to increase participation by student members. In the age of managed care and limited fiscal resources, research-based practice is a growing need among counselors. In order to facilitate counselor development, students are encouraged to integrate assessment and research best practices throughout their education and emerging practice as counseling professionals. AACE assists students by providing resources for developing efficacious standards-based counseling practice among students. However, counselor educators and long-time practicing counselors often have a different perspective than those of new professionals and students who are in the process of becoming professional counselors.

Student Perspectives fills an important gap in the organization’s existing services by providing an outlet for students to identify, discuss, and make recommendations regarding research-based practice that may be less evident to experienced professional counselors. In this light, both master’s and doctoral level students are encouraged to submit contributions to the column editor, Rebekah J Byrd, at rebekah.byrd@gmail.com. Submissions should highlight issues related to the process of research proposal development; teaching methods they have experienced that have assisted their development as researchers and as users of assessment measures; topics related to research design, dissertation writing, and presentation of research; experiences as students learning research methods; perspectives on assessment use among counselors, particularly related to training and professional development in using assessment measures; experiences with finding funding support and writing small grants; as well as locating and participating in professional development activities related to the AACE mission. Submissions should range between 500-800 words, with a writing style that is consistent with the APA 5th edition Style Manual, and clearly indicate a student-based perspective on the topic featured. Further questions and comments regarding this column may be forwarded to the column editor. If you have thoughts about a particular experience or if you are unsure about a topic, you may email the column editor for assistance with further idea development. The approach taken will be developmental in nature, assisting emerging professionals with their first efforts at writing and publication in a less formal context, although with the opportunity for national exposure.
The Association for Assessment in Counseling and Education (AACE) is an organization of counselors, educators, and other professionals that advances the counseling profession by providing leadership, training, and research in the creation, development, production, and use of assessment and diagnostic techniques. The mission of AACE is to promote and recognize scholarship, professionalism, leadership, and excellence in the development and use of assessment and diagnostic techniques in counseling.

CALL FOR SUBMISSIONS

If you have any information related to the activities of AACE members that you think should be highlighted, please send pictures and commentary to Amanda Healey at ahealey@shsu.edu. Of particular interest are stories related to conference activities, publication, inventory development/review, program evaluation, and members who have received professional awards or service recognition. Please submit any information as a Microsoft Word attachment and send photographs as a .jpg file attachment. Do not send more than three photographs related to any individual article. Interest articles from students, practitioners, and counselor educators are equally welcome and encouraged. Newsletters are published in February, May, August, and November of each year. Any submissions will be due on the 10th day of those publication months. Please consider serving AACE by contributing your voice to this publication.

Student Perspectives Editor: Rebekah J. Byrd, East Tennessee State University
(Rebekah.Byrd@gmail.com)

Test Review Editor: Donna Sheperis, Walden University
(donna.sheperis@waldenu.edu)