PsychPress
Talent Management Psychologists

Clinical
Catalogue

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Welcome

to **PsychPress**
Talent Management Psychologists

Psych Press prides itself on being Australia's leading 'one-stop shop' for world class psychological based assessment solutions. With a professional and outstanding customer service team, we are committed to search far and wide to locate and deliver to you any psychological assessment you may wish to purchase.

Since our establishment in 1992 we have been offering our loyal customers who include psychologists of all disciplines, mental health counsellors, educators and trainers, the best quality and largest range of products. With a focused team of dedicated customer service staff, you can be assured that you will receive personal attention and service at all times as we make every effort to meet your individual requirements.

We recognise that superior psychological products are essential to achieve success. Therefore, we have made it our mission to improve the available resources in a commercially viable manner by establishing relationships and engaging in developing assessments with leading commercial and research organisations around the world. An example of such a relationship was the development of the Australian Version of Cattell's popular personality questionnaire (based on the 16 Factor Model). The Australian version was developed by Psych Press over a three year period, in conjunction with the Institute for Personality and Ability Testing (IPAT) to reflect Australian item content, terminology and norms. We also maintain very strong relationships with Western Psychological Services (WPS), Psychological Assessment Resources (PAR), Multi-Health Systems (MHS) and the American Psychiatric Publishing Inc. (APPI) and many other research institutions. We have also published a Post Traumatic Stress Scale (PTSS), Customer Service Predictor (CSP), a Retail Screening Questionnaire (RSQ), an Emotional Reasoning Questionnaire (ERQ) and many more assessments.

Psych Press intends to continue its superb service offering by actively seeking new tests, acquiring additional data on existing tests, and supporting research to further develop the usefulness of the assessment development products which we publish or distribute.

We look forward to meeting your professional needs and encourage you to comment on your impressions of our products and services, as well as any ideas you may have for the future by e-mailing us at info@psychpress.com.au or calling one of our consultants directly on **1300 308 076** or **03 9670 0590**.

We look forward to our next contact with you!

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CONTENTS

AAMR Adaptive Behaviour Scales: Second Edition (ABS-2)

The ABS-2, developed by the American Association on Mental Retardation, assesses the ability of individuals who are mentally retarded, emotionally maladjusted, or developmentally disabled to cope with the natural and social demands of their environment. It is available in two versions, one for residential and community settings, the other for schools.

Residential and Community Edition (ABS-RC:2)
by Kazuo Nihira, Henry Leland, and Nadine Lambert

This version of the ABS-2 can be used with adults in residential settings. Items have been modified to better discriminate among mentally retarded individuals who are institutionalized and those who are in the community, functioning at various levels.

The first part of the scale covers skills and habits in 10 behaviour domains:

- Independent Functioning
- Physical Development
- Economic Activity
- Language Development
- Prevocational/Vocational Activity
- Domestic Activity
- Numbers and Time
- Self-Direction
- Responsibility
- Socialization

The individual completing the ABS-RC: 2 simply checks the items that apply to the person being evaluated.

The second part of the scale assesses maladaptive behaviour in eight domains:

- Violent and Antisocial Behaviour
- Rebellious Behaviour
- Eccentric and Self-Abusive Behaviour
- Untrustworthy Behaviour
- Withdrawal
- Stereotyped and Hyperactive Behaviour
- Inappropriate Body Exposure
- Disturbed Behaviour

Raw scores for each domain can be quickly computed and then converted to standard scores and percentiles. The scale also yields five factor scores: Personal Self-Sufficiency, Community Self-Sufficiency, Personal/Social Responsibility, Social Adjustment, and Personal Adjustment. Norms are based on a sample of 4,000 people with developmental disabilities (ages 18 and over).

The scale can be completed by institutional aides and nurses, parents, teachers, workshop supervisors, home service workers, and home trainers, as well as psychologists, social workers,

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and speech-language-hearing professionals.

School Edition (ABS-S:2)
by Nadine Lambert, Henry Leland, and Kazuo Nihira

A second form of the scale, the ABS School Edition (ABS-S: 2), is available specifically for school-based assessment. This edition helps school personnel evaluate children's independence, social skills, and need for special programs. It can help schools provide appropriate educational experiences in the least restrictive environment, and is especially useful in evaluating the functional level of children with mental retardation, developmental problems, or autism.

The *ABS School Edition* assesses the same domains as the residential and community version (except Domestic Ability and Inappropriate Body Exposure), providing standard scores and percentiles, plus the same five factor scores. Norms are based on two samples: 1,000 public school children with developmental disabilities and 1,000 students with no disabilities (from 3 through 16 years of age). The ABS-S: 2 Manual tells you how to use scale results in instructional planning and IEP development.

The ABS-2 can be used to help make curriculum and placement decisions, to evaluate curricula or training programs, to compare an individual's adaptive behaviour in different settings, and to compare ratings made by various individuals. These scales are an important supplement to the IQ score because they tell the evaluator how the individual handles the demands of daily living.

Achievement Motivation Profile (AMP)
by Jotham Friedland, Ph.D., Harvey Mandel, Ph.D., and Sander Marcus, Ph.D.

This convenient self-report inventory is an ideal way to evaluate underachieving or unmotivated students, ages 14 and up. It gives you a complete picture of the personal factors that affect an individual☐s academic performance and provides specific recommendations for improvement.

The AMP includes two forms: the original form designed for high school and college students and the new Junior Form for students in grades 5 through 8. The former is composed of 140 items, the latter, 107 items. The scales and scale domains are identical on the two forms, except that occupation interest areas are not addressed on the Junior Form. Both forms produce scale scores in four domains:

Motivation for Achievement
   Achievement
   Motivation
   Competitiveness
   Goal Orientation
Inner Resources
   Relaxed Style
   Happiness
   Patience
   Self-Confidence

Interpersonal Strengths
   Assertiveness
   Personal Diplomacy
   Extraversion
   Cooperativeness
Work Habits
   Planning and Organization
   Initiative
   Team Player

Also, three validity measures alert you to inconsistent, self-enhancing, and self-criticizing response styles.

The AMP form for high school and college students can be completed in just 20 to 30 minutes. Items are written at a fourth-grade reading level. Students respond using a 5-point Likert-type scale, which provides a more refined self-description than a true-false format. Most students report that the AMP produces a more accurate self-portrait than personality tests do.

The AMP can be computer scored using WPS TEST REPORT prepaid Mail-In Answer Sheets, CD, or FAX Service. All of these computer options give you a complete interpretive report. If the student is identified as underachieving, the report describes his or her particular kind of underachievement and lists contributing personality factors. It also provides individualized recommendations for counseling the student and improving school performance.

Normed on more than 3,000 students, the AMP provides a sound basis for instructional or psychotherapeutic intervention. Unlike other tests used for academic counseling, the AMP is designed specifically to measure motivation, and it is validated against objective measures of achievement.

Adaptive Behaviour Inventory (ABI)
by Linda Brown and James E. Leigh

The ABI measures adaptive behaviour--an important component of psychological and school-based evaluations. It is a comprehensive, norm-referenced measure, appropriate for students from 5 through 18 years of age.

The ABI is composed of 150 brief items covering five scales: Self-Care Skills, Communication Skills, Social Skills, Academic Skills, and Occupational Skills. It is completed by a classroom teacher or another professional who has regular contact with the child being evaluated. He or she rates the child on each item, using a 4-point scale ranging from "does not perform the skill in question" to "has mastered the skill."

Within each scale, items are arranged in order of difficulty so that basals and ceilings can be used in administering the test. Because the scales are normed independently, the examiner may choose to complete the entire inventory or only one or two scales. Administration time is approximately 5 minutes per scale, less than half an hour for the entire instrument.

The ABI is easily scored, and raw scores can be quickly converted to standard scores and percentiles for each scale. Norms are provided for both normal school-age children and students diagnosed as mentally retarded.

The ABI can be extremely useful in diagnosing mental retardation and in identifying students

who may qualify for special education. A Short Form, composed of 50 items from the full ABI, requires only 5 to 10 minutes to complete. It can be used to quickly screen students suspected of being mentally retarded or emotionally disturbed, or to re-evaluate those already enrolled in special education programs.

ADD-H Comprehensive Teacher's Rating Scale (ACTeRS)
Second Edition
by Rina K. Ullmann, M.Ed., Esther K. Sleator, M.D., and Robert L. Sprague, Ph.D.

This brief checklist assesses one of the most prevalent childhood behaviour problems: attention-deficit disorder, with or without hyper- activity. Because this disorder manifests itself primarily in the classroom, it is best evaluated by teacher ratings.
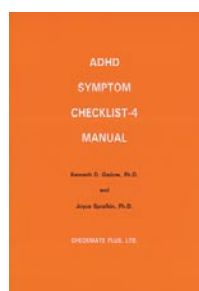
ACTeRS is composed of 24 items that cover four factors: Attention, Hyperactivity, Social Skills, and Oppositional Behaviour. The teacher rates the child on each item, using a five-point scale, ranging from "Almost Never" to "Almost Always." Item scores can be quickly totalled and profiled to obtain percentiles for the four scales. Standardization is based on approximately 2,400 children in kindergarten through eighth grade, and separate norms are provided for boys and girls.

The scale is highly useful in evaluating and monitoring children who can't seem to pay attention in class. Because it is so quick and cost-effective, ACTeRS can be used to screen students or to confirm a suspected diagnosis of ADD or ADD-H. It has proven particularly useful in differentiating children with learning disorders from those with ADD-H.

For even greater diagnostic accuracy, you can supplement the teacher rating scale with the ACTeRS Parent Form and the ACTeRS Self-Report. These give you additional perspectives on the child's behaviour. The Parent Form provides scores for the same four subscales in the original ACTeRS, plus an additional scale focusing on early childhood behaviour. Since this behaviour is known to the parent but not the teacher, the Parent Form brings a new dimension to your assessment. The 35-item Self-Report provides scores for three scales--Attention, Hyperactivity/Impulsivity, and Social Adjustment.

ADHD Symptom Checklist-4 (ADHD-SC4)
by Kenneth D. Gadow, Ph.D., and Joyce Sprafkin, Ph.D.

The ADHD-SC4 is a 50-item rating scale completed by parents and teachers to screen for ADHD and Oppositional Defiant Disorder in children and teens from 3 to 18 years of age. Items are based on DSM-IV and worded for easy comprehension. The ADHD-SC4 contains a *Peer Conflict Scale*, which measures peer aggression, and a *Stimulant Side Effects Checklist* to monitor medication.
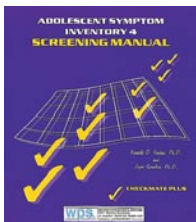
The Checklist as a whole shows a high correspondence with actual psychiatric diagnoses, and it differentiates clinical and nonclinical populations. The *Peer Conflict Scale* shows high agreement with direct observations of child aggression, and all four ADHD-SC4 categories are sensitive indicators of response to treatment.

Norms are based on teacher ratings of 1,527 children aged 3 to 12 and parent ratings of 522 children and teens from 3 to 18. Raw scores and T-scores are presented on Score Sheets according to symptom severity.

Requiring just 5 minutes, the ADHD-SC4 is a quick and reliable measure of attention problems.

Adolescent Symptom Inventory- 4 (ASI-4)
by Kenneth D. Gadow, Ph.D., and Joyce Sprafkin, Ph.D.

The third in this series of DSM-IV-based symptom checklists, the ASI-4 can be used to evaluate 12- through 18-year-olds. It consists of two checklists--one completed by the teacher and one completed by the parent or anyone familiar with the teenager's behavioural and emotional functioning.
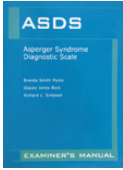
The ASI screens for symptoms of the most common adolescent disorders and problem areas specified in the Individuals with Disabilities Education Act (IDEA):

ADHD	Schizophrenia
Conduct Disorder	Schizoid Personality
Antisocial Personality	Panic Attack
Separation Anxiety	Specific Phobia
Generalized Anxiety	Bipolar Disorder
Social Phobia	Vocal Tics
Depression	Motor Tics
Dysthymia	Anorexia
Oppositional Defiant Disorder	Bulimia
Obsessive-Compulsive Disorder	Drug Use

Completed in just 10 to 15 minutes, the ASI-4 provides symptom cut-off scores based on DSM-IV. School personnel can use these scores to help determine whether a formal clinical evaluation is warranted. Clinical psychologists and psychiatrists can use them to focus their diagnostic evaluations.

Asperger Syndrome Diagnostic Scale (ASDS)

Brenda Myles, Ph.D, Stacy Jones-Bock, Ph.D, & Richard Simpson, Ph.D

Diagnosis of Asperger Syndrome is difficult because the characteristics of the disorder often resemble those of autism, behavior disorders, Attention-Deficit/Hyperactivity Disorder, and learning disabilities. The ASDS examines five specific areas of behavior to help you quickly assess the likelihood of Asperger Syndrome, document behavioral progress, target goals for change and intervention on the student's Individualized Education Program (IEP), and measure Asperger Syndrome for research purposes. The scale can be completed by anyone who knows the client well.

The ASDS scale was normed on 227 children and adolescents from across the United States with Asperger Syndrome, autism, learning disabilities, behavior disorders, and Attention-Deficit/Hyperactivity Disorder

Attention-Deficit/Hyperactivity Disorder Test (ADHDT)

by James E. Gilliam, Ph.D.

 In just 5 to 10 minutes, this convenient rating scale can identify individuals, between 3 and 23 years of age, who have attention-deficit/hyperactivity disorder. It is easily completed by teachers, parents, or others who know the referred individual.

   Based on DSM-IV criteria for attention-deficit hyperactivity disorder, the test is composed of 36 items and 3 subtests: Hyperactivity, Impulsivity, Inattention.

   Raw scores for these subtests are converted to percentiles and standard scores. A full-scale percentile rank and an overall ADHD quotient are also provided. Norms--collected on a national sample of 1,200 people diagnosed with ADHD--are presented separately for males and females.

   Carefully constructed and psychometrically sound, this test can be used with confidence to identify students who have ADHD, to evaluate children referred for behaviour problems, and to determine appropriate intervention.

Bender Visual-Motor Gestalt Test, Second Edition (Bender Gestalt II)

by Gary Brannigan and Scott Decker

Originally published in 1938 by Lauretta Bender, M.D., the *Bender Visual-Motor Gestalt Test* is one of the most widely used psychological tests. The Second Edition (*Bender Gestalt //*) updates this classic assessment and continues its tradition as a brief test of visual-motor integration that can provide useful information about an individual's development and psychological functioning.

Appropriate for ages 3 to 85+ years, the *Bender Gestalt //* is a reliable way to assess visual-motor development. It is also a useful introduction to any battery of educational, psychological, or neuropsychological tests. The *Bender Gestalt //* provides helpful information in preschool screening as well as geriatric assessment. And it can offer insight into many conditions, including ADHD, mental retardation, giftedness, learning disabilities, autism, and Alzheimer's Disease.

The *Bender Gestalt //* consists of a series of stimulus cards, each displaying a unique figure. The individual is asked to draw each figure as he or she observes it. The stimulus card is not removed until the drawing is complete.
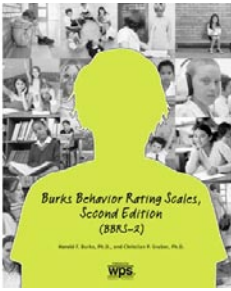
This edition of the test adds items and extends the range of ability assessed. New recall procedures to measure visual-motor memory ensure a more comprehensive assessment of visual-motor skills. And supplemental tests of simple motor and perceptual ability help identify specific visual-motor deficits. An optional timing component allows the examiner to time each drawing, and scoring is now quicker and easier.

Co-normed with the *Stanford-Binet Intelligence Scales*, Fifth Edition, the *Bender Gestalt II* was standardized on more than 4,000 individuals ranging in age from 4 through 85+ years. The composition of the standardization sample corresponds to the 2000 U.S. population.

The *Bender Gestalt II* is an ideal way to start an extended psychological test battery. With its simple design and administration, the test is a nonthreatening way to warm up to more challenging assessments.

Burks Behaviour Rating Scales, Second Edition (BBRS-2)

by Harold F. Burks, Ph.D.

This second edition of the *Burks Behaviour Rating Scales* (BBRS) helps you diagnose and treat children with behaviour problems. Administered and scored in minutes, these scales identify the nature and severity of pathological symptoms in children from prekindergarten through 12th grade (ages 4 through 18 years). This revision features updated norms, simpler and more efficient administration and scoring, and fewer scales for easier interpretation. All changes in this edition respect the strengths of the original BBRS and take into account the input of the many school psychologists who continue to use this assessment for effective and economical evaluation of disruptive and troubled children.

The BBRS-2 is available in two forms: the Parent form and the Teacher form. The test questions are the same for both groups, but each group has distinct test norms. Parent and Teacher Profile Sheets used for diagnostic purposes are included on their respective forms. The use of multiple raters in the BBRS-2 helps reduce bias and provides a more comprehensive understanding of the child's behaviour problems.

The BBRS-2 includes 100 items, each describing a behaviour infrequently observed in nonreferred children. A parent or teacher simply indicates, on a 5-point response scale, how often the behaviour is seen in the child being evaluated.

The BBRS-2 produces seven scale scores:

- Disruptive Behaviour
- Attention and Impulse Control Problems
- Emotional Problems
- Social Withdrawal
- Ability Deficits
- Physical Deficits
- Weak Self-Confidence

BBRS-2 scores can be used to:

1. Pinpoint personality areas that require further evaluation or treatment
2. Identify behaviours that may interfere with school functioning
3. Identify children who will (or will not) benefit from special education
4. Provide parents with information that is concrete, specific, and easy to understand

Normative data is based on a nationally representative sample of 2,864 individuals, including separate samplings of teachers ($N = 1,481$) and parents ($N = 1,383$). The BBRS-2 was validated on a clinical

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sample of 860 individuals; demonstrated strong internal consistency, retest reliability, and content validity; and was validated against widely used concurrent measures.

This useful revision offers a practical and proven way to identify problem behaviour in children.

Childhood Autism Rating Scale (CARS)
Eric Schopler, Ph.D., Robert J. Reichler, M.D., & Barbara Rochen Renner, Ph.D.

The CARS helps to identify children with autism, specifically distinguishing them from developmentally disabled children who are not autistic. In addition, it distinguishes mild-to-moderate from severe autism. Brief and convenient to administer, the CARS makes it much easier for you to recognize and classify autistic children. Professionals such as physicians, special educators, school psychologists, speech pathologists, and audiologists, who have had only minimal exposure to autism, can easily be trained to use the CARS.

Developed over a 15-year period with more than 1,500 cases, the CARS includes items drawn from five prominent systems for diagnosing autism, and provides quantifiable ratings based on direct behavior observation. Each item covers a particular characteristic, ability of behavior.

Coping Inventory for Stressful Situations (CISS)
Norman Endler, Ph.D. & James D. A. Parker, Ph.D.

The CISS assessment allows you to effectively measure three major types of coping styles: Task-Oriented, Emotion-Oriented, and Avoidance Coping. It also identifies two types of avoidance patterns: Distraction and Social Diversion.

This 48-item inventory is available in versions for adolescents and adults. Gender-specific norms are available for adults, college students, adolescents, correctional populations, psychiatric patients, and various occupational groups.

The manual describes the development and potential uses of the CISS assessment and includes relevant examples. MHS QuikScore™ Forms enable easy recording, scoring, and response profiling.

The CISS self-report is especially useful for making assessment and placement decisions for psychiatric patients, correctional populations, college counseling centers, employee hiring and

counseling situations, medical patients, stress and wellness programs, and any other situations where it is useful to assess an individual's coping style and ability.

CISS: Situation Specific Version

The CISS: SSC form is a 21-item measure for adults. The instructions are modified such that responses are given with a designated stressful situation in mind. Norms are given for situations involving social evaluation, change in social situation, relationship or interpersonal conflict, and general stress.

Carroll Depression Scales (CDS)
Bernard Carroll, M.B., Ph.D

The CDS are dependable measures of depressive symptom severity. In response to the growing need for documentation, the Carroll Depression Scales–Revised (CDS–R) build upon the original CDS to parallel DSM-IV™ criteria and record severity and type of depression. They are ideal for geriatric populations and primary care settings.

The normative sample consisted of 959 inpatients and outpatients who were diagnosed with Major Depression and 248 nonclinical individuals.

Brief CDS

The Brief CDS form is a 12-statement, self-report, screening instrument that will save you time during intake, clinical interviews, or during follow-up with clients in remission. The Brief CDS is more effective than longer scales that, despite their length, do not provide a cross-reference with DSM-IV™. With its simple yes/no format, the Brief CDS form is easily understood and quickly administered—an advantage over many other measures of depression.

Reliable, valid, and accurate measures of outcome assessment, the CDS-R and Brief CDS are the perfect tools for detecting depressive symptoms, making a diagnosis, or measuring change in depressive symptoms over time.

Profile Reports present scores graphically and numerically for a single CDS administration.

Children's Depression Inventory (CDI)

Maria Kovacs, Ph.D.

The CDI evaluates the presence and severity of specific depressive symptoms in children so that you can develop a targeted treatment plan. It is commonly administered in schools, guidance clinics, and medical paediatric settings by psychologists, social workers, counselors, and mental health professionals.

The short version (CDI: S) provides a quick measure of depressive symptoms, which is ideal for measuring changes in symptom severity and monitoring the progress of treatment. It is also often used as a screening instrument. Parent (CDI: P) and teacher (CDI: T) versions give multiple dimensions to your assessment. Parents view the child's behaviour at home in family situations, while teachers rate the child's behaviour in academic and social situations at school. The parent and teacher versions each have the following two scales—Emotional Problems and Functional Problems.
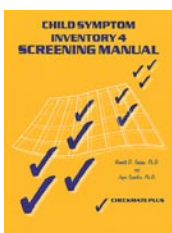
The normative sample for the self-report consisted of 529 boys and 647 girls between the ages of 7 and 16. The sample used to standardize the parent and teacher versions consisted of 1,187 nonclinical parent evaluations and 631 nonclinical teacher evaluations; and 167 clinical parent evaluations and 114 clinical teacher evaluations of children with various diagnoses. Norms are separated into two age groups: 7 to 12 years and 13 to 17 years.

Profile Reports present scores graphically and numerically to summarize the results of each self-report, parent, and teach administration. A list of responses is also included.

Comparison Reports compare multiple self-report, parent, or teacher administrations for the same client to measure progress. They are free with the purchase of CDI V.5 Profile Reports.

Child Symptom Inventory - 4 (CSI-4)

by Kenneth D. Gadow, Ph.D., and Joyce Sprafkin, Ph.D.

These two rating scales--one completed by the teacher, one by the parent--are used to screen 5- to 12-year-olds for symptoms of common childhood psychiatric disorders. Based on DSM-IV diagnostic criteria, these scales assist both educators and clinicians. They give schools a cost-effective way to convey clinically relevant information about the students they refer for evaluation or special services. And they give clinicians useful diagnostic information from parents and teachers. Completed and scored before the child sees the clinician, the CSI-4 makes it easier to conduct a focused, efficient interview, detect comorbid conditions, and make differential diagnoses.

The inventory offers both criterion-related cut-off scores and norm-based scores for

determining symptom severity (low, moderate, or high, based on teacher and parent ratings of 6- to 12-year-olds).

A practical alternative to expensive, time-consuming psychiatric interviews, the CSI-4 lists symptoms of emotional and behavioural disorders specified in the Individuals with Disabilities Education Act (IDEA):

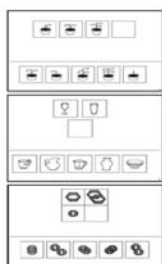|	
ADHD	Dysthymia
Oppositional Defiant Disorder	Asperger's Syndrome
Conduct Disorder	Pervasive Developmental Disorder
Separation Anxiety	Schizophrenia
Generalized Anxiety	Obsessive-Compulsive Disorder
Social Phobia	Posttraumatic Stress Disorder
Specific Phobia	Motor Tic Disorder
Depression	Vocal Tic Disorder

The Parent Checklist contains 97 items covering 17 disorders, while the Teacher Checklist contains 77 items related to 13 disorders. The teacher or parent rates each item on a 4-point response scale, indicating how often the symptom is observed in the child being evaluated. Responses are scored for symptom count and symptom severity. These two scores are compared to determine whether the child should be evaluated further.

The Checklists can also be computer scored. CSI-4 Software prints three reports: raw scores, scores above the cutoff, and a narrative describing the disorders associated with above-cutoff scores. These reports can be printed or sent to a text file for editing.

Completed in just 10 minutes, the CSI-4 integrates medical and educational classification systems. It gathers information from parents and teachers in a way that's compatible with the diagnostic system used by physicians and psychologists. This improves communication between the school and the mental health practitioner, and it provides the basis for a DSM-IV diagnosis-- often required for reimbursement.

Comprehensive Test of Nonverbal Intelligence (CTONI)
by Donald D. Hammill, Nils A. Pearson, and J. Lee Wiederholt

Here is an intelligence test that is particularly appropriate for use with people who are bilingual, non-English speaking, socially or economically disadvantaged, deaf, language disordered, or motor-impaired. The CTONI requires no oral responses, no reading or writing, and no object manipulation. All the examinee has to do is point to his or her selected response.

The scale measures six different kinds of nonverbal reasoning abilities. It is composed of the following subtests:

Pictorial Analogies	Geometric Categories	Geometric Analogies
Pictorial Sequences	Pictorial Categories	Geometric Sequences

These generate six subtest and three composite scores: Global Nonverbal IQ, Pictorial Nonverbal IQ, and Geometric Nonverbal IQ.

Originally standardized for 6- through 18-year-olds, the CTONI now provides additional norms for adults, aged 19 through 90. The entire scale can be administered in 40 to 60 minutes. Items are presented in sturdy, spiral bound Picture Books, each with a handy easel back. Directions can be given orally to individuals who speak English. Gestures can be used with those who are deaf or do not understand English.

Easy to administer, fun to take, and free of gender and racial bias, the CTONI allows you to assess the reasoning ability of individuals who would otherwise be difficult to test.

Conners 3rd Edition (Conners 3)
C. Keith Conners, Ph.D.

Based on the solid findings and key elements of its predecessor, the *Conners' Rating Scales–Revised* (CRS–R™), the Conners 3 offers a more thorough assessment of ADHD. The Conners 3 now addresses comorbid disorders such as oppositional defiant disorder and conduct disorder. Each parent, teacher, and self-report form is available in full-length and short versions.

You will benefit from the following enhancements:

- A large representative normative sample based on the latest U.S. census data
- A refined focus on ADHD in school-age children with a new age range (6–18 for parent and teacher scales and 8–18 for self-report scales)
- Strengthened *Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition* (DSM-IV-TR™) connections
- Clear applications in education settings that help identify children with clinical symptoms
- A manual that provides step-by-step guidance on how to use the tool in intervention planning and monitoring

As with its predecessor, the new Conners 3 is a multi-informant assessment. Gathering information from parents, teachers and youth provides a v

Conners 3rd Edition ADHD Index (Conners 3AI)
C. Keith Conners, Ph.D.

The Conners 3 moves forward with a refreshed 10-item Conners 3 ADHD Index (Conners 3AI). The items are taken from the Conners 3 full length form and are the perfect tool when time is of the essence. The brief index also works well when you need to screen a large group of children and adolescents to see if further assessment of ADHD is warranted. Additionally, this form can be used to monitor the effectiveness of treatment plans, and measure the patient's response to intervention.

The items were specifically selected for this form and are proven to be the best items in differentiating between youth with ADHD from those without a clinical diagnosis.

The Conners 3AI is included in the full length Conners 3 or can be purchased separately.

Conners 3rd Edition Global Index (Conners 3GI)
C. Keith Conners, Ph.D.

The Conners 3 Global Index (Conners 3GI) is a fast and effective measure of general psychopathology. It includes the 10 best predictive items from the trusted market leader, *Conners' Rating Scales - Revised (CRS–R)* , parent and teacher rating scales.

Conners Comprehensive Behavior Rating Scales (Conners CBRS)
C. Keith Conners, Ph.D.

Those working in the field of child and youth psychology can now use the Conners CBRS to assess a wide spectrum of behaviors, emotions, and academic problems in today's youth.

The Conners CBRS includes the *Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition* (DSM-IV-TR™) symptom scales, empirical and rational scales, as well as other clinical indicators and critical and impairment items. Refer to the Scales Chart for more information.

The age range suitable for this assessment is 6–18 for parent and teacher forms and 8–18 for self-report forms.

The Conners CBRS also provides:

- Direct and clear links to the DSM-IV-TR and the *Individuals with Disabilities Education Improvement Act 2004* (IDEA 2004)
- Spanish versions are available for parent and self-report forms.
- Straightforward administration, scoring and reports
- Excellent reliability and validity

Meeting Your Diverse Needs

The Conners CBRS is a comprehensive multi-informant tool that:

- Assists in the diagnostic process
- Identifies and qualifies students for inclusion or exclusion in special education/research studies
- Assists in the development of intervention treatment plans
- Monitors your patient's response to intervention/treatment
- Evaluates the effectiveness of intervention/ treatment plans

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Conners' ADHD/DSM-IV Scales (CADS)

C. Keith Conners, Ph.D.

The CADS consist of the items of the CRS-R that best differentiate ADHD children from nonclinical children. The DSM-IV™ Symptom Scales directly correspond to DSM-IV criteria for ADHD diagnosis with parent (CAD-P), teacher (CADS-T) and self-report (CADS-A) forms. Feedback Handouts summarize results.

Profile Reports present scores for each CADS scale numerically and graphically, along with a list of responses. Available as part of the CRS–R Version 5 software or with CRS–R online reports.

Rater Comparison Reports allow you to select two to four administrations and compare results. They are free with CRS–R Version 5 software or with CRS–R online reports.

Progress Reports compare the results of two to four administrations for the same client. They are free with CRS–R Version 5 software and CRS–R online reports.

Conners' Adult ADHD Diagnostic Interview for DSM-IV™ (CAADID)

Jeff Epstein, Ph.D., Diane Johnson, Ph.D., & C. Keith Conners, Ph.D.

The Conners' Adult ADHD Diagnostic Interview for the DSM-IV™ (CAADID) is a structured interview that aids the process of diagnosing adult ADHD. It provides clinicians and researchers with the categorical diagnosis they require when assessing ADHD. The CAADID is most effective when used with other types of ADHD measures, such as the Conners' CPT II and the CAARS; their joint use is illustrated by case studies in the technical manual.

The interview is divided into Parts I and II, administered separately, with each part requiring about 90 minutes to complete. Part I is the Patient History Questionnaire, which can be administered as either a clinical interview or as a self-report questionnaire. It contains questions about the demographic history of the client, the developmental course of the client's attention problems, associated risk factors, and comorbidity screening questions.

Part II, the Diagnostic Criteria Interview, is presented in interview format. The clinician uses the information obtained from Part I to assess the client against the DSM-IV™ criteria for ADHD.

Information is also gathered on age of onset, pervasiveness, and level of impairment for any ADHD symptoms that are indicated.

Conners' Adult ADHD History
C. Keith Conners, Ph.D.

Send the Conners' Adult ADHD History Form to your clients prior to their first visit or have them complete it at the initial consultation. It covers historical information that is of clinical importance in assessing an adult for ADHD and gives you the opportunity to evaluate your client's handwritten responses to questions about current problems, employment, family, past school history, relevant medical information, medications, and other areas.

Conners' Adult ADHD Rating Scales (CAARS)
C. Keith Conners, Ph.D., Drew Erhardt, Ph.D., & Elizabeth Sparrow, Ph.D

When ADHD stays with a person into adulthood, it usually contributes to larger personal and professional difficulties. The CAARS scales measure the presence and severity of ADHD symptoms so that you can determine whether or not ADHD is a contributing factor to a client's difficulties. Suitable for clinical, research, rehabilitation, and correctional settings, the CAARS scales quantitatively measure ADHD symptoms across clinically significant domains, while examining the manifestations of those symptoms.

The CAARS scales provide a multiple-informant assessment with self-report (CAARS–S) and observer ratings (CAARS–O). They address the same behaviors and contain identical scales, subscales, and indexes. Long, short, and screening versions are available for each (see below).

Normative data for the self-report forms consist of 1,026 nonclinical adults, while the normative data for the observer forms consist of ratings by spouses, family members, or friends of 943 nonclinical adults. Separate norms are available by gender and age-group intervals (18–29, 30–39, 40–49, and 50+ years). Raw scores and *T*-scores are produced for each scale, subscale, and index, and are plotted on profile forms. These forms are ideal for result presentation and to compare results over time.

CAARS: For Use in Correctional Settings

Studies show that ADHD is found in correctional settings at a relatively high rate and that adults with ADHD are at an especially high risk to recidivate. The Conners' Adult ADHD Rating Scales (CAARS): For Use in Correctional Settings supplement uses a vast research base that was validated on a large adult correctional sample to identify inmates with ADHD.

Long Versions

The long self-report (CAARS-S:L) and observer (CAARS-O:L) forms include 66 items and contain 9 empirically derived scales that assess a broad range of problem behaviors. Long forms include 3 DSM-IV™ Symptom measures (Inattentive, Hyperactive-Impulsive, and Total ADHD Symptoms), a 12-item ADHD Index, and an Inconsistency Index for identifying random or careless responding

Short Versions

The short self-report (CAARS-S:S) and observer (CAARS-O:S) forms contain 26 items and are abbreviated versions of the factor-derived subscales that appear on the long forms. The ADHD Index and the Inconsistency Index are also incorporated. the short forms are designed to display key dimensions when time with respondents is limited.

Screening Versions

The CAARS:SV include the same 12-item ADHD Index of the long and short CAARS forms and contain the DSM-IV™ ADHD Symptom Subscales (18 items that relate to DSM-IV™ criteria for ADHD). The Screening Versions are deal when insufficient time is available to complete the lengthier forms.

Profile Reports present scores for each of the scales, subscales and indexes graphically and numerically to summarize results for each respondent. They are available for all three versions (long, short, and screening).

Interpretive Reports contain detailed descriptions of the scales, a list of elevated item responses, and intervention strategy suggestions in addition to scores. They are available for only the long and short versions (not screening).

Conners' Continuous Performance Test II Version 5 for Windows (CPT II V.5)
C. Keith Conners, Ph.D. & MHS Staff

The CPT II V.5 is widely used with psychiatric and general medical patients to assess attention disorders and neurological functioning. When used with the CRS-R, it adds a task-oriented component to support parent and teacher ratings. It can also be used with offenders, where there is a higher than average rate of adolescent and adult ADHD. To complete the CPT II V.5, respondents react to target letters on the screen. The unique Conners paradigm still forms the basis of the program.

This program was standardized with a clinical sample of 378 diagnosed ADHD cases and 223 adult individuals identified to have some type of neuropsychological impairment. An assortment of additional clinical cases (anxiety problems, conduct problems, depression, etc.) were included. The nonclinical sample included 1,920 individuals.

The CPT II V.5 software is an unlimited-use program; therefore, users can administer, score, and generate reports an unlimited number of times. However, the number of users of the program is limited to the number of installations purchased. Contact MHS for multiple installation and network pricing.

Conners' Multimodal Integrated Reports combine CPT II V.5 results with the attention-related scales of the CRS–R V.5 or CAARS V.5 software in one convenient document.

Profile Reports summarize results of an individual administration.

Progress Reports allow you to compare the results of two to four administrations for the same client, which is ideal for monitoring treatment efficacy.

Conners' Global Index (CGI)
C. Keith Conners, Ph.D.

The CGI evaluates a reported behavior with 10 critical items to help you determine which direction to take with further examination. It is especially useful for treatment monitoring. It has been cross-validated on large independent samples of community and expertly diagnosed cases. The Treatment Progress ColorPlot™ forms make it easy to visually monitor parent (CGI–P), teacher (CGI–T), and self-report ratings (CADS–A).

Profile Reports present scores numerically and graphically with a list of responses. They are available as part of the CRS–R Version 5 software and CRS–R online formats.

Rater Comparison Reports allow you to select two to four administrations and compare results. They are free with CRS–R Version 5 software and CRS–R online reports.

Progress Reports compare the results of two to four administrations for the same client. They are free with   CRS–R Version 5 software and CRS–R online reports

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Conners' Rating Scales-Revised (CRS-R)
C. Keith Conners, Ph.D.

The Conners' Rating Scales–Revised (CRS–R), published by MHS, are the result of 30 years of research on child and adolescent behaviour by Dr. C. Keith Conners. They provide a comprehensive, versatile assessment of psychopathology and problem behaviour for children and adolescents.

With items that represent internalizing and externalizing behaviours, the CRS–R scales evaluate problem behaviours, ADHD, and comorbid disorders as reported by teachers, parents (or alternative caregivers), and adolescents. This Multimodal approach provides the most accurate information possible on which to base practical intervention strategies. Direct links to DSM-IV^{TM} criteria facilitate differential diagnosis and the ADHD Index provides the best set of items for distinguishing ADHD children from nonclinical children.

Widely used by school psychologists, child psychiatrists, paediatricians, clinics, child protective service agencies, juvenile detention facilities, residential treatment centers, and private practitioners, the CRS–R scales have become the standard for attention and behaviour assessment in children and adolescents.

The Parent Rating Scales (CPRS), Teacher Ratings Scales (CTRS), and adolescent Self-Report (CASS) come in both long and short versions. The long versions provide a comprehensive rating across several subscales and include DSM-IV Symptom subscales. The short versions yield scores on all subscales that are identical for all for all three versions, allowing a direct comparison of results across informants. The Conners' Global Index is sensitive to treatment change, making it useful for monitoring progress and outcomes assessment, Treatment Progress ColorPlot^{TM} Forms display results in graphical format for easy comparison.

The CRS–R scales were standardized using a large normative database compiled from over 200 data collection sites throughout North America. Separate norms for boys and girls are provided in 3-year intervals for ages 3 through 17. Profile Sheets (included in QuickScore Forms) summarized the key information. They are age- and gender-specific and show raw scores for the subscales, allow for conversion to standard scores, provide graphs of scores, and link responses directly to DSM-IV criteria (long forms only).

The comprehensive Technical Manual address CRS–R administration, scoring, interpretation, development, normative sample, validity, and reliability. The succinct User's Manual is ideal for those who require only administration, scoring, and interpretive information.

CRS–R Parent Rating Scales–Revised (CPRS–R)

The CPRS–R scales assess problem behaviours reported by parents. Both long (CPRS–R: L) and short (CPRS–R: S) versions are available. Normative data for these revised scales come from the ratings of more than 2,000 parents.

The 80-item CPRS–R: L includes the following subscales:

- Oppositional
- Social Problems
- Cognitive Problems/Inattention
- Psychosomatic
- Hyperactivity
- DSM-IV Symptom Subscales Anxious-Shy
- ADHD Index
- Perfectionism
- Conners' Global Index

The 27-item CPRS–R: S includes the following subscales:

- Oppositional
- Hyperactivity
- Cognitive Problems/Inattention
- ADHD Index

CRS–R Teacher Rating Scales–Revised (CTRS–R)

The CTRS–R forms assess problem behaviours reported by teachers. Both long (CTRS–R: L) and short (CTRS–R: S) versions are available. The CTRS–R: L consists of all the same subscales as the CPRS–R: L except for the Psychosomatic scale. The CTRS–R: S includes the same four subscales as the CPRS–R: L (see above). Normative data for these revised scales come from the ratings of approximately 2,000 teachers.

Conners-Wells Adolescent Self-Report Scales (CASS)

The CASS forms assess problem behaviours in youth aged 12 to 17 in a self-report format. Both long (CASS: L) and short (CASS: S) versions are available. Normative data for these scales come from the ratings of over 3,000 adolescent respondents.

The 87-item CASS: L includes the following subscales:

- Family Problems
- Conduct Problems
- Anger Control Problems
- DSM-IV Symptom Subscales
- ADHD Index
- Emotional Problems
- Cognitive Problems/Inattention
- Hyperactivity

The 27-item CASS: S includes the following subscales:

- Conduct Problems
- Hyperactivity
- Cognitive Problems/Inattention
- ADHD Index

Conners' Teacher Information Form (CTIF)

The CTIF is ideal for use with the CTRS–R: L and CTRS–R: S scales, but can be used with any teacher rating scale or checklist. The CTIF collects and organizes information about a child to help you write reports, plan treatment, and provide feedback.

Conners' Global Index (CGI)

Ideal for treatment monitoring, the relatively brief CGI evaluates the reported problem behaviour with 10 items found to be critical in assessing the severity of childhood problems. The CGI scale is incorporated into the CPRS–R: L and the CTRS–R: L forms and is also available separately.

CRS–R Feedback Handouts
Summarize individual results from your CRS–R QuickScore Forms with professionally designed handouts for parents, teachers, and adolescents.

Profile Reports present scores for each scale and subscale numerically and graphically, along with a list of responses.

Rater Comparison Reports allow you to select two to four administrations and compare results. They are free with CRS–R Version 5 software reports and CRS–R online reports.

Progress Reports compare the results of two to four administrations for the same client. They are free with CRS–R Version 5 software reports and CRS–R online reports.

Rater Comparison and Progress Reports for the CGI and CADS auxilliary scales are also available.

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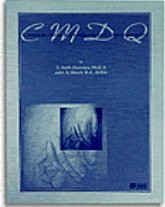
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Progress Reports compare the results of two to four administrations for the same client. They are free with CRS–R Version 5 software reports and CRS–R online reports.

Rater Comparison and Progress Reports for the CGI and CADS auxilliary scales are also available.

Conners-March Development Questionnaire (CMDQ)
C. Keith Conners, Ph.D. & John S. March, M.D.

Key Areas Measured:
Description of Problem(s)
Treatment History
Motor Development
History of Family and Child
Temperament
Home Environment
Birth History
Medical and Psychiatric History
Medication History
School Behaviour & Performance

An expert-endorsed treatment standard, the parent-completed CMDQ saves you time when collecting information about your clients. It can be mailed to parents and completed before they come for their first visit, or it can be given to the parent(s) during the first session.

Computer Scoring Program for the Symptom Inventories: Version 2
by Kenneth D. Gadow, Ph.D., Joyce Sprafkin, Ph.D., and Joseph Gartner, M.D.

This unlimited-use Windows program scores the *Child Symptom Inventory-4, Early Childhood Inventory-4, Adolescent Symptom Inventory-4, and Youth's Inventory-4*. Respondents can complete the checklists prior to clinical evaluation; item responses can be entered from the paper-and-pencil administration; and results can then be used to focus the interview. This saves valuable time because relevant symptoms and DSM-IV disorders are immediately called to the clinician's attention.

The score sheet appears on screen in an easy-to-read format designed to reduce data entry errors. The software generates a 5-page report, with item scores, *T*-scores, and DSM-IV scores. *Minimum hardware requirements:* 486 Mhz PC or compatible, Windows 95, 98, or 2000.

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Conners Comprehensive Behaviour Rating Scales (Conners CBRS)
by C. Keith Conners, Ph.D.

Three Sources of Information

The CBRS is composed of three rating scales: one completed by the teacher (204 items), one by the parent or caregiver (203 items), and one by the student being evaluated (179 items). The teacher and parent scales, written at a fourth-grade reading level, can be used to assess students 6 through 18 years of age. The self-report scale, written at a third-grade level, is appropriate for 8- through 18-year-olds.

A Broad Spectrum Assessment

The three CBRS forms cover the following scales:

DSM-IV-TR Symptom Scales

- ADHD
- Conduct Disorder
- Oppositional Defiant Disorder
- Major Depressive Episode

- Manic Episode
- Mixed Episode
- Generalized Anxiety Disorder
- Separation Anxiety Disorder

- Social Phobia
- Obsessive-Compulsive Disorder
- Autistic Disorder
- Asperger's Disorder

Empirical Scales

- Emotional Distress
- Aggressive Behaviours
- Academic Difficulties
- Hyperactivity or Hyperactivity/Impulsivity
- Separation Fears
- Social Problems
- Perfectionistic and Compulsive Behaviours

Validity Scales

- Positive Impression
- Negative Impression
- Inconsistency Index

Rational Scales

- Violence Potential
- Physical Symptoms

The Empirical Scales identify a wide range of emotional, behavioural, and academic problems; the Rational Scales alert you to the student's potential for violence; and the DSM-IV-TR Symptom Scales support formal diagnosis by linking symptoms to established diagnostic criteria.

Critical Items and Indicators

While scale scores are important, useful information can be derived from specific items as well. These items, along clinical indicators, reveal issues that may warrant further investigation severe conduct, self harm, functional impairment, bullying, panic attack, post-traumatic stress disorder, enuresis/encopresis, pervasive developmental disorder, specific phobia, substance use, tics, and more.

Clinical Index

The CBRS also includes a 25-item Clinical Index, which tells you how likely it is that a given child will have a clinical diagnosis. Completed in less than 5 minutes, it is useful when you are monitoring

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treatment progress and must assess the child repeatedly. Although it is included on the teacher, parent, and self-report forms, the Clinical Index can also be purchased separately.

Unlimited-Use Computer Scoring

Because the CBRS is such a comprehensive test, it must be computer scored. With unlimited-use software, you can quickly score the test and generate a variety of helpful reports that provide clear links to DSM-IV-TR diagnostic criteria and IDEA eligibility indicators. Portions of these reports can be cut and pasted into your own documents, allowing you to create individualized narratives for each student assessed.

A Single Instrument Answering Diverse Needs

No matter how diverse your students or young clients are, the CBRS can help you identify their problems or determine their diagnoses. It can tell you who qualifies for special services, which interventions are likely to be effective, and how well treatment is working. This single assessment addresses a multitude of problems and guides you toward individualized solutions.

Conners Third Edition (Conners 3) by C. Keith Conners, Ph.D.

This updated third edition of the popular *Conners' Rating Scales* sets a new standard for assessing attention-deficit/hyperactivity disorder (ADHD) and related learning, behaviour, and emotional problems in children and teens. Like previous versions, the *Conners 3* combines teacher, parent, and student reports to provide a particularly detailed and comprehensive evaluation of student behaviour. This edition offers a more refined assessment of ADHD and comorbid disorders; stronger links to the *DSM-IV-TR*; new symptom and validity scales; updated norms; and more.

A Complete Profile
The *Conners 3* is composed of the following scales:

Empirical Scales	*DSM-IV-TR* Symptom Scales	Validity Scales
Hyperactivity/Impulsivity	ADHD Hyperactive/Impulsive	Positive Impression New
Executive Functioning	ADHD Inattentive	Negative Impression New
Learning Problems	ADHD Combined	Inconsistency Index New
Aggression	Oppositional Defiant Disorder New	
Peer Relations	Conduct Disorder New	**Rational Scale**
Family Relations		Inattention

Also included are two useful indexes, each composed of 10 items:

- Global Index
- ADHD Index

In addition, the *Conners 3* includes new items that alert you to specific problems:

Screener Items	Impairment Items	Critical Items
Anxiety	Schoolwork/Grades	Severe Conduct
Depression	Friendships/Relationships	
	Home Life	

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The Screener Items uncover mood disorders that might otherwise go undetected, while the Impairment Items tell you how the student's problems are affecting his or her academic functioning, home life, and friendships. The Critical Items identify youngsters with severe behaviour problems (such as weapons use or fire-setting) who need immediate attention.

Three Rating Scales and Three Perspectives

The *Conners 3* includes three rating scales, one completed by the teacher, one by the parent or caregiver, and one by the student. All are available in long and short forms:

Teacher Rating Scale	Parent Rating Scale	Self-Report Rating Scale
Long Form -- 115 items	Long Form -- 110 items	Long Form -- 59 items
Short Form -- 39 items	Short Form -- 43 items	Short Form -- 39 items

The Teacher and Parent Scales, written at a fourth- to fifth-grade reading level, can be used to evaluate students from 6 through 18 years of age. The Self-Report Scale, written at a third-grade reading level, is appropriate for 8- through 18-year-olds. Long forms take about 20 minutes to complete, while short forms require only 10 minutes.

When to Use Long and Short Forms

Because they yield more detailed information, the long forms are recommended for initial evaluation. They support diagnosis through direct links to the *DSM-IV-TR* and are helpful in identifying the specific needs of each student.

The short forms are useful when time is limited or when you are planning multiple administrations over a given period, as you would for progress monitoring. They include the strongest items from the following long-form scales: Hyperactivity/Impulsivity, Inattention, Executive Functioning, Learning Problems, Aggression, Peer Relations, Positive Impression, and Negative Impression.

ADHD Index

The *Conners 3* also offers a convenient ADHD Index. Composed of the 10 items that best differentiate children with ADHD from those without a clinical diagnosis, this brief index is ideal for screening large numbers of children and teens. It's also a quick way to measure treatment effectiveness or response to intervention. Available as a parent, teacher, or self-report rating, the index is included in the full-length *Conners 3* but can be purchased separately as well--a convenient option when you want to rapidly identify students at risk for ADHD.

Hand Scoring or Unlimited-Use Computer Scoring

With the *Conners 3*, you can choose the Hand-Scored Kit or the Software Kit. The latter gives you unlimited computer scoring, quick and effortless profile generation, links to *DSM-IV-TR* diagnostic criteria, IDEA eligibility indicators, and three useful reports:

- **Assessment Report**
  Comprehensive results, including a total score and a symptom count score.
- **Feedback Report**
  An assessment summary that's easy for parents and teachers to understand.
- **Progress Report**
  A comparison of results from two to four administrations of the *Conners 3* to the same student, documenting changes over time.

You can cut and paste portions of these reports into your own documents to create a customized narrative for each child assessed.

Normative data, based on 1,200 parent ratings, 1,200 teacher ratings, and 1,000 self-reports, are presented at 1-year age intervals and separated by sex. The standardization sample reflects the U.S. population in regard to race, ethnicity, gender, and parent education.

Problem Identification and Intervention Guidance

The *Conners 3* gives you the complete picture, from assessment to intervention. It draws on three sources of information; it measures not only ADHD, but also accompanying behavioural, emotional, cognitive, family, and social problems; and it guides you in planning effective intervention. Results from the *Conners 3* help you create, monitor, and modify individualized treatment programs.

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Comprehensive Test of Nonverbal Intelligence (CTONI)
Donald D. Hammill, Ed.D., Nils A. Pearson, Ph.D., & J. Lee Wiederholt, Ph.D.

The CTONI test is an unbiased measure of nonverbal reasoning abilities in individuals for whom most other mental ability tests are either inappropriate or biased. Results are useful for estimating the intelligence of individuals who experience undue language or fine motor skill difficulties. No oral responses, reading, writing, or object manipulation is required.

The CTONI test was standardized on more than 2,500 individuals from 25 U.S. states, Canada, and Panama. It includes an Analogies Book, a Categories Picture Book, a Sequences Picture Book, and Profile/Examiner Record Forms for recording responses.

Software

The CTONI-Computer Administration (CTONI-CA) is an innovative interactive multimedia program. The program gives instructions to the examinee in a clear, pleasant voice. The examinee clicks through the items of a subtest until a ceiling is reached. Subsequent subtests are introduced one by one. The program quickly scores the test and automatically applies ceilings and converts raw scores into standard scores, percentiles, and composite scores. The examiner can generate a comprehensive report, which can be printed and saved for use with other report writing software. The CTONI-CA software comes with 25 test administrations and includes both an Examiner's Manual and an Installation Guide. The system requirements are a 386 or faster processor, Windows 3.1 or higher, 4MB RAM, 10MB of hard disk space, 8- or 16-bit Soundblaster-compatible sound card, a mouse or other pointing device, and a 256-color SVGA monitor (640x480).

Decoding Skills Test (DST)
by Ellis Richardson, Ph.D. and Barbara DiBenedetto

The *Decoding Skills Test* (DST) helps you diagnose and treat specific reading disabilities, including dyslexia. It gives you a clear picture of the processes involved in reading and shows you the particular area in which an individual needs help.

Three Subtests

Designed for children and adults who are reading at first- through fifth-grade levels, the DST provides a diagnostic profile of the decoding skills that are essential to reading comprehension.

- **Subtest I, Basal Vocabulary,** measures the ability to recognize words taught in most basal reading programs.
- **Subtest II, Phonic Patterns,** assesses the ability to decode words using letter-sound correspondence. The examinees response to both real and nonsense words shows you how well he or she can apply known phonic patterns to decode unknown words.
- **Subtest III, Contextual Decoding,** presents story passages that correspond to first- through fifth-grade reading levels. It assesses the effect of context on decoding skills. And it measures comprehension, reading rate, and error rate.

A Detailed Diagnostic Profile

Individually administered in 15 to 30 minutes, the DST provides criterion-referenced scores that relate directly to the reading curriculum. These scores give you a variety of useful information, including:

- Reading achievement level
- Frustration level
- Phonic pattern knowledge
- Phonic decoding deficiencies
- The effect of context on the child's word recognition and decoding skills
- Oral fluency at various reading levels
- Oral reading errors

Clear Guidelines for Remediation

While the DST can be used for screening, it is primarily diagnostic and prescriptive. The test is especially useful with students already known to have reading difficulties, including dyslexia. Because it detects specific aspects of the reading problem, the DST provides clear treatment guidelines. It helps you form reading groups, make program decisions, and determine appropriate remediation.

Developed under contract with the National Institutes of Health, the DST allows you to identify and treat reading problems--early and accurately.

Decoding-Encoding Screener for Dyslexia (DESD)
by John R. Griffin, O.D., M.S.Ed., Howard N. Walton, O.D., M.S., and Garth N. Christenson, O.D., M.S.Ed.

The *Decoding-Encoding Screener for Dyslexia* (DESD) is a screening test that allows you to assess a student's specific reading difficulties in less than 10 minutes. The DESD consists of three sections: Decoding, Encoding, and Letter Writing. The Decoding section provides a norm-referenced measure of sight-word recognition (Reading Standard Score). Additionally, qualitative indicators in the Encoding section allow you to distinguish deficits in sight-word recognition from deficits in phonetic analysis. The test identifies the specific skills that a child brings to bear on the task of reading words. This information makes it easier to detect and describe reading problems and to refer students for appropriate educational therapy.

The DESD allows identification of children who are at risk for dyslexia, so they can be referred without delay to special services. The early screening and intervention made possible by the DESD

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vastly improves the effectiveness of educational therapy and helps minimize the secondary emotional problems dyslexia can create. Standardized on a sample of 678 students in grades 1 through 8, the DESD can be administered and scored in 5 to 10 minutes.

Detroit Tests of Learning Aptitude: Fourth Edition (DTLA-4)
by Donald D. Hammill

 The DTLA-4 isolates individual strengths and weaknesses, identifying students (6 to 17 years of age) who are deficient in general or discrete skills. It also reveals the effects of language, attention, and motor skills on test performance.

 An excellent tool for diagnosing learning disabilities, the DTLA-4 yields a detailed profile of 10 subtests:

Subtest
- Word Opposites
- Design Sequences
- Sentence Imitation
- Reversed Letters
- Story Construction
- Design Reproduction
- Basic Information
- Symbolic Relations
- Word Sequences
- Story Sequences

Ability Measured
- Vocabulary
- Visual Discrimination and Memory
- Grammar
- Order Recall, Auditory
- Storytelling
- Drawing From Memory
- Everyday Fact Knowledge
- Reasoning, Visual
- Repeating Words
- Organizing Meaningful Segments

 Scores on these subtests are used to create 16 composites, which reflect both general intelligence and discrete abilities:

- Overall Composite--the best estimate of overall intelligence
- Optimal Level Composite--the best indicator of potential
- Verbal Composite
- Nonverbal Composite
- Attention-Enhanced Composite--concentration, attending, short-term memory

- Attention-Reduced Composite--long-term memory
- Motor-Enhanced Composite--complex manual dexterity
- Motor-Reduced Composite--relatively motor-free abilities
- Fluid Intelligence
- Crystallized Intelligence
- Associative Level
- Cognitive Level
- Simultaneous Processing
- Synthesized Processing
- Verbal Scale
- Performance Scale

Subtest and composite results are provided in the form of standard scores, percentiles, and age equivalents.

The DTLA-4 was normed on 1,350 students reflecting the U.S. population data with regard to gender, region, ethnicity, race, and urban/rural residence, family income, and educational attainment of parents. Norms are stratified by age.

Detroit Tests of Learning Aptitude-Primary (DTLA-P: 3)
Third Edition

This quick, easily administered test measures general aptitude in young children. It is particularly useful with low-functioning youngsters aged 3-0 through 9-11. This revision includes 100 items and 6 subtests covering 3 cognitive domains:

Verbal Domain

Verbal-Enhanced. Items require knowledge of words and their use.

Verbal-Reduced. Items involve neither spoken nor written words.

Attention Domain

Attention-Enhanced. Items require concentration and use of short-term memory.

Attention-Reduced. Items emphasize long-term memory.

Motor Domain

Motor-Enhanced. Items require visual-motor skills and complex manual dexterity.

Motor-Reduced. Items are relatively motor free and require simple pointing or oral responses.

Individually administered in 15 to 45 minutes, these subtests sample 16 different abilities (articulating speech sounds, matching semantic concepts, reproducing designs, repeating digits, drawing figures, sequencing letters and objects, following directions, producing antonyms, and more). The DTLA-P: 3 generates an overall ability score plus subtest scores.

This edition adds new norms derived from a nationally representative sample of more than 1,000 children. Data are stratified by age, region, gender, race, ethnicity, socioeconomic status, and parent education. In addition, stimulus pictures are now in full colour and presented in a convenient, spiralbound easel book. The new manual provides more information on score interpretation and offers evidence of the test's reliability and validity for specific groups and for the general population.

Developmental Assessment of Young Children (DAYC)

by Judith K. Voress and Taddy Maddox

Use the DAYC to identify developmental delays or deficits in children (from birth through 5 years, 11 months) who may benefit from early intervention. The DAYC comprises five subtests that measure the assessment areas mandated by IDEA:

Cognition
  Attention
  Memory
  Purposive Planning
  Decision Making
  Discrimination

Communication
  Receptive and Expressive
  Language
  Verbal or Nonverbal Expression

Social-Emotional Development
    Social Interactions

Adaptive Behaviour
    Self-Help Skills

Physical Development
    Gross and Fine Motor
    Development

  Because you can assess any combination of the five domains, the test can be tailored to the particular child's needs. Subtests can be individually administered, separately or as a comprehensive battery, in approximately 10-20 minutes. The test format allows you to collect information about a child's abilities through observation, caregiver interview, and direct assessment.

  Normed on a national sample of 1,269 children, the test yields percentile ranks and age

equivalents.

The DAYC is an invaluable tool that provides clinicians with a base from which to monitor change and evaluate a child's progress in special early childhood settings.

Developmental Profile 3 (DP-3)
by Gerald D. Alpern, Ph.D.

This fully revised third edition of the *Developmental Profile* strengthens and updates an instrument already considered the best of its kind. Like previous versions, the new DP-3 evaluates children's functioning in five key areas, in just 20 to 40 minutes. However, this edition adds norm-based standard scores, an expanded age range, updated item content, clearer interpretive guidelines, a nationally representative standardization sample, suggested remediation activities, and unlimited computer scoring and interpretation.

Designed to evaluate children from birth through 12 years, 11 months, the DP-3 includes 180 items, each describing a particular skill. The respondent simply indicates whether or not the child has mastered the skill in question.

The DP-3 provides a General Development score as well as the following scale scores:

- **Physical**
  Large- and small-muscle coordination, strength, stamina, flexibility, and sequential motor skills
- **Adaptive Behaviour**
  Ability to cope independently with the environment--to eat, dress, work, use modern technology, and take care of self and others
- **Social-Emotional**
  Interpersonal abilities, social and emotional understanding, functional performance in social situations, and manner in which the child relates to friends, relatives, and adults
- **Cognitive**
  Intellectual abilities and skills prerequisite to academic achievement
- **Communication**
  Expressive and receptive communication skills, including written, spoken, and gestural language

Administration Options

Typically, the DP-3 is administered as an interview, in which a parent or caregiver answers yes-or-no questions about the child. Within each scale, basals and ceilings are used, so you don't have to administer all 180 items. Start and stop points ensure that you ask only age-appropriate questions, making the interview focused and efficient. And because each scale has its own norms, you don't have to use all five scales if you're interested in just one.

While the Interview Form is the preferred method of administration, the DP-3 offers an alternative that's useful when time, research, or clinical needs make an interview unfeasible. A new Parent/Caregiver Checklist contains the same item content as the Interview Form (though language has been altered slightly). Written at a sixth-grade reading level, the Checklist can be completed by the child's parent or caregiver without your supervision. It offers a convenient option when a face-to-face interview is not possible.

National Norms and Five Kinds of Scores
DP-3 norms are based on a sample of 2,216 typically developing children representative of the U.S. population in regard to ethnicity, geography, and socioeconomic status. Scores are available in five formats: standard scores, percentile ranks, stanines, age equivalents, and descriptive ranges. This gives you flexibility in using, reporting, and explaining test results. For example, you might choose standard scores for eligibility determination or progress monitoring; age equivalents for parent conferences; and stanines or percentiles for school records. The DP-3 lets you choose the score format that suits your assessment setting and purpose.

Unlimited Computer Scoring and Interpretation
Provided on an unlimited-use CD, the DP-3 computer program saves time, reduces the chance of error, and gives you a wealth of information. It includes the following features:

- **Scoring and Interpretation**
  The program calculates all DP-3 scores (standard scores, percentile ranks, stanines, and age equivalents) and provides a ready-to-use interpretive analysis.
- **Graphical Representation of Scores**
  A clear-cut graphic profile makes it easy to spot advanced or delayed development across the five scales and the General Development score.
- **Scale Pattern Analysis and Scale-by-Scale Item Analysis**
  These calculations--which are difficult or impossible in hand scoring--allow you to tease out subtle distinctions in a child's profile. Scale comparisons reveal statistical significance in the pattern of strengths and weaknesses, while item analysis pinpoints skills not yet mastered (i.e., items failed) below the child's ability level on each scale.
- **Individualized Intervention Activities**
  For each scale, the program suggests teaching activities that address the child's specific weaknesses.
- **Clinician and Parent Reports**
  The CD generates both a thorough clinical report for professionals and an easy-to-understand summary for parents. Compatible with most word processing programs, these reports can be easily customized.

IDEA Compliance
Efficient and accurate, the DP-3 is an excellent way to identify developmental delays early in a child's life. Its norm-based standard scores allow you to compare children's functioning with that of their peers, design interventions that meet their particular needs, and monitor their progress over time.

Because the DP-3 meets federal criteria for evaluating children with developmental problems, it's useful in determining eligibility for special education, planning IEPs, and implementing periodic screening programs. Its five scales correspond to the five domains specified in IDEA for assessing developmental delays. In addition, the DP-3's interview format and provision of a parent report satisfy the federal requirement that parents be involved in their child's assessment.

Developmental Test of Visual Perception: Second Edition (DTVP-2)
by Donald D. Hammill, Nils A. Pearson, and Judith K. Voress

This revision of Marianne Frostig's popular *Developmental Test of Visual Perception* (DTVP) improves this classic test. Administered to more than 6 million children in its original format, the DTVP-2 continues to provide a useful measure of visual perception and visual-motor integration skills in children.

The Second Edition can be used with 4- through 9-year-olds. Individually administered in just 35 minutes, it is composed of eight subtests:

- Eye-Hand Coordination
- Copying
- Spatial Relations
- Position in Space
- Figure Ground
- Visual Closure
- Visual-Motor Speed
- Form Constancy

The DTVP-2 provides scores for both pure visual perception (with no motor response) and visual-motor integration abilities. These scores are reliable (.8 or .9 levels) for all age groups. Norms are based on a large sample, representative of 1990 U.S. census data, and studies have shown that the test is unbiased in regard to race and gender.

Because it documents the presence and degree of visual-perceptual and visual-motor difficulties, the DTVP-2 is especially useful in identifying candidates for special programs. It is also helpful in verifying program effectiveness and providing evidence of possible organic impairment.

Developmental Test of Visual-Motor Integration (VMI)
5th Edition
by Keith E. Beery, Ph.D. and Norman A. Buktenica, and Natasha A. Beery

This highly acclaimed test measures visual-motor integration in children and adults. Backed by decades of research and clinical use, the VMI, in its fifth revision, offers a convenient and economical way to screen for visual-motor deficits that can lead to learning and behaviour problems. While it is used primarily with young children, the VMI can also be administered to adolescents and adults.

The Fifth Edition extends the norms downward to 2 years of age, offers five new teaching tools, and includes a fully revised Manual, with approximately 600 age-specific norms, from birth through age 6. These norms reflect developmental "stepping stones" identified by research. They have proven useful in helping parents understand their child's current level of development.

The Fifth Edition was standardized on a national sample of 2,512 individuals aged 2 to 18.

The test presents the examinee with drawings of 24 geometric forms, arranged in developmental sequence, from less to more complex. The examinee simply copies these forms in the Test Booklet. The test can be individually or group administered in just 10 to 15 minutes. A Short Form, composed of 15 drawings, is often used with 3- to 8-year-old children.

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Two supplemental test--the VMI Visual Test and the VMI Motor Test--can each be administered in 5 minutes or less. They are generally given if full- or short-form VMI results indicate a need for further testing. The supplemental tests use the same VMI stimulus forms, so it's easy to compare results from all three tests, using a profile form provided in the Test Booklet.

A revised scoring system permits finer discrimination between performances, especially at older age levels. The Manual presents very clear scoring criteria, standard scores, percentiles, and teaching suggestions. It also reports recent medical and neuropsychological applications of the VMI.
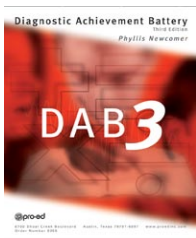
Five teaching tools, new to the Fifth Edition, offer activities and exercises that help teachers respond to VMI results. These are described below.

The Adult Version, for use with individuals aged 19 to 100, facilitates the identification of neurological and related problems in the adult population.

One of the most well researched instruments of its kind, the VMI is useful in assessing learning, neuropsychological, and emotional disorders.

Diagnostic Achievement Battery 3 (DAB-3)
by Phyllis L. Newcomer

This popular achievement test provides a comprehensive assessment of academic abilities in 6- to 14-year-old students. It profiles strengths and weaknesses in the following areas: Listening, Speaking, Reading, Writing, and Mathematics. DAB-3 is particularly useful in identifying students for special education placement or remedial planning.

The battery includes 14 subtests, all relevant to the assessment of learning disabilities:

- Story Comprehension
- Capitalization
- Characteristics
- Punctuation
- Synonyms
- Spelling
- Grammatic Completion

- Contextual Language
- Alphabet/Word Knowledge
- Math Reasoning
- Reading Comprehension
- Math Calculation
- Story Construction
- Phonemic Analysis

The entire battery can be individually administered in about 45 minutes. To reduce administration time, you can give the Spelling, Capitalization, Punctuation, and Math Calculation subtests in small groups. In addition, any of the 14 subtests can be administered independently and used diagnostically.

Standardized on more than 1,500 students, DAB-3 provides standard scores and percentiles for each subtest. By combining subtests, you can also generate various composite scores: Listening, Speaking, Reading, Writing, Mathematics, Spoken Language, Written Language, and Total Achievement. These are useful in determining the child's global strengths and weaknesses.

The DAB-3 includes studies showing the absence of gender, ethnic, and disability bias; all new normative data; new validity studies; a new Story Comprehension audio tape; a supplemental manual that enables the examiner to probe student responses; realistic colour pictures; and clearer administration procedures.

Easy to administer and score, the DAB-3 is an excellent resource for school psychologists and others concerned with the identification of learning problems, special education placement, and remedial planning.

Emotional Disturbance Decision Tree (EDDT)
Bryan L. Euler, PhD

The EDDT is the first instrument of its kind to provide a standardized approach to the assessment of Emotional Disturbance (ED) that covers all of the federal criteria and addresses the broad emotional and behavioral nuances of children ages 5-18 years suspected of requiring special education services for an ED. The federal criteria, from the U.S. Code of Federal Regulations and the reauthorization of the Individuals With Disabilities Education Act (IDEA; 2004), is challenging because it mandates that certain conditions be present in order to receive services, yet provides no guidelines for assessing these conditions. Designed by a working school psychologist, the EDDT includes five sections that match up with the specific components of the federal criteria, thus enabling evaluators to work through each criterion--one by one.

One of the most difficult assessment issues surrounding ED is that of Social Maladjustment (SM). According to the federal criteria, children who are socially maladjusted do not meet the criteria for special education services as ED unless it is determined that the child is both socially maladjusted and emotionally disturbed. This single clause in the federal definition has sparked significant controversy. The EDDT addresses some of the challenges surrounding this issue by treating SM as a supplemental trait and assessing it after ED characteristics have been assessed.

The EDDT is useful for school psychologists, counseling/clinical psychologists, guidance counselors, evaluation specialists, teachers, educational diagnosticians, and speech/language pathologists within the school setting as well as within juvenile correctional facilities. that covers all of the federal criteria and addresses the broad emotional and behavioral nuances of children ages 5-18 years suspected of requiring special education services for an ED. The federal criteria, from the U.S. Code of Federal Regulations and the reauthorization of the Individuals With Disabilities Education Act (IDEA; 2004), is challenging because it mandates that certain conditions be present in order to receive services, yet provides no guidelines for assessing these conditions. Designed by a working school psychologist, the EDDT includes five sections that match up with the specific components of the federal criteria, thus enabling evaluators to work through each criterion--one by one.

The Emotional Disturbance Characteristics section of the EDDT consists of the following scales: Inability to Build or Maintain Relationships (REL), Inappropriate Behaviors or Feelings (IBF), Pervasive Mood/Depression (PM/DEP), Physical Symptoms or Fears (FEARS), and the EDDT Total Score (TOTAL). In addition, two cluster scores are derived from this section:

Attention Deficit Hyperactivity Disorder (ADHD) Cluster and Possible Psychosis/Schizophrenia (PSYCHOSIS) Cluster.

One of the most difficult assessment issues surrounding ED is that of Social Maladjustment (SM). According to the federal criteria, children who are socially maladjusted do not meet the criteria for special education services as ED unless it is determined that the child is both socially maladjusted and emotionally disturbed. This single clause in the federal definition has sparked significant controversy. The EDDT addresses some of the challenges surrounding this issue by treating SM as a supplemental trait and assessing it after ED characteristics have been assessed.

In addition, it also addresses the severity and the educational impact of emotional and behavioral problems on students through two clusters--the Level of Severity (SEVERITY) Cluster and the Educational Impact (IMPACT) Cluster. These two clusters aid in the development of recommendations and interventions.

Standardization, Reliability, and Validity
The EDDT standardization sample was composed of 601 children ages 5-18 years that were well-matched to the U.S. population for gender, race/ethnicity, and geographic region. In addition, data were collected on a sample of 404 children eligible for Special Education due to ED.

- Internal consistency was high ($r = .94$) for the EDDT TOTAL Score, ranging from .75-.88 for the other EDDT scales.

- Test-retest stability was high ($r = .92$) for the EDDT TOTAL Score, ranging from .81-.94 (interval of 1-44 days, mean = 18 days).

- Interrater reliability was good ($r = .84$) for the EDDT TOTAL Score (mean T-score change = 1.04).

- Convergent validity was examined for the normative sample using the Clinical Assessment of Behavior™ (CAB™) Teacher Form and the Behavior Assessment System for Children, Second Edition (BASC-2) Teacher Form. These same forms were used to examine convergent validity for a subgroup of the ED sample, along with the CAB Parent Form and the Teacher Report Form of the Achenbach Child Behavior Checklist (CBCL).

- Validity also was examined using six specific samples of children who were representative of various Special Education exceptionalities--specific learning disability (SLD), speech/language impairment (SLI), mental retardation (MR), attention-deficit hyperactivity disorder (ADHD), autism spectrum disorder (ASD), and socially maladjusted (SM) using the following measures:
  - CAB™; Teacher Form
  - BASC-2 Teacher Form
  - Clinical Assessment of Attention Deficit for Children™ (CAT-C™) Teacher Form
  - Gilliam Autism Rating Scale (GARS)
  - Gilliam Asperger Disorder Scale (GADS)
  - Conduct Disorder Scale (CDS)
  - Differential Test of Conduct and Emotional Problems (DTCEP)
  - Jesness Inventory-Revised (JI-R)

EDDT Materials

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The EDDT is composed of a Professional Manual, a reusable Item Booklet, a carbonless Response Booklet, and the Score Summary Booklet. The Professional Manual contains administration and scoring information, normative tables, reliability and validity information, along with eight detailed case studies. The Score Summary Booklet includes five sections that mirror the five sections in the Item Booklet, the Emotional Disturbance Characteristics Profile, and an optional table to assist in the interpretation of EDDT data in conjunction with the federal criteria.

The EDDT is useful for school psychologists, counseling/clinical psychologists, guidance counselors, evaluation specialists, teachers, educational diagnosticians, and speech/language pathologists within the school setting as well as within juvenile correctional facilities.

Early Childhood Inventory-4 (ECI-4)

by Joyce Sprafkin, Ph.D., and Kenneth D. Gadow, Ph.D.

Modelled closely on the *Child Symptom Inventory-4*, the *Early Childhood Inventory-4* (ECI-4) screens for emotional and behavioural disorders in children from 3 to 5 years of age. A Teacher Checklist and a Parent Checklist, based on DSM-IV criteria, cover symptoms for the same disorders as the CSI-4, except that they do not cover schizophrenia but add reactive attachment disorder, selective mutism, and eating, sleeping, and elimination problems. In addition, a brief developmental section gives a global impression of the child's speech and language abilities, fine and gross motor coordination, and social skills.

Like the CSI-4, the ECI-4 offers a Screening Cutoff Score and a Symptom Severity Score, which together give a good picture of the child's symptoms and groundwork for a DSM-IV diagnosis.

The ECI-4 Manual addresses appropriate concerns and cautions about applying DSM-IV diagnostic criteria to preschool children.

Endler Multidimensional Anxiety Scales (EMAS)
Norman S. Endler, Ph.D., F.R.S.C., Jean M. Edwards, Ph.D., & Romeo Vitelli, Ph.D.

The EMAS scales asses and predict anxiety across situations and measure treatment response. They are useful when evaluating social phobias, the cause of panic attacks, General Anxiety Disorder, and Posttraumatic Stress Disorder. They are also an effective method of monitoring treatment progress over time.

The EMAS consists of three main scales. The EMAS-State (EMAS-S) scale measures state anxiety - an individual's transitory anxiety response. The EMAS-Trait (EMAS-T) scale measures an individual's predisposition to experience anxiety in four types of situations: socially evaluative, physically dangerous, new or ambiguous, and routine. The EMAS-Perception (EMAS-P) scale evaluates one's perception. The EMAS-S is on one form, while the EMAS-T and EMAS-P are on a second form.

Feelings Attitudes and Behaviors Scale for Children (FAB-C)
Joseph H. Beitchman, M.D.

While parents are rating their children using the CRS–R scales (see page 6), children under 13 should complete the FAB–C questionnaire to obtain a multidimensional assessment of his or her feelings and behaviors. It will also highlight discrepancies between parents, teachers, and the child to ensure that you are basing treatment on the most accurate information.
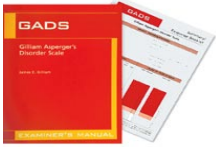
Suited for clinical and research purposes, the FAB–C is used as a routine screening device in schools, outpatient clinics, residential treatment centers, child protective services, and private practices.

The normative sample consisted of 1,988 children. Separate norms are available for boys and girls in 2-year age intervals. Raw scores are easily converted to T-scores with the QuikScore™ Form.

Profile Reports present scores graphically and numerically to summarize the results of each administration
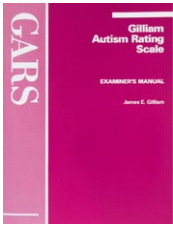
Gilliam Asperger Disorder Scale (GADS)

James E. Gillam, Ph.D.

The GADS has been particularly noted for its ability to distinguish Asperger Disorder from Autistic Disorder. It provides documentation about the essential behavior characteristics necessary for diagnosis and can be used to document behavioral progress, to target goals for Individualized Education Programs (IEP), and for research purposes.

Gilliam Autism Rating Scale (GARS)

James E. Gilliam, Ph.D.

The GARS-2 assists in identifying autism in children and youth from 3 to 22 years of age. It also indicates the severity of autism in an individual so that appropriate coping strategies can be developed.

The GARS-2 uses objective, frequency-based ratings and consists of 42 items describing the characteristic behaviors of individuals with autism. All items on are based on the definitions of autism adopted by the Autism Society of America and the *Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition-Text Revision* (DSM-IV-TR).

The GARS-2 manual provides updated interpretation guidelines and new normative data from a sample of 1,107 individuals with autism from 48 states in the United States. In addition, the GARS-2 replaces the *Early Development* subscale with a structured parent interview to gather diagnostically important information from the child's parents.

Gray Diagnostic Reading Tests, Second Edition (GDRT-2)

by Brian R. Bryant, J. Lee Wiederholt, and Diane P. Bryant

The GDRT-2 is a norm-referenced, reliable, and valid assessment of oral reading ability. Individually administered in 45-60 minutes, the GDRT-2 is appropriate for individuals aged 6-0 to 13-11. It can be used to assess students who have difficulty reading continuous print or who require an evaluation of specific abilities and weaknesses. Two parallel forms are provided, allowing you to monitor a student's reading progress over time. Teachers and reading specialists find this test a useful and efficient way to gauge reading skills progress.

The GDRT-2 has four core subtests, each of which measures an important reading skill:

- Letter/Word Identification
- Phonetic Analysis
- Reading Vocabulary
- Meaningful Reading

- In addition, there are three supplemental subtests that measure skills considered important in diagnosing or teaching developmental readers or children with dyslexia. The three supplemental subtests are:
- Listening Vocabulary
- Rapid Naming
- Phonological Awareness

To enhance the clinical and diagnostic usefulness of the GDRT-2, scaled scores for the core subtests can be combined to form three composites:

- Decoding Composite
- Comprehension Composite
- General Reading Composite

The test was standardized on a sample of 1,018 students ages 6 through 18. The normative sample was stratified to correspond to key demographic variables (e.g., race, gender, and geographic region).

Gray Oral Reading Tests--Fourth Edition (GORT-4)

by J. Lee Wiederholt and Brian R. Bryant

The GORT-4 provides an objective measure of growth in oral reading and helps diagnose oral reading difficulties. This version features updated and expanded norms, new reliability and validity data, and studies showing absence of gender and ethnic bias. In addition, a new, easier reading passage was added.

The GORT-4 includes two equivalent forms (A and B), that can be used interchangeably. This allows the examiner to study an individual's oral reading progress over time. Both forms contain 14 developmentally sequenced passages, each followed by 5 comprehension questions. The test provides scores for Rate, Accuracy, Fluency, and Comprehension. These are reported as standard scores, percentile ranks, and grade equivalents. The Fluency and Comprehension scores are combined to obtain an Oral Reading Quotient.
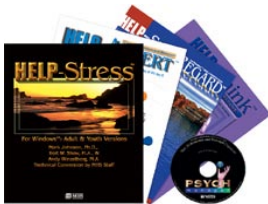
The GORT-4 is appropriate for students from 6-0 through 18-11 years of age. The standardization sample includes more than 1,600 typical students from various geographic, ethnic, linguistic, and socioeconomic backgrounds.

Administration time varies from 20 to 30 minutes. The examiner records the student's reading rate, deviations from the printed passages, and miscues. The Manual provides clear scoring guidelines and a system for analyzing miscues in four areas: Meaning Similarity, Function Similarity, Graphic/Phonemic Similarity, and Self-Correction.

The GORT-4 is widely used to identify students who are significantly below their peers in oral reading proficiency, to determine reading strengths and weaknesses of individual students, and to document reading progress as a consequence of intervention.

Help Self Regard for Windows: Adult & Youth

Nancy Levyn Chaconas, M.A.

The HELP Self Regard™ program helps clients develop a realistic, positive self-image by teaching concepts and skills such as identifying and challenging self-defeating thoughts. The program includes 11 sessions.

The HELP Series for Windows software offers strategies to help adolescents (13-17) and adults (18 and older) improve aspects of their interpersonal and intrapersonal functioning. Each program consists of multiple sessions, and each session takes 30 minutes to complete. The programs are user-friendly and can be administered to a caseload of 6, 12, or 24 clients, which makes them ideal for large settings such as schools, hospitals, correctional facilities, and work environments.

Help-Think for Windows: Adult & Youth

Mark Johnson, Ph.D.

The HELP Think™ program is an interactive supplement to psychotherapy and counseling. The tool uses cognitive behavioral principles and interactive exercises to foster awareness, motivate for positive change, and provide practical strategies for rapid, effective, and long lasting personal change. The program includes nine sessions.

The HELP Series for Windows® offers strategies to help adolescents (13-17) and adults (18 and older) improve aspects of their interpersonal and intrapersonal functioning. Each program consists of multiple sessions, and each session takes 30 minutes to complete. The programs are user-friendly and can be administered to a caseload of 6, 12, 24 clients, which makes them ideal for large settings such as schools, hospitals, correctional facilities, and work environments.

Jordan Left-Right Reversal Test
by Brian T. Jordan, Ph.D.

This norm-referenced test assesses visual reversals of letters, numbers, and words in students 5 years of age and older. It is an excellent screening instrument for the early detection of learning disabilities.

Untimed, the test can be administered and scored in about 20 minutes to individuals or groups. It consists of two levels. Level I requires the student to identify reversals of single letters and numbers, while Level II includes reversals of letters within words and reversals of whole words within sentences. Younger children (5 through 8 years of age) are given Level I only. Level II is added for children 9 and above.

Error scores are converted to Developmental Age scores and percentiles, with Normal, Borderline, and Deviant ranges indicated. Laterality Checklists allow you to evaluate the child's preference for one side of the body, for unilateral tasks. Once the child has settled on a lateral preference, it is easier to remediate letter reversals.

Norms are based on a population of more than 3,000 children between 5 and 12 years of age in average classroom settings. Separated by sex and presented at half-year intervals, these norms allow fine discrimination, resulting in few false negatives.

This edition provides an accurate and cost-effective way to screen for learning problems and plan remediation.

Kaufman Assessment Battery for Children, Second Edition (KABC-II)
by Alan S. Kaufman and Nadeen L. Kaufman

This revision of the highly regarded Kaufman Assessment Battery for Children makes it the assessment tool you can use with all children. An optional Knowledge/ Crystallized Ability Scale expands the test's utility, while the battery as a whole continues to measure other broad abilities and processes with a minimum of verbalization.

This fully revised edition offers the following features:

- An expanded age range, from 3 through 18 years
- Two assessment approaches: Luria's neuropsychological model and the Cattell/Horn/Carroll (CHC) method of categorizing cognitive abilities
- The Knowledge/Crystallized Ability Scale, replacing the original Achievement Scale

These changes allow you to administer and interpret the instrument in a way that is best suited to the child's linguistic and cultural background. You can choose the CHC model, which treats verbal skill as a cognitive ability and includes it in the overall composite. Or you can choose the Luria model if you want a mental-processing composite that does not include verbal ability. And for an even more language-free assessment, you can use the Nonverbal Composite.

Scales are labelled differently for the Luria and CHC models, and each is composed of two to four subtests:

Luria Model	CHC Model
SCALE NAMES	
Simultaneous Processing	Visual Processing
Sequential Processing	Short-Term Memory
Planning Ability	Fluid Reasoning
Learning Ability	Long-Term Storage/Retrieval
	Knowledge/Crystallized Ability

OVERALL COMPOSITES

Mental Processing Composite	Fluid-Crystallized Index
Nonverbal Composite	Nonverbal Composite

Three-year-olds take a brief five- to seven-subtest battery that yields the overall composites but not scores for the ability/ processing scales. KABC-II subtests are designed to minimize verbal instructions and responses. This gives you in-depth data with less filtering due to language.

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Completed in 35 to 70 minutes, the KABC-II retains the strengths of the original battery while giving you more flexibility and more accurate results. Administration and scoring procedures are easy to learn and apply, and test content is attractive to children, which makes it easier to keep them focused during the assessment.

Kaufman Brief Intelligence Test, Second Edition (KBIT-2)
by Alan S. Kaufman and Nadeen L. Kaufman

This popular measure, now available in a fully revised Second Edition, gives you more information than any other brief intelligence test. Individually administered in just 20 minutes, it assesses both verbal and nonverbal intelligence in people from 4 through 90 years of age.

The KBIT-2 is composed of two separate scales. The Verbal Scale contains two kinds of items-- Verbal Knowledge and Riddles--both of which assess crystallized ability (knowledge of words and their meanings). Items cover both receptive and expressive vocabulary, and they do not require reading or spelling.

The Nonverbal Scale includes a Matrices subtest that assesses fluid thinking--the ability to solve new problems by perceiving relationships and completing analogies. Because items contain pictures and abstract designs rather than words, you can assess nonverbal ability even when language skills are limited. Full-colour items appeal to children, particularly those who are reluctant to be tested.

The KBIT-2 provides Verbal and Nonverbal Scores, plus a composite IQ. Test items are free of cultural and gender bias.

The KBIT-2 is an efficient way to compare verbal and nonverbal abilities, screen for gifted students, get a quick estimate of intelligence in institutional settings (such as prisons, group homes, rehabilitation centers, and mental health clinics), and reevaluate individuals previously given a comprehensive IQ test. Brief and easy to use, it also offers impressive reliability and validity.

Kaufman Survey of Early Academic and Language Skills (K-SEALS)
by Alan S. Kaufman and Nadeen L. Kaufman

This versatile instrument measures children's expressive and receptive language skills, pre-academic skills, and articulation. Normed for 3- through 6-year-olds, the K-SEALS is ideal for preschools, kindergartens, elementary schools, speech and language clinics, and other settings where young children are assessed. It is commonly used to test for school readiness, to identify gifted children, and to evaluate early intervention programs.

Individually administered in just 15 to 25 minutes, the test includes four scales, three subtests, and a composite score:

Scales
Expressive Skills
Receptive Skills
Number Skills
Letter and Word Skills

Subtests
Vocabulary
Numbers, Letters, and Words
Articulation Survey

Composite
Early Academic and Language Skills

Scores provided are age-based standard scores, percentile ranks, descriptive categories, and age equivalents. In addition, K-SEALS allows you to observe the child's test-taking behaviours and interpret scores in the context of these behaviours.

Easy to administer and score, K-SEALS gives you a balanced assessment of early academic and language skills.

Kent Inventory of Developmental Skills (KIDS)

by Jeanette Reuter, Ph.D., Lewis Katoff, Ph.D., and Chris Gruber, Ph.D.

Here is an ideal way to respond to current mandates for early intervention. This new rating scale can be used to assess the developmental status of any infant less than 15 months of age--or children, up to age 6, who have severe developmental disabilities.

Completed by the child's caregiver, and therefore based on numerous behaviour observations across a wide range of conditions, the KIDS assesses the following domains:

Cognitive	Motor
Communication	Self-Help
Social	

For each domain, the KIDS provides developmental age scores, which both parents and professionals find easy to understand.

The scale can be completed in about 45 minutes by a parent, teacher, nurse, baby-sitter, or child care worker--anyone who is directly responsible for a significant portion of the child's daily care. If the caregiver has trouble reading or writing, a trained interviewer can read the KIDS items aloud and record the caregiver's responses. Otherwise, the caregiver need not be under professional supervision when completing the scale. He or she may complete it at home and return it for scoring.

The developmental age scores produced by the KIDS give you a clear picture of the child's overall developmental status as well as his or her relative strengths and needs. The KIDS profile tells you whether the child is "developmentally delayed," "at risk," or "not delayed." In addition, standard scores allow you to compare developmental status across time, samples, and measures. And optional developmental timetables identify emergent behaviours in each domain--behaviours that the child can be expected to learn next if development is proceeding normally.

The KIDS CD allows you to administer the inventory on your computer (or enter responses from the Answer Sheet), score it instantly, and print out a complete interpretive report on the spot. The computer report provides developmental age scores and standard scores for the full scale and each of the five domains. It explains the scores, noting any skills that are in the "delayed" or "at risk" range; it prints developmental timetables for each domain; and it suggests activities tailored to the child's specific developmental status.

Standardized on samples of healthy infants in the U.S. and Europe, the KIDS has proven valid with diverse populations, in various settings--including hospitals, neonatal ICU follow-up programs, early intervention programs, adoption agencies, parenting classes, and programs for mothers with substance abuse problems.

In addition, the KIDS offers economy, easy administration and scoring, and a natural way to bring caregivers into the assessment and treatment process, as mandated by IDEA (PL 101-476). It is an excellent first step in any early intervention program.

Koppitz Developmental Scoring System for the Bender Gestalt Test -- Second Edition (KOPPITZ-2)
by Cecil R. Reynolds, Ph.D.

This revision of Elizabeth Koppitz's Bender Gestalt scoring system retains the developmental approach that made the original so popular while adding new norms, an expanded age range, and improved reliability. These changes give clinicians and educators a highly useful measure of visual-motor integration across the life span.

Using the Bender Gestalt II Stimulus Cards, the KOPPITZ-2 requires the examinee to draw increasingly complex figures on a plain sheet of white paper. This relatively unstructured task assesses the individual's ability to relate visual stimuli to motor responses and to organize the effort independently.

Individually administered in just 5 to 10 minutes, the KOPPITZ-2 includes the following key features:

- New norms based on a nationally representative sample of 3,600 people
- An expanded age range -- from 5 to 85 years (which allows evaluation of special education students up to age 21)
- Separate scoring systems for young children (ages 5 to 7 years) and older children and adults (ages 8 to 85+ years)
- The addition of two- and three-dimensional drawings for older children and adults -- drawings that can reveal subtle visual-motor integration deficits
- A completely nonverbal format that makes the test appropriate for individuals from all cultural and ethnic backgrounds
- High reliability across age, gender, and ethnicity
- Detailed scoring guidelines that insure high interscorer reliability
- A variety of scores -- standard scores, percentile ranks, specialized scores, and age equivalents -- to meet the needs of all practitioners
- A separate section of the Manual explaining how to use Koppitz Emotional Indicators (EIs) and a specialized form for this purpose

More clinically useful than ever, the KOPPITZ-2 can help you determine the presence and degree of visual-motor problems; identify candidates for remediation or visual-motor training; monitor progress in cases of acute injury or degenerative disease; and evaluate the effectiveness of intervention efforts.

The Learning Disabilities Diagnostic Inventory (LDDI)
by Donald D. Hammill and Brian R. Bryant

Now you can diagnose learning disabilities without depending solely on IQ tests, achievement tests, or discrepancy formulas. This new rating scale is specifically designed to help psychologists,

diagnosticians, LD specialists, speech-language pathologists, and others identify learning disabilities in students between the ages of 8-0 and 17-11. A reliable and valid norm-referenced inventory, the LDDI is composed of six independent scales--one for each of the areas identified by the U.S. Office of Education and National Joint Committee on Learning Disabilities:

- Listening
- Speaking
- Reading
- Writing
- Mathematics
- Reasoning

 The LDDI helps diagnose receptive and expressive dysphasia, dyslexia, dysgraphia, dyscalculia, and disorders in executive functioning. Not an achievement or ability test, the LDDI was built for the single purpose of helping professionals identify learning disabilities in individual students. Scores are reported in terms of stanines and percentiles.

This test tells you the extent to which a student's skill patterns in a particular area (e.g., reading, writing) are consistent with those of individuals known to have a learning disability in that area (e.g., dyslexia, dysgraphia). Thus, the LDDI shifts the diagnostic emphasis away from interpreting norm-referenced ability test scores and toward an analysis of individual skill patterns. The LDDI is quick, easy to administer and interpret, and free of cultural, gender, and racial bias. It brings clinical/teacher judgment back into the diagnostic process.

Learning Efficiency Test II (LET-II)
by Raymond E. Webster, Ph.D.

The *Learning Efficiency Test II* (LET-II) is a quick and reliable measure of the visual and auditory memory of individuals aged 5 to 75 years and above. Individually administered in just 10--20 minutes, it uses nonrhyming letters as stimulus items, presented in sequences that range from two to nine letters. Raw scores are converted to standard score equivalents and percentile ranks, with separate norms provided for each year up to age 15 and for various age ranges between 15 and 75 years.

The LET-II includes two subtests--visual and auditory--which each measure three conditions: immediate recall, short-term recall, and long-term recall. Assessing both ordered and unordered memory, the test provides six scores for each subtest.

This edition features expanded norms, new case studies, broader remediation strategies, and an improved Record Form and scoring system.

The LET-II predicts actual classroom reading and mathematics achievement levels for children with cognitive or emotional problems and identifies preferred learning styles. It is also useful in assessing the effects of aging and physical injury on the cognitive functioning of adults and children, and in developing specific individualized educational programs for atypical learners.

A handbook, *Clinical Interpretations for the LET-II*, written by the test author, introduces

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users to four different approaches to test interpretation. Highly practical, this handbook also presents remedial techniques and learning strategies for atypical learners. In addition, 10 case studies illustrate both interpretation and remediation.

Learning Styles Inventory (LSI)
by Albert A. Canfield, Ph.D.

The *Learning Styles Inventory* (LSI) makes it easier to determine which learning environments--and which instructors--are best for particular students. In both academic settings and industrial training programs, the LSI can improve student or trainee performance and reduce dropout rates.

Designed for junior high, high school, and college students as well as adults, the LSI is a self-report inventory that measures learning preferences. It is composed of 30 items that give you four kinds of information:

1. **Preferred Conditions for Learning**
   Does the student like teamwork, independent study, competition, classroom discipline, organized coursework, a close relationship with the instructor, or detailed information on assignments and requirements?

2. **Areas of Interest**
   Does the student like to work with numbers, language, things, or people?

3. **Mode of Learning**
   Does the student prefer to obtain new information through listening, reading, interpreting illustrations or graphs, or through hands-on experience?

4. **Expectation for Course Grade**
   How well does the student expect to perform in the class?

LSI scores are used to classify the student into one of nine learner types. This Learner Typology allows you to identify groups of students who have similar learning styles.

The LSI can be completed in just 15-20 minutes. Students can easily score their own tests and classify themselves on the Learner Typology grid. This saves you time and also gives students immediate feedback.

Standardized on more than 2,500 individuals, the LSI is available in four forms. Form A uses college norms; Form B, high school norms; and Form C, junior high school norms. These three forms all have a 7th-grade reading level. Form E is an easy-to-read edition, with college norms and a 4th-grade reading level.

In counseling centers, classrooms, and industrial training programs, the LSI is used to adapt instructional strategies to learner needs, to design alternative curricula, to help individuals select courses or work environments compatible with their learning styles, and to help reduce dropout rates.

Leiter International Performance Scale-Revised (Leiter-R)
by Gale H. Roid, Ph.D., and Lucy J. Miller, Ph.D.

The fully revised Leiter-R is completely nonverbal. Neither the examiner nor the child is required to speak, and the child doesn't need to read or write, either. The test's engaging, game-like tasks hold the child's interest, and its easy administration and quick, objective scoring make for an efficient assessment.

Because the Leiter-R is nonverbal, it is especially suitable for children and adolescents who are cognitively delayed, disadvantaged, nonverbal or non-English speaking, speech or hearing impaired, motor impaired, ADHD, autistic, or suffering from traumatic brain injury. It spans ages 2 years, 0 months through 20 years, 11 months.

The Leiter-R consists of two nationally standardized batteries:

Visualization and Reasoning Battery	**Attention and Memory Battery**
REASONING:	MEMORY:
Classification	Memory Span (Forward)
Sequential Order	Spatial Memory
Repeated Patterns	Associative Memory
Design Analogies	Immediate Recognition
	Memory Span (Reverse)
VISUALIZATION:	Visual Coding (Symbol and Digit)
Matching	Associative Delayed Memory
Picture Context	Delayed Recognition
Figure-Ground	
Paper Folding	ATTENTION:
Form Completion	Attention-Sustained
Figure Rotation	Attention-Divided

The Attention and Memory Battery distinguishes children with ADHD or other neuropsychological impairments from typical children. It also enhances interpretation of the global IQ score by providing valuable diagnostic indicators that help explain scores on the Visualization and Reasoning Battery. For example, the battery enables psychologists to determine whether low academic achievement in subjects such as mathematics, spelling, and reading is a result of a low IQ or specific neuropsychological causes such as ADHD.

Included in both batteries are unique "growth" scores, which measure small, but important, improvement in children with significant cognitive disabilities. This allows psychologists, educators, and parents to see improvement across time, regardless of age-based standard scores.

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Unlike other IQ tests, the Leiter-R emphasizes fluid intelligence, considered by many the truest measure of a person's innate ability. The Leiter-R IQ score is not significantly influenced by the child's educational, social, and family experience. The test provides meaningful information about the child's abilities rather than focusing on deficits. Charts showing progressive skills provide graphic representations of what the scores mean rather than simply reporting results as standard scores.

In addition to traditional IQ scores, Leiter-R provides scaled scores for its subtests, which identify specific strengths and weaknesses, as well as percentile and age equivalents, making test results easier to understand for parents and other professionals. Also, four social-emotional rating scales (Examiner, Parent, Self, and Teacher ratings) provide essential information about the child's activity level, attention, impulse control, and other emotional characteristics that may interact with test performance and functional performance at home and school.

The Leiter-R was standardized on 1,719 typical children and adolescents, and 692 atypical children (representing 9 clinical groups), aged 2 years, 0 months to 20 years, 11 months. Caucasian, Hispanic-American, African-American, Asian-American, and Native American children were included.

Typical administration times are:

Reasoning and Visual Battery: 40 min.   IQ Screening: 25 min.

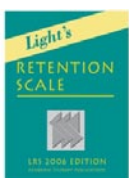Memory and Attention Battery: 35 min.   Gifted Screening: 35 min.

LD/ADHD Screening: 25 min.

The Leiter-R correlates .85 with WISC-III Full Scale IQ and .85 with the original Leiter IQ Scale. Psychometric studies on Native American, Hispanic, and African-American groups show the Leiter-R to be exceptionally fair, regardless of the child's cultural, ethnic, or socio- economic background.

The Leiter-R Training DVD answers the most commonly asked questions about Leiter-R administration, scoring, and interpretation. The DVD is appropriate for both beginning and advanced examiners and includes sample administrations and helpful tips.

Light's Retention Scale
2006 Edition
by H. Wayne Light, Ph.D.

This useful scale helps teachers, parents, and administrators understand the pros and cons of grade retention for students at the elementary and secondary levels (ages 6 through 18 years). It is an economical way to arrive at a sound decision regarding grade retention--a decision that takes into account the individual situation and the needs of the child. The 2006 edition features an updated literature review, which is one of the most comprehensive and current available on grade retention.

Usually completed and discussed during parent/teacher conferences, the scale is composed of 20 categories related to grade retention. The student is rated from 1 to 5 on each of these categories, and a total score is computed. This score tells you whether grade retention would be helpful or harmful to the student in question. The *Light's Retention Scale* provides opportunities for dialogue between parents and educators, and assures all involved that the decision is based on thoughtful, professional findings. A Parent Guide explains the rating criteria in a straightforward, easy-to-understand manner.

While not a standardized test, this is an excellent counseling and decision-making tool. It requires only 10 minutes, yet it provides an objective, structured, and legally defensible analysis of the factors that should be considered in making a decision about grade retention.

An optional School Administrator's Kit contains Worksheets, Parent Consent Forms, and Appeal Forms that are useful when documenting the decision process.

Multidimensional Anxiety Scale for Children (MASC)
John S. March, M.D.

The choice of experts for symptom-specific measures, the MASC assessment distinguishes between important anxiety symptoms for focused treatment, incorporates and reconciles multiple observations, and tracks changes in symptom type and level for treatment monitoring and outcome evaluations. It is commonly used in schools, outpatient clinics, residential treatment centers, child protective services, juvenile detention centers, and private practices to assess anxiety disorders and develop appropropriate treatment strategies for children and adolescents.

The MASC-10 is designed for repeat testing. This one-dimensional measure combines the four basic anxiety scales from the long version to produce one score. Easy to administer and score, it is well-suited for group testing situations and for treatment monitoring.

The normative sample consists of 2,698 children and adolescents. Raw scores are plotted on a Profile Form for easy conversion to T-scores, which are separated into three age groups.

McDowell Vision Screening Kit
by P. Marlene McDowell, PN, BSN, M.A. and Richard L. McDowell, Ed.D.

Detect vision problems early

With the *McDowell Vision Screening Kit*, you can test virtually any child for vision problems--even very young and severely disabled children who are too inattentive, difficult, or impaired to evaluate with conventional vision screeners. This unique test lets you assess the functional vision of children previously considered untestable.

Convenient, quick, and economical, the *McDowell* provides a *complete evaluation.* It gives you a behavioural assessment of visual performance in five areas:

Distance Visual Acuity

Observation of visual fixation and tracking of collared balls.

Near Point Visual Acuity

Observation of visual fixation and visual response to black dots positioned randomly on white cards.

Ocular Alignment and Motility

The cover-uncover test in conjunction with the pupillary light reflex test.

Colour Perception

Matching blocks in primary colours.

Ocular Function

Observation of scanning ability shifts of attention, visual tracking, and ocular convergence, conjugate gaze, visual fields, and blink reflex.

The *McDowell Kit* contains all the toys, objects, and recording forms you need to do a comprehensive screening. The entire process takes only 10 to 20 minutes, and scoring is based on simple pass/fail criteria. If the child fails in a given area, referral recommendations are provided.

Minimize misdiagnosis

The procedures used in the *McDowell Vision Screening Kit* consistently identify children with the three most common and correctable vision problems: refractive errors, ocular alignment dysfunction, and amblyopia. Virtually all children, regardless of their developmental level, can complete these procedures.

Studies reported in the Manual--based on 181 children from 2.9 to 5.4 years of age, from varied cultural and socioeconomic backgrounds, with IQs from the mentally retarded range to gifted--demonstrate that the *McDowell* is valid, accurate, and reliable. Test-retest reliability coefficients range from .89 to 1.00. And correlations between *McDowell scores* and results of standard vision screening procedures range from .90 to 1.00. In addition, vision problems identified by the *McDowell* were later confirmed by licensed eye-care specialists.

Do all mandated vision screening

The *McDowell* is a real breakthrough because it gives schools the means to do all appropriate and mandated vision screening--at a low cost. No other instrument can be used effectively with preschool and severely disabled children. Unlike other vision screeners, the *McDowell* requires no matching skills and no verbal skills. It permits early detection and treatment of vision problems--before they cause permanent damage or developmental delays.

Merrill-Palmer-Revised (M-P-R) Scales of Development
by Gale H. Roid, Ph.D., and Jackie L. Sampers, Ph.D.

Revised and expanded, this edition of the *Merrill-Palmer Scales of Development* retains the kind of engaging "hands-on" activities that made previous versions of the test so popular with early childhood assessment specialists. These toy-based activities hold the interest of even very young or distractible children, allowing you to do a comprehensive developmental evaluation in just 45 minutes.

Appropriate for children from 1 month to 6 1/2 years of age, the M-P-R assesses all IDEA-specified domains:

- Cognitive Development
- Language/Communication
- Motor Development
- Social-Emotional Behaviour
- Self-Help/Adaptive Behaviour

These domains are assessed through performance tasks and activities as well as parent and examiner rating scales. For each domain, the M-P-R provides standard scores, percentiles, age equivalents, and "growth scores" that reflect even small incremental changes. When these scores are plotted on the M-P-R Growth Score Profile, it's easy to spot the child's specific deficits. Norms are based on a nationally representative sample of more than 1,000 children. A training DVD offers administration and scoring instructions plus interpretive guidance.
M-P-R results can be used to:

- Identify developmental delays early in a child's life
- Monitor premature infants, using the highly sensitive Growth Scores
- Measure incremental improvement in children up to 6 1/2 years
- Assess youngsters with hearing impairments, autism, or limited language skills
- Provide the kind of comprehensive assessment required by IDEA for Family Service Plans and Individual Education Plans (IEPs)

The M-P-R comes in a convenient, portable travel case with wheels. All toys and manipulatives are "choke-safe."

Miller Assessment for Preschoolers (MAP)
by Lucy J. Miller

This short but comprehensive preschool assessment instrument helps you evaluate young children for mild to moderate developmental delays. Items are objective and easy to administer, and they give you a broad overview of a child's developmental status relative to other children the same age. A colour-coded Record Form clearly shows age-appropriate performance for each item.
    Designed for children from 2.9 through 5.8 years of age, MAP provides a separate form for

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each of six age levels. All forms evaluate five areas of performance, yielding the following Index Scores:

Foundations Index
Assesses abilities involving basic motor tasks and the awareness of sensations.

Coordination Index
Assesses complex gross, fine, and oral motor abilities.

Verbal Index
Focuses on memory, sequencing, comprehension, association, and expression in a verbal context.

Nonverbal Index
Examines memory, sequencing, visualization, and the performance of mental manipulations not requiring spoken language.
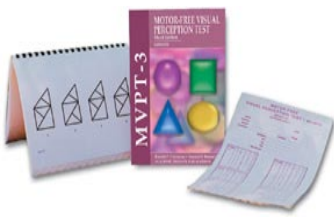
Complex Tasks Index
Measures sensorimotor abilities in conjunction with cognitive abilities that require interpretation of visuospatial information.

Administered in 30 to 40 minutes, the test presents scores as percentile ranks. Test development was based on research involving more than 4,000 children and 800 items to insure a comprehensive determination of developmental status.

Motor-Free Visual Perception Test, Third Edition (MVPT-3)
by Ronald P. Colarusso, Ed.D., and Donald D. Hammill, Ed.D.

The MVPT-3 assesses an individual's visual perceptual ability--with no motor involvement needed to make a response. It is especially useful with those who may have learning, motor, or cognitive disabilities.

MVPT-3 norms are based on a nationally representative sample. An optional, feature of the MVPT-3 is response time norms, often useful in rehabilitation settings. The test can be used for screening; diagnosis; or research by educators, psychologists, occupational therapists, optometrists, and others who need a quick, reliable, and valid measure of overall visual perceptual ability in children and adults (ages 4 through 70).

The test format is a visual multiple choice: the individual is shown a line drawing and is then asked to choose the matching drawing from a set of four on the following plate.

Five categories of visual perception are measured:

- Spatial Relationship
- Visual Closure
- Visual Discrimination
- Visual Memory

- Figure Ground

The test provides a perceptual quotient and a perceptual age score.

The MVPT-3 takes approximately 25 minutes to administer. The horizontal, multiple-choice item format of earlier versions has been retained. Test plates are contained in one easy-to-use book with an easel back. Administration cues are provided on the record form to simplify testing. Scoring is extremely easy; no basals or ceilings are needed. Raw scores are quickly converted to standard scores and percentile ranks. Optional response time data identifies whether an individual's responses are significantly delayed.

OWLS: Listening Comprehension (LC) and Oral Expression (OE) Scales (OWLS OE/LC)
Elizabeth Carrow-Woolfolk, PhD

The OWLS, consisting of the Listening Comprehension (LC) scales and the Oral Expression (OE) scales, provides an individually administered assessment of receptive and expressive language for children and young adults ages 3-21.11 years.

The LC is a measure of receptive language. Using a convenient easel, the examiner reads a verbal stimulus aloud. The examinee responds by indicating a picture on the examinee's side of the Easel. Correct responses are indicated on the examiner's side of the Easel and on the Record Form.

The OE is a measure of expressive language. The examinee answers a question, completes a sentence, or generates one or more sentences in response to a visual/verbal stimulus. Common correct and incorrect responses are included on the Record Form.

Administration is easy. Neither scale requires the examinee to read. Descriptive Analysis Worksheet Masters that allow you to categorize responses by item type (lexical, syntactic, pragmatic, and supralinguistic) are provided in each package of Record Forms.

Scoring is fast and reliable. The LC Easel and the Record Form contain correct responses for each item for on-the-spot scoring. For the OE, the examiner may do a preliminary tally and then consult the item-by-item scoring rules to determine scores of particular items.

Age-based norms can be used in learning disabilities assessments to meet requirements of P.L. 94-102 (IDEA, P.L. 101-476) for the areas of listening comprehension and oral expression. Raw scores can be converted to standard scores, percentile ranks, normal curve equivalents, stanines, and age equivalents.

The Manual reports correlations of OWLS scales with other measures of receptive and expressive language, as well as with tests of cognitive ability and academic achievement. Also, the score profiles of seven clinical groups are compared with matched control samples.

LC/OE Computer ASSIST™

The LC/OE Computer ASSIST is available on one CD-ROM for Windows® and Macintosh®. The program provides many report options, including a score profile, suggested exercises by grade range, a narrative report, and item responses.

Requirements: Windows® 3.1 or higher, CD-ROM drive, 8MB hard drive space; Macintosh® System 7.0 or higher, CD-ROM drive, 8MB hard drive space, 14-inch monitor or larger, and a 68020 CPU or higher

OWLS: Written Expression Scale (WE)

Elizabeth Carrow-Woolfolk, PhD

The OWLS WE provides an assessment of written language that may be administered individually or in small groups to persons ages 5.0-21.11 years. The scale's wide age range offers a broad-based record of growth. It is designed to measure the ability to use conventions (letter formation, spelling/incorrect words, punctuation, capitalization, conventional structures), to use linguistic forms (modifiers, phrases, question form, verb forms, sentences, complex sentence structures), and to communicate meaningfully (appropriate content, details, coherence, supporting ideas, word choice, unity).

The OWLS WE is easy to use and score. To administer the scale, the examiner reads aloud a verbal stimulus. The examinee responds by writing in the Response Booklet. Some items are presented with pictures or print for the examinee's reference when responding.

The Manual features detailed scoring guidelines with samples of actual responses. The Record Form contains representations of score patterns, a record of item-by-item results, and a summary of score comparisons. The scale has high validity and reliability.

WE Computer ASSIST

The WE Computer ASSIST is available on one CD-ROM for Windows® and Macintosh®. The program provides a score profile, score narrative, suggested exercises, and a descriptive analysis.

Requirements: Windows® 3.1 or higher, CD-ROM drive, 8MB hard drive space; Macintosh® System 7.0 or higher, CD-ROM drive, 8MB hard drive space, 14-inch monitor or larger, and a 68020 CPU or higher

PDD Behaviour Inventory™ (PDDBI™)

Ira L. Cohen, PhD, Vicki Sudhalter, PhD

The PDDBI is an informant-based rating scale that is designed to assist in the assessment of children from the age of 1 year 6 months to 12 years 5 months who have been diagnosed with a pervasive developmental disorder (PDD) as defined by the *DSM-IV™*. PDD is characterized by severe and pervasive impairments in several areas of development (e.g., communication skills, reciprocal social interaction skills, presence of stereotypical behaviors/activities). Unlike existing assessments for autism/PDD, the PDDBI was developed to assess both problem behaviors as well as appropriate social, language, and learning/memory skills. It was also designed to provide age-standardized scores for both parent and teacher ratings.

The PDDBI can be utilized across a variety of settings. For example, it can be used as a clinical tool for assisting in diagnosis and treatment recommendations and for assessing change over time. In addition, the PDDBI can be useful in educational settings (e.g., placement decisions, intervention planning, evaluating outcomes) and research applications (e.g., dependent measure for treatment intervention).

The PDDBI materials include the Professional Manual, the Parent Rating Form, the Teacher Rating Form, the Parent Score Summary Sheet, the Teacher Score Summary Sheet, and the Profile Form. Each of the Rating Forms includes an extended set of items (Parent = PDDBI-PX, with 188 items; Teacher = PDDBI-TX, with 180 items) and a standard set of items (Parent = PDDBI-P and Teacher = PDDBI-T, each with 124 items), allowing the clinician to decide on a case-by-case basis how he or she wishes to administer the items. The extended form is appropriate for use when the clinician wishes to assess other aspects of the child's behaviors beyond those that are specifically associated with autism. These other behaviors (e.g., fear, aggression) may be important to the clinician who is concerned with placement issues and treatment recommendations. The standard form is appropriate if the primary concerns are specifically related to autism (e.g., whether treatment is specifically affecting targeted behaviors). The PDDBI Extended Rating Forms consist of 10 domains for both the parent and the teacher versions; the standard forms both consist of six domains. Each domain consists of a variable number of behavioral clusters that best represent that domain. The clusters help to identify those behaviors that contribute most to a child's score on a given domain. Domain scores are divided into two sections, Approach/Withdrawal Problems and Receptive-Expressive Social Communications Abilities.

Standardization, Reliability, and Validity

The PDDBI is appropriate with children from a broad range of racial/ethnic and socioeconomic contexts. The standardization sample consisted of 369 parents and 277 teachers of children with well-defined autism from a range of racial/ethnic backgrounds and geographic regions.

- Test-retest stability for the teacher ratings ranged from .65-.99 over an average 2-week interval. For the parent sample, test-retest stability ratings ranged from .38-.91 over a 12-month interval.

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- Concurrent validity for the PDDBI was assessed via comparison with the Childhood Autism Rating Scale, the Nisonger Child Behavior Scales, the Vineland Adaptive Behavior Scales, and the Griffiths Mental Development Scales.

- Clinical validity was assessed via comparison with the Autism Diagnostic Observation Interview-Revised, the Autism Diagnostic Observation Schedule-Generic, and the Vineland Adaptive Functioning Level.

PDD Behaviour Inventory™ Scoring Program (PDDBI™-SP)
Ira L. Cohen, PhD, Vicki Sudhalter, PhD, PAR Staff

The PDDBI-SP scores and profiles an individual's responses to the PDDBI. After demographic and item response information is manually entered from the individual's completed Parent or Teacher Rating Form (standard or extended form), the PDDBI-SP generates a Score Report. The PDDBI Score Report includes client information, the Domain/Composite Score Summary Table, Discrepancy Score Summary Table, Repeated Assessment Score Summary Table, Cluster Score Summary Table, the individual's Profile, and an Item Response Table. Program functionality includes navigational tools (e.g., menu system, Quickstart dialog box, Toolbar, Status Bar), file handling, and report editing.

- Provides unlimited scoring and report generation after hand-entry of an individual's PDD Behavior Inventory responses. Generates profile graphs with the ability to overlay profiles from prior administrations for the same client. .

- Generates Score Reports of the PDD Behavior Inventory results.

- Includes built-in, easy-to-use report editing features.

- Exports client data to many spreadsheet and database programs.

- Exports client reports to common word processing programs.

- Includes an optional password feature to ensure privacy and security of client data.

Requirements: Windows® 2000/XP/Vista™; NTFS file system; CD-ROM drive for installation; Internet connection or telephone for software activation

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Peabody Developmental Motor Scales, 2nd Ed. (PDMS-2)

M. Rhonda Folio, Rebecca R. Fewell

The PDMS-2 is an early childhood motor development program that provides both in-depth assessment and training or remediation of gross and fine motor skills. The assessment is composed of six subtests that measure the interrelated motor abilities that develop early in life from birth through 5 years of age. Reliability and validity have been determined empirically. The normative sample consisted of 2,003 children residing in 46 states.

PDMS-2 Subtests:

Reflexes--8 items measure a child's ability to automatically react to environmental events.

Stationary--30 items measure a child's ability to sustain control of his or her body within its center of gravity and retain equilibrium.

Locomotion--89 items measure a child's ability to move from one place to another by crawling, walking, running, hopping, and jumping forward.

Object Manipulation--24 items measure a child's ability to manipulate balls by catching, throwing, and kicking. Because these skills are not apparent until a child has reached the age of 11 months, this subtest is only given to children ages 12 months and older.

Grasping--26 items measure a child's ability to use his or her hands. It begins with the ability to hold an object with one hand and progresses to actions involving the controlled use of the fingers of both hands.

Visual-Motor Integration--72 items measure a child's ability to use his or her visual-perceptual skills to perform complex eye-hand coordination tasks such as reaching and grasping for an object, building with blocks, and copying designs.

The PDMS-2 Has Been Improved in Several Ways

- Includes new normative data that has been stratified by age.
- Studies showing the absence of gender and racial bias have been added.
- New **Profile/Summary Forms** enable you to record the child's PDMS-2 scores to graphically display the child's performance and to compare that child's performance on the items he/she has mastered with that of the normative sample.
- New Examiner Record Booklets contain all of the items to be administered.
- New *Illustrated Guide to Administering and Scoring the PDMS-2 Items* provides a detailed description of every PDMS-2 item. The items are referenced by number within each subtest and each item description includes the age at which 50% of the children in the normative sample have mastered the item; the position the child should be in when the item is

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administered; the stimulus (if needed) for presenting the item; the procedure used to test the item; the criterion used to score the item; an illustration of a child performing the item.

- The **Peabody Motor Activities Program (P-MAP)** is the instruction/treatment program for the PDMS-2. It contains units organized developmentally by skill area. After a child's motor skills have been assessed and the examiner has completed all sections of the Profile/Summary Form, the examiner selects units from the P-MAP to use to facilitate the child's development in specific skill areas.

- The new **Peabody Motor Development Chart** provides the examiner with a convenient reference for the motor skills measured by the PDMS-2 and the ages at which 50% of the normative sample were able to perform the skill. Each of the subtests is represented along with numerous illustrations of children demonstrating the behaviors described in the text.

Profile of Moods States (POMS)
Maurice Lorr, Ph.D., Douglas M. McNair, Ph.D. & J.W. Heuchert

The POMS assessment provides a rapid, economical method of assessing transient, fluctuating active mood states. It is an ideal instrument for measuring and monitoring treatment change in clinical, medical, and addiction counseling centers. It is also well-suited to clinical drug trials because its sensitivity to change allows you to accurately document the effects of drugs on mood state. Because the POMS can be readministered as frequently as every week, you can choose the time frame that is appropriate for your situation. An extensive bibliography of POMS research is available **here**.

POMS Bipolar Version (POMS-Bi)

The POMS-Bi measures moods and feelings in clinical and nonclinical settings. It can help to determine a client's psychiatric status for therapy, or be used to compare mood profiles associated with various personality disorders. It is also a useful instrument in identifying the effects of drug treatments. In nonclinical settings, the POMS-Bi can assess mood changes produced by techniques such as psychotherapy or meditation. High school and college norms are included.

Psychoeducational Profile, 3rd Ed. (PEP-3)

Eric Schopler, PhD, Margaret D. Lansing, Robert J. Reichler, MD, and Lee M. Marcus

The PEP-3 assesses the skills and behaviors of children with autism and communicative disabilities who function between the ages of 6 months to 7 years. The profile resulting from the PEP-3 graphically charts uneven and idiosyncratic development, emerging skills, and autistic behavioral characteristics. The PEP-3 meets the need for an assessment tool to assist in the educational programming for young children (ages 3 through 5) with disabilities and is particularly useful in planning for older students' Individualized Education Programs (IEPs).
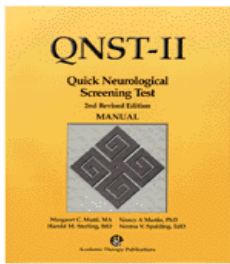
The PEP-3 now includes a Caregiver Report. This report utilizes parent input and is completed prior to the administration of the assessment. The form asks the parent or caregiver to estimate the child's developmental level compared with typical children. This form has been shown to help orient teachers to a student's developmental inconsistencies. The PEP-3 has included additional data that identify special learning strengths and teachable skills. Also, the third edition is improved by offering normative data both from a group of children in the autism spectrum as well as from a comparison group of children without autism.

Improvements to the PEP-3:

1. The function domains have been revised to reflect current research and clinical concerns, especially in the area of social and communication functions.
2. All of the toys and materials needed to administer the test (except food, drink, and a light switch) are now included with the test.
3. New items and subtests have been added; obsolete ones were deleted.
4. Normative data were collected from 2002 to 2003, with large national samples of children in the autism spectrum and of typical children ranging in ages from 2-7.5 years. These are the first normative data provided for comparison of a child's PEP results with children of either comparison group.
5. Reliability coefficients have been computed by age for subgroups within the normative sample (i.e., males, females, White, Black, and Hispanic Americans.)
6. Validity evidence is provided for children in the autism spectrum for all areas measured by the test.
7. The scoring has been quantified as 0, 1, and 2; and each score is clearly defined, making statistical comparisons more accurate. At the same time, the flexibility of the previous system, using pass, emerge, and fail, has been maintained.
8. A Caregiver Report has been added which includes Current Developmental Levels, Diagnostic Categories and Degree of Problem, and three subtests: Problem Behaviors, Personal Self-Care, and Adaptive Behavior.

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Quick Neurological Screening Test-II (QNST-II)

Margaret C. Mutti, MA, Harold M. Sterling, MD, Nancy A. Martin, PhD, Norma V. Spalding, EdD
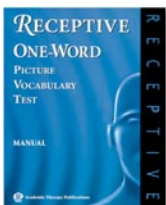
The QNST-II identifies whether behaviors seen in the classroom have physiological (organic) or emotional origins. The detailed scoring provides invaluable information for planning appropriate remediation. The 15 areas of neurological development assessed include manual dexterity, visual tracking, spatial orientation, tactile perceptual abilities, and fine and gross motor movements.

- The Manual provides simple instructions for administrating and scoring each of the 15 subtests.
- Provides information for planning remediation.
- QNST-II protocol sheets include a handy summary of all subtest scores and classifications as well as the overall score and functional category determination.
- Appropriate for ages 5-18 years.

Receptive One-Word Picture Vocabulary Test, 2000 Ed. (ROWPVT)

Edited by Rick Brownell

This is an individually administered, norm-referenced test of an individual's ability to understand the meaning of single words. The individual's performance, when compared to the normative group, gives an indication of his or her English-hearing vocabulary.
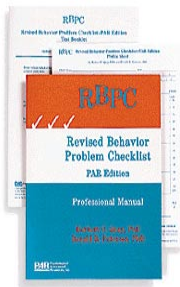
The ROWPVT has a number of specific uses, including assessing the extent of hearing vocabulary, assessing cognitive ability, diagnosing reading difficulties, diagnosing expressive aphasia, screening preschool and kindergarten children, evaluating an English-learner's vocabulary, monitoring growth, and evaluating program effectiveness.

- All Test Plate illustrations have been rendered in full color with drawings that are easy to interpret and hold the examinee's interest.
- Norms are based on a representative sample of 2,327 school-age individuals ages 4.0-12.11 years in the U.S.; the sample was stratified by age, geographic region, ethnicity, level of parent education, community size, and gender.
- The test is conormed with the Expressive One-Word Picture Vocabulary Test for easy comparison of expressive and receptive vocabulary.

- Directions are included on each Record Form along with a list of item prompts.
- Instructions for using examiner prompts and cues are included to ensure assessment accuracy.
- Easy to use--The Manual provides detailed administration instructions, development procedures, and national norms; the Test Plates are bound in a spiral booklet with a fold-out easel.

Revised Behaviour Problem Checklist-PAR Edition (RBPC)
Herbert C. Quay, PhD, Donald R. Peterson, PhD

The RBPC is used to rate problem behaviours observed in adolescents and young children ages 5-18 years. The six RBPC subscales measure Conduct Disorder, Socialized Aggression, Attention Problems-Immaturity, Anxiety-Withdrawal, Psychotic Behaviour, and Motor Tension-Excess.

The RBPC has been used for a wide variety of purposes:

- To screen for behavioural disorders in schools
- As an aid in clinical diagnosis
- To measure behavioural change associated with psychological or pharmacological interventions
- As part of a battery to classify juvenile offenders
- To select subjects for research on behavioural disorders in children and adolescents

Overview of the RBPC Scales

- **Conduct Disorder (CD/22)**--Items focus on behavioural problems of physical aggression, difficulty controlling anger, and open disobedience, defiance, and oppositionality.
- **Socialized Aggression (SA/17)**--Items tap behaviours associated with Adolescent Conduct Disorder. Items focus on the commission of conduct-disordered behaviours in the company of others, including stealing and substance use in the company of others, truancy from school, gang membership, stealing, and lying.
- **Attention Problems-Immaturity (AP/16)**--Items focus on symptoms associated with Attention Deficit Disorder (ADD), including short attention span, diminished concentration, distractibility, impulsivity, as well as the social and interpersonal correlates of ADD, including passivity, undependability, and childishness.
- **Anxiety-Withdrawal (AW/11)**--Items measure the behavioural components of internalizing disorders, including poor self-confidence and self-esteem, hypersensitivity to criticism and rejection, generalized fearfulness and anxiety, and reluctance to try new behaviours because of fear of failure.
- **Psychotic Behaviour (PB/6)**--Items tap psychotic symptoms, including speech disturbance, bizarre ideation, delusions, and impaired reality testing.

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- **Motor Tension-Excess (ME/5)**--Items focus on motoric symptoms of overactivity, including restlessness, tension, and "jumpiness."

Administration and Scoring

Administration and scoring are straightforward. Raters respond to the 89 items on the top page of the carbonless Test Booklet. Responses transfer to the bottom sheet, which contains scoring instructions and a scoring key. The RBPC Profile Sheet is used to record the obtained raw and *T* scores and to plot the pattern of the test results.

The Professional Manual contains information on the development of the RBPC, psychometric properties, additional reliability and validity studies, and tables for converting raw scores to *T* scores. Norms based on teacher ratings are provided for Grades K-12. Mean internal consistency reliabilities range from .73-.94 for the six subscales. Interrater reliabilities, based on teacher ratings, range from .52-.85.

The Rating Form is designed for use in conjunction with other measures (e.g., intelligence and achievement tests, behaviour observations, and interviews) as part of an overall assessment of the individual. The Rating Form can be completed by a parent, teacher, or other observer in about 20 minutes. Scoring and profiling take about 10 minutes.

Revised Children's Manifest Anxiety Scale (RCMAS)
Cecil R. Reynolds, Ph.D. & Bert O. Richmond, Ed.D

The Revised Children's Manifest Anxiety Scale (RCMAS) is a renowned assessment of child anxiety, designed to be the first important step in treating troubled children. The RCMAS quickly identifies the root cause and level of anxiety in children so that future steps can be taken to reduce stress levels. The simple format and language style makes the RCMAS a comprehensible measure for identifying the presence of academic stress, test anxiety, peer and family conflicts, or drug problems. Clinicians, teachers, and parents alike find the RCMAS to be a useful tool within their respective settings.

HOW TO USE THE ASSESSMENT
The RCMAS is known for its quick 10-minute administration and scoring process. It consists of a set of 37 yes/no items. Responses from these items contribute to the Total Anxiety score and four separate subscales. The respondent is asked to read each descriptive item and respond with either a yes or no answer on the convenient AutoScore™ Answer Form.

NORMATIVE DATA
The RCMAS was developed using a normative sample of nearly 5,000 school-age children and adolescents. This sample included those enrolled in classes for regular, gifted, and learning-disabled students. In addition to this data, separate norms based on African-American populations are now available.

Reynolds Adolescent Depression Scale, 2nd Ed. (RADS-2)
William M. Reynolds, Ph.D.

The Reynolds Adolescent Depression Scale (RADS-2™) is a self-report tool that identifies adolescents who exhibit significant depressive symptoms. This revision contains a number of updated features, such as an expanded age range that allows for a greater range of respondents, and updated normative data. The RADS-2 is used in both clinical and educational settings, and is suitable for adolescents between the ages of 11 and 20 years of age.

HOW TO USE THE ASSESSMENT
Components of the RADS-2 include the handscored Test Booklet, and the Summary/Profile Form. The Test Booklet contains a series of 30 items for the respondent to complete. Items are written at a third grade reading level, making the RADS-2 a fully comprehensible assessment for a wide range of ages. In addition to scores for four different subscales, the Depression Total score is obtained, which represents the individual's overall severity level of depression. The RADS-2 Test Booklet takes approximately 5–10 minutes to complete, and scoring can be done just as quickly.

NORMATIVE DATA
The RADS-2 was developed using an extensive normative sample. Each age group (11–13 years, 14–16 years, and 17–20 years) included 1,100 participants respectively, and both genders were equally represented.

Reynolds Intellectual Assessment Scales (RIAS)
Cecil R. Reynolds

Over the past few years, a clear need has emerged for a comprehensive, cost-effective, high-quality intelligence test. The RIAS™ scales meet that need. They provide a thorough assessment of the client's level of intellectual functioning and allow the assessor to evaluate the relationship between the client's memory and cognitive skills. The RIAS™ scales are ideal for schools and institutions, clinical settings, and for individual practitioners who are looking for ways to control costs and maximize professional time.

The RIAS™ scales include a Verbal Intelligence Index (VIX), a Nonverbal Intelligence Index (NIX), and a Composite Intelligence Index (CIX), which assesses overall intelligence including the ability to reason, solve problems, and learn. The scales also include a Composite Memory Index (CMX) that assesses verbal and nonverbal memory.

Normative data for the RIAS™ scales are based on a sample of 2,438 individuals between the ages of 3 and 94 from 41 states. They were matched to the 2001 U.S. census data for age, gender, geographic region, ethnicity, and years of education completed.

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The RIAS™ scales include a 3-volume set of Stimulus Books and 25 RIAS Record Forms for recording responses. These materials come in a soft-sides attaché case.

Screening Version

The Reynolds Intellectual Screening Test (RIST™) is a shorter version of the RIAS™ scales intended for use as a screening tool. Consisting of two RIAS™ subtests, the RIST™ helps to identify individuals who need a more comprehensive intellectual assessment. It takes about 10 minutes to administer.

Screening Assessment for Gifted Elementary and Middle School Students, 2nd Ed. (SAGES-2)

Susan K. Johnsen, Anne L. Corn

The SAGES-2 is helpful in identifying gifted students in kindergarten through eighth grade. Its three subtests assess aptitude and achievement to identify gifted students. Aptitude is measured via the Reasoning subtest. The student is asked to solve problems by identifying relationships among pictures and figures. The other two subtests (Mathematics/Science and Language Arts/Social Studies) assess achievement. Both of these subtests require the child to respond to questions in a multiple-choice format; items require recall, understanding, and application of ideas and basic concepts in the content areas. The subtests can be used to examine the relationships between aptitude and achievement.

The SAGES-2 can be used with students ranging in age from 5.0-14.11 years. Each untimed subtest requires approximately 20 minutes to administer. All of the SAGES-2 subtests can be administered individually or in small groups.

The SAGES-2 has several uses:

- To identify students as gifted in the areas of intellectual and academic ability.
- To screen entire pools of students for possible inclusion in gifted programs.
- To examine strengths and weaknesses in academic and reasoning abilities.
- To serve as a measurement device in research studies investigating intellectual and academic ability in gifted students.

The SAGES-2 was normed on two large samples tested in 1998 and 1999. Sample One (normal sample) consisted of 3,023 students who were in heterogeneous classrooms, and Sample Two (gifted sample) consisted of 2,290 students who were identified as gifted by their local school districts. The demographic characteristics of both samples were matched to those of the 1997 U.S. Census. The normative sample was stratified on the basis of age, gender, race, ethnic group membership, and geographic location. Standard scores and percentile ranks are provided for both samples.

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The reliability coefficients for the test are high, ranging from .77-.95; 97% of these reach or exceed .80, and 74% reach or exceed .90. Test-retest studies show that the SAGES-2 is stable over time.

Extensive validity data are reported as well, documenting the test's relationship to the WISC®-III, OLSAT™, Stanford Achievement Test, and Gifted and Talented Evaluation Scale, and its efficiency in discriminating groups appropriately.

Note: The SAGES-2 is not intended for identifying children for classes emphasizing talents in creative, artistic, or leadership areas.

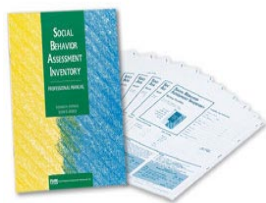## Slossen Intelligence Test-Revised (SIT-R3)
Richard L. Slosson, M.A.; revised by Charles L. Nicholson, Ph.D. & Terry L. Hibpshman, M.A.; Supplementary Manual by Sue Larson, Ph.D.

The Slosson Intelligence Test–Revised is a quick and reliable individual screening test of crystalized verbal intelligence. The new SIT–R3 test is a multidimensional assessment that is suitable for testing regular education populations as well as most special populations. It can be used by teachers, psychologists, guidance counselors, special educators, learning disability instructors, and others who evaluate an individual's mental ability. Because the SIT–R3 test has minimal performance items, embossed materials now allow testing of the visually impaired and the blind.

Social Behaviour Assessment Inventory (SBAI)
Thomas M. Stephens, DEd, Kevin D. Arnold, PhD

The SBAI measures the level of social behaviors exhibited by children and adolescents in classroom settings (grades K-9). It is appropriate for special education classes or any classroom where behavior problems may exist.

The SBAI consists of 136 items that describe social skills commonly observed in the classroom. A teacher or other individual (such as a counselor or parent) who has observed a student's behavior rates each item on a 4-point scale describing both the presence and level of the behaviors exhibited by the student.

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Results from the 4 behavior scales (Environmental, Interpersonal, Self-Related, and Task-Related) and 30 subscales can be used to develop social skills instructional strategies.

Social Competence & Behavior Evaluation (SCBE)
Peter J. LaFreniere, Ph.D. & Jean E. Dumas, Ph.D.

The Social Competence and Behavior Evaluation Preschool Edition (SCBE) evaluation measures social competence, affective expression, and adjustment in preschoolers (2.5–6 years). The primary objective of the SCBE evaluation is to describe a child's behavior for purposes of socialization and education, rather than diagnosis. The SCBE is completed by teachers and focuses on a child's adaptation to and functioning within his or her environment, which is particularly relevant to teachers. It contains 80 items and can usually be completed in 15 minutes.

Used for years as the Preschool Socio-Affective Profile, the SCBE evaluation has been renamed and standardized on more than 1,200 U.S. preschool children.

Social Adjustment Scale–Self-Report (SAS-SR)
Myrna Weissman, Ph.D.

The SAS–SR provides you with an understanding of an individual's level of satisfaction with his or her social situation. It is often used to evaluate the efficacy of treatment by revealing the effect treatment is having on the respondent. The SAS–SR is used by psychiatrists, psychologists, social workers, and other mental health professionals in clinical or research settings.

How to Use the Assessment
The SAS–SR includes the original version, as well as the new short (SAS–SR: Short) and screener (SAS–SR: Screener) versions.

SAS–SR: Short
The short version is ideal with time with the respondent is limited, but information from each role area is required. It provides scores for both the Instrumental and Expressive role area; however, it does provide as much detail at the item response level. It is also often used to measure progress over time.
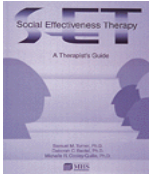
SAS–SR: Screener
The screener version is a unidimensional scale that is intended for screening, for test batteries, or for pharmaceutical research programs. It provides one score that indicates whether or not further examination may be necessary.

Normative Data

The normative sample for the SAS–SR included 482 individuals ranging in age from 24 to 20.

Social Effectiveness Therapy (SET)

Samuel M. Turner, Ph.D., Deborah C. Beidel, Ph.D., & Michele R. Cooley-Quille, Ph.D.

The SET is a behavioural treatment program for adults that reduces social anxiety, improves interpersonal skills, and increases one's range of social activities. Exercises in flexibility, exposure to anxiety-inducing situations, and role-playing are incorporated. Individual sessions include imaginal and in vivo flooding to address fear-inducing situations unique to each client. The program consists of 28 sessions that are usually spread out over a 4-month period. The SET workbook contains weekly assignments for the client.

Social Effectiveness Therapy - Child Version (SET-C)

Deborah C. Beidel, Ph.D., Samuel M. Turner, Ph.D., & Tracey L. Morris, Ph.D.

The Social Effectiveness Therapy for Children and Adolescents (SET–C) behavioral therapy program helps children and adolescents decrease their social anxiety, increase their interpersonal skills, and expand their range of enjoyable social activities. The program helps children become more comfortable in social situations by educating them about their fears, providing social skills training, and exposing them to feared social situations.

Children and adolescents complete one introductory educational session with their parents, 12 group sessions, and 12 in-vivo exposure sessions over a 12-week period to help them improve their social skills. The SET–C group sessions provide instruction and practice, including activities where socially anxious participants interact with nonanxious peers. The individual in-vivo exposure component is designed to reduce anxiety in distressing social situations by making them more familiar. Concurrently, parents use positive reinforcement and shaping sequencing to effectively assist the progress of the SET–C program. These therapy components are detailed in the Therapist's Guide, along with helpful suggestions for implementation, including recruiting peers for group sessions.

The assessment materials include a Therapist's Guide, a Parent's Guide describing reinforcement theories, activity cards for group sessions, and weekly contracts for setting behavioral goals.

Social Phobia and Anxiety Inventory (SPAI)
Samuel M. Turner, Ph.D., Deborah C. Beidel, Ph.D., & Constance V. Dancu, Ph.D.

The SPAI is a self-report instrument for adolescents and adults aged 14 and older that assesses specific somatic symptoms, cognitions, and behaviours across a wide range of potentially fear-producing situations to measure social anxiety and fear, It is particularly useful when distinguishing between Panic Disorder, Agoraphobia, and Social Phobia.

The SPAI is ideal for use as a screening device in schools, outpatient clinics, hospitals, residential treatment facilities, prisons, and other correctional and employment settings. It is effective in monitoring treatment change, and takes only 30 minutes to administer. For children under 14, the SPAI-C is also available.

Social Phobia and Anxiety Inventory for Children (SPAI-C)
Samuel M. Turner, Ph.D., Deborah C. Beidel, Ph.D., &
Tracy L. Morris, Ph.D.

The SPAI–C evaluates the somatic, cognitive and behavioral aspects of social phobia so that you can determine the best course of action for the child. In school environments it detects the existence of social fears that may be related to poor school performance, oppositional behavior, or truancy.

State Trait Anxiety Inventory (STAI)
Charles D. Spielberger, Ph.D.

The State-Trait Anxiety Inventory (STAI) differentiates between the temporary condition of state anxiety and the longstanding quality of trait anxiety so that you can plan appropriate treatment. It also helps professionals distinguish between a client's feelings of anxiety and depression to allow for proper follow-up.

Each type of anxiety is addressed by a 20-item scale. Norms are provided for clinical patients, high school and college students, and working adults. A version for children younger than 15 is available.

Profile Reports display scores graphically and numerically for easy interpretation.

State-Trait Anxiety Inventory for Children (STAIC)
Charles Spielberger, Ph.D.

The STAIC—the "How I Feel" questionnaire—contains two 20-item scales measuring trait and state anxiety. The A-State scale examines the shorter-term state anxiety that is commonly specific to situations. It prompts the child to rate 20 statements from *hardly ever* true to *often* true. The A-Trait scale items address how the child generally feels to measure the longer-term trait anxiety. A separate score is produced for the State scale and the Trait scale to determine which type of anxiety is dominant.

Profile Reports present scores graphically and numerically to summarize the results of each administration.

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Student-Teacher Relationship Scale™ (STRS™)

Robert C. Pianta, PhD

The STRS can be used separately or as part of the Students, Teachers, and Relationship Support™ (STARS™) program to identify student-teacher relationships that could benefit from intervention and support. The STRS can be used (a) to evaluate changes in the quality of student-teacher relationships as a function of using the STARS intervention, (b) as part of an educational assessment battery to determine the extent to which relationship problems or strengths should be addressed in program planning, and (c) as a tool for researching classroom processes.

- Consists of 28 items rated on a 5-point Likert-type scale.
- Contains three subscales that measure Conflict, Closeness, and Dependency.
- Normative sample consisted of 275 teachers who rated at least one child from the 1,535 preschool through 3rd-grade group.

Students, Teachers, and Relationship Support™ (STARS™)

Robert C. Pianta, PhD, Bridget K. Hamre, PhD

The STARS is a 3-part program consisting of Assessment, Teacher Support, and Banking Time stages. The STARS Program is designed to enhance the relationship between a student and teacher by providing positive support to at-risk children and to teachers on the verge of burnout. By improving the quality of the student-teacher relationship, the quality of the student's academic and social functioning also should improve.

- During the STARS Assessment stage, the consultant incorporates information from both quantitative Student-Teacher Relationship Scale™ (STRS™) and qualitative (student interview, teacher interviews, and classroom observations) assessments to identify problem areas and available resources.
- In the STARS Teacher Support Assessment stage, the consultant helps the teacher to change his/her perception of the student-teacher relationship.

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- In the STARS Banking Time stage, the teacher uses a set of specific techniques to create positive interactions with a student and to establish a supportive relationship pattern.
- Appropriate for teachers of preschool to 5th-grade students.

Test of Early Reading Ability, Third Ed. (TERA-3)
D. Kim Reid, Wayne P. Hresko, Donald D. Hammill, EdD

The TERA-3 is a unique, direct measure of the reading ability of young children ages 3.6-8.6 years. Rather than assessing children's readiness for reading, the TERA-3 assesses their mastery of early developing reading skills. This new edition has been redesigned to provide the examiner with three subtests: Alphabet (measures knowledge of the alphabet and its uses); Conventions (measures knowledge of the conventions of print); and Meaning (measures the construction of meaning from print). Standard scores are provided for each subtest. An overall Reading Quotient is computed using all three subtest scores.
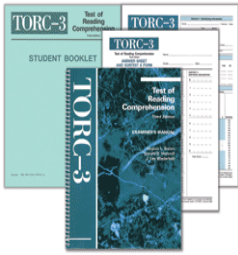
The TERA-3 has many uses: (a) to identify those children who are significantly below their peers in reading development and may be candidates for early intervention; (b) to identify strengths and weaknesses of individual children; (c) to document a child's progress as a consequence of early reading intervention programs; (d) to serve as a measure in research studying reading development in young children; and (e) to serve as an adjunct to other assessments.

The TERA-3 has been improved in the following ways:

- All new normative data were collected during 1999 and 2000; the normative information is stratified by age relative to geography, gender, race, residence, and ethnicity.
- Studies showing the absence of gender, racial, disability, and ethnic bias have been added.
- Reliability is consistently high across all three types of reliability studied. All but 2 of the 32 coefficients reported approach or exceed .90.
- New validity studies have been conducted; special attention has been devoted to showing that the test is valid for a wide variety of subgroups as well as for a general population.
- New items have been added to make the test more reliable and valid for the upper and lower ages covered by the test.
- Age and grade equivalents are provided.

Test of Reading Comprehension, 3rd Ed. (TORC-3)

Virginia Brown, Donald D. Hammill, EdD, J. Lee Wiederholt, PhD

The TORC-3 may be used to identify students whose reading comprehension scores are significantly below those of their peers and who might benefit from interventions designed to (a) improve reading comprehension, (b) determine areas of relative strength and weakness across reading comprehension abilities, (c) document overall progress in reading development as a result of intervention programs, and (d) serve as a measure for research efforts designed to investigate reading comprehension.

The TORC-3, developed for students ages 7.0-17.11 years, assesses the understanding of written language, focusing on the holistic, cognitive, and linguistic aspects of reading. The test comprises four subtests that are grouped under the General Reading Comprehension Core and four supplementary subtests that can be used to gain a clearer understanding of reading in terms of content-specific areas. The General Reading Comprehension Core yields the Reading Comprehension Quotient (RCQ) that can be compared to other measures of abstract thinking, oral language abilities, and achievement.

The TORC-3 yields six types of scores--raw scores, standard scores, grade equivalents, age equivalents, percentiles, subtest standard scores, and the Reading Comprehension Quotient (RCQ). The RCQ is derived through score transformation of the comprehensive core subtests: General Vocabulary, Syntactical Similarities, Paragraph Reading, and Sentence Sequencing. These four subtests best represent the construct of general reading comprehension. The RCQ is the most reliable, valid, and useful measure of reading comprehension derived from the TORC-3. The TORC-3 was standardized on 1,962 students from 19 states. Data are provided supporting test-retest and internal consistency reliability.

Special Features of TORC-3

- Information about the normative sample relative to geographic region, gender, residence, race, ethnicity, and disability status is reported.
- The normative information has been stratified by age.
- Characteristics of the normative sample are keyed to the 1990 U.S. Census data.
- Studies showing the absence of gender and racial bias have been added.
- Research supporting criterion-related validity has been updated and expanded.
- Discussion of content validity has been enhanced, especially for three of the four content-area subtests (i.e., Mathematics, Social Studies, and Science).
- Because they are required by many state and local school agencies, grade and age equivalents are provided.

Test of Variables of Attention (T.O.V.A.®/T.O.V.A.-A.®)

Lawrence Greenberg, MD, Robert A. Leark, PhD, Tammy R. Dupuy, MS, Clifford L. Corman, MD, Carol L. Kindschi, RN, MSN

The Tests of Variables of Attention are objective, standardized, extensively normed (2,200 respondents for T.O.V.A. and 2,500 for T.O.V.A.-A.), and highly accurate continuous performance tests (CPTs) that are used to assess attention in normal and clinical populations (ages 4-80 years). The T.O.V.A. is the visual version, and the T.O.V.A.-A. is the auditory version. They can be used in conjunction with other information gathering tools or diagnostic tests in neuropsychological or psychological evaluations. Free updates will be sent to you by the publisher.

These tests were developed to measure attentional and impulse control processes in four areas: inattention or omissions; impulse control or commissions; response time; and response time variability. They are non-language based, computerized tests that require no left-right discrimination or sequencing and have no appreciable practice effects. Test responses are recorded with a specially designed electronic microswitch that eliminates inherent variability of keyboard and mouse response time.

The software automatically records an individual's responses, non-responses, and reaction times, and then calculates raw scores and percentages (eliminating examiner error). Data are reported by standardized scores and standard deviations, and are presented in quarters, halves, and totals for the full 21.6 minutes of the test. A full printable report instantaneously displays the test results in narrative and graphic form. A discriminant function measure, the ADHD Score, is provided for each individual. Unique test paradigms with stimulus infrequent and frequent conditions accurately measure attention and impulsivity. Test parameters can be modified for research and clinical applications.

Requirements:MS DOS 6.22/FreeDOS 0.9 or later with compatible parallel printer; Windows® 95/98 with DOS-compatible parallel printer; Windows® Me with DOS boot floppy disk or CD, DOS-compatible parallel printer; Windows 2000/XP with Windows-compatible printer; 4-bit VGA mode, DOS-compatible parallel port, x386 or better processor, 5MB disk space, 2MB RAM, CD-ROM drive, DVD player

Test of Verbal Conceptualization and Fluency (TVCF)
Cecil R. Reynolds, PhD and Arthur MacNeill Horton, Jr., Ed

The TVCF is designed to measure multiple aspects of executive functions principally related to the integrity of the frontal lobes of the brain through the use of several verbally weighted tasks. The TVCF is useful in clinical neuropsychological examinations to detect brain injury and track rehabilitation progress, in the evaluation of language functions and verbal ability, for disability determination under the Individuals with Disabilities Education Act (IDEA), in psychoeducational testing, and in research on brain function, as well as in other applications.

The TVCF has four easy-to-administer subtests of primarily verbal and nonverbal tasks that emphasize multiple aspects of verbal fluency, set-shifting and rule induction, concept identification, sequencing, and visual search skills. The TVCF was designed and standardized for use with individuals ages 8-89 years. Standardized scores (or scaled scores) are provided in the form of normalized *T*-scores, along with their accompanying supplementary score conversions.

The TVCF subtests require a total administration time of 20-30 minutes for most individuals. The four TVCF subtests are listed below.

- *Categorical Fluency* measures an individual's ability to retrieve words that fit within a conceptual category (e.g., animals, things to eat) and fluency of ideation.

- *Classification* is a verbal measure of shifting and rule induction that is designed as a language-based analog to the well-known Wisconsin Card Sorting Test™ (Grant & Berg, 1948). Three scores are obtained: numbers of items correct, number of perseveration errors, and number of categories achieved.

- *Letter Naming* measures word retrieval by initial sound and fluency of ideation.

- *Trails C* measures the ability to coordinate high attentional demands, sequencing, visual search capacity, and the ability to shift rapidly between Arabic numerals and linguistic representations of numbers. The trails task is a variation of several other "trail-making" tasks and was taken from the previously published Comprehensive Trail-Making Test (Reynolds, 2003) and completely renormed with the other TVCF tasks.

Applications of the TVCF
Because the TVCF can be administered in 20-30 minutes, it is useful for large or small group screening of students and may be administered as part of a prereferral intervention strategy. The TVCF also is appropriate for individually assessing students with recognized disabilities and children suspected of having one or more learning disabilities. The brevity of the TVCF, as well as the particular mental dimensions it assesses, also makes it useful in evaluating children suspected of having or known to have ADHD, emotional disturbances, and sensory or orthopedic impairments.

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The TVCF also provides a well-standardized and efficient procedure to assess executive function deficits in clinical patients, whether those deficits are due to CNS disease, drug addiction, trauma, or specific forms of emotional disturbance such as schizophrenia. It is a time- and cost-efficient tool for assessing the executive functioning of individuals with traumatic brain injury, dementia, and speech/language impairment.

Test of Visual-Perceptual Skills (Non-motor), 3rd Ed. (TVPS-3)
Nancy A. Martin, PhD

The TVPS-3 assesses the following visual perceptual skills: Visual Discrimination, Visual Memory, Visual-Spatial Relationships, Form Constancy, Visual Sequential Memory, Visual Figure-Ground, and Visual-Closure. It is designed to be used by psychologists, occupational therapists, education diagnosticians, developmental optometrists, learning specialists, and other assessment professionals.

The TVPS-3 utilizes black and white designs as stimuli for all of the perceptual tasks. Within each area, the items are arranged in a developmental progression. The items are presented in a multiple-choice format; item responses are made vocally or by pointing. This format is ideal for children who may have impairments in motor, speech, hearing, neurological, or cognitive functioning. The TVPS-3 contains 16 plates for each perceptual area; each area is normed separately so that the clinician may reliably differentiate the various visual perceptual processes. The plates are spiral bound with fold-out easels to make presentation easy. The Manual includes a completed and scored protocol for instructional purposes.

Analysis of the subtest score patterns provides functional comparisons that enable the clinician to make a comprehensive diagnosis of a child's perceptual abilities separate from motor skills. The TVPS-3 also provides new, nationally stratified norms based on data from more than 2,000 children and adolescents.

Administration and Scoring

The TVPS-3 may be administered to individuals or small groups. The test takes approximately 30-40 minutes to complete, depending on the age and the abilities of the individual being tested. No basals are needed and ceilings are used to minimize any fatigue effects.

Scoring is quick and easy and can be completed in approximately 5 minutes. The front of the Record Form provides a convenient graphic to display subtest scores.

Scores are presented as individual subtest scaled scores, and one overall standard score, enabling the TVPS-3 scores to be compared easily to scores from other standardized tests. Percentile ranks and age equivalents also are provided.

Test of Nonverbal Intelligence (TONI-3) Third Edition
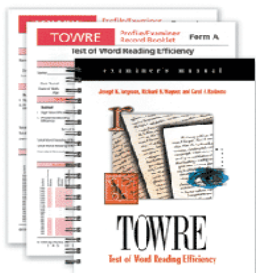Linda Brown Ph.D., Rita J. Sherbenou Ph.D., & Susan K. Johnsen, Ph.D.

The Test of Nonverbal Intelligence, Third Edition (TONI-3) is a major revision of the popular Test of Nonverbal Intelligence. A norm-referenced measure of intelligence, aptitude, abstract reasoning, and problem solving, the TONI-3 requires no reading, writing, speaking, or listening on the part of the respondent. The TONI-3 is also motor-free, requiring only a slight gesture to indicate response choices. This is an ideal instrument for evaluating clients with thinking or communication difficulties, disorders, or impairments.

Fifty tasks of increasing complexity are presented. Tasks are abstract drawings designed to prevent cultural loading of the test items. Available in two equivalent forms (Form A and Form B), the TONI-3 is ideal for pre- and post-testing situations. Scores are easily converted from raw scores to percentile ranks and standard scores.

The TONI-3 meets the highest psychometric standards for norms, reliability, and validity. The comprehensive manual provides details of normative data.

Test of Word Reading Efficiency (TOWRE)
Joseph Torgesen, PhD, Richard Wagner, PhD, Carol Rashotte, PhD

The TOWRE is a nationally normed measure of word reading accuracy and fluency. Because it can be administered very quickly, the test provides an efficient means of monitoring the growth of two kinds of word reading skills that are critical in the development of overall reading ability: the ability to accurately recognize familiar words as whole units or "sight words" and the ability to "sound out" words quickly.

The TOWRE contains two subtests: the Sight Word Efficiency (SWE) subtest assesses the number of real printed words that can be accurately identified within 45 seconds, and the Phonetic Decoding Efficiency (PDE) subtest measures the number of pronounceable printed nonwords that can be accurately decoded within 45 seconds. Each subtest has two forms (Forms A and B) that are of

equivalent difficulty, and either one or both forms of each subtest may be given depending upon the purposes of the assessment.

Percentiles, standard scores, and age and grade equivalents are provided. Subtest standard scores have a mean of 100 and a standard deviation of 15. Age and grade equivalents show the relative standing of the individual's scores. The TOWRE was normed on more than 1,500 individuals ranging in age from 6.0-24.11 years and residing in 30 states. The sample characteristics were stratified by age and keyed to the demographic characteristics reported in the *1997 Statistical Abstract of the United States.*

Reliability of the TOWRE was investigated using estimates of content sampling, time sampling, and scorer differences. The average alternate forms reliability coefficients (content sampling) all exceed .90. The test/retest (time sampling) coefficients range from .83-.96. The magnitude of the coefficients reported from all the reliability studies suggests that there is little error in the TOWRE and that examiners can have confidence in the results. Extensive evidence of the validity of TOWRE test scores is provided for content-description validity, criterion-prediction validity, and construct-identification validity.

Test of Written Language-3rd Ed. (TOWL-3)
Donald D. Hammill, EdD, Stephen C. Larsen, PhD

The TOWL-3 is an eight subtest battery that measures student writing competence, using both easy analysis (spontaneous) formats and traditional test (contrived) formats. Two alternative, equivalent forms (A and B) are available to evaluate student growth in writing, using pre- and post-testing that is not contaminated by memory.

The TOWL-3 subtests are: Vocabulary, Spelling, Style, Logical Sentences, Sentence Combining, Contextual Conventions, Contextual Language, and Story Construction.

- *Vocabulary*--The student writes a sentence that incorporates a stimulus word.
- *Spelling*--The student writes sentences from dictation, taking particular care to make proper use of spelling rules.
- *Style*--The student writes sentences from dictation, taking particular care to make proper use of punctuation and capitalization rules.
- *Logical Sentences*--The student edits an illogical sentence so that it makes better sense.
- *Sentence Combining*--The student integrates the meaning of several short sentences into one grammatically correct written sentence.
- *Contextual Conventions*--The student writes a story in response to a stimulus picture. Points are earned for satisfying specific requirements relative to capitalization, punctuation, spelling, or other arbitrary elements in writing.
- *Contextual Language*--The student's story is evaluated relative to the quality of its vocabulary, sentence construction, and grammar.

- *Story Construction*--The student's story is evaluated relative to the quality of its plot, prose, development of characters, interest to the reader, and other compositional aspects.

The TOWL-3 yields five types of scores: raw scores, age and grade equivalents, percentiles, subtest standard scores, and composite quotients. The three composite scores generated using the TOWL-3 are: Overall Writing, Contrived Writing, and Spontaneous Writing. These composite scores enable you to estimate a student's general writing proficiency and to determine any strengths or weaknesses relative to contrived or spontaneous testing formats.

The TOWL-3 can be used to identify students who perform more poorly than their peers in writing and who may need special help; determine a student's particular strengths and weaknesses in various writing abilities; document a student's progress in a special writing program; and conduct research in writing.

- Stimulus pictures are appealing to students of all ages.
- The Manual provides suggestions for assessing written language and gives ideas to use when remediating writing deficits.
- The TOWL-3 Profile/Story Scoring Form makes scoring easy.
- With the exception of the 15 minutes allocated to story writing, the TOWL-3 has no set time limits; the entire test battery can be administered in approximately 1-1/2 hours.
- Standardized on a 26-state sample of more than 2,000 public and private school students in Grades 2-12 (ages 7.6-17.11 years).

The Stress Profile
Kenneth M. Nowack, Ph.D.

The Stress Profile measures all personal traits and lifestyle habits that have been shown to moderate the stress-illness relationship. Because it is quick and easy to administer, the Stress Profile is ideal for routine use in organizations, outpatient clinics, hospitals, and medical practices.

The Stress Profile can be scored in just 10 minutes and measures response bias and inconsistent responding are also included. Norms are based on an ethnically diverse sample of 1,111 men and women, aged 20 to 68, from various working environments.

Workshops given by the author demonstrate the test's value in executive coaching, organizational stress management, wellness programs, EAP, and behavioural health interventions.

WRAT-Expanded Early Reading Assessment (ERA)

Gary J. Robertson, PhD

The ERA is part of the WRAT-Expanded series and is an individually administered measure of important pre-reading and beginning reading skills for use in grades pre-K, K, and 1. Four subtests measure these important aspects of early reading: letter recognition and visual perception of word parts, letter sounds, word comprehension, and sentence comprehension. Performance may be interpreted on each of the subtests and on three composites: Pre-reading Skills, Reading Skills, and Total Battery.

Administration

The child's reading skill acquisition determines whether the entire test is given or whether only selected subtests are used. Children who are not yet reading words and sentences can be assessed with only the two pre-reading tests (letter recognition/visual perception and letter sounds), whereas children already reading would most likely be given only the two reading tests (word comprehension and sentence comprehension). Administration of all four subtests requires about 40 minutes, with the two parts--pre-reading and reading - requiring about 20 minutes each.

Interpretation

National norms are available based upon both age and grade reference groups. Subtest scaled scores, standard scores for the three composites, percentile ranks, and stanines are available. The Record Form provides a convenient score summary and profile to facilitate the interpretation and use of the test results. The manual contains useful illustrations of appropriate uses and interpretation of results.

WRAT4 Progress Monitoring Version Scoring Program (WRAT4-PMV:SP)

Gale H. Roid, PhD, Mark F. Ledbetter, PsyD, and PAR Staff

The WRAT4-PMV: SP provides unlimited scoring and report generation after entry of a student's WRAT4-PMV raw scores. Program functionality includes navigational tools, file handling, and report editing.

- Generates graphical profiles of a student's Total Raw Scores. The Profile includes shaded grade-based bands that indicate average expected performance. Profile options enable the examiner to produce customized graphs, including the ability to overlay profile results from prior test administrations.

- Generates Within Level Score Reports that include a Score Summary Table, a Level Profile of Total Raw Scores, and a Profile of Level Equivalent (LE) scores. The report enables the examiner to compare any combination of repeated test administrations and displays a table indicating the statistical significance of score difference.

- Generates Across Level Score Reports that include a Profile of LE scores and a LE Score Significant Difference Table. The scoring program converts all Within Level Total Raw Scores to LE scores and performs all necessary calculations to evaluate the statistical significance of all LE score differences. User-defined features enable the examiner to customize the LE Score Profile.

- Includes built-in, easy-to-use report editing features.

- Exports a student's data into common formats that can be imported into many spreadsheet and database programs. The exporting feature allows for both individual and group exporting of data. Also exports a student's reports, including the graphical profiles to most common word processing programs.

- Includes an optional password feature to ensure privacy and security of client data.

Requirements: Windows® 2000/XP/Vista™; NTFS file system; CD-ROM drive for installation; Internet connection or telephone for software activation

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Wide Range Achievement Test 4 (WRAT4)

Gary S. Wilkinson, PhD and Gary J. Robertson, PhD

The Wide Range Achievement Test 4 (WRAT4) is the latest offering in a test series first published in 1946. The various editions of the Wide Range Achievement Test (WRAT) have enjoyed widespread use in a variety of settings as a measure of the basic academic skills necessary for effective learning, communication, and thinking: reading and spelling words and performing basic mathematical calculations. The WRAT4 continues to measure these basic content areas and preserves those features that made the WRAT3 and earlier editions so popular with users--ease of administration and scoring, and the provision of a significant amount of information gained through a relatively brief investment of testing time.

Several new features have been added to the WRAT4. In addition to updated norms, the WRAT4 contains an entirely new measure of reading achievement--Sentence Comprehension--added to enhance the scope of the content measured and to meet a need often expressed by users of previous editions for a measure of reading comprehension.

The interpretation of WRAT4 scores has been enhanced by the addition of grade-based norms, thereby increasing the usefulness of the test in grades K-12. The age-based norms also have been extended from age 75 in the third edition to age 94 so that the basic literacy skills of older adults could be assessed.

Description of the WRAT4

The WRAT4 is a norm-referenced test that measures the basic academic skills of word reading, sentence comprehension, spelling, and math computation. It was standardized on a representative national sample of over 3,000 individuals ranging in age from 5-94 years. The normative sample was selected according to a stratified national sampling procedure with proportionate allocation controlled for age, gender, ethnicity, geographic region, and parental/obtained education as an index of socioeconomic status. Alternate forms, designated the Blue Form and the Green Form, were developed and equated during standardization by use of a common-person research design. Derived scores were developed for both age- and grade-referenced groups. Standard scores, percentile ranks, stanines, normal curve equivalents, grade equivalents, and Rasch ability scaled scores are provided.

The Blue Form and the Green Form can be used interchangeably with comparable results, thus permitting retesting within short periods of time without the potential practice effects that may occur from repeating the same items. The alternate forms also can be administered together (i.e., Combined Form) in a single examination. For those interested in a more qualitative assessment of academic skills, the Combined Form provides an additional opportunity for performance observance.

The WRAT4 includes four subtests:

- **Word Reading** measures letter and word decoding through letter identification and word recognition.

- **Sentence Comprehension** measures an individual's ability to gain meaning from words and to comprehend ideas and information contained in sentences through the use of a modified cloze technique.

- **Spelling** measures an individual's ability to encode sounds into written form through the use of a dictated spelling format containing both letters and words.

- **Math Computation** measures an individual's ability to perform basic mathematics computations through counting, identifying numbers, solving simple oral problems, and calculating written mathematics problems.

In addition to providing derived scores and interpretive information for the subtests, the WRAT4 also yields a Reading Composite score, obtained by combining the Word Reading and Sentence Comprehension standard scores.

The recommended order of testing is Word Reading, Sentence Comprehension, Spelling, and Math Computation. This is the order in which the subtests were administered during standardization; however, the subtests may be administered in any order, with one exception.

The Word Reading subtest should be administered before the Sentence Comprehension subtest because an individual's scores on the Word Reading [Part 2] of the Word Reading subtest can be used as a routing test to determine the appropriate starting item on Sentence Comprehension, thereby shortening the time required. In addition, the Word Reading score also determines whether or not the Sentence Comprehension subtest should be administered at all.

Administration Time
Administration time varies depending upon the age, skill, and behavioral style of the individual being tested. For children (ages 8 years and older) and adults, the administration time is between 30-45 minutes. For younger children (ages 5-7 years) the administration time is between 15-25 minutes.

Small-Group Administration
Although the WRAT4 will most often be administered individually, some of the subtests or sections of subtests may be administered to small groups. The Spelling and Math Computation sections of the respective subtests may be administered to small groups. It is recommended that small groups be limited to no more than 5 participants.

Uses of the WRAT4
The WRAT4 is intended for use by those professionals who need a quick, simple, psychometrically sound assessment of important fundamental academic skills. Such measures are valuable in initial evaluations or individuals referred for learning, behavioral, or vocational difficulties. The results of the WRAT4 by themselves are not intended to provide formal identification of learning or cognitive disorders. Use of the WRAT4 results together with a broad array of comprehensive information such as additional assessment and psychometric data, background history, behavioral observations, and more formal assessments of behavioral functioning will assist in the identification and diagnosis of such disorders.

The ease of administration and the simplicity of the WRAT4 make it useful for assessment professionals who can use the results to:

- Collect initial data for psychological, educational, and vocational assessments,

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- Permits time-efficient small group administration in selected math and spelling areas to assist in identification of individuals requiring a more comprehensive academic evaluation,

- Assess, in conjunction with the WRAT-Expanded, a broader range of academic skills useful in the diagnosis of specific learning disorders,

- Reevaluate individuals diagnosed with learning and/or cognitive disorders,

- Contribute to research projects needing assessment of basic academic skills for pretesting and posttesting purposes,

- Evaluate achievement-ability discrepancies to identify specific learning disabilities,

- Assess specific academic skills as part of a more comprehensive study of psychological and neuropsychological functioning,

- Determine a minimal level of proficiency needed to perform in certain educational and/or vocational settings, and

- Assess an individual's academic progress over time.

WRAT4 Materials

Professional Manual
The new WRAT4 Professional Manual summarizes the information users will need to administer and interpret the WRAT4.

- Beginning with an historical overview, Chapter 1 contains a description of the revised test battery, including recommended uses of the WRAT4.

- Chapter 2 provides a description of the materials needed to administer the test, user qualifications, and the general and specific instructions needed to administer and score the WRAT4 subtests.

- Chapter 3 contains an explanation of the derived scores offered for test interpretation along with recommended interpretive guidelines.

- Chapter 4 provides the pertinent background information about the development and standardization of the WRAT4.

- Chapter 5 contains extensive technical data summarizing various aspects of reliability and validity.

- The appendixes contain additional scoring information for the Sentence Comprehension and Math Computation subtests and the age-based and grade-based normative tables for the Blue, Green, and Combined forms. Conversion tables are also provided for percentile ranks, normal curve equivalents, stanines, grade equivalents, Rasch ability scaled scores, statistical significance of standard score difference tables, and prevalence of standard score difference tables.

WRAT4 Test Forms
This form includes the administration instructions for the Word Reading, Spelling, and Math

Computation subtests. The form is used to record and summarize the scores for each of the WRAT4 subtests. There is a separate Test Form for each of the alternate (Blue and Green) forms.

WRAT4 Response Forms
This form includes spaces for responding to both sections of the Spelling and Math Computation subtests. There is a separate Response Form for each of the alternate (Blue and Green) forms.

WRAT4 Sentence Comprehension Test Form
This form contains the administration instructions, test items, spaces for recording responses, and correct and incorrect responses for the Sentence Comprehension subtest. There is a separate Sentence Comprehension Test Form for each of the alternate (Blue and Green) forms.

WRAT4 Word Reading List/Spelling List Card
This card is two-sided; one side contains the letters and words for the Word Reading subtest, which is used by the test-taker. The opposite side of the card contains the letters and words for the Spelling subtest, which are dictated by the examiner to the test-taker. There is a separate card for each of the alternate (Blue and Green) forms.

WRAT4 Sentence Comprehension Card
This card contains the 50 Sentence Comprehension items. There is a separate card for each of the alternate (Blue and Green) forms.

WRAT4 Sentence Comprehension Sample Card
This card contains sample items to be administered prior to administering the Sentence Comprehension subtest. It is used with both (Blue and Green) test forms.

Reliability
Reliability evidence for the WRAT4 is shown to be strong and includes information based on classical test reliability theory, such as internal consistency, alternate-form (immediate and delayed retest stability), standard error of measurement, and standard score confidence intervals, as well as IRT applications termed Rasch statistics.

Median Internal Consistency Reliability Coefficients of WRAT4 Subtests and Reading Composite for an Age-Based Sample

Subtest/Composite	Form		
	Blue	Green	Combined
Word Reading	.92	.92	.96
Sentence Comprehension	.93	.93	.96
Reading Composite	.96	.96	.98
Spelling	.91	.90	.95
Math Computation	.89	.87	.94

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Median Internal Consistency Reliability Coefficients of WRAT4 Subtests and Reading Composite for a Grade-Based Sample

Subtest/Composite	Form		
	Blue	Green	Combined
Word Reading	.93	.92	.96
Sentence Comprehension	.93	.90	.94
Reading Composite	.96	.95	.98
Spelling	.89	.88	.92
Math Computation	.87	.83	.92

- Alternate-Form Immediate Retest Reliability Coefficients ranged from .78-.89 for an age-based sample and .86-.90 for a grade-based sample.

- Alternate-Form Delayed (approximately 30 days) Retest Study indicated that practice effects are quite small. Mean score difference of 0.4-2.2 for an aged-based sample and 0.1-0.5 for a grade-based sample.

Validity

WRAT4 validity evidence is derived from the content and structure of the test battery, studies with special groups of individuals, and correlations with other widely used achievement and cognitive ability measures. The measures used for the external validity studies are listed below.

- WIAT®-II

- SB-5

- WJ®-III

- WRAT-Expanded

- KBIT

- WRIT

- KTEA-II Comprehensive

- WISC®-IV

- KTEA-II Brief

- WASI™

- RIAS™

- WAIS®-III

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Wide Range Achievement Test 4 Interpretive Report (WRAT4-IR)

Software: Gary S. Wilkinson, PhD and PAR Staff, Interpretive Reports: Jack Martin, PhD, Gary S. Wilkinson, PhD, and PAR Staff

The WRAT4-IR scores, profiles, and interprets an individual's performance on the WRAT4 Forms. After manual entry of the individual's raw subtest scores, the software can generate one or more of the following five reports:

Score Report/Combined Score Report

- Score Summary Table--includes raw scores, standard scores (based on either age-based or grade-based norms), confidence interval (85%, 90%, or 95%), percentile rank, and three optional scores (grade equivalents, NCEs, or stanines).

- Standard Score Profile--graphical representation of standard scores.

- Standard Score Comparison Table--indicates the significance and prevalence of Standard Score differences.

Interpretive Report/Combined Interpretive Report

- Overview.

- Score Summary Table--includes raw scores, standard scores (based on either age-based or grade-based norms), confidence interval (85%, 90%, or 95%), percentile rank, and three optional scores (grade equivalents, NCEs, or stanines).

- Score Comparison Summary
  - Standard Score Profile-graphical representation of standard scores.
  - Subtest and Composite Summary-description of scores obtained from the subtests and composite.

- Subtest Comparisons--description of inter-subtest comparisons as well as suggested interpretation of each score comparison.

- Recommendations--based on subtest standard scores and the significance of score comparisons recommendations are provided for use in educational intervention planning.

Feedback Report

- Overview.

- Subtest and Composite Summary--description of scores obtained.

- Score Comparison--summary of score comparisons; also includes age-appropriate recommendations that are useful in both the home and in the classroom.

Program functionality includes navigational tools (e.g., menu system, Quickstart dialog box, Toolbar, Status Bar), file handling, and report editing features.

Features of the WRAT4 Interpretive Report

- Provides comprehensive reports that save valuable clinician report-writing time .

- Provides useful documentation to assist in educational and intervention planning for children and adults.

- Can be easily edited on screen to incorporate additional clinical information and interpretive statements.

- Generates profile graphs with the ability to overlay profiles from prior administrations for the same client.

- Quick and easy data entry.

Requirements: Windows® 2000/XP/Vista™; NTFS file system; CD-ROM drive for installation; Internet connection or telephone for software activation

Wide Range Achievement Test 4 Progress Monitoring Version (WRAT4-PMV)
Gale H. Roid, PhD and Mark F. Ledbetter, PsyD

The WRAT4-PMV is an adaptation of the Wide Range Achievement Test Fourth Edition (WRAT4) and is specifically designed as a reliable, time-efficient instrument for monitoring the academic progress of students in Grades K-12 and college. Measuring four basic academic areas (i.e., word reading, sentence comprehension, spelling, math computation), the WRAT4-PMV is composed of six levels that correspond to specific grade-range academic content appropriate for assessing Grades K-1, 2-3, 4-5, 6-8, 9-12, and 13-16 (i.e., college). Each WRAT4-PMV level consists of four parallel 15-item forms (or "probes") that are psychometrically equivalent.

Uses of the WRAT4-PMV
The WRAT4-PMV is an ideal instrument for teachers, psychologists, educational diagnosticians, and other assessment professionals to use to obtain a performance baseline and, if necessary, to monitor a student's academic performance via brief repeated test administrations throughout the school year. The WRAT4-PMV expands the utility of the WRAT4 by providing design features that enable users to efficiently monitor the progress of students who have learning difficulties, students in special

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education placements, underachieving students in regular education placements, and students who exhibit other conditions that affect school learning. Specific applications of the WRAT4-PMV include:

- Monitoring students who are not making adequate progress within the standard curriculum or general education instructional approach in order to document the need for an informal or formal evaluation referral.

- Quarterly progress monitoring of students in special education programs.

- Monitoring of instructional effectiveness for students in general education in order to evaluate response to alternative instructional methods.

- Monitoring effectiveness of informal or formal tutoring programs, or response to intensive specialized interventions.

- Normative benchmark evaluation of basic academic areas.

- Monitoring to assist with informing decisions regarding future educational placement of students.

- Assist educational decision making by providing a norm-referenced perspective that can be combined with informal curriculum or criterion-referenced probes.

- Although the methods and standards for establishing adequate yearly progress (AYP) are varied in different states and local districts, repeated testing during the school year may assist schools in showing student progress in special education and No Child Left Behind funded programs in order to meet federal standards for AYP.

- Researchers who are validating evidence-based instructional programs must show convincing research data on student learning outcomes. The WRAT4-PMV can provide researchers with brief, easy-to-use tests that utilize national norms, offering evidence of progress and improvement in basic academic skills.

Evaluating Level of Performance
Examiners can determine a student's level of performance relative to a nationally representative sample of grade-level peers by using the color-shaded normative profile. This eliminates the need to convert Total Raw Scores to derived scores when evaluating performance within a WRAT4-PMV level.

Out of Level Testing
Out of level testing can provide valuable information as well as an accurate measurement and it can be accomplished using shorter tests. Depending on the achievement level of a student, examiners can administer a WRAT4-PMV level that is below or above the student's enrolled grade level. Matching the appropriate test difficulty level with the achievement grade level of a student (i.e., "out of level" testing) can be an effective way to elicit student participation in the evaluation.

Evaluating Changes in Performance Over Time
Within a WRAT4-PMV level, repeated administrations of equivalent subtest forms enable examiners to graphically examine student performance at various time intervals. Evaluating meaningful change in performance over time is facilitated by using Within Level Score Comparison Tables.

For progress monitoring across grades using different WRAT4-PMV levels, Total Raw Scores on any

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subtest level/form can be converted to derived Level Equivalent (LE) scores. LE scores provide a common metric across WRAT4-PMV levels, grades, and forms, and are particularly useful in assessing across level score differences and by graphically representing potential growth or decline over longer periods of time.

Standardization
For the WRAT4-PMV normative sample, 1,929 individuals enrolled in Grades K-16 and ranging in age from 5 to 24 years were selected from the larger pool of WRAT4 standardization participants in order to obtain a nationally representative sample that was largely reflective of the development goals of the WRAT4-PMV. The WRAT4-PMV normative sample used demographic stratification variables for gender, race/ethnicity, educational attainment (as an index of socioeconomic status), and geographic region.

Reliability

- Median alpha reliability coefficients across the WRAT4-PMV six levels and four forms demonstrate very good internal consistency, especially given the brevity of the 15-item test forms. Alpha coefficients for the Word Reading, Sentence Comprehension, Spelling, and Math Computation Subtests were .80, .81, .79, and .74, respectively.

- Test-retest stability coefficients and alternate-form reliabilities are presented for all WRAT4-PMV Form combinations. Average test-retest reliability coefficients for the Word Reading, Sentence Comprehension, Spelling, and Math Computation Subtests were .88, .89, .93, and .77, respectively. Average alternate-form reliability coefficients were .80 (Word Reading), .80 (Sentence Comprehension), .81 (Spelling), and .63 (Math Computation).

- The equivalency of the WRAT4-PMV Forms within each of the six levels was rigorously examined using several methodologies. The median difference between the Total Raw Score means for the four forms across the six WRAT4-PMV levels ranged from .11 (Math Computation) to .18 (Spelling), demonstrating an extremely high degree of equivalency.

Validity

- Validity evidence for the WRAT4-PMV is derived from evaluating patterns of correlations among external measures of established constructs. Measures of achievement include the Kaufman Test of Educational Achievement: Second Edition-Brief Form (KTEA-II), and the Wechsler Individual Achievement Test®: Second Edition (WIAT®-II), measures of cognitive ability include the Stanford-Binet Intelligence Scale-Fifth Edition (SB5), and the Reynolds Intellectual Assessment Scale™ (RIAS™).

- Validity evidence also was derived from developmental studies and studies with groups of students with known characteristics (i.e., learning disabilities, above average and below average IQ, high or low verbal abilities relative to nonverbal abilities).

WRAT4-PMV Materials
Professional Manual--is comprehensive and contains all the information needed to administer, score, and interpret the WRAT4-PMV.

WRAT4-PMV Level Equivalent Profile--is provided to plot Level Equivalent scores and can be used with all levels and all subtests.

Word Reading Subtest
WRAT4-PMV Word Reading Record Sheet--is used by the examiner and contains the

administration instructions and the letter and/or the words for each of the four forms on one side and space to summarize and profile scores on the other side. There is a separate Word Reading Record Form for each of the six levels.

WRAT4-PMV Word Reading List Card--contains the letters and/or the words for the Word Reading Subtest, which is used by the participant. There is a separate Word Reading List Card for each of the six levels.

Sentence Comprehension Subtest
WRAT4-PMV Sentence Comprehension Record Booklet--is used by the examiner and contains the administration instructions, a place to record and score the participant's responses, and a list of correct and incorrect responses for each of the four forms. It also contains space to summarize and profile scores. There is a separate Sentence Comprehension Record Booklet for each of the six levels.

WRAT4-PMV Sentence Comprehension Card--includes the Sentence Comprehension Subtest items that are read by the participant. It contains all four forms of the subtest. There is a separate card for each of the six levels.

WRAT4-PMV Sentence Comprehension Sample Card--contains the sample items that are administered for practice purposes prior to the actual administration of the subtest. There is only one Sample Card used for all forms and all six levels.

Place Marker--is provided for the participant to use as an aid while reading the sentences from the Sentence Comprehension Card.

Spelling Subtest
WRAT4-PMV Spelling Response Booklet--is used by the participant and contains space for the participant to record responses for each of the four forms. There is a separate Spelling Response Booklet for each of the six levels.

WRAT4-PMV Spelling Card--is used by the examiner and includes the administration instructions and the letter and/or words that are read to the participant. There is a separate Spelling Card for each of the six levels.

Math Computation Subtest
WRAT4-PMV Math Computation Response Booklet--is used by both the participant and the examiner. For Levels 1-3, it contains the correct responses for the Oral Math items and space to score the participant's responses. For all of the levels, space is provided for the participant to record responses for the Math Computation items and for the examiner to summarize and profile scores. There is a separate Math Computation Response Booklet for each of the six levels.

WRAT4-PMV Math Computation Card--is used by the examiner and contains the administration instructions and the correct responses to the Math Computation items. There is a separate Math Computation Card for each of the six levels.

WRAT4-PMV Oral Math Stimulus Card--is used with Levels 1-3 only.

Wide Range Achievement Test-Expanded (WRAT-Expanded)

Gary J. Robertson, PhD

The WRAT-Expanded is a brief achievement instrument that provides an overall assessment of the general skill level of classroom students.

- The WRAT-Expanded provides both individually and group administered forms, which have been co-normed to enable direct comparisons between the two forms.

- The Group (Form G) and the Individual (Form I) forms may be given three months apart allowing for short term pre-test and post-test assessment.

- The Group form may be administered by classroom teachers to screen the entire class at the beginning of the year, taking only three class periods, a maximum 40 minutes each period.

- The Group form may be used by learning specialists (Resource Room teachers, Special Education teachers) to quickly evaluate small groups of referrals, rather than assessing each one individually.

- The Group form provides a nonverbal reasoning component, which gives an assessment of reasoning ability, factoring out language handicaps which might be interfering with school achievement. The Group form also provides content skill analysis for both the Reading and Mathematics tests.

- On the Individual form, recommended test Levels and the "Level Scoring Rule" allow for assessment using a minimal number of items, thus saving time.

- Tables provide age and grade norms, as well as "out of level" norms for students who have been retained a grade, or classes being instructed below grade level.

- WRAT-Expanded was normed on ages 5-24 years, covering college age students who might be having learning difficulties.

- Grade levels for the Group form are color coded for easy identification.

Wide Range Assessment of Visual Motor Abilities (WRAVMA)

Wayne Adams, PhD, David Sheslow, PhD

The WRAVMA is a well-standardized tool that provides a reliable, accurate evaluation of visual-motor skills of children and adolescents ages 3-17 years. The WRAVMA assesses three areas using three tests: the Drawing (Visual Motor) Test, the Matching (Visual-Spatial) Test, and the Pegboard (Fine Motor) Test. The norms for each test were derived from the same standardization sample of 2,600 children, permitting a psychometrically sound comparison of a child's overall visual-motor ability. Although each WRAVMA test can be used individually, all three tests can be administered in combination, yielding a comparison of a child's integrated visual-motor ability with the skill areas of visual-spatial and fine motor abilities.

The three areas were selected because of their relevance to school-related activities. Difficulties performing visual-motor tasks, such as copying from the chalkboard, drawing, or handwriting, can be linked to either fine motor deficits, spatial deficits, and/or to an integration deficit when motor and spatial systems are combined. The WRAVMA is uniquely suited to evaluate visual-motor ability because of its capability of making meaningful psychometric distinctions between important contributing subareas. The multifactorial nature of the WRAVMA provides a basis for explanations of such common occurrences as a kindergartner whose block building skills are adequate but who cannot write well, or the child who has trouble copying from the blackboard but performs well on puzzle construction tasks, or the teen who can draw single designs or write individual spelling words well enough, but who shows an obvious deficit in writing a page of text.

The WRAVMA provides a Visual-Motor Integration Composite derived from the three separate subtest assessments of Fine-Motor, Visual-Spatial, and Visual-Motor abilities. A scaled score, standard score, age equivalent, and percentile may be obtained for each of these subtests. Reliability measures of the three subtests of the WRAVMA show internal consistency coefficients exceeding .90 and test-retest reliability coefficients ranging from .81-.91. Construct validity is supported by item separations of .99.

The WRAVMA provides:

- Comprehensive and economical visual-motor assessment.

- Psychometric superiority.

- Extensive child/adolescent age range.

- 4 case studies with Reason for Referral, Relevant Background, Tests Administered, Discussion, and Recommendations.

- Attractive and easy-to-administer materials.

Young Children's Achievement Test (YCAT)

Wayne P. Hresko, PhD, Pamela K. Peak, PhD, Shelley R. Herron, PhD, Deanna L. Bridges

Research has shown that the best predictor of later academic success is early academic ability and that direct, early intervention prevents or ameliorates potential academic problems. The YCAT is a quick, reliable, and valid instrument that helps determine early academic abilities. It is designed for use with preschool, kindergarten, and first-grade children ages 4.0-7.11 years.

- **Primary uses:** Identify children who are developing normally or significantly below their peers in academic achievement, document educational progress, and for research purposes.
- Yields an overall Early Achievement standard score.
- Includes five subtests that may be administered independently of each other, providing flexible scheduling for testing sessions: General Information, Mathematics, Reading, Writing, Spoken Language.
- Standard scores, percentiles, and age equivalents are provided for both the subtests and the composite.
- For the 4- and 5-year-old child, the YCAT is an accurate representation of a child who has received no (or minimal) formal instruction; for the older child, the YCAT represents how the child has benefited from formal academic instruction in school.
- Normed on 1,224 children from 32 states and the District of Columbia.
- High reliability and validity.

The 5 YCAT subtests combine to form an Early Achievement Composite (EAC), which indicates a child's overall achievement in early academic areas.

- **General Information (GI)**--measures overall comprehension of common knowledge and concepts. Items focus on quantity, direction and position, sorting, categorization, time, days of the week, seasons of the year, colors, body parts, shapes, community helpers, dangers, and personal data.
- **Reading (RE)**--measures the meaning of printed symbols, the alphabet, and print conventions. Items focus on the naming and sounding of alphabet letters, rhyming, reading words in isolation as well as in context, and reading comprehension.
- **Mathematics (MA)**--measures understanding of math concepts. Items focus on counting, ordinal positions, number identification, calculation, concepts of relative magnitude, time, money, and problem solving.
- **Writing (WR)**--measures knowledge about writing; the uses of writing; the tools of writing; and the child's ability to copy, to write the alphabet, to write his or her name, and to write elementary spelling words and sentences.
- **Spoken Language (SL)**--measures a child's knowledge of receptive and expressive vocabulary, syntax, communication skills, and phonological awareness.

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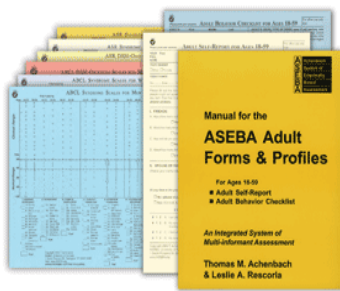
Alcadd Test, Revised (AT)

by Morse P. Manson, Ph.D

This objective paper-and-pencil test assesses extent of alcoholic addiction, measuring specific areas of maladjustment. It also yields Alcoholic Probability Index, which tells you how likely it is that, the individual taking the test is a member of an alcoholic population. It is easily administered in just 510 minutes. The *Alcadd* demonstrates high reliability and validity and is an excellent tool for diagnosis, therapy, and research

ASEBA Adult Self-Report/18-59 and the ASEBA Adult Behaviour Checklist/18-59 (ASR, ABCL)

Thomas M. Achenbach, PhD, Leslie A. Rescorla, PhD

The ASR is a self-administered instrument that examines diverse aspects of adaptive functioning and problems. The ABCL is a parallel form used to obtain information about the individual being assessed from others who know the individual well, such as a spouse, partner, family member, or friend. Both forms are valuable for assessing adults in a variety of settings such as mental health, forensic, counseling, medical, and substance abuse.

The profiles for scoring the ASR and the ABCL include normed scales for adaptive functioning, empirically-based syndromes, substance use, internalizing, externalizing, and total problems. The profiles display scale scores in relation to norms for each gender at ages 18-35 years and 36-59 years. The profiles also include a Critical Items scale, consisting of items that are of particular interest to the clinician. Responses from both forms can be hand-scored. The Manual (i.e., ASEBA Adult Manual [Achenbach System of Empirically Based Assessment]) provides full documentation for the scales, reliability, and validity, and illustrates numerous clinical and research applications for the instruments.

Eight syndromes were derived from factor analyses of the ASR and the ABCL. Both forms have parallel scales for Substance Use, Critical Items, Internalizing, Externalizing, and Total Problems. The eight syndromes are: Anxious/Depressed, Withdrawn, Somatic Complaints, Thought Problems, Attention Problems, Aggressive Behaviour, Rule-Breaking Behaviour, and Intrusive.

Six scales were constructed to have characteristics consistent with *DSM-IV*[TM] categories (Depressive Problems, Anxiety Problems, Somatic Problems, Avoidant Personality Problems, Attention Deficit/Hyperactivity Problems, and Antisocial Personality Problems).
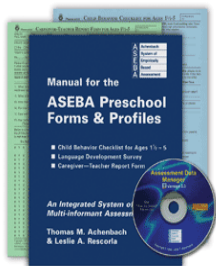
Assessment Data Manager (ADM)
With the ADM software, you can quickly enter, score, compare, and save data from parent-, teacher-, and self-reports. ADM's cross-informant comparisons help you efficiently integrate multi-source data for evaluations, interventions, and measurement of outcomes. ADM displays cross-informant comparisons of up to eight forms per client, including side-by-side item scores and scale scores from each completed form, correlations between informants, and reports on whether agreement between informants is below average, average, or above average.

With ADM, you get precise cross-informant comparisons between parallel problem scores for the CBCL Preschool and C-TRF forms, and also for the CBCL 6-18, TRF 6-18, and YSR 11-18 forms. For adults, the ADM compares scores for the ASR and the ABCL forms; for older adults, the ADM compares scores for the OASR and the OABCL forms.

Requirements: Windows® 95/98/NT/XP/2000; 128 MB RAM; 75 MB free hard disk space; 166 MHz Pentium processor.

ASEBA Child Behaviour Checklist for Ages 1.5-5, and ASEBA Caregiver-Teacher Report Form for Ages 1.5-5 (CBCL 1.5-5, C-TRF)
Thomas M. Achenbach, PhD, Leslie A. Rescorla, PhD

The Child Behaviour Checklist for Ages 1.5-5 (CBCL 1.5-5) and the Caregiver-Teacher Report Form for Ages 1.5-5 (C-TRF) (formerly the CBCL 2-3 and the accompanying caregiver-teacher form), now span a wider age range.

The CBCL 1.5-5

- Consists of 99 items rated by parents concerning issues, disabilities, descriptions of problems about the child being rated, and the best things about the child being rated.

- CBCL 1.5-5 scales are based on ratings of 1,728 children; normed on a new national sample of 700 children.

The C-TRF

- Obtains caregiver's/teacher's ratings on 99 items, plus descriptions of problems, disabilities, issues that concern the respondent most about the child, and things that respondent views to be best about the child.

- C-TRF scales are based on ratings of 1,113 children; normed on 1,192 children.

Using a new national normative sample and larger clinical samples, the following cross-informant syndromes were derived for both forms: Emotionally Reactive, Anxious/Depressed, Somatic Complaints, Withdrawn, Attention Problems, and Aggressive Behaviour. The three primary scales (Internalizing, Externalizing, Total Problems) are scored from both forms. The CBCL 1.5-5 also includes a Sleep Problems syndrome.

- Profile layouts of the CBCL 1.5-5 and the C-TRF are similar, making comparisons between multiple hand-scored profiles easy.

- CBCL 1.5-5 now includes the Language Development Survey (LDS) indicating whether a child's vocabulary and word combinations are delayed relative to norms for ages 18-35 months.

- LDS provides comparisons with norms up to 35 months for language-delayed older children.

DSM-Oriented Scales

Five scales were constructed from ratings by experienced psychiatrists who identified characteristics consistent with *DSM*™ categories.

- Affective Problems

- Pervasive Developmental Problems

- Anxiety Problems

- Oppositional Defiant Problems

- Attention Deficit/Hyperactivity Problems

Assessment Data Manager (ADM)

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With ADM, you get precise cross-informant comparisons between parallel problem scores for the CBCL Preschool and C-TRF forms, and also for the CBCL 6-18, TRF 6-18, and YSR 11-18 forms. For adults, the ADM compares scores for the ASR and the ABCL forms; for older adults, the ADM compares scores for the OASR and the OABCL forms.

Requirements: Windows® 95/98/NT/XP/2000; 128 MB RAM; 75 MB free hard disk space; 166 MHz Pentium processor

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ASEBA Child Behaviour Checklist for Ages 6-18, ASEBA Teacher's Report Form for Ages 6-18, and ASEBA Youth Self-Report for Ages 11-18 (CBCL 6-18, TRF 6-18, YSR 11-18)

Thomas M. Achenbach, PhD, Leslie A. Rescorla, PhD

The Child Behaviour Checklist for Ages 6-18 (CBCL 6-18), the Teacher's Report Form for Ages 6-18 (TRF), and the Youth Self-Report for Ages 11-18 (YSR), each provides raw scores, *T* scores, and percentiles, and are based on a new U. S. national sample that spans the ages of 6-18 years.

The CBCL 6-18

- Consists of 118 items rated by parents that describe specific behavioural and emotional problems, plus two open-ended items used to report additional problems.

- Parent ratings based on how true each item is now or has been within the past 6 months on a 3-point scale.

- CBCL 6-18 scales are based on new factor analyses from parent ratings of 4,994 clinically referred children; normed on 1,753 children ages 6-18 years.

The TRF 6-18

- Designed to obtain teachers' reports of the child's academic performance, adaptive functioning, and behavioural/emotional problems.

- Teachers rate academic performance, adaptive functioning and appropriateness of the child behaviour, how much the child is learning, how hard the child works, and how happy he/she is.

- Consists of 118 problem items, of which 93 have counterparts on the CBCL 6-18; remaining items concern school behaviours.

- TRF syndromes based on new factor analyses of 4,437 referred students; normed on 2,319 nonreferred students.

The YSR 11-18

- Completed by youths having 5th-grade reading skills, or can be administered orally.

- Youth rate themselves for how true each item is now or has been during the past 6 months, using the same 3-point scale as the CBCL 6-18 and the TRF. YSR also has 14 socially desirable items that most youths endorse about themselves.

- YSR scales based on 2,581 high-scoring youths; normed on 1,057 nonreferred youths. New national norms were used for the problem, competence, and adaptive scales. The revised

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school-age profiles feature *DSM™*-oriented scales in addition to empirically based scales. The following cross-informant syndromes were derived from factor analyses of the three forms: Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Social Problems, Thought Problems, Attention Problems, Rule-Breaking Behaviour, and Aggressive Behaviour. All forms are parallel regarding the three primary scales (Internalizing, Externalizing, Total Problems).

DSM-Oriented Scales

Six scales were identified and constructed to have characteristics consistent with *DSM* categories:

- Affective Problems

- Attention Deficit/Hyperactivity Problems

- Anxiety Problems

- Oppositional Defiant Problems

- Somatic Problems

- Conduct Problems

Assessment Data Manager (ADM)

With the ADM software, you can quickly enter, score, compare, and save data from parent-, teacher- and self-reports. ADM's cross-informant comparisons help you efficiently integrate multi-source data for evaluations, interventions, and measurement of outcomes. ADM displays cross-informant comparisons of up to eight forms per client, including side-by-side item scores and scale scores from each completed form, correlations between informants, and reports on whether agreement between informants is below average, average, or above average.

With ADM, you get precise cross-informant comparisons between parallel problem scores for the CBCL Preschool and C-TRF forms, and also for the CBCL 6-18, TRF 6-18, and YSR 11-18 forms. For adults, the ADM compares scores for the ASR and the ABCL forms; for older adults, the ADM compares scores for the OASR and the OABCL forms.

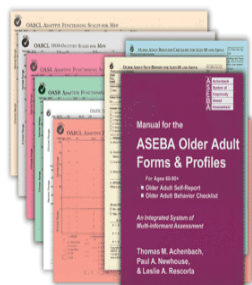## New! Module for Ages 6-18 with Multicultural Options

Replacing the 2001-2006 ages 6-18 modules, this new module displays problem-scale profiles and cross-informant bar graphs in relation to multicultural (including U.S.) norms. If the user selects a society for which norms are available, the Module displays the child's scale scores with norms for that society. If the norms are unavailable, the user can elect default norms of other norms deemed appropriate for the child. Different norms can be selected for a child's CBCL, TRF, and YSR forms. The same scale scores also can be displayed with different norms. The new Module scores the same scales as the previous edition, plus Obsessive-Compulsive Problems, Posttraumatic Stress Problems, Sluggish Cognitive Tempo (only on CBCL and TRF), and Positive Qualities (only on YSR) scales. All forms have parallel Internalizing, Externalizing, and Total Problems scales.

The new *Multicultural Supplement to the Manual for ASEBA School-Age Forms and Profiles* documents the basis for the multicultural norms and illustrates applications.

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Requirements: Windows® 95/98/NT/XP/2000; 128 MB RAM; 75 MB free hard disk space; 166 MHz Pentium processor, CD-ROM drive

ASEBA Older Adult Self-Report and the ASEBA Older Adult Behaviour Checklist (OASR, OABCL)

Thomas M. Achenbach, PhD, Paul A. Newhouse, MD, Leslie A. Rescorla,PhD

The OASR is a self-administered instrument appropriate for ages 60-90 years and older that examines diverse aspects of adaptive functioning and problems. The OABCL is a parallel form used to obtain information about the individual being assessed from others who know that individual well, such as a spouse or partner, a family member or friend, a caregiver or healthcare provider.

The OASR and the OABCL are scored on profiles that make it easy to see similarities and differences between the self-report(s) and the report(s) given by the observer(s). The profile displays scale scores in relation to gender- and age-specific norms. Responses from both forms can be hand-scored, taking between 5-10 minutes. The Manual (i.e., ASEBA Adult Manual [Achenbach System of Empirically Based Assessment]) provides full documentation for the scales, reliability, and validity, and illustrates numerous clinical and research applications for the instruments.

The OASR and the OABCL can aid assessment in a variety of settings. To measure changes in functioning, the forms can be completed at specified intervals in order to determine whether functioning is stable, improving, or worsening.

The forms for scoring the OASR and the OABCL include normed scales for adaptive functioning, empirically-based syndromes, *DSM*-oriented scales, critical items, and total problems. The Manual provides full documentation for the scales, reliability, and validity, and illustrates numerous clinical and research applications for the instruments.

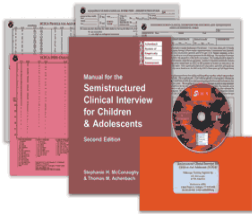### Assessment Data Manager (ADM)

With the ADM software, you can quickly enter, score, compare, and save data from parent-, teacher- and self-reports. ADM's cross-informant comparisons help you efficiently integrate multi-source data for evaluations, interventions, and measurement of outcomes. ADM displays cross-informant comparisons of up to eight forms per client, including side-by-side item scores and scale scores from each completed form, correlations between informants, and reports on whether agreement between informants is below average, average, or above average.

With ADM, you get precise cross-informant comparisons between parallel problem scores for the CBCL Preschool and C-TRF forms, and also for the CBCL 6-18, TRF 6-18, and YSR 11-18 forms. For adults, the ADM compares scores for the ASR and the ABCL forms; for older adults, the ADM compares scores for the OASR and the OABCL forms.

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Requirements: Windows® 95/98/NT/XP/2000; 128 MB RAM; 75 MB free hard disk space; 166 MHz Pentium processor.

ASEBA Semistructured Clinical Interview for Children & Adolescents (SCICA/6-18)
Thomas Achenbach, PhD

The SCICA is a standardized clinical interview for children ages 6-18 years. It was designed to be part of the Achenbach System of Empirically Based Assessment (ASEBA®), an integrated set of rating forms for assessing competencies, adaptive functioning, and problems in an easy and cost-effective manner.

The SCICA maximizes the value of interviews with a flexible user-friendly protocol, along with a self-report and observational items rated by the interviewer. The SCICA scoring profile includes eight syndrome scales: Aggressive/Rule-Breaking Behaviour, Anxious, Anxious/Depressed, Attention Problems, Somatic Complaints (ages 12-18 only), and Withdrawn/Depressed, as well as Internalizing, Externalizing, and separate Total Problems for Observation and Self-Report items. Some of the syndromes have counterparts on the CBCL/6-18, TRF/6-18, and YSR.

- Items are scored on empirically based syndromes, *DSM*-oriented scales, Internalizing, Externalizing, and separate scales for total observed and self-reported problems.

- The SCICA includes a *DSM*-oriented ADH Problems scale with Inattention and Hyperactivity-Impulsivity subscales.

- The following topics are addressed in the SCICA: activities, school, job; friends; family relations; fantasies; self-perceptions, feelings; parent-/teacher-reported problems; and achievement tests (optional).

- The SCICA also screens for fine and gross motor abnormalities (optional for ages 6-11 years); somatic complaints; alcohol; drugs; and trouble with the law (for ages 12-18 years).

- Both hand-scored and computer-scored profiles are available.

The SCICA has demonstrated reliability and validity. Weighted combinations of the SCICA syndromes yielded 66.7% sensitivity and 80.8% specificity for ages 6-11 years and 67.5% sensitivity and 92.5% specificity for ages 12-18 years.

SCICA materials include the Manual, Protocol Form for the interviewer, Observation and Self-Report Forms, and Profiles for Ages 6-18 (hand-scored or computer-scored). The Profile Forms for hand-scoring accommodate both genders so no templates are required. The SCICA can be used in a variety

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of settings such as mental health outpatient clinics, community mental health centers, educational settings, and forensic settings for custody evaluations and placement decisions.

Requirements: Windows® 95/98/NT/XP/2000; 128MB RAM; 75MB free hard disk space; 166 MHz Pentium processor; CD-ROM drive, DVD player

Adolescent Drinking Index (ADI)

Adele V. Harrell, PhD, Philip W. Wirtz, PhD

The ADI quickly assesses alcohol abuse in adolescents with psychological, emotional, or behavioural problems; identifies referred adolescents who need further alcohol abuse evaluation or treatment; and defines the type of drinking problem the adolescent is experiencing. The ADI can also help in developing treatment plans and recommendations.

Description

This 24-item rating scale measures the severity of drinking problems, differentiating between alcohol use considered to be normal in adolescent development and alcohol use that is not considered to be normal. ADI items focus on the problems that arise from alcohol use, not on the amount or the frequency of consumption. ADI items were selected to represent the four domains of problem drinking indicators: loss of control of drinking; social indicators; psychological indicators; and physical indicators.

Administration/Scoring

The ADI can be administered to individuals or groups by counselors, teachers, or others who work with adolescents. Adolescents with 5th-grade reading skills can complete the ADI, and scoring is quick and easy.

Reliability/Validity

The ADI is normed on three groups ages 12-17 years: adolescents in school, adolescents under evaluation for psychological problems, and adolescents in substance abuse programs. Internal consistency coefficients across adolescent samples are uniformly high, exceeding .90. The cutoff score has an 82% accuracy rate, and the ADI correlates .60 to .63 with the Michigan Alcoholism Screening Test (MAST).

Adolescent SASSI-A2 (SASSI-A2)

The SASSI Institute

The SASSI-A2 replaces the SASSI Adolescent Kit and components. It takes only 15 minutes to administer and score and requires only a 3rd-grade reading level. The SASSI-A2 is proven to be effective even with individuals who are unable or unwilling to acknowledge relevant behaviours (ages 12-18 years).

New Features

- **Improved Accuracy:** Empirically validated as a screening instrument for Substance Use Disorders (for both substance dependence and substance abuse):

- 94% overall accuracy rate for substance use disorders.
- 96% accuracy rate for substance dependence.
- 90% accuracy rate for substance abuse.

- **User's Guide:** Easy-to-understand instructions for administration, scoring, and interpretation.
- **Manual:** Comprehensive information on development, reliability, and validity.

Five New Scales

- **Family & Friends Risk Scale (*FRISK*)** -- Measures the extent to which the adolescent is part of a family/social system that is likely to enable substance misuse.
- **Attitudes Toward Substance Use (*ATT*)** -- Measures the adolescent's attitudes and beliefs regarding substance use.
- **Symptoms of Substance Misuse (*SYM*)** -- Measures the consequences of substance misuse and loss-of-control in usage.
- **Validity Check (*VAL*)** -- Identifies some individuals for whom further evaluation may be valuable even though the Adolescent SASSI-A2 indicates they have a low probability of having a substance use disorder--abuse or dependence.
- **Secondary Classification Scale (*SCS*)** -- Helps distinguish between substance abuse and dependence; and, like high *VAL* scores, serves as an indication that further assessment may be of value for some individuals with negative test results.

Cigarette Use Questionnaire (CUQ)
by Ken C. Winters, Ph.D.

Quickly determine what factors contribute to a smoker's addiction

Cigarette smoking is one of the most persistent addictions. Only 6% of smokers who try to quit succeed for more than a month. These odds can be improved, however, if health professionals identify and address the personal and environmental factors that sustain addiction.

The *Cigarette Use Questionnaire* (CUQ) helps clinicians evaluate, refer, and treat people who wish to quit smoking or must do so for health reasons. It is intended to measure factors related to cigarette use for the purpose of discussing, planning, and evaluating effective smoking cessation treatment and for research about cigarette use. This straightforward self-report questionnaire can be administered to individuals or groups in only 10 minutes. With 44 items written at a fifth-grade reading level, the CUQ generates the following scores:

- Nicotine Addiction
- Environmental Cues
- Negative Emotional Relief
- Readiness for Change

In addition, two validity scores alert clinicians to defensiveness and inconsistent responding on the client's part.
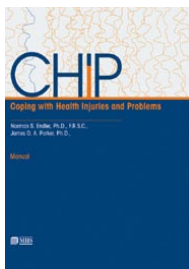
CUQ scores correlate with frequency, intensity, and duration of cigarette smoking, and with participation in smoking cessation treatment. Norms are based on a nationally representative sample of 609 adults, aged 18 to 83.

Increase the likelihood of success

Research shows that therapy is more effective when it's individualized. This is why the CUQ is such a powerful smoking cessation tool. For each smoker, the test identifies personal and situational factors related to cigarette use, making it easier for clinicians to understand the particular addiction and plan effective treatment. The personalized assessment provided by the CUQ increases the odds of success in any smoking cessation program -- particularly those that employ a cognitive-behavioural approach.

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Coping With Health Injuries and Problems (CHIP)

Norman S. Endler, Ph.D. & James D. A. Parker, Ph.D.

Current conceptions relating psychological variables to health recognize the key role of coping processes as mediating variables between stress and illness, yet few reliable and valid instruments exist for the assessment of coping with physical health problems. With the CHIP inventory you can identify a patient's typical coping strategies and suggest coping strategies that will best help the patient cope with and overcome his or her health problem.

The CHIP inventory examines four basic coping dimensions for responding to health problems: distraction, palliative, instrumental, and emotional preoccupation. It can be administered over the course of a specific health problem to help determine the coping strategies used at different times in the development and/or treatment of the problem. It has also been used effectively with chronic pain, cancer, asthma, and diabetes patients, as well as with other health problems such as sports injuries.

The CHIP was normed on 2,358 subjects—1,312 American and Canadian adults, 476 university students, and 391 adults seeking medical treatment.

Chronic Pain Coping Inventory™ (CPCI™)

Mark P. Jensen, PhD, Judith A. Turner, PhD, Joan M. Romano, PhD, and Warren R. Nielson, PhD

Designed to assess the use of coping strategies that are typically targeted for change in multidisciplinary pain treatment programs, the CPCI addresses several shortcomings of existing measures, including the lack of behavioural-strategy assessment. It is a 70-item self-report instrument on which the individual is asked to indicate the number of days during the past week he/she used the listed coping strategy to deal with his/her pain. This newly standardized version of the CPCI was normed using a sample of 527 patients with chronic pain. The CPCI was designed to assist numerous health care providers, including psychologists, physicians, psychiatrists, clinical social workers, occupational therapists, and physical therapists, as well as other mental health and health care providers working with adults ages 21-80 years.

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The CPCI assesses pain coping strategies that have been identified as contributors to the adjustments a patient makes to chronic pain. The CPCI can be used in a variety of testing situations, including:

- pretreatment screening to determine treatment necessity;

- pretreatment and posttreatment to determine treatment effectiveness; and

- periodic reevaluations to document treatment progress.

The CPCI consists of nine scales that are divided into two domains--the Illness-Focused Coping Domain and the Wellness-Focused Coping Domain.

Illness-Focused Coping Domain

- **Guarding Scale**--Assesses the extent to which a patient reports restricting the use/movement of a body part as a way of coping with pain.

- **Resting Scale**--Assesses the extent to which a patient uses pain-contingent rest (e.g., lying down) as a way to cope with pain.

- **Asking for Assistance Scale**--Assesses the frequency with which a patient asks someone (e.g., a family member) for help with a chore when he/she is in pain.

Wellness-Focused Coping Domain

- **Exercise/Stretch Scale**--Assesses how many days per week a patient stretches various muscle groups, engages in various muscle strengthening exercises, and engages in aerobic exercise for at least 15 minutes.

- **Relaxation Scale**--Assesses the frequency with which a patient uses strategies (e.g., imagery, listening to music, meditation, self-hypnosis) to experience relaxation.

- **Task Persistence Scale**--Assesses the extent to which a patient continues normal activity despite his/her pain.

- **Coping Self-Statements Scale**--Assesses the frequency with which a patient purposefully uses adaptive cognitions when he/she experiences pain.

- **Pacing Scale**--Assesses the extent to which a patient is able to conduct activities in a paced, steady manner that is not contingent on pain.

- **Seeking Social Support Scale**--Assesses the frequency with which a patient seeks out a friend/loved one for companionship and support when in pain.

Features of the CPCI

- Standardized on a sample of 527 chronic pain patients.

- *T* scores and percentiles are included for calculating scores.

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- Reliable Change scores are included to assist in determining if there are differences between scores obtained on two different testing occasions (e.g., pretreatment vs. posttreatment).

- Interpretive guidelines and case examples are included.

- Profile Form includes a skyline for clinically elevated scores and treatment goals.

Reliability and Validity

- Median internal consistency for the nine CPCI scales ranges from .70 to .94 for the four subsamples of chronic pain patients that compose the standardization sample.

- Corrected correlations for the test-retest stability of the CPCI scales range from .55 to .84.

- The validity of the CPCI is discussed in terms of evidence based on intercorrelations among the CPCI scales, factor analysis of the CPCI, correlational analyses examining the relationships between the CPCI scores and scores on related measures (i.e., coping, mental health/psychological functioning, physical dysfunction/disability, stages of change, pain attitudes/beliefs), and the use of the CPCI as a measure of treatment outcome.

Clinical Assessment of Attention Deficit--Adult™ (CAT-A™)
Bruce A. Bracken, PhD and Barbara S. Boatwright, PhD

The CAT-A is a 108-item self-report instrument that is comprehensive, highly reliable, and sensitive to the symptomatology of attentional deficits both with and without hyperactivity for adults. Closely aligned with current diagnostic criteria, the CAT-A includes scales, clusters, and items that are sensitive to symptom presentation in differing contexts and as expressed as either internal sensations or overt behaviours.

The CAT-A consists of two parts: Part 1 (Childhood Memories) assesses the individual's memories of his/her behaviours and sensations as a child; and Part 2 (Current Symptoms) assesses parallel issues in adulthood. The CAT-A provides Clinical Index scores for the Childhood Memories section, the Current Symptoms section, as well as the summation of these two sections. In addition, three validity scales are embedded within the instrument--Negative Impression, Infrequency, and Positive Impression.

The CAT-A closely resembles the child version of the CAT (CAT-C™). All item content, Clinical scales, Context clusters, and Locus clusters are similar and parallel between both forms. Together, the CAT-C and the CAT-A assess a continuum of behaviours and sensations across an individual's life span.

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The CAT-A assessment materials consist of the CAT-A/CAT-C Professional Manual, the carbonless CAT-A Rating Form, and the CAT-A Score Summary/Profile Form. The Rating Form can be hand-scored, or item responses can be hand-entered into the CAT Software Portfolio™ (CAT-SP™).

Standardization and Validity
The CAT-A was standardized on a sample of 800 adults ages 19-79 years. The sample was well-matched to the U.S. population for gender, race/ethnicity, and education level. Concurrent validity for the CAT-A was assessed via comparison with the Conners' Rating Scales, the Brown Attention-Deficit Disorder Scales®, and the Clinical Assessment of Depression™, revealing correlations for both the nonclinical and combined clinical samples that are in the moderate-to-high range.

Special Features of the CAT-A

- Consists of a self-report form that is appropriate for individuals ages 19-79 years.

- Represents a well-defined, theoretically and empirically supported measure of behaviours, characteristics, and diagnostic criteria associated with ADD/ADHD.

- Thorough and complete score reporting system that includes standard scores (*T* scores), percentile ranks, confidence intervals, qualitative classifications, and graphical profile displays.

- Linkage to the *DSM-IV*™ diagnostic criteria with comprehensive content coverage both within and across scales/clusters, assisting in rendering a differential diagnoses.

- Context clusters that indicate contexts in which ADD/ADHD symptoms are most problematic and Locus clusters that indicate the extent to which ADD/ADHD symptoms are experienced internally as sensations versus symptoms that are acted out upon as overt behaviours.

Clinical Assessment of Attention Deficit--Child™ (CAT-C™)
Bruce A. Bracken, PhD and Barbara S. Boatwright, PhD

The CAT-C is a 42-item assessment instrument with three parallel forms: a Self-Rating Form completed by the child/adolescent; a Parent Rating Form completed by one or both parents; and a Teacher Rating Form completed by the child's/adolescent's teacher(s). All three CAT-C Rating Forms are comprehensive, highly reliable, and sensitive to the symptomatology of attentional deficits both with and without hyperactivity for children and adolescents.

Closely aligned with current diagnostic criteria, the CAT-C includes scales, clusters, and items that are sensitive to symptom presentation in differing contexts and as expressed as either internal sensations or overt behaviours. The CAT-C presents a balanced framework of clinical diagnostic content

dispersed across important life contexts. In addition, three validity scales are embedded within the instrument--Negative Impression, Infrequency, and Positive Impression.

In keeping with the goal of instrument development, the CAT-C closely resembles the adult version of the CAT (CAT-A™). All item content, Clinical scales, Context clusters, and Locus clusters are similar and parallel between both forms. Together, the CAT-C and the CAT-A assess a continuum of behaviours and sensations across an individual's life span.

The CAT-C assessment materials consist of the CAT-A/CAT-C Professional Manual, three carbonless CAT-C Rating Form (one each for the Self-Rating, Parent Rating, Teacher Rating Forms), and the three CAT-C Score Summary Profile Forms, each corresponding to one of the Rating Forms. The three Rating Forms can be hand-scored or the item responses can be hand-entered into the CAT Software Portfolio (CAT-SP™).

Standardization and Validity

The CAT-C was standardized on a sample of 800 children/adolescents ages 8-18 years, 800 matched parents of the children/adolescents, and 500 teachers of these same children. The sample was well-matched to the U.S. population for gender, race/ethnicity, and education level.

Concurrent validity for the CAT-C was assessed via comparison with the Conners' Rating Scales, the Attention-Deficit/Hyperactivity Disorder Test, the Clinical Assessment of Behaviour™, and the Clinical Assessment of Depression™, revealing correlations for both the nonclinical and the combined clinical samples that are in the moderate-to-high range across all three Rating Forms.

Special Features of the CAT-C

- Consists of three forms--a self-report form, a parent report form, and a teacher report form.

- Thorough and complete score reporting system that includes standard scores (*T* scores), percentile ranks, confidence intervals, qualitative classifications, and graphical profile displays.

- Linkage to the *DSM-IV*™ diagnostic criteria with comprehensive content coverage both within and across scales/clusters, assisting in rendering a differential diagnoses.

- Context clusters that indicate contexts in which ADD/ADHD symptoms are most problematic and Locus clusters that indicate the extent to which ADD/ADHD symptoms are experienced internally as sensations versus symptoms that are acted out upon as overt behaviours.

Clinical Assessment of Attention Deficit--Software Portfolio™ (CAT-SP™)

Bruce A. Bracken, PhD, Barbara S. Boatwright, PhD, and PAR Staff

The CAT-SP scores and profiles an individual's performance on either the CAT-A™ or any of the three CAT-C™ Rating Forms. After demographic and item response information is hand-entered from an individual's completed Rating Form, the CAT-SP generates a Score Report.

The CAT-A Score Report includes: demographic information; CAT-A Validity Scales Table; CAT-A Childhood Memories Scales/Clusters/Index Table; CAT-A Current Symptoms Scales/Clusters/Index Table; CAT-A *T*-Score Profile; CAT-A Percentile Profile; and Item Responses Table.

The CAT-C Score Reports include: demographic information; CAT-C Validity Scales Table; CAT-C Scales/Clusters Index Table; CAT-C *T*-Score Profile; CAT-C Percentile Profile; and Item Responses Table.

The CAT-SP provides unlimited scoring and report generation after hand-entry of an individual's CAT responses. The program generates profile graphs with the ability to overlay profiles from prior administrations for the same client; for the CAT-C, it allows for overlays of different raters' responses (e.g., parent's profile overlaid with child's profile). The software includes built-in, easy-to-use report editing features. Client data can be exported to many spreadsheet and database programs, and client reports can be exported to common word processing programs.

Requirements: Windows® 2000/XP/Vista™; NTFS file system; CD-ROM drive for installation; Internet connection or telephone for software activation

Clinical Assessment of Behaviour™ (CAB™)

Bruce A. Bracken, PhD, Lori K. Keith, PhD

The CAB is an objective, comprehensive, and highly reliable behaviour rating scale that is closely aligned with current diagnostic criteria found in the *DSM-IV-TR*™ and IDEA. Standardized on a large representative national sample, the CAB assists in the identification of children and adolescents across

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a wide age range who are in need of behavioural, educational, or psychiatric treatment or intervention. It enables professionals to identify behaviours associated with educationally relevant exceptionalities.

The CAB offers a balanced theoretical framework of both competence-based qualities and problem-based concerns for the CAB scales and clusters, making it useful for evaluating adaptive strengths and clinical risks in children and adolescents. The CAB assesses behaviours that reflect current societal concerns and issues about youth and their behaviour (e.g., bullying, aggression, executive function, gifted and talented). It includes both Parent and Teacher Rating Forms, thus providing a multisource, multicontext assessment of children's and adolescents' behaviours.

Features of the CAB

- Provides three separate Rating Forms: the Parent Extended Rating Form (CAB-PX), with a total of 170 items, and the Parent Rating Form (CAB-P) and the Teacher Rating Form (CAB-T), each with a total of 70 items.
- Provides Parent (ages 2-18 years) and Teacher (ages 5-18 years) Rating Forms with corresponding items, thus allowing both parents and teachers to contribute equally to the evaluation of target behaviours.
- Requires only an 8th-grade reading level for completion.
- Rating Forms are quick to administer and can be efficiently scored by the CAB Scoring Program (CAB-SP).
- Normative data includes 2,114 parent ratings and 1,689 teacher ratings.

Based on scale and cluster internal consistency (alpha) coefficients in the .88 and higher range across the three CAB Rating Forms, examiners can expect to use the CAB-PX, CAB-P, and CAB-T Rating Forms with confidence to assist in making important diagnostic or intervention decisions for individual children and adolescents. Scale and cluster reliabilities also were consistently high across age level, gender, and race/ethnicity. Test-retest reliability coefficients across the three CAB forms ranged from .77-.95 with a mean test-retest interval of 17.6-19.3 days. Interrater reliabilities indicate a high level of agreement between parents and teachers (.44-.56) and even higher agreement between pairs of parent raters (.70-.90). Finally, the CAB-PX, CAB-P, and CAB-T scales and clusters demonstrate good evidence of validity based on test content, factor analytic studies, convergent and discriminant evidence, and concurrent validity studies across various clinical groups, including conduct/disruptive behavioural disorders, cognitive dysfunction, and ADD/ADHD.

New! CAB™ Scales Can Now Distinguish Emotional Disturbance From Social Maladjustment

Scales for Differentiating Emotional Disturbance From Social Maladjustment
The Individuals With Disabilities Education Act (IDEA; 1997) requires treatment for students with emotional disturbance because it is viewed as an educationally related disorder. The Act further requires that emotional disturbance be differentiated from social maladjustment, which is not considered to be an educationally related disorder and, therefore, requires no mandated services under the law. In response to the difficulties faced by many clinicians in distinguishing emotional disturbance from social maladjustment, the CAB can now be used to help differentiate these conditions for students between the ages of 2 and 18 years (i.e., Grades Pre-K through 12).

These new scales appear in Appendix H of the CAB Professional Manual. They also are available free by contacting one of our Customer Support Specialists (**1.800.331.8378**). The new scales, Emotional Disturbance (*ED*) and Social Maladjustment (*SM*), are discussed in terms of item assignments for each of the CAB Forms (CAB-PX, CAB-P, and CAB-T) and norms development based on the same *T-*
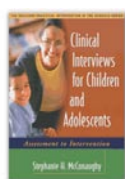
score metric as the other CAB scales. A case example is included and interpretation is discussed. Discrepancy score tables are included for each of the CAB Forms that further differentiate Emotional Disturbance and Social Maladjustment. The CAB Scoring Program (CAB-SP) also has been updated to provide *T* scores for both scales by age and gender, and each scale can be considered in light of its respective qualitative classifications.

Free CAB Scoring Program (CAB™-SP) Is Included!
The CAB-SP calculates raw and *T* scores and percentiles for all scales and clusters. After paper-and-pencil administration, the parents' and/or teachers' responses are entered manually using the CAB-SP. The software offers easy and rapid data entry for CAB items, calculation of all scores, and generation of a complete Score Report and profile for each of the three CAB Rating Forms.

Clinical Interviews for Children and Adolescents
Stephanie H. McConaughy, PhD

This easy-to-read and well-organized text offers guidelines for interviewing children and their parents and teachers. The author provides an empirically based approach to clinical interviewing and shows how to use assessment data in planning early interventions. The reproducible worksheets, interview guidelines, illustrative case examples, and chapters on assessing risk for suicide and violence are helpful additions.

Conduct Disorder Scale (CDS)
James E. Gilliam, EdD

The CDS is appropriate for individuals ages 5-22 years who present unique behavioural problems. It is designed to help in the diagnosis of Conduct Disorder and can be administered by anyone who has had direct, sustained contact with the referred individual (e.g., teachers, parents, siblings). Items on the subscales have strong face validity because they are based on the diagnostic criteria for Conduct Disorder published in the *DSM-IV-TR*.

- The CDS consists of 40 items in a behavioural checklist format that is easily rated using objective frequency-based ratings.
- A detailed interview form is provided to document infrequent but serious behavioural problems that are indicative of individuals who have Conduct Disorder.

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- The test was standardized on 1,040 persons representing the following diagnostic groups: normal, gifted and talented, mentally retarded, attention-deficit/hyperactivity disorder, emotionally disturbed, learning disabled, physically handicapped, and persons with Conduct Disorder.
- Norms were developed based on 644 representative individuals with a Conduct Disorder.
- The amount of time required to complete an individual rating is minimal (approximately 5-10 minutes in most cases).
- Standard scores and percentiles are provided. A Conduct Disorder Quotient is derived based on information from all four subscales.
- *The Conduct Disorder Quotient* is an interpretation guide provided for determining the likelihood that a participant has a Conduct Disorder and for assessing the severity of the disorder.

Coping Responses Inventory (CRI)
Rudolf H. Moos, PhD

Use the CRI in counseling, stress management education, and other settings to identify and monitor coping strategies in adults and adolescents, to develop better clinical case descriptions, and to plan and evaluate the outcome of treatment.

This brief self-report inventory identifies cognitive and behavioural responses the individual used to cope with a recent problem or stressful situation. The 8 scales include Approach Coping Styles (Logical Analysis, Positive Reappraisal, Seeking Guidance and Support, and Problem Solving) and Avoidant Coping Styles (Cognitive Avoidance, Acceptance or Resignation, Seeking Alternative Rewards, and Emotional Discharge). Information about reliability and validity is presented in the professional manual for each version.

Two separate versions of the CRI have been developed, the CRI-Adult (over 18 years of age) and the CRI-Youth (ages 12-18 years). Each version has its own manual, with information about reliability and validity, and an Ideal and an Actual form. The Ideal form may be used to compare actual and preferred coping styles, to set treatment goals, and to monitor progress. The Actual form surveys the individual's actual coping behaviour, while the Ideal form surveys preferred coping styles. Both forms are written at a 6th-grade reading level.

Individuals complete the self-report inventory, marking answers on the answer sheet. The carbonless bottom sheet contains a scoring grid for quick and easy calculation of raw scores.

The back page of the answer sheet contains a profile for determining and plotting *T* scores and examining patterns of coping. Scoring and profiling take about 5 minutes.

Coping Responses Inventory: An Update on Research Applications and Validity (Manual Supplement)
Rudolf H. Moos, PhD

The CRI assesses an individual's approach and avoidance coping skills in response to stressful life circumstances and other challenges. The CRI also allows clinicians to develop more complete case descriptions and to evaluate treatment outcomes.

This Manual Supplement to the original manuals for both versions of the Coping Responses Inventory (i.e., CRI-Adult, CRI-Youth) includes a review of studies that have utilized the CRI to examine coping and well-being in children, adolescents, and adults. This Manual Supplement also presents new normative and psychometric data for the CRI appraisal items and new data on the long-term stability of the subscales for both men and women. Topics covered include, but are not limited to, the following:

- Family-related stressors (e.g., bereavement, divorce, caregiving for impaired family members).
- Work-related stressors (e.g., service-related professions, exposure to traumatic situations).
- Health-related stressors (e.g., life-threatening illness such as stroke, HIV/AIDS, and cancer; chronic disorders such as diabetes, hypertension, cardiac disease, and weight gain).
- School-related stressors (e.g., transition from elementary to junior high school, transition to college).
- Physical and sexual abuse.
- Economic distress and poverty (e.g., homelessness, lack of income).
- War-related and natural disasters (e.g., flood, tornado).
- Combat stress and internment (e.g., combat exposure and subsequent PTSD, depression).
- Alcohol and substance use.
- Psychiatric disorders (e.g., depression, anxiety, PTSD, and dual diagnoses).

An invaluable companion for researchers and clinicians who use the CRI, this Manual Supplement provides a broad range of information about recent applications of the CRI-Adult and CRI-Youth versions and summarizes validity information based on more than 180 studies and dissertations published over the past decade. With its extensive reference list, the Manual Supplement is an excellent resource for clinicians and for researchers involved in teaching, research, and/or grant writing.

Early Childhood Parenting Skills (ECPS)

Richard R. Abidin, EdD

This modular program is designed to teach parents the skills that are recognized as key to successful parenting: developing a positive relationship, communication, discipline, managing emotions, and developing appropriate structure.

Program Manual for the Mental Health Professional

The manual organizes current knowledge about children and their development into a systematic program for basic parenting skills training. Section I provides information that will be useful to the professional before the training begins. Section II contains a scripted narrative and notes to the professional for each of the 19 sessions that form the substantive core of the program. These sessions are drawn from four general areas: self-concept, relationships, behavioural principles, and cognitive psychology. Professionals are free to use this modular program in a flexible manner, selecting appropriate sessions and/or modules to meet specific needs. Section III provides five different lecture/workshops designed as single-session presentations. Section IV provides an extensive annotated bibliography, which is also included in the Parenting Skills Workbook.

Workbook for Parents

The workbook contains home practice exercises designed to help parents master the ideas and skills presented in each of the 19 core program sessions. The homework exercise for each session includes a review of the main ideas, practical examples, practice exercises, and a main homework assignment. Through this structured program, the professional continuously interacts with the parents in ways that foster a positive parenting self-concept. In turn, parents learn the importance of interacting with their children in ways that help develop a positive self-concept in each child.

Although this ECPS program is structured to provide a curriculum for group instruction, the concepts and skills are equally applicable to one-on-one consultations with parents of young children in a variety of settings.

Emotional Disturbance Decision Tree™ (EDDT™)
Bryan L. Euler, PhD

The EDDT is the first instrument of its kind to provide a standardized approach to the assessment of Emotional Disturbance (ED) that covers all of the federal criteria and addresses the broad emotional and behavioural nuances of children ages 5-18 years suspected of requiring special education services for an ED. The federal criteria, from the U.S. Code of Federal Regulations and the reauthorization of the Individuals With Disabilities Education Act (IDEA; 2004), is challenging because it mandates that certain conditions be present in order to receive services, yet provides no guidelines for assessing these conditions. Designed by a working school psychologist, the EDDT includes five sections that match up with the specific components of the federal criteria, thus enabling evaluators to work through each criterion--one by one.

The Emotional Disturbance Characteristics section of the EDDT consists of the following scales: Inability to Build or Maintain Relationships (REL), Inappropriate Behaviours or Feelings (IBF), Pervasive Mood/Depression (PM/DEP), Physical Symptoms or Fears (FEARS), and the EDDT Total Score (TOTAL). In addition, two cluster scores are derived from this section: Attention Deficit Hyperactivity Disorder (ADHD) Cluster and Possible Psychosis/Schizophrenia (PSYCHOSIS) Cluster.

One of the most difficult assessment issues surrounding ED is that of Social Maladjustment (SM). According to the federal criteria, children who are socially maladjusted do not meet the criteria for special education services as ED unless it is determined that the child is both socially maladjusted and emotionally disturbed. This single clause in the federal definition has sparked significant controversy. The EDDT addresses some of the challenges surrounding this issue by treating SM as a supplemental trait and assessing it after ED characteristics have been assessed.

In addition, it also addresses the severity and the educational impact of emotional and behavioural problems on students through two clusters--the Level of Severity (SEVERITY) Cluster and the Educational Impact (IMPACT) Cluster. These two clusters aid in the development of recommendations and interventions.

Standardization, Reliability, and Validity
The EDDT standardization sample was composed of 601 children ages 5-18 years that were well-matched to the U.S. population for gender, race/ethnicity, and geographic region. In addition, data were collected on a sample of 404 children eligible for Special Education due to ED.

- Internal consistency was high ($r = .94$) for the EDDT TOTAL Score, ranging from .75-.88 for the other EDDT scales.

- Test-retest stability was high ($r = .92$) for the EDDT TOTAL Score, ranging from .81-.94 (interval of 1-44 days, mean = 18 days).

- Interrater reliability was good ($r = .84$) for the EDDT TOTAL Score (mean T-score change = 1.04).

- Convergent validity was examined for the normative sample using the Clinical Assessment of Behaviour™ (CAB™) Teacher Form and the Behaviour Assessment System for Children, Second Edition (BASC-2) Teacher Form. These same forms were used to examine convergent validity for a subgroup of the ED sample, along with the CAB Parent Form and the Teacher Report Form of the Achenbach Child Behaviour Checklist (CBCL).

- Validity also was examined using six specific samples of children who were representative of various Special Education exceptionalities--specific learning disability (SLD), speech/language impairment (SLI), mental retardation (MR), attention-deficit hyperactivity disorder (ADHD), autism spectrum disorder (ASD), and socially maladjusted (SM) using the following measures:
  - CAB™; Teacher Form
  - BASC-2 Teacher Form
  - Clinical Assessment of Attention Deficit for Children™ (CAT-C™) Teacher Form
  - Gilliam Autism Rating Scale (GARS)
  - Gilliam Asperger Disorder Scale (GADS)
  - Conduct Disorder Scale (CDS)
  - Differential Test of Conduct and Emotional Problems (DTCEP)
  - Jesness Inventory-Revised (JI-R)

EDDT Materials

The EDDT is composed of a Professional Manual, a reusable Item Booklet, a carbonless Response Booklet, and the Score Summary Booklet. The Professional Manual contains administration and scoring information, normative tables, reliability and validity information, along with eight detailed case studies. The Score Summary Booklet includes five sections that mirror the five sections in the Item Booklet, the Emotional Disturbance Characteristics Profile, and an optional table to assist in the interpretation of EDDT data in conjunction with the federal criteria.

The EDDT is useful for school psychologists, counseling/clinical psychologists, guidance counselors, evaluation specialists, teachers, educational diagnosticians, and speech/language pathologists within the school setting as well as within juvenile correctional facilities.

Eyberg Child Behaviour Inventory™ (ECBI™) & Sutter-Eyberg Student Behaviour Inventory- Revised™ (SESBI-R™) (ECBI SESBI-R)

Sheila Eyberg, PhD

The ECBI and the SESBI-R are comprehensive, behaviourally specific rating scales that assess the current frequency and severity of disruptive behaviours in the home and school settings, as well as the

extent to which parents and/or teachers find the behaviour troublesome. Both instruments consist of items that represent common behaviours in all children. The variety and frequency of these behaviours distinguishes normal behaviour problems from conduct-disordered behaviour in children and adolescents. The non-age-specific nature of the items also makes them widely generalizable. On both the 36-item ECBI and the 38-item SESBI-R, the parent or teacher indicates how often each behaviour currently occurs (7-point Intensity scale) and whether or not the behaviour is a problem (Yes/No Problem scale). ECBI and SESBI-R scores can be quickly and easily computed by hand in about 5 minutes each.

Test Materials

Test materials include the Professional Manual and the individual ECBI and SESBI-R Test Sheets. Completion of each rating sheet requires a 6th-grade reading level. Both instruments are also suitable for group administration or for administration via telephone.

The Professional Manual provides normative data and information on the psychometric strength of both instruments. The ECBI and the SESBI-R are reliable and valid instruments for efficient screening and tracking of disruptive behaviours in children and adolescents. The ECBI Intensity and Problem scales demonstrated high internal consistency, significant test-retest reliability, and significant interrater reliability, as well as convergent and discriminant validity. The newly developed SESBI-R Intensity and Problem scales demonstrated high internal consistency and significant test-retest reliability, as well as convergent, discriminant, and predictive validity. Both measures are sensitive to changes that can occur during treatment.

The section on interpretation includes case studies, as well as information about appropriate uses of the instruments for treatment screening and assessment of treatment outcome. Raw score-to-*T*-score conversions for the ECBI and SESBI-R Intensity and Problem scales for the total normative sample are provided in the appendix tables. A separate appendix lists various studies using the two instruments.

Using the ECBI and the SESBI-R

Used together, the ECBI and SESBI-R provide useful information for identifying and treating disruptive behaviour in children and adolescents, ages 2 through 16 years. Each instrument provides a single set of non-age-specific items with a constant cutoff score across the ages from 2 to 16 years that facilitates longitudinal measurement of treatment progress and evaluation of the long-term effects of treatment. Because they measure both the frequency of each problem behaviour and the parent's (or teacher's) reaction to the child's behaviour, they may provide additional insights into areas of the adult-child interaction that should be addressed.

Family Assessment Measure, Version III (FAM-III)

Harvey A. Skinner, PhD, Paul D. Steinhauer, MD, Jack Santa-Barbara, PhD

The FAM-III is a self-report measure that assesses the strengths and weaknesses within a family. It can be completed by pre-adolescents, adolescents, and adult family members (ages 10 years to adult).

The FAM-III consists of three types of forms: a 50-item General Scale that examines overall family health; a 42-item Dyadic Relationship Scale that examines how a family member views his or her relationship with other family members; and a 42-item Self-Rating Scale that allows each person to rate his or her own functioning within the family. By comparing these scales, you can obtain a comprehensive picture of how family members view levels of family interaction.

Two types of profiles are available for the FAM-III. The FAM-III Colorplot® of Family Perceptions is color-coded and can be used to present results to clients in an easy-to-understand manner. The Progress Colorplot is specifically designed for displaying changes in family functioning over time.

FAM Brief Version

Ideally suited for preliminary screening, the Brief FAM provides an overview of family functioning in 5-10 minutes. The Brief FAM QuikScore® Forms are self-contained, allowing for administration, scoring, and comparison to norms. Information regarding the use and interpretation of the Brief FAM is provided in the FAM-III Manual.

Firestone Assessment of Violent Thoughts™ (FAVT™)

Robert W. Firestone, PhD and Lisa A. Firestone, PhD

The FAVT is designed to be a brief, efficient indicator of an individual's violence potential. Designed on the basic hypothesis that an individual's thought process strongly influences his or her behaviour, this self-report assessment tool measures the different types of thoughts that have been found to predispose an individual to violent behaviour. It is valuable for helping clinicians to make decisions regarding safety and for separating violent individuals from prospective targets.

- FAVT items are organized into five Levels (i.e., Paranoid/Suspicious, Persecuted Misfit, Self-Depreciating/Pseudo-Independent, Self-Aggrandizing, Overtly Aggressive) and two Theoretical Subscales (i.e., Instrumental/Proactive Violence, Hostile/Reactive Violence), which allow a better understanding of the individual in order to offer more targeted treatment.

- The FAVT was standardized on a sample of 639 individuals that was well-matched to the U.S. population in terms of age, gender, race/ethnicity, educational attainment, and geographic region.
- In addition, demographic and FAVT data on two reference groups (i.e., Incarcerated, Anger Management) also were collected as part of the standardization process. These data provide the evaluator with valuable information for making level-of-care/restriction decisions and for identifying the appropriate intervention intensity.
- Two validity scales (i.e., Inconsistency Scale, Negativity Scale) are included to assist the examiner in determining whether or not the administration is accurate.
- Change score tables are provided across four different levels of significance for the four normative groups and for the two reference groups so that clinicians can easily find out if a significant change has occurred in an individual's FAVT score over two administrations.
- Test items were taken directly from thoughts experienced by violent individuals prior to engaging in violent behaviour. Because violent individuals who are administered the FAVT are able to recognize the exact content of their thoughts in the items, the FAVT taps directly into the cognitions of violent individuals.

The FAVT is ideal for use (a) as a screening device of violence potential within normal, clinical, and forensic settings; (b) as a threat assessment measure; (c) in the identification of violent thoughts and subsequent clinical intervention; and (d) in tracking changes in behaviour over time and in response to intervention (RTI). The FAVT is directly tied to treatment because the thoughts endorsed are those that need to be addressed in treatment. In whatever modality the clinician is working, he or she has an opportunity to deal directly with the thoughts that are driving the client's violent behaviour

Gilliam Asperger's Disorder Scale (GADS)
James E. Gilliam, EdD

The GADS is a norm referenced test designed to evaluate individuals with unique behavioural problems who may have Asperger's Disorder. Based on the most current and relevant definitions and diagnostic criteria of Asperger's Disorder, the GADS is useful for contributing valuable information toward the identification of individuals who have this disorder. Easily completed by a parent and professional who knows the individual, the GADS provides documentation about the essential behaviour characteristics of Asperger's Disorder necessary for diagnosis. It can be used in the assessment process to document behavioural progress, to target goals for IEPs, and for research purposes. The validity of the GADS was demonstrated by confirming that (a) the items of the test are directly related to the definitions of Asperger's Disorder, (b) the subscales are strongly related to each other and the overall diagnosis of Asperger's Disorder, and (c) the GADS scores discriminate persons with Asperger's Disorder from persons with autism and other behavioural disorders.

The GADS has the following characteristics:

- Thirty-two clearly stated items divided into four subscales describe specific, observable, and measurable behaviours.

- Eight additional items are included for parents to contribute data about their child's development during the first 3 years of life.
- Items are based on the most current definitions of Asperger's Disorder.
- The test was normed on 371 representative individuals with Asperger's Disorder (ages 3-22 years) from 27 states, the District of Columbia, Canada, and Australia.
- Behaviours are rated using objective, frequency-based ratings.
- Standard scores and percentiles are provided.
- A table is provided for determining the likelihood that an individual has Asperger's Disorder.
- A list of books, journals, media, Internet sites, and organizations concerned about Asperger's Disorder are provided to give teachers, parents, and others information about Asperger's Disorder.

Health Dynamics Inventory (HDI)
Stephen Saunders, Ph.D. & James Wojcik, Ph.D.

The HDI identifies psychological or psychiatric symptoms in order to highlight areas the areas that require further attention. It is often administered prior to or at the first meeting with an individual. During treatment, the HDI can be readminisitered to monitor symptom change and document progress. At termination, it can be used to document outcomes.

How To Use The Assessment
The HDI consists of a self-report form (HDI–Self), a parent form (HDI–Parent), and a Background Information Questionnaire. The Background Information questionnaire systematically collects important demographic information and medical/mental health history. All components are available in handscored and software format. With the software format, you can instantly generate Interpretive Reports or Medical Summary Reports.

HDI–Self (HDI–S)
The HDI–Self gathers information from the individual being assessed and provides scores for all the scales and subscales. It is use with individuals 14 years of age and older.

HDI–Parent (HDI–P)
The HDI–Parent gathers information from parents when the individual being assessed in between the ages of 4 and 19.

Normative Data
The normative sample for the HDI included 2,161 patients and 1,574 nonpatients.

Reports
Interpretive Reports provide scores graphically and numerically, as well as a narrative text to aid mental health professionals in the interpretation process.

Medical Summary Reports are a subset of the Interpretive Report. They are ideal for rapid analysis and

treatment decisions in health care settings where the full Interpretive Report may be unnecessary.

Illness Effects Questionnaire -Multi-Perspective (IEQ-MP)
Glen D. Greenberg, Ph.D. & Rolf A. Peterson, Ph.D.

With the IEQ–MP, you can accurately assess the effects that an illness and treatment are having on a patient's life. The tool's strength lies in its ability to improve communication among patients, families, and healthcare providers using four separate questionnaires to assess a patient's medical experience from multiple perspectives.

Using the IEQ–Self-Report (IEQ–S), the patient communicates his or her perception of the impact an illness is having on his or her life. The IEQ–Professional (IEQ–Pro) allows medical professionals to describe their perception of the effects the illness is having on the patient. The IEQ–Observer (IEQ–O) lets someone close to the patient report the impact of the illness on the patient's life. Rounding out the assessment of the medical experience, the IEQ–Treatment Effects (IEQ–Tx) is a self-report form to measure the patient's biological, psychological, and social effects resulting from the treatment he or she is receiving. Finally, a Comparative and Integrated Profile (IEQ–CIP) facilitates the monitoring of illness effects over time from all perspectives.

Index of Teaching Stress™ (ITS™)
Richard R. Abidin, EdD, Ross W. Greene, PhD, Timothy R. Konold, PhD

The ITS is a 90 item self report measure normed on 1488 teachers. It is designed to be used as either a part of individual case consultations. or as a screening measure to identify situations where excessive levels of stress are being experienced by the teacher in relation to teaching a specific student.

The ITS evaluates a teacher's level of stress in three domains (Attention-Deficit/Hyperactivity Disorder, Student Characteristics and Teacher Characteristics). The domain and sub scales alert the clinician to specific needs or perceptions that impinge on or may be disrupting the teaching process,

and the teacher-student relationship. The subscales of the ITS assess teaching stressors related to the following student characteristics: emotional lability, learning limitations, aggressiveness, anxiety, ADHD type behaviours. The ITS also assesses teaching stressors related to the teacher's perceptions of loss of satisfaction from their teaching role, sense of competence, lack of support, disruption of the teaching process, and frustration working with the student's parents.

The ITS's validity data indicates that teachers who are highly stressed in relation to a specific student may alter their teaching behaviours in negative ways toward both that student and other students in their class; that they are actively considering leaving the profession; and that their physical health is being affected. The ITS allows the clinician to be aware of the teacher's need for specific forms of support, which is critical if any teacher-based-intervention is being considered for the targeted student.

When used as a screening measure, the ITS helps teachers to self-identify particularly distressing teaching situations, and helps the clinician to prioritize cases. The ITS recognizes that teachers create the learning environment that facilitates student success.

The ITS includes a Professional Manual, a reusable Item Booklet, a hand-scorable carbonless Answer Sheet, and a two-sided Profile Form. Based on the purpose of the evaluation, the ITS Profile Form provides the clinician with a choice of comparison samples (i.e., Randomly Selected Student Normative Sample, Behaviour Problem Student Normative Sample), for use in the interpretation of examinee responses.

Interpersonal Adjective Scales (IAS)
Jerry S. Wiggins, PhD

The IAS is a self-report instrument that yields a reliable, valid, efficient, and theoretically sound assessment of the two primary dimensions of interpersonal transactions: Dominance and Nurturance. It provides important information about how an individual typically behaves in different interpersonal situations. The structural model underlying this instrument has been applied widely within the area of clinical psychology and personality assessment over the last 35 years.

The IAS was normed on 4,000 college students and adults, and separate norms are available for each group. Administration and scoring can be performed by individuals who have no formal training in psychology or related fields. IAS interpretation requires professional training in clinical or counseling psychology.

The test materials consist of the IAS Professional Manual, a 4-page Test Booklet, a 1-page glossary of terms, and a 4-page Scoring Booklet. The IAS Professional Manual includes information concerning the usefulness of this instrument in a clinical context and provides normative information as well as case illustrations. The test booklet lists 64 adjectives that describe interpersonal interactions. Respondents use an 8-point Likert scale (ranging from *Extremely Inaccurate* to *Extremely Accurate*) to rate how accurately each adjective describes

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them as individuals. The glossary clarifies the meaning of the 64 adjectives and is an important part of the test. The IAS requires 10th-grade reading ability.

The scoring booklet provides instructions for summing and scoring the respondent's answers and plotting these scores on the interpersonal circumplex. Responses to the 64 adjectives yield scores on eight interpersonal interactions (Assured-Dominant, Arrogant-Calculating, Cold-Hearted, Aloof-Introverted, Unassured-Submissive, Unassuming-Ingenuous, Warm-Agreeable, and Gregarious-Extraverted). These interpersonal types are distributed continuously around a circle whose primary axes are Dominance and Nurturance.

The IAS measures the respondent's interpersonal type and the intensity of that type and utilizes a framework within which all interpersonal behaviours may be represented as "blends" of the two primary axes. The IAS may be conveniently converted to an observer rating form by changing the instructions from rating self to rating a specified other person.

In most clinical situations, the IAS should be supplemented by instruments that measure additional dimensions of personality, particularly the remaining dimensions of the 5-factor model. In screening and research contexts, the efficiency of the IAS may justify its use as the single instrument of choice.

Jesness Inventory--Revised (JI-R)
Carl F. Jesness, PhD

The JI-R is a restandardized version of the Jesness Inventory (JI) with new norms based on large and diverse samples of approximately 3,500 general population individuals and 1,000 offenders/delinquents (ages 8 years to adult). An easy-to-understand, 160-item true/false questionnaire, the JI-R provides valuable information about functioning across a variety of different areas. It has 11 personality subtype scales that measure key traits and attitudes, including Social Maladjustment, Manifest Aggression, Value Orientation, Withdrawal-Depression, Immaturity, Social Anxiety, Autism, Repression, Alienation, Denial, and Asocial Index.

The JI-R also provides subtype evaluation with nine distinct subtype areas. The subtype system not only helps you understand the individuals being assessed, but also leads to specific suggestions about treatment and risk. The nine subtypes are Undersocialized/Active, Undersocialized/Passive, Conformist, Group-Oriented, Pragmatist, Autonomy-Oriented, Introspective, Inhibited, and Adaptive.

This revision to the JI includes two new scales: the Conduct Disorder and Oppositional Defiant Disorder scales. These new scales are fully normed and add to the clinical diagnostic utility of the Jesness scale. The JI-R also contains validity scales to assess potentially invalid response patterns. There is a Lie scale, as well as a Random Response scale that can be easily scored and interpreted when using the inventory.

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The JI-R Technical Manual describes the development of the scales, new norms and validation, and provides information on administration, use, and interpretation. Scoring time is greatly reduced using the JI-R Scoring Templates.

Job Stress Survey™ (JSS™)
Charles D. Spielberger, PhD, Peter R. Vagg, PhD

Occupational stress affects productivity, absenteeism, accidents, worker turnover, and stress-related health problems. Identifying major sources of stress in a workplace can help to identify changes in the work environment and other interventions that will reduce stress and increase productivity. The JSS was developed to assess generic sources of work-related stress experienced by men and women ages 18 years and older in a wide variety of business, industrial, and educational settings.

The JSS focuses on common work situations that often result in psychological strain. Each of the 30 items describes a job-related stressor event and assesses both the perceived severity and the frequency of occurrence of that event. In addition to providing information about stressors that adversely affect individual employees, the JSS can also help to identify sources of occupational stress for groups of workers and allow comparison of stress levels among employees in different departments or divisions within the same organization.

Consists of Three Scales Based on all 30 Items and Six 10-Item Subscales

- The JSS Severity and Frequency scales provide information on the average level of perceived severity and frequency of occurrence of the 30 JSS stressor events.
- The Stress Index assesses the overall level of stress based on the combined severity and frequency ratings of all 30 stressor events.
- The 10-item JSS subscales measure components of occupational stress associated with the job itself (Job Pressure) and with lack of support from supervisors, coworkers, or the policies and procedures of the organization (Lack of Organizational Support).

In addition to the scales and subscales, individual JSS items provide valuable information about the specific aspects of a particular job or a work environment that may be good targets for job redesign, organizational change, or other interventions.

Test materials include the JSS Professional Manual and the hand-scorable JSS Test Booklet. An optional computerized Scoring Program is also available. A special OCR-scannable test form (Form SP) has been developed for use with the scoring software (responses must be entered into the software) or for large group administrations or research projects.

Administration, Scoring, and Interpretation

A 6th-grade reading ability is generally sufficient to understand and respond to the JSS items. First, the individual rates the perceived severity of each of the 30 stressor events on a 9-point scale. Then the

individual indicates (on a scale of 0 to 9+ days) how often each event has occurred during the preceding 6 months. Scores are then calculated for the three JSS scales and 6 subscales. To compare an individual's scores with those of other workers in a particular normative group, percentile ranks and *T* scores can be obtained from the appendix tables in the Professional Manual.

Comparison of item scores with appropriate norms provides important information about how the stress experienced by an individual or group of employees compares with that of others engaged in similar activities. Scores may be plotted on the JSS Profile Form. Scoring Program users key the individual's responses into the software, and the program rapidly calculates the raw scores, percentiles, and *T* scores.

The Professional Manual provides information on administration, scoring, and interpretation of the JSS, as well as the development and standardization of the instrument. Normative data were obtained from 2,173 adults employed in business and industry, university, and military settings. Normative groups include managers, professionals, clerical employees, skilled-trades or maintenance employees, and military personnel. Gender-specific and combined-gender norms are provided.

Computerized scoring program (JSS-SP) also is available!

- Users key the individual's responses into the software.
- The program rapidly calculates the raw scores, percentiles, and *T* scores.
- A special test form (Form SP) has been developed for use with the scoring software (responses must be entered into the software), or for large group administrations or research projects.

Requirements: Windows® 2000/XP/Vista™; NTFS file system; CD-ROM drive for installation; Internet connection or telephone for software activation

Life Stressors and Social Resources Inventory (LISRES-A and LISRES-Y) (LISRES)
Rudolf H. Moos, PhD

The LISRES provides a unified framework to measure ongoing life stressors and social resources and their changes over time. Integrating these 2 domains in 1 assessment tool provides a comprehensive picture of an individual's overall life context. This inventory identifies the level of current stressors and their sources as well as the available social resources.

Two separate versions of the LISRES are available, the LISRES-A (for adults 18 years and older) and the LISRES-Y (for youth ages 12-18 years). Each version has its own Manual, coauthored by Bernice S. Moos, that describes the development of the instrument and provides normative data, as well as complete instructions for administration, scoring, and interpretation. The Manuals also discuss validity and research applications.

The LISRES-A may be used with healthy adults, psychiatric, substance abuse, or medical patients. It covers eight major areas of life experience: Physical Health, Spouse/Partner, Finances, Work, Home/Neighborhood, Children, Friends & Social Activities, and Extended Family.

The LISRES-Y may be used with healthy teenagers, those with conduct disorders, or adolescent medical and psychiatric patients. It covers eight major areas of life experiences: Physical Health, School, Home & Money, Parents, Siblings, Extended Family, Boyfriend/Girlfriend, and Friends & Social Activities.

The LISRES can be used as a structured interview with individuals whose reading and comprehension skills are below a 6th-grade level. The LISRES can be administered and scored by those with no formal training in clinical or counseling psychology.

The respondent answers the 200 (LISRES-A) or 208 (LISRES-Y) items contained in the 8-page reusable Item Booklet. Responses are marked on the 2-part carbonless Answer/Profile Form.

Reliability/Validity

The LISRES-A was normed on 1,884 adults (1,181 men and 703 women). Internal consistency reliabilities range from .77-.93 for the Stressor scales and from .50-.92 for the Social Resources scales.

The LISRES-Y was normed on 400 youth (179 boys and 221 girls). Internal consistency reliabilities range from .66-.92 for Stressor scales and from .78-.93 for Social Resources scales.

Marital Satisfaction Inventory, Revised (MSI-R)
Douglas K. Snyder, PhD

The revised edition of the Marital Satisfaction Inventory (MSI) assesses the nature and extent of conflict within a marriage or relationship. It is an excellent tool to use at the beginning of marital therapy to guide subsequent treatment, because it helps couples communicate hard-to-express feelings, thereby providing an easy, economical way to gather information about a broad range of issues. The MSI-R also helps you identify relationship issues that may be contributing to individual or family problems: depression, substance abuse, and trouble with children or adolescents.

- 150 True-False items (129 items if the couple has no children).

- Scores for both partners can be plotted on a single profile (AutoScore™ Answer Form).

- Two additional scales indicate inconsistency and a tendency to respond in an unrealistically positive manner, giving you a quick, graphic comparison of the two sets of scores.

- The profile highlights the primary concerns of each partner, clearly indicating differences in their perceptions of the relationship.

- Normative data collected from 2,040 people (1,020 intact couples).

- Standardization sample approximated the U.S. population in regard to geographic region, education, and ethnicity; gender-specific norms provided.

- Hand-scorable computerized scoring and interpretation program also available (20 uses; ordered separately).

Maryland Addictions Questionnaire (MAQ)
by William E. O'Donnell, Ph.D., MPH, Clinton B. DeSoto, Ph.D., and Janet L. DeSoto, Ed.D.

Brief, economical, and easy to administer and score, the MAQ is one of the best treatment planning tools you'll find. Administered at intake, it quickly tells you how severe the addiction is, how motivated the patient is, which treatment approach is most likely to work, what the risk of relapse is, and whether treatment may be complicated by cognitive difficulties, anxiety, or depression.

Find out if the patient will benefit from treatment.
The MAQ can be used with anyone aged 17 or older who can read at a fifth-grade level. It is a self-report inventory composed of 111 items on the following scales:

Substance Abuse Scales
Alcoholism Severity
Drug Abuse Severity
Craving
Control
Resentment

Summary Scores
Emotional Distress
Resistance to Treatment
Admission of Problems

Treatment Scales
Motivation for Treatment
Social Anxiety
Antisocial Behaviour
Cognitive Impairment
Affective Disturbance

Validity Scales
  Inconsistent Responding
  Defensiveness

The test gives you standard scores and percentiles for each of these scales. Based on the relative elevation of the Summary Scores, it also assigns the patient one of six Summary Codes, indicating his or her ability to benefit from treatment.

Determine treatment readiness, treatment approach, and relapse risk.
   The MAQ can be completed in just 15 to 20 minutes. (A 30-item Short Form, which includes the scales Alcoholism Severity, Drug Abuse Severity, Craving, Control, and Affective Disturbance, can be completed in only 5 minutes.) While the AutoScore[TM] Answer Sheet makes hand scoring quick and easy, the test can also be computer scored using WPS TEST REPORT Mail-In Answer Sheets, CD, or FAX Service. All of these computer options give you an interpretive report full of concrete, specific information about the most productive treatment approach, the patient's treatment readiness, relapse risk, and related problems.
   Norms are based on a large sample of people receiving substance abuse treatment at outpatient clinics, residential facilities, or halfway house programs.
   The MAQ is brief yet multidimensional, the items are easy to complete, the scales are easy to interpret, and the results facilitate treatment planning. All of this makes it the ideal intake measure for patients entering an addiction treatment program.

Mind Body Wellness Geriatric Rehabilitation and Restorative Assessment System[TM] (GRRAS[TM])
P. Andrew Clifford, PhD, Kristi D. Roper, PhD, and Daisha J. Cipher, PhD

The GRRAS is designed to assess emotional and behavioural dysfunction that is associated with medical and psychiatric comorbidities of geriatric individuals who reside in long-term care (LTC) settings. It is intended to be used by psychologists, psychiatrists, psychiatric nurse practitioners, clinical social workers, and geriatric psychotherapists for the evaluation of LTC (i.e., nursing home, assisted living facility, rehabilitation setting) residents who display emotional and behavioural dysfunction associated with chronic medical conditions and psychiatric syndromes. Because the GRRAS documents the frequency, duration, and intensity of symptoms of psychiatric conditions and medical-psychiatric comorbidities, it plays an important role in establishing the medical necessity for mental health services for this population.

The GRRAS is composed of three clinician rating forms. These three forms can be used jointly as part of a comprehensive rehabilitation and restorative assessment evaluation and/or they can be used in treatment planning, in establishing medical necessity, and for monitoring response to intervention. The Psychosocial Resistance to Activities of Daily Living Index

(PRADLI) Rating Form is an 8-item measure that assesses the level of LTC residents' resistance to and cooperation with staff in performing ADLs (on a 7-point scale) that, when resisted, commonly triggers a psychiatric or psychological referral. The Geriatric Multidimensional Pain/Illness Inventory (GMPI) Rating Form is a 14-item measure that assesses (on a 10-point scale) the perceptual, functional, and emotional concomitants of pain and illness as they have affected the resident's abilities to perform activities within the past 7 days. The Geriatric Level of Dysfunction Scale (GLDS) Rating Form assesses the intensity, frequency, and duration (each on a 7-point scale) of 20 behaviours that can potentially interfere with care provided in the LTC setting, such as agitation, wandering, unsafe/impulsive behaviours, and low activity levels.

For each of the three GRRAS measures, percentile ranks and predetermined clinical raw score ranges were established based on a criterion-referenced approach. A raw score of a specific magnitude on the GRRAS reflects a particular level of pain severity, behavioural disturbance, or activity impairment. Item and scale analyses enable ease of tracking progress over time and monitoring of response to intervention. Using the GRRAS Profile Form, visual profiles of single or repeated administrations enable the easy identification of trends in an individual's rehabilitation process.

Reliability and Validity

- Internal consistency for the PRADLI and the GMPI ranges from .71 to .93; for the GLDS, the range is from .68 to .80.

- Interrater reliability for all GRRAS Total and Cluster scores range from .87-.97.

- Validity of the GRRAS measures was examined in terms of concurrent validity, content validity, construct validity, convergent and divergent validity, clinical group contrasts, and treatment utility.

Mind Body Wellness Geriatric Rehabilitation and Restorative Assessment System™ Software Portfolio (GRRAS™-SP)
P. Andrew Clifford, PhD, Kristi D. Roper, PhD, Daisha J. Cipher, PhD, and PAR Staff

The GRRAS-SP is used to score and generate reports for the Mind Body Wellness Geriatric Rehabilitation and Restorative Assessment System™. After the examiner enters the client's demographic information and GRRAS scores, the program generates up to three useful and informative reports:

- The **GRRAS Score Report** includes a description of the GRRAS measures and components, a Score Summary Table, Scale and Cluster Score Profiles, an Item Summary Table, Brief Scale and Cluster Score Interpretations, Item Score Profiles, and a Critical Elevation Care Plan. The Critical Elevation Care Plan provides basic

recommendations for critical items and elevated scales.

- The **GRRAS Progress Monitoring Report** includes a Longitudinal Assessment Summary Table, Scale and Cluster Score Profiles, Longitudinal Item Summary Tables, and Item Score Profiles. Up to three protocols can be selected from the client's prior history to compare to the current protocol.

- The **GRRAS Quick Note Report** includes a Score Summary Table and a Critical Item Summary Table and is designed for easy placement in a resident's clinical chart.

To obtain comparisons between the client's scores and those of others, the examiner can choose a comparison group (i.e., General Unaffected, General Affected, Dementia, Pain) for each report. The easy-to-use software enables the examiner to edit reports, organize protocols into individual client files, and compare a client's prior administrations. The system is user-friendly, allowing for simple program navigation and file handling as well as easy viewing of the On-Screen Software Manual.

Requirements: Windows® 2000/XP/Vista™; NTFS file system; CD-ROM drive for installation; Internet connection or telephone for software activation

Multidimensional Health Profile™ (MHP™)
Linda S. Ruehlman, PhD, Richard I. Lanyon, PhD, Paul Karoly, PhD

The MHP is a comprehensive screening instrument designed for general use in health-related settings. Evidence over the past 30 years indicates that early identification of adjustment disorders, dysfunctional attitudes, and health-compromising habits can facilitate cost-effective prevention programs and overall improvement of health care quality. This is the first instrument to provide comprehensive information about psychosocial and health functioning. National representative norms based on a sample of 2,411 participants are available by gender for three age groups (18-32 years, 33-50 years, and 51-90 years).

- Detects areas of clinical concern and targets areas for follow-up evaluation.
- Developed and standardized for use with individuals ages 18 years and older.
- Consists of two 4-page carbonless, hand-scorable Test Booklets for use together or separately.

The MHP materials consist of a Professional Manual and two test booklets written at a fourth-grade reading level. The MHP-Psychosocial Functioning (MHP-P) booklet contains 58 items that cover four major areas of concern: life stress, coping skills, social resources, and mental health. The MHP-Health Functioning (MHP-H) booklet consists of 69 items that provide information in five major areas of concern: response to illness, health habits, adult health history, health care utilization, and health beliefs and attitudes.

Once the respondent has completed the booklet, the health professional peels back the top page to reveal the scoring page. Scale scores are plotted on the profile grid provided in the booklet. *T* scores are used to interpret the respondent's level of psychosocial and health functioning.

The MHP Professional Manual provides information on the development of the instrument; guidelines for administration, scoring, and interpretation; normative data; and data bearing on the reliability and validity of the scales.

Occupational Stress Inventory-Revised™ (OSI-R™)
Samuel H. Osipow, PhD

The OSI-R is a concise measure of three domains of occupational adjustment: occupational stress, psychological strain, and coping resources. The original research edition of the OSI was designed to (a) develop an integrated theoretical model to link these three important dimensions, and (b) develop generic occupational stress measures that would apply across different occupational levels and environments. This revision, appropriate for ages 18 years and older, provides normative data for both gender and specific occupational categories (i.e., executive, professional, technical, administrative support, public service/safety, and agricultural/production/laborer). It also includes modifications to several original OSI items and generates new items for each of the three domains. A number of correlational and multivariate studies using the OSI provide evidence of the relationship among stress, strain, and coping.

OSI-R Scales Assess Three Dimensions of Occupational Adjustment

- Occupational stress is measured by a set of six scales that comprise the **Occupational Roles Questionnaire (ORQ)**. The ORQ scales measure the following stress-inducing work roles: Role Overload, Role Insufficiency, Role Ambiguity, Role Boundary, Responsibility, and Physical Environment.
- Psychological strain is measured by a set of four scales that comprise the **Personal Strain Questionnaire (PSQ)**. The PSQ scales reflect affective responses in four major categories: Vocational Strain, Psychological Strain, Interpersonal Strain, and Physical Strain.
- Coping resources are measured by four scales that comprise the **Personal Resources Questionnaire (PRQ)**: Recreation, Self-Care, Social Support, and Rational/Cognitive Coping.

The OSI-R test materials include an Item Booklet, a Hand-scorable Answer Sheet, and two types of Profile Forms. The Gender-Specific profile form has a male profile grid on one side and a female profile grid on the other. The generic profile form can be used with *T* scores from the total normative sample ($N = 983$) or from one of the specific occupational groups. The Professional Manual provides information on test development and validation; test administration, scoring, and interpretation; and research studies using both the original and the revised OSI. Three composite case studies illustrate appropriate uses of the instrument to assess occupational stress, personal strain, and/or current coping resources.

The OSI-R is suitable for a number of important mental health applications:

- Individual screening can provide information about the work roles that are producing the individual's stress in order to help him or her develop coping strategies.
- Organizational/occupational assessment can help to identify the sources of stress and the symptoms of strain prevalent in a specific occupational unit or group.
- Programs for employee assistance and counseling can utilize the results of the OSI-R to help the individual understand the sources of his or her occupational stress.
- Career counseling may help an employee to either adjust to the present situation or change to a more appropriate position.
- The OSI-R can serve as a reliable and consistent outcome measure to establish the effectiveness of individual or organizational interventions.

Overeating Questionnaire (OQ)
by William E. O'Donnell, Ph.D., MPH and W. L. Warren, Ph.D.

Get a relevant psychological profile and personalized plan of action in just 20 minutes
Recent surveys indicate that nearly half of all American children are overweight. While most instruments related to eating behaviour focus on bulimia and anorexia, the Overeating Questionnaire (OQ) measures key habits, thoughts, and attitudes related to obesity. Appropriate for individuals as young as 9 years of age, it can be extremely helpful in designing effective individualized weight-reduction programs.

The OQ is an 80-item self-report questionnaire that can be group or individually administered in about 20 minutes. (Items are written at a fourth-grade reading level.) It yields the following scores:

Overeating	Health Habits
Undereating	Body Image
Craving	Social Isolation
Expectations About Eating	Affective Disturbance
Rationalizations	Motivation to Lose Weight

The first six scores relate to eating habits and attitudes, while the last four help identify problems that may need to be addressed concurrently with obesity. Two additional scores -- Inconsistent Responding and Defensiveness -- assess response bias. Norms are based on a nationally representative sample of 1,788 individuals aged 9 through 98.

Clients trust a treatment plan based on scientifically valid and defensible evidence
OQ scores correlate with other measures of eating-related characteristics, body mass index, health habits, mood disturbance, social functioning, and successful engagement in weight-loss activities. Information generated by the OQ is invaluable in planning effective individualized weight-loss

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programs. And because the test can be administered and scored by any trained and supervised technician, it is a practical and cost-effective addition to any treatment effort focused on weight loss and related psychological problems.

OQ Case Study: Michael

Michael seems to passively accept his weight gain. What's behind his apparent apathy?

Michael is a 138-pound, 11-year-old boy whose weight problem has escalated alarmingly over the past 2 years. He believes that obesity "runs in the family." His mother has observed that he has been "moodier than usual" lately.

Michael's pediatrician referred him to a weight-loss program for preteens. There he took the *Overeating Questionnaire* as part of a routine intake procedure.

Michael's high scores on the "Rationalization" and "Affective Disturbance" scales suggest that he attributes his weight to factors other than his own behaviour and that mood disturbances divert his attention and energy away from his weight-loss efforts. His high score on the "Motivation to Lose Weight" scale indicates that apathy is not to blame.

The most important insight Michael's counsellor took away from the OQ profile is that Michael's eating habits are closely tied to his moods. Michael eats to alleviate stress and loneliness. This knowledge allowed his counsellor to design a plan that addresses Michael's emotional issues, encourages him to find diversions that will help him control his emotional overeating, and teaches him to assume responsibility for whatever successes or failures he may encounter in his effort to shed pounds.

Parenting Alliance Measure™ (PAM™)
Richard R. Abidin, EdD, Timothy R. Konold, PhD

The PAM is a useful screening and diagnostic instrument for family counseling, joint custody evaluations, identification of dysfunctional parenting skills, and assessing the impact of intervention. The PAM was standardized on 1,224 parents of children from the general population and a clinical sample of 272 parents of children diagnosed with ADHD, CD, ODD, or other problems.

- The only measure that assesses the parenting aspects of a couple's relationship.
- Provides you with the parents' perspective of how cooperative, communicative, and mutually respectful they are with regard to caring for their child(ren).
- Quick and easy for parents to complete (10 minutes).
- Easy to score (5 minutes).
- Appropriate for a variety of parenting partners (married, divorced, unmarried, etc.).
- Appropriate for parents of children ages 1-19 years.

Reliability/Validity

The PAM is highly reliable, with an internal consistency of .97. The test-retest reliability after a 4- to 6-week period was .80. Validity studies show the PAM to be correlated in the expected directions with measures of parenting stress, family and marital functioning, children's social skills and psychosocial adjustment, and other parent characteristics.

Administration/Scoring

The PAM materials consist of the Professional Manual and a self-scoring 20-item PAM test form written at a 3rd-grade reading level. Once the parent has completed the test form, the administrator peels back the top page to reveal the scoring page. Both *T* scores and percentile scores can be used to determine the strength of the parenting alliance. Separate norms are available for fathers and mothers.

The PAM Professional Manual provides information on the PAM materials, administration, scoring, interpretation, development, and psychometric characteristics. It includes summaries of the content, convergent, and discriminant validity studies. The Appendixes include the raw score to percentile and raw score to *T*-score conversion tables.

Parenting Stress Index Software Portfolio (PSI-SP)
Richard R. Abidin, EdD, PAR Staff

The PSI-SP allows you to administer either the 120-item PSI or the 36-item PSI Short Form on-screen or to enter item responses from the PSI or the PSI Short Form. The software automatically scores the item responses and generates a report. All reports can be edited on-screen. The software program contains modifications to the interpretive statements, empirically based cutoff scores, and reference lists of PSI research that are searchable by topic.

The PSI Report Includes the Following:

- 7-9 page report designed to assist you in clinical interpretation of PSI results.

- PSI profile; score summary.

- Information on validity.

- Clinical description of the respondent's perception of his/her personal stress.

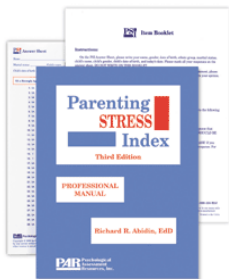- Recommendations on diagnosis, treatment planning, and management.

The PSI Short Form Report Includes the Following:

- 2-3 page report.

- PSI Short Form profile; score summary.

- No per-report fees.

Requirements: Windows® 2000/XP/Vista™; NTFS file system; CD-ROM drive for installation; Internet connection or telephone for software activation.

Parenting Stress Index, 3rd Ed. (PSI)
Richard R. Abidin, EdD

The PSI addresses the early identification and assessment needs recognized by the *Report of the Surgeon General's Conference on Children's Mental Health* (January 2001). It is well-suited for use in primary health care and paediatric practices, as well as in other settings and programs that serve at-risk children and families, or which provide early childhood educational and developmental experiences. The PSI is designed for the early identification of parenting and family characteristics that fail to promote normal development and functioning in children, children with behavioural and emotional problems, and parents who are at-risk for dysfunctional parenting. It can be used with parents of children as young as one month.

The PSI was developed on the theory that the total stress a parent experiences is a function of certain salient child characteristics, parent characteristics, and situations that are directly related to the role of being a parent. The PSI identifies dysfunctional parenting and predicts the potential for parental behaviour problems and child adjustment difficulties within the family system. Although its primary focus is on the preschool child, the PSI can be used with parents whose children are 12 years of age or younger.

The PSI consists of 120 items and takes less than 30 minutes for the parent to complete. It yields a Total Stress Score, plus scale scores for both Child and Parent Characteristics, which pinpoint sources of stress within the family.

The child characteristics are measured in six subscales: Distractibility/Hyperactivity, Adaptability, Reinforces Parent, Demandingness, Mood, and Acceptability. The parent personality and situational variables component consists of seven subscales: Competence, Isolation, Attachment, Health, Role Restriction, Depression, and Spouse. The PSI is particularly helpful in:

- Early identification of dysfunctional parent-child systems.
- Prevention programs aimed at reducing stress.
- Intervention and treatment planning in high stress areas.

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- Family functioning and parenting skills.
- Assessment of child-abuse risk.
- Forensic evaluation for child custody.

Validated With Diverse Populations

The PSI has been empirically validated to predict observed parenting behaviour, and children's current and future behavioural and emotional adjustment, not only in a variety of U.S. populations but in a variety of international populations. The transcultural research has involved populations as diverse as Chinese, Portuguese, French Canadian, Italian, Korean, etc. These studies demonstrated comparable statistical characteristics to those reported in the PSI Manual, suggesting that the PSI is a robust diagnostic measure that maintains its validity with diverse non-English-speaking cultures. This ability to effectively survive translation and demonstrate its usefulness as a diagnostic tool with non-English-speaking populations suggests that it is likely to maintain its validity with a variety of different U.S. populations.

Description

The Manual has 118 pages of information, including reference group profiles and case illustrations, Hispanic norms, and expanded norms by age. A 5th-grade reading level is required.

The PSI consists of a 120-item test booklet with an optional 19-item Life Stress scale; and an all-in-one self-scoring answer sheet/profile form. It yields 17 scores, including seven Child Domain scores, eight Parent Domain scores, and a Total Stress score, plus the optional Life Stress score.

The PSI Short Form is a direct derivative of the full-length test and consists of a 36-item self-scoring questionnaire/ profile. It yields a Total Stress score from three scales: Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child.

Personal Experience Inventory (PEI) A Measure of Substance Abuse in Adolescents
by Ken C. Winters, Ph.D. and George A. Henly, Ph.D.

The PEI helps you identify, refer, and treat teenagers with drug and alcohol problems. It is particularly useful because it covers all forms of substance abuse, assesses both chemical involvement and related psychosocial problems, and documents the need for treatment.

This convenient self-report inventory, used with more than 100,000 adolescents in facilities throughout the country, documents chemical involvement in 12- to 18-year-olds and identifies personal risk factors that may precipitate or sustain substance abuse.

| **Problem Severity Scales** | **Drug Use, Frequency, Duration, and Age of Onset** |

Personal Involvement With Chemicals

Effects From Drug Use

Social Benefits of Drug Use

Personal Consequences of Drug Use

Polydrug Use

Transituational Drug Use

Psychological Benefits of Drug Use

Social-Recreational Drug Use

Preoccupation With Drugs

Loss of Control

Alcohol

Amphetamines

Marijuana or Hashish

Quaaludes

Barbiturates

LSD

Other Psychedelics

Tranquilizers

Cocaine/Crack

Inhalants

Heroin

Other Opiates

Psychosocial Scales

Negative Self-Image

Psychological Disturbance

Social Isolation

Uncontrolled

Rejecting Convention

Deviant Behaviour

Absence of Goals

Spiritual Isolation

Peer Chemical Involvement

Sibling Chemical Use

Sibling Chemical Use

Family Pathology

Family Estrangement

Problem Screens

Family Chemical Dependency

Sexual Abuse

Physical Abuse

Eating Disorder

Suicide Potential

Psychiatric Referral

In addition, five validity scales alert you to response distortion, including defensiveness, "faking bad," and inattentive responding. Norms, based on nearly 2,000 adolescents, are provided by age and sex for both drug clinic populations and regular high school samples. So you can see where the teenager stands in relation not only to the most extreme cases but also to average adolescents.

The PEI is routinely used in substance abuse treatment programs, student assistance programs, juvenile rehabilitation centers, and private practice. Reinforcing the trend toward earlier intervention, the PEI makes it easier to evaluate the many adolescents who are entering the health care system at younger ages, with more poorly defined problems. It permits more specialized treatment. And it documents the need for treatment--for insurance companies, the juvenile justice system, and parents.

Psychosocial Evaluation & Threat Risk Assessment™ (PETRA™)

Jay Schneller, PhD

The PETRA is a 60-item, self-report psychosocial assessment instrument for use with adolescents ages 11-18 years who exhibit threatening behaviour. Following a threat of violence, the PETRA allows for an analysis of the context of psychosocial, social, and ecological factors to assist in the identification, assessment, and management of adolescents who pose a risk for targeted violence through intervention before the violent act occurs. Critical Items identify known threat risk factors.

The PETRA provides four domain scores (i.e., Psychosocial, Resiliency Problems, Ecological, Total), eight cluster scores (i.e., Depressed Mood, Alienation, Egocentricism, Aggression, Family/Home, School, Stress, Coping Problems), two Response Style Indicators (i.e., Inconsistency, Social Desirability), and eight Critical Items. Also included is the PETRA Threat Assessment Matrix, which is used to classify the content of a threat as low, medium, or high risk based on the information gleaned from the threat itself.

Conversion tables for the domains, clusters, and Response Style Indicators are grouped by age and gender in the appendix tables of the Professional Manual to assist the clinician in obtaining *T* scores, percentiles, and 90% confidence intervals from an individual's raw scores. Interpretation of the PETRA is straightforward using a five step process that is systematic with thorough methodology for gathering, guiding, and interpreting multisource data. These interpretive steps take into consideration the results in light of other data, including background information, information from other informants, and information gleaned from follow-up interviews. These steps also emphasize the simultaneous and dynamic interpretation necessary to fully understand the content and context of a threat of violence.
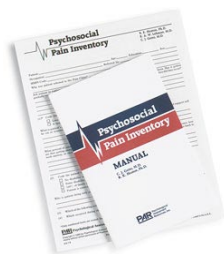
Reliability and Validity

- Internal consistency for the PETRA domains ranged from .66-.90.

- Test-retest stability coefficients (corrected) ranged from .63 for the Coping Problems cluster to .88 for the Aggression cluster.

- Validity studies comparing the PETRA with the Adolescent & Child Urgent Threat Evaluation™ (ACUTE™), Behaviour Assessment System for Children Self-Report of Personality (BASC-SRP); the Achenbach System of Empirically Based Assessment, Child Behaviour Checklist (CBCL); the Clinical Assessment of Depression™ (CAD™); the Children's Depression Inventory (CDI); and the Suicidal Ideation Questionnaire (SIQ) are presented in the Professional Manual.

- PETRA domains and clusters demonstrated moderate to high correlations for both males and females, with the correlations of highest magnitude for each cluster falling onto its assigned domain.

The PETRA materials consist of the Professional Manual, the carbonless Rating Form/Scoring Sheet, and the Score Summary/Profile Form. Written at a 3rd-grade reading level, the PETRA was normed, standardized, and validated with males and females ages 11-18 years that were representative of a wide range of racial/ethnic backgrounds, and urban, suburban, and rural communities ($N = 1,770$).

Psychosocial Pain Inventory (PSPI)
Robert K. Heaton, PhD, Ralph A. W. Lehman, MD, Carl J. Getto, MD

Use the PSPI to evaluate psychosocial factors important in maintaining and exacerbating chronic pain problems. It evaluates several forms of secondary gain, the effects of pain behaviour on interpersonal relationships, stressful life events that may contribute to subjective distress or promote avoidance learning, and components of past learning that familiarize the patient with the chronic invalid role and its personal and social consequences.

Based on a large sample of chronic pain patients, PSPI scores form a normal distribution and provide for high interrater reliability. The PSPI and the Personality Assessement Inventory™ (PAI®) provide complementary information for evaluating patients. In addition, high scores on the PSPI have been found to predict poor response to medical treatment for pain.

Quality of Life Questionnaire (QLQ)
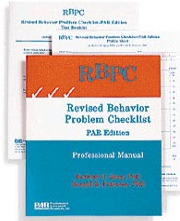David Evans, Ph.D. & Wendy Cope, M.A.

The Quality of Life Questionnaire (QLQ) measures the relationship between a client's quality of life and other behaviours or afflictions, such as physical health, psychological health, and alcohol or other substance use. Results highlight areas of the client's life that may require change to alleviate specific symptoms. Its efficient design makes the QLQ an ideal screening tool for employee assistance, wellness, stress, weight control, or any other program in which people desire change.

The QLQ consists of five major domains, 15 content scales, and a social desirability scale. The five major domains are: General Well-Being, Interpersonal Relations, Organizational Activity, Occupational Activity, and Leisure and Recreational Activity. The QLQ was normed on 437 subjects.

Profile Reports graphically and numerically provide scores for each scale to summarize a QLQ administration.

Revised Behaviour Problem Checklist-PAR Edition (RBPC)
Herbert C. Quay, PhD, Donald R. Peterson, PhD

The RBPC is used to rate problem behaviours observed in adolescents and young children ages 5-18 years. The six RBPC subscales measure Conduct Disorder, Socialized Aggression, Attention Problems-Immaturity, Anxiety-Withdrawal, Psychotic Behaviour, and Motor Tension-Excess.

The RBPC has been used for a wide variety of purposes:

- To screen for behavioural disorders in schools
- As an aid in clinical diagnosis
- To measure behavioural change associated with psychological or pharmacological interventions
- As part of a battery to classify juvenile offenders
- To select subjects for research on behavioural disorders in children and adolescents

Overview of the RBPC Scales

- **Conduct Disorder (CD/22)**--Items focus on behavioural problems of physical aggression, difficulty controlling anger, and open disobedience, defiance, and oppositionality.
- **Socialized Aggression (SA/17)**--Items tap behaviours associated with Adolescent Conduct Disorder. Items focus on the commission of conduct-disordered behaviours in the company of others, including stealing and substance use in the company of others, truancy from school, gang membership, stealing, and lying.
- **Attention Problems-Immaturity (AP/16)**--Items focus on symptoms associated with Attention Deficit Disorder (ADD), including short attention span, diminished concentration, distractibility, impulsivity, as well as the social and interpersonal correlates of ADD, including passivity, undependability, and childishness.
- **Anxiety-Withdrawal (AW/11)**--Items measure the behavioural components of internalizing disorders, including poor self-confidence and self-esteem, hypersensitivity to criticism and rejection, generalized fearfulness and anxiety, and reluctance to try new behaviours because of fear of failure.
- **Psychotic Behaviour (PB/6)**--Items tap psychotic symptoms, including speech disturbance, bizarre ideation, delusions, and impaired reality testing.
- **Motor Tension-Excess (ME/5)**--Items focus on motoric symptoms of overactivity, including restlessness, tension, and "jumpiness."

Administration and Scoring

Administration and scoring are straightforward. Raters respond to the 89 items on the top page of the carbonless Test Booklet. Responses transfer to the bottom sheet, which contains scoring instructions and a scoring key. The RBPC Profile Sheet is used to record the obtained raw and *T* scores and to plot the pattern of the test results.

The Professional Manual contains information on the development of the RBPC, psychometric properties, additional reliability and validity studies, and tables for converting raw scores to *T* scores. Norms based on teacher ratings are provided for Grades K-12. Mean internal consistency reliabilities range from .73-.94 for the six subscales. Interrater reliabilities, based on teacher ratings, range from .52-.85.

The Rating Form is designed for use in conjunction with other measures (e.g., intelligence and achievement tests, behaviour observations, and interviews) as part of an overall assessment of the individual. The Rating Form can be completed by a parent, teacher, or other observer in about 20 minutes. Scoring and profiling take about 10 minutes.

School Motivation and Learning Strategies Inventory (SMALSI)
Kathy Stroud, PhD and Cecil Reynolds, PhD

Poor study skills, ineffective learning strategies, test anxiety--all these things impede academic success. With the new SMALSI you can now measure the skills related to academic success early in a student's school career, enabling you to proactively address weaknesses.

Unlike many other learning measures, the SMALSI does not assess learning styles, preferences, or other process dimensions. Instead, it assesses the actual strategies students use in learning and test-taking--strategies shown through research to be related to academic success.

Designed for both special and general education students, this self-report inventory assesses 10 primary constructs associated with academic motivation, learning strategies, and studies--7 focusing on student strengths and 3 focusing on student liabilities.

Social Behaviour Assessment Inventory (SBAI)

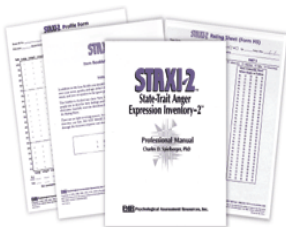Thomas M. Stephens, DEd, Kevin D. Arnold, PhD

The SBAI measures the level of social behaviours exhibited by children and adolescents in classroom settings (grades K-9). It is appropriate for special education classes or any classroom where behaviour problems may exist.

The SBAI consists of 136 items that describe social skills commonly observed in the classroom. A teacher or other individual (such as a counsellor or parent) who has observed a student's behaviour rates each item on a 4-point scale describing both the presence and level of the behaviours exhibited by the student.

Results from the 4 behaviour scales (Environmental, Interpersonal, Self-Related, and Task-Related) and 30 subscales can be used to develop social skills instructional strategies.

State-Trait Anger Expression Inventory-2™ (STAXI-2™)

Charles D. Spielberger, PhD, ABPP

The STAXI-2™ provides easily administered and objectively scored measures of the experience, expression, and control of anger for adults and adolescents, ages 16 years and older. The STAXI-2 was developed to assess components of anger and anger expression for a detailed evaluations of normal and abnormal personality and to measure the way these components of anger contribute to medical conditions such as hypertension and coronary heart disease. Recent studies on the nature of anger and its effects on mental and physical health guided the development of the STAXI-2. To investigate the effects of anger on mental and physical disorders, the *experience* of anger must be clearly distinguished from anger *expression* and *control.*

The 57-item STAXI-2 consists of six scales, five subscales, and an Anger Expression Index that provides an overall measure of total anger expression. The STAXI-2 scales and subscales are listed below:

STAXI-2 Scales and Subscales:

State Anger
Feeling Angry

Feel Like Expressing Anger Verbally
Feel Like Expressing Anger Physically

Trait Anger
Angry Temperament
Angry Reaction

Anger Expression-Out
Anger Expression-In
Anger Control-Out
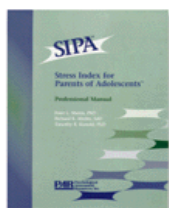**Anger Control-In**
Anger Expression Index

The STAXI-2 State Anger scale assesses the intensity of anger as an emotional state at a particular time. The Trait Anger scale measures how often angry feelings are experienced over time. The Anger Expression and Anger Control scales assess four relatively independent anger-related traits: (a) expression of anger toward other persons or objects in the environment (Anger Expression-Out); (b) holding in or suppressing angry feelings (Anger Expression-In); (c) controlling angry feelings by preventing the expression of anger toward other persons or objects in the environment (Anger Control-Out); and (d) controlling suppressed angry feelings by calming down or cooling off (Anger Control-In).

A 6th-grade reading ability is generally required to complete the STAXI-2. Individuals rate themselves on 4-point scales that assess both the intensity of their anger at a particular time and the frequency that anger is experienced, expressed, and controlled. The normative sample for the STAXI-2 included more than 1,900 individuals (1,644 normal adults, 276 hospitalized psychiatric patients). Normative tables provide raw score-to-percentile and raw score-to-T-score conversions for STAXI-2 scale and subscale scores for the total normative sample, as well as by gender for three age groups: 16-19 years, 20-29 years, and 30 years and older. The STAXI-2 can be administered and scored by individuals with limited training. Interpretation requires professional training in psychology, psychiatry, or educational testing.

The STAXI-2 materials include the professional manual, reusable item booklets, carbonless self-rating sheets, and profile forms. The manual provides directions for administration and scoring, information on the construction and development of the STAXI/STAXI-2, guidelines for interpretation, validation studies, a summary of current research, and an extensive Bibliography. A profile form for graphing percentiles or T scores facilitates the interpretation of individual patterns in scale and subscale scores.

Stress Index for Parents of Adolescents™ (SIPA™)

Peter L. Sheras, PhD, Richard R. Abidin, EdD. Professional Manual by Peter L. Sheras, PhD, Richard R. Abidin, EdD, Timothy R. Konold, PhD

The SIPA is a screening and diagnostic instrument that identifies areas of stress in parent-adolescent interactions and is appropriate for parents of adolescents ages 11-19 years. This

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upward extension of the popular Parenting Stress Index (PSI) for parents of children ages 1 month to 12 years allows a clinician or researcher to examine the relationship of parenting stress to adolescent characteristics, parent characteristics, the quality of the adolescent-parent interactions, and stressful life circumstances.

Four subscales measure adolescent characteristics:

- Moodiness/Emotional Lability
- Social Isolation/Withdrawal
- Delinquency/Antisocial
- Failure to Achieve or Persevere

Four subscales measure parent characteristics:

- Life Restrictions
- Relationship with Spouse/Partner
- Social Alienation
- Incompetence/Guilt

The SIPA is useful for family counseling, forensic evaluations for adolescent custody, identification of dysfunctional parent-adolescent systems, prevention programs designed to reduce parental stress, and intervention and treatment planning in high stress areas. The SIPA was developed from a normative sample consisting of 778 parents of adolescents from the general population and a clinical sample of 159 parents of adolescents who had received a *DSM-IV*™ diagnosis, usually in the cluster of disruptive behaviour disorders.

Reliability/Validity

The SIPA is highly reliable. Internal consistency for the SIPA subscales exceeds .80 with the majority equal to the high .80s-.90. The alpha coefficients for the three SIPA domains (adolescent, parent, adolescent-parent relationship), and the Index of Total Parenting Stress exceed .90. The 4-week test-retest reliability coefficients for the subscales range from .74-.91, suggesting that responses to SIPA responses remain stable over a period of time. Confidence intervals are provided in the SIPA Professional Manual.
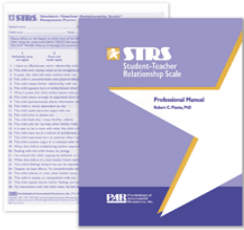
Administration/Scoring

The 112 SIPA items are contained in a reusable item booklet. Parents record their responses on a separate, carbonless, hand-scorable answer sheet/profile form. Completion of the SIPA requires approximately 20 minutes and a 5th-grade reading level. Scoring the responses is easy: SIPA scores are plotted on the profile form (included as part of the answer sheet) and then converted to percentiles to compare the parent's scores to general population scores.

The SIPA Professional Manual provides information on materials, administration, scoring, interpretation, normative data, and psychometric characteristics. It contains information supporting the factor structure of the SIPA, as well as summaries of the reliability and the content, convergent, and discriminant validity studies. The Appendix tables provide the raw score to percentile and raw score to *T*-score conversions.

Student-Teacher Relationship Scale™ (STRS™)

Robert C. Pianta, PhD

The STRS can be used separately or as part of the Students, Teachers, and Relationship Support™ (STARS™) program to identify student-teacher relationships that could benefit from intervention and support. The STRS can be used (a) to evaluate changes in the quality of student-teacher relationships as a function of using the STARS intervention, (b) as part of an educational assessment battery to determine the extent to which relationship problems or strengths should be addressed in program planning, and (c) as a tool for researching classroom processes.

- Consists of 28 items rated on a 5-point Likert-type scale.
- Contains three subscales that measure Conflict, Closeness, and Dependency.
- Normative sample consisted of 275 teachers who rated at least one child from the 1,535 preschool through 3rd-grade group.

Students, Teachers, and Relationship Support™ (STARS™)

Robert C. Pianta, PhD, Bridget K. Hamre, PhD

The STARS is a 3-part program consisting of Assessment, Teacher Support, and Banking Time stages. The STARS Program is designed to enhance the relationship between a student and teacher by providing positive support to at-risk children and to teachers on the verge of burnout. By improving the quality of the student-teacher relationship, the quality of the student's academic and social functioning also should improve.

- During the STARS Assessment stage, the consultant incorporates information from both quantitative Student-Teacher Relationship Scale™ (STRS™) and qualitative (student interview, teacher interviews, and classroom observations) assessments to identify problem areas and available resources.
- In the STARS Teacher Support Assessment stage, the consultant helps the teacher to change his/her perception of the student-teacher relationship.
- In the STARS Banking Time stage, the teacher uses a set of specific techniques to create positive interactions with a student and to establish a supportive relationship pattern.
- Appropriate for teachers of preschool to 5th-grade students.

Substance Abuse Relapse Assessment (SARA)

Lawrence Schonfeld, PhD, Roger Peters, PhD, Addis Dolente, PsyD

The SARA is a structured interview designed as a treatment planning instrument for psychologists, psychiatrists, counselors, social workers, nurses, and other professionals who work with substance abusers. It is especially helpful in developing relapse prevention goals for clients who tend to use multiple substances and in monitoring the achievement of these goals during treatment. Based on a model of the substance abuse behaviour chain (antecedents, behaviours, and consequences), the SARA helps the individual to identify the events that typically precede his/her substance use, as well as the consequences that may reinforce that use. The behaviour chain is then used to develop an individualized treatment plan with specific strategies for coping with high risk situations, slips, and relapses.

The SARA is designed for use with adolescents and adults who have a history of drug and/or alcohol abuse or whose ability to avoid relapse is in question. The 12-page Interview Record Form is administered orally. It focuses on the individual pattern of substance use, positive and negative consequences of substance use, current coping skills, and level of self-confidence. The three Relapse Prevention Planning Forms allow the professional to summarize the interview responses, help to identify the individual's substance behaviour chain (Form 1), survey current coping skills (Form 2), and develop treatment plan goals (Form 3).

Survey of Pain Attitudes™ (SOPA™)

Mark P. Jensen, PhD and Paul Karoly, PhD

Research conducted over the past decade indicates that patients' attitudes and beliefs about pain play a key role in their adjustment and treatment outcome. The SOPA was designed to assist clinicians in the understanding of seven key pain-related beliefs of patients who have chronic pain with the assumption that these beliefs reflect and influence patient functioning. It is a self-report instrument on which individuals are asked to indicate their level of agreement with 57 statements using a 5-point Likert scale. This newly standardized version of the SOPA was normed using a sample of 415 patients with

chronic pain. The SOPA was designed to assist numerous health care providers working with adults ages 21-80 years.

The SOPA can be used in a variety of testing situations, including pretreatment screening to determine treatment necessity, pretreatment and posttreatment to determine treatment effectiveness, and periodic reevaluations to document treatment progress.

The SOPA consists of seven scales that are divided into two domains--the Adaptive Beliefs Domain and the Maladaptive Beliefs Domain.

Adaptive Beliefs Domain

- **Control Scale**--Assesses the extent to which a patient sees himself/herself as having control over his/her pain.

- **Emotion Scale**--Assesses the patient's belief that emotions have an impact on pain.

Maladaptive Beliefs Domain

- **Disability Scale**--Assesses the extent to which a patient believes that he/she is disabled by pain.

- **Harm Scale**--Assesses a patient's beliefs that pain is a signal/sign of physical damage and that in the presence of pain, exercise/activity should be avoided.

- **Medication Scale**--Assesses a patient's belief that medications are an appropriate treatment for his/her pain problem.

- **Solicitude Scale**--Assesses the extent to which a patient believes that others (e.g., family) should be helpful/solicitous in response to his/her pain (e.g., taking over chores).

- **Medical Cure Scale**--Assesses the extent to which a patient believes that a cure will be found for his/her pain and that the primary responsibility for the management of his/her pain rests with the physician.

Features of the SOPA

- *T* scores and percentiles are included for calculating scores; a validity scale (i.e., Inconsistency Score) is included to measure inconsistency of responses.

- Reliable Change scores are included to assist in determining if there are differences between scores obtained on two different testing occasions (e.g., pre-treatment vs. posttreatment).

- Interpretive guidelines and case examples are included.

- Profile Form includes a skyline for clinically elevated scores and treatment goals.

Reliability and Validity

- Internal consistency for the seven SOPA scales ranges from .65 to .82 for the standardization sample.

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- Test-retest stability for the SOPA scales is moderate to good, ranging from .67 to .79 ($n = 130$).

- The validity of the SOPA is discussed in terms of evidence based on intercorrelations among the SOPA scales, correlational analyses examining the relationships between the SOPA scores and scores on related measures (i.e., mental health/psychological functioning, physical dysfunction/disability, medical utilization), and the use of the SOPA as a measure of treatment outcome.

Forensic Psychology Products

Alcadd Test, Revised (AT)
by Morse P. Manson, Ph.D

This objective paper-and-pencil test assesses extent of alcoholic addiction, measuring specific areas of maladjustment. It also yields Alcoholic Probability Index, which tells you how likely it is that, the individual taking the test is a member of an alcoholic population. It is easily administered in just 510 minutes. The *Alcadd* demonstrates high reliability and validity and is an excellent tool for diagnosis, therapy, and research

Antisocial Process Screening Device (APSD)
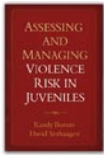Paul J. Frick, Ph.D. & Robert D. Hare, Ph.D.

In recent years, societal concerns over the dramatic rise in juvenile crime—especially violent crime—has reaffirmed the importance of research in this area. Children who commit antisocial, delinquent, and violent acts constitute a heterogeneous group in terms of the types of antisocial behaviours they exhibit, the causes of their behaviour problems, and the developmental course of their antisocial behaviour.

The APSD assessment detects antisocial processes in young populations so that preventative measures can be taken before tendencies lead to crime and other destructive behaviours. Based on the highly popular Hare PCL–R™ assessment, the APSD screens for Antisocial Personality Disorder or psychopathy. The child is rated on a dimensional scale that probes the characteristic psychopathic pattern of interpersonal, affective, and behavioural symptoms. In addition to the parent (APSD–P) and teacher (APSD–T) forms, a combined form (APSD–C) allows you to integrate and reconcile the responses of multiple informants.

The normative samples consisted of 1,120 nonreferred and nonadjudicated elementary school children from the third, fourth, sixth, and seventh grades. Raw scores are plotted on a Profile Form included with QuikScore™ Forms for conversion to *T*-scores.

Assessing and Managing Violence Risk in Juveniles

Randy Borum, PsyD and David Verhaagen, PhD

From leading experts in the field, this book is an excellent resource for mental health practitioners working with youth at risk for violent behaviour. The text provides a comprehensive framework for evaluating juveniles in the justice system or those whose behaviour in school, therapy sessions, or other contexts raises concern about violence. Detailed case examples illustrate the authors' scientifically grounded approach to selecting appropriate instruments, analyzing and communicating assessment results, and designing effective interventions. Special problems addressed include bullying, sexual aggression, fire setting, and homicide. The book also examines the development of aggressive conduct problems and their connections to other emotional and behavioural disorders. The book also suggests practical ways to translate assessment findings into an effective treatment plan.

Ackerman-Schoendorf Scales of Parent Evaluation of Custody (ASPECT)

Marc J. Ackerman, PhD, Kathleen Schoendorf, PsyD

Easy to use and interpret, ASPECT offers a practical, standardized, and defensible approach to child custody evaluations. It draws information from a variety of sources, reducing the likelihood of examiner bias.

ASPECT produces an overall score, the Parental Custody Index (PCI), which guides custody decisions. It not only tells you which parent is more effective, it also tells how much more effective that parent is. If neither parent is effective, the PCI will reflect that, too.

In addition, ASPECT differentiates situations in which one parent should obtain full custody from those in which joint custody is appropriate; it has also proven effective in identifying parents who need supervision during child visitation. Consistent with APA Guidelines for Child Custody Evaluations, ASPECT requires the clinician to answer 56 yes-or-no questions based on information obtained from the following sources: the ASPECT Parent Questionnaire; interview with and observation of each parent with and without the child; and scores obtained from tests routinely used for child custody evaluation and an IQ measure for the child (these tests are not included in the ASPECT kit).

Adolescent SASSI-A2 (SASSI-A2)

The SASSI Institute

The SASSI-A2 replaces the SASSI Adolescent Kit and components. It takes only 15 minutes to administer and score and requires only a 3rd-grade reading level. The SASSI-A2 is proven to be effective even with individuals who are unable or unwilling to acknowledge relevant behaviours (ages 12-18 years).

New Features

- **Improved Accuracy:** Empirically validated as a screening instrument for Substance Use Disorders (for both substance dependence and substance abuse):

  o 94% overall accuracy rate for substance use disorders.
  o 96% accuracy rate for substance dependence.
  o 90% accuracy rate for substance abuse.

- **User's Guide:** Easy-to-understand instructions for administration, scoring, and interpretation.
- **Manual:** Comprehensive information on development, reliability, and validity.

Five New Scales

- **Family & Friends Risk Scale (*FRISK*)** -- Measures the extent to which the adolescent is part of a family/social system that is likely to enable substance misuse.
- **Attitudes Toward Substance Use (*ATT*)** -- Measures the adolescent's attitudes and beliefs regarding substance use.
- **Symptoms of Substance Misuse (*SYM*)** -- Measures the consequences of substance misuse and loss-of-control in usage.
- **Validity Check (*VAL*)** -- Identifies some individuals for whom further evaluation may be valuable even though the Adolescent SASSI-A2 indicates they have a low probability of having a substance use disorder--abuse or dependence.
- **Secondary Classification Scale (*SCS*)** -- Helps distinguish between substance abuse and dependence; and, like high *VAL* scores, serves as an indication that further assessment may be of value for some individuals with negative test results.

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Carlson Psychological Survey (CPS)

Kenneth A. Carlson, PhD

The CPS assesses and classifies criminal offenders and others who have come before the criminal justice or the social welfare system. Appropriate for adolescents and adults, the CPS is quite useful with anyone presenting behavioural or substance abuse problems.

Description

This 50-item questionnaire with a 5-category response format also has space for additional respondent comments. The average reading level of the items is 4th grade, and test time is about 15 minutes. The CPS is appropriate for research/evaluation regarding effects of intervention programs.

The scale scores provided represent four content areas and one validity check: Chemical Abuse; Thought Disturbance; Antisocial Tendencies; Self-deprecation; and Validity. The CPS uses special hand-scorable sheets to categorize and sum individual responses. The profile sheet graphically displays the five scale scores in standardized form. An outstanding feature of the CPS is the information it offers for classifying respondents.

Using multivariate statistical techniques, 18 offender types are identified and described in detail in the manual. Also included are descriptive summaries, presentence reports, sample case histories, psychological and psychiatric reports, and data regarding institutional behaviour and four-year post-release adjustment. Studies on reliability, validity, correlations with the MMPI, and sensitivity to treatment effects are all reported.

Checklist for Child Abuse Evaluation (CCAE)

Joseph Petty, PhD

This valuable information-gathering tool is used for investigating and evaluating children and adolescents who may have been abused or neglected. You may obtain extensive data for preparing clinical reports or standard documents in the clinical file. The Checklist is transferable to all pertinent professionals to eliminate repetitive stressful questioning of the child. Using the Checklist will also enhance the possibility of providing legally sound conclusions.

Psychologists, social workers, and other professionals involved in child abuse investigations and evaluations will agree that this checklist provides an excellent survey of child abuse symptomatology.

Description

The 264-item, 40-page CCAE contains 24 sections including:

- Child's Historical & Current Status.
- Emotional Abuse (child & witness reports).
- Sexual Abuse (child & witness reports).
- Physical Abuse (child & witness reports).
- Neglect (child & witness reports).
- Child's Psychological Status.
- Credibility/Competence of the Child.
- Conclusions in 6 Categories.
- Case-specific Treatment Recommendations & Issues.
- When conducting an evaluation, you can use the entire checklist or only those sections applicable to the specific situation.

Chemical Dependency Assessment Profile (CDAP)
L. Michael Honaker, Ph.D., Thomas Harrell, Ph.D., & Anthony Ciminero, Ph.D.
Key Areas Measured:
History of Dependancies
Patterns and Reinforcement Dimensions of Use
Beliefs About Use and Dependency
Self-Concept and Interpersonal Relations

The Chemical Dependency Assessment Profile (CDAP) questionnaire saves you valuable time as it efficiently documents details about your client's drug and alcohol use. The CDAP is for individuals 16 and older who are being assessed for alcohol and chemical dependency problems. It investigates alcohol use, use of other substances, and mixed or poly-drug abuse patterns. It evaluates a spectrum of alcohol and substance use, including:

- History of dependencies
- Patterns and reinforcement dimensions of use
- Beliefs about use and dependency
- Self-concept and interpersonal relations

You can administer the CDAP questionnaire on your computer or print the paper-and-pencil version to have the client complete it, and then enter the results into the CDAP program. A report is generated that organizes information for treatment planning and case conceptualization.

Child Abuse Potential Inventory (CAP)

Joel S. Milner, PhD

The CAP Inventory was designed primarily as a screening tool for the detection of physical child abuse by protective services workers in their investigations of reported child abuse cases. The CAP Inventory is a 160-item, reliable and valid objective self-report screening instrument that can assist protective services workers in making case decisions. It contains a total of 10 scales. The primary clinical scale (Abuse) can be divided into six factor scales: Distress, Rigidity, Unhappiness, Problems With Child and Self, Problems With Family, and Problems With Others. In addition, the CAP Inventory contains three validity scales: Lie, Random Response, and Inconsistency.

The CAP Inventory is appropriate for use as a preliminary screening tool in cases where a group of high-risk patients have been identified and the professional desires to quickly screen this identified population for a subgroup of individuals who are most likely to be at-risk for physical child abuse. Intervention/treatment programs have successfully used the CAP Inventory at pre- and post-treatment and on a follow-up basis to assist in program evaluation.

- Overall, the 77-item CAP Abuse scale has high internal consistency reliabilities (i.e., .92-.96 for controls and .95-.98 for abusers); temporal stability estimates for the abuse scale are also adequate (i.e., .91 and .75 for one-day and three-month intervals, respectively).
- *The Child Abuse Potential Inventory Manual, 2nd Ed.* includes information about administration, scoring, and interpretation procedures.
- *An Interpretive Manual for the Child Abuse Potential Inventory* provides additional information for interpretation of the CAP Inventory, including applications, limitations and related issues, scale descriptions, and references.
- The CAP Inventory Form VI is a four-page test booklet with test items printed in large type for easy reading. Raw Score Summary Sheets provide a form for recording all the raw data generated from a client's CAP Inventory; Inconsistency Scale Scoring Sheets are used with the Inconsistency Scale Transparent Scoring Template to obtain an Inconsistency Scale Score

Cigarette Use Questionnaire (CUQ)

by Ken C. Winters, Ph.D.

Quickly determine what factors contribute to a smoker's addiction

Cigarette smoking is one of the most persistent addictions. Only 6% of smokers who try to quit succeed for more than a month. These odds can be improved, however, if health professionals identify and address the personal and environmental factors that sustain addiction.

The *Cigarette Use Questionnaire* (CUQ) helps clinicians evaluate, refer, and treat people who wish to quit smoking or must do so for health reasons. It is intended to measure factors related to cigarette use for the purpose of discussing, planning, and evaluating effective smoking cessation treatment and for

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research about cigarette use. This straightforward self-report questionnaire can be administered to individuals or groups in only 10 minutes. With 44 items written at a fifth-grade reading level, the CUQ generates the following scores:

- Nicotine Addiction
- Environmental Cues
- Negative Emotional Relief
- Readiness for Change

In addition, two validity scores alert clinicians to defensiveness and inconsistent responding on the client's part.

CUQ scores correlate with frequency, intensity, and duration of cigarette smoking, and with participation in smoking cessation treatment. Norms are based on a nationally representative sample of 609 adults, aged 18 to 83.

Increase the likelihood of success

Research shows that therapy is more effective when it's individualized. This is why the CUQ is such a powerful smoking cessation tool. For each smoker, the test identifies personal and situational factors related to cigarette use, making it easier for clinicians to understand the particular addiction and plan effective treatment. The personalized assessment provided by the CUQ increases the odds of success in any smoking cessation program -- particularly those that employ a cognitive-behavioural approach.

Clarke Sex History Questionnaire for Males-Revised (SHQ-R)
Ron Langevin, Ph.D. & Dan Paitich, Ph.D.

Twenty-three scales (including two validity scales) provide a comprehensive sexual history to help evaluate an offender's risk to others and potential for rehabilitation. The SHQ–R questionnaire determines a respondent's specific sexual experiences and also investigates his history of voyeurism, sexual dysfunction, exhibitionism, transvestism, toucheurism, fetishism, frotteurism, fantasy, sexual abuse, and exposure to pornography.

The SHQ–R Technical Manual contains specific descriptions of the various samples on which the instrument was normed. Ask a Client Service Specialist for a free brochure.

Comprehensive Reports provide a graphical representation of the rating results on each scale.

Classification of Violence Risk™ (COVR™)

John Monahan, PhD, Henry J. Steadman, PhD, Paul S. Appelbaum, MD, Thomas Grisso, PhD, Edward P. Mulvey, PhD, Loren H. Roth, MD, MPH, Pamela Clark Robbins, BA, Steven Banks, PhD, and Eric Silver, PhD

The COVR is an interactive software program designed to estimate the risk of an acute civil psychiatric patient becoming violent to others over the next several months after discharge into the community. The program guides the evaluator through a brief chart review and a 10-minute interview with the patient. The COVR then generates a report that contains a statistically valid estimate of the patient's violence risk, including the confidence interval for that estimate and a list of the questions used to produce the estimate.

Because a number of variables might be potential risk factors for violence among people with a mental disorder, the authors assessed personal factors (e.g., demographic and personality variables), historical

factors (e.g., past violence, mental hospitalizations), contextual factors (e.g., social support, social networks), and clinical factors (e.g., diagnosis, specific symptoms). Patients in acute psychiatric facilities ($N = 1,136$) were assessed on 106 potential risk factors for violent behaviour and were followed for 20 weeks in the community after discharge from the hospital.

The COVR is based on a "classification tree" method. A classification tree approach prioritizes an interactive and contingent model of violence--one that allows many different combinations of risk factors to classify an individual at a given level of risk. Each assessment is individualized; the particular questions asked depend on the answers given to prior questions. This approach contrasts with a regression approach in which a common set of questions is asked of everyone being assessed, and every answer is weighted to produce a score that can be used for purposes of categorization.

The program was designed to be administered to individuals ages 18-60 years, from a wide variety of racial/ethnic backgrounds and psychiatric diagnoses, and from different regions of the U.S.

Requirements: Windows® 2000/XP/Vista™; NTFS file system; CD-ROM drive for installation; Internet connection or telephone for software activation.

HCR-20: Assessing Risk for Violence (Version 2) (HCR-20)

Christopher D. Webster, PhD, Kevin S. Douglas, LLB, PhD, Derek Eaves, MD, Stephen D. Hart, PhD

The HCR-20 is a 20-item checklist to assess the risk for future violent behaviour in criminal and psychiatric populations. Items were chosen based on a comprehensive review of the literature and input from experienced forensic clinicians. The HCR-20 includes variables which capture relevant past, present, and future considerations and should be regarded as an important first step in the risk assessment process. The manual provides information about how and when to conduct violence risk assessments, research on which the basic risk factors are based, and key questions to address when making judgments about risk.

Violence is defined as "actual, attempted, or threatened harm to a person or persons." The professional who completes the HCR-20 Coding Sheet must first determine the presence or absence of each of the 20 risk factors according to three levels of certainty (i.e., Absent, Possibly Present, Definitely Present). In some settings, responsibility for the assessment may be divided among several different professionals.

The 20 Items Are Divided Into Three Sections:

- 10 Historical Items (previous violence, age at first violent offense, family and vocational background, etc.).
- Five Clinical Items (current symptomatology and psychosocial adjustment).
- Five Risk Management Items (release and treatment plan, necessary services and support).

Historical information serves as an anchor for risk assessments because there is a strong predictive link between past and future violent behaviour. Such information should be verified carefully, as historical considerations may modify analyses of clinical and situational factors. In some cases, it may be necessary to contact friends or family members of the individual for verification of past events. The five clinical variables

can be assessed at regular intervals so that risk level may be modified accordingly. The risk management items focus on predicting how individuals will adjust to future circumstances, and this is directly related to the context within which the individual will be living.

The final judgment regarding the risk for future violence (Low, Moderate, and High) should be based on a careful analysis of the 20 risk factor items. Any statements of risk should take into consideration the base rate of violence in the particular population or setting (e.g., low, moderate, or high risk relative to other correctional inmates).
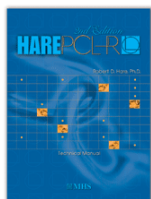
Now Available!
HCR-20 Violence Risk Management Companion Guide
This handy volume provides brief descriptions of violence intervention strategies. Section One covers general issues pertaining to violence risk assessment and management using the HCR-20. Section Two

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suggests intervention and management strategies that stem from the Clinical ("C") factors of the HCR-20. Section Three addresses strategies that stem from the Risk Management ("R") factors. Section Four offers practical assistance to people interested in using the HCR-20 for planning and tracking risk management activities.

Hare Psychopathy Checklist-Revised: 2nd Ed. (PCL-R™)
Robert D. Hare, PhD

This second edition of the PCL-R supplants its predecessor as the accepted standard for conducting forensic assessments of psychopathy. Revisions are based on the large numbers of articles, reports, presentations, and dissertations that have appeared since the original instrument was published in 1991.

The PCL-R is a 20-item symptom-construct rating scale designed to assess psychopathic (antisocial) personality disorders in forensic populations (ages 18 years and older). The PCL-R Rating Booklet facilitates rating the 20-item scale; the Quikscore™ Form is used to record the ratings, obtain the scores, and profile the results. The ratings are based on responses to the semi structured interview and on a review of collateral information.
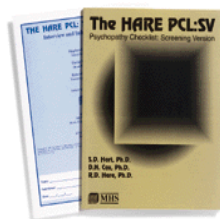
As in the original version, the PCL-R: 2nd Ed. provides a Total score that is important for the overall assessment of psychopathy. The Total score can be interpreted dimensionally in terms of degree of match to the prototypical psychopath, or it can be used categorically to help identify or diagnose psychopaths. This new edition retains the original two factors that reflect the two major facets of psychopathy: the callous, selfish, remorseless use of others (Factor 1), and a chronically unstable and antisocial lifestyle (Factor 2). The interpretive power of the PCL-R has been enriched through the evolution of four subfactors. Factor 1 and Factor 2 have been divided into two empirically derived and validated subfactors: Factor 1a, Interpersonal (4 items); Factor 1b, Affective (4 items); Factor 2a, Impulsive Lifestyle (5 items); and Factor 2b, Antisocial Behaviour (5 items).

The PCL-R is highly reliable and has impressive concurrent, predictive, and construct validity. Ratings are made using a semistructured interview and a review of collateral information. Scoring is based on the degree to which a person's personality/behaviour matches the Rating Booklet items. The Manual provides item descriptions, scoring procedures, extensive reliability and validity information, and normative data. New large-sample descriptive and validation data are provided for use of PCL-R with male and female offenders, substance-abusers, sex offenders, African American offenders, and forensic psychiatric clients.

Percentile and *T*-score tables are provided for male and female offenders, for male forensic psychiatric patients who have been assessed with the standard PCL-R procedure (interview plus file information), and for male offenders and forensic psychiatric patients whose assessments are based solely on file reviews. New research findings derived from confirmatory factor analysis and item response theory are presented along with the implications of these findings for research, clinical, and forensic purposes.

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Hare Psychopathy Checklist: Screening Version (PCL:SV)

Stephen D. Hart, PhD, David N. Cox, PhD, Robert D. Hare, PhD

The PCL: SV offers a quick, cost-effective way to assess the interpersonal, affective, and social deviance symptoms of psychopathy in both forensic and nonforensic populations. This is an abbreviated version of the Hare Psychopathy Checklist-Revised (PCL-R).

Highly correlated with the PCL-R, the PCL: SV was not designed to replace the PCL-R, but rather to provide an efficient tool to screen for the possible presence of psychopathy. Cutoff scores indicate when to follow up the PCL: SV with the complete PCL-R, thereby providing a more detailed and reliable assessment of psychopathy.

The PCL: SV provides a 12-item scale based on a subset of the PCL-R items that can be completed in under 1 1/2 hours. In forensic populations, the PCL: SV functions as a screening tool for psychopathy; in civic settings, it can be used in psychiatric evaluations, personnel selection, and community studies. Norms are available for the following populations:

- Forensic nonpsychiatric.
- Forensic psychiatric.
- Civil psychiatric.
- Noncriminal nonpsychiatric.

The PCL: SV should only be administered and interpreted by individuals who are familiar with the theory and research documented in the PCL-R.

Hare Psychopathy Checklist: Youth Version (PCL: YV™)

Adelle E. Forth, PhD, David S. Kosson, PhD, Robert D. Hare, PhD

The PCL: YV is a 20-item rating scale for the assessment of psychopathic traits in male and female offenders, ages 12-18 years. Based on the Hare Psychopathy Checklist--Revised (PCL-R™), the PCL: YV uses a semistructured interview and collateral information to measure interpersonal, affective, and behavioural features of psychopathy. It yields dimensional scores for clinical purposes, and also may be used to classify individuals into groups for research purposes.

Items in the PCL:YV include Impression management, grandiose sense of self worth; stimulation seeking; pathological lying; manipulation for personal gain; lack of remorse; shallow affect; callous/lack of empathy; parasitic orientation; poor anger control; impersonal sexual behaviour; early behaviour problems; lacks goals; impulsivity; irresponsibility; failure to accept responsibility; unstable interpersonal relationships; serious criminal behaviour; serious violations of conditional release; and criminal versatility.

The PCL: YV consists of a Technical Manual, Interview Guide, QuikScore™ Forms, and Rating Booklet. The Technical Manual provides the information needed to administer, score, and interpret the PCL: YV; it also provides information on the psychometric properties of the PCL: YV.

The Interview Guide includes the interview questions recommended to elicit information. Space is provided for the interviewer to note responses. The interview covers the domains of school adjustment, work history, career goals, psychiatric history, health, family life, interpersonal relationships, drug use, attitudes toward self and others, and childhood and adolescent antisocial behaviour.

The QuikScore™ Form is used to record the ratings of the individual on each of the 20 PCL: YV items. Then, the rater can easily obtain total scores for the PCL: YV and convert them into percentile ranks or *T* scores.

The Rating Booklet contains the rating criteria detailed in the Technical Manual. It is designed to be a convenient, self-contained administration and rating guide for examiners who do not wish to carry the manual.

- The PCL: YV provides clinicians with a standardized method of assessing the presence of traits and behaviours central to the construct of psychopathy.
- The PCL: YV provides researchers with a reliable and valid measure of psychopathy in adolescents.
- The length of time it takes to administer a complete PCL: YV assessment depends on a number of factors, including the length of the interview, familiarity with the case, the amount of chart information to review, and whether collateral interviews need to be conducted.
- The standard PCL:YV administration procedure consists of a semistructured interview, which takes approximately 2 hours to complete and may be spread over several sessions; and a review of collateral information, such as institutional files, court documents, police reports, school

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records, psychiatric, psychological, and social work assessments, and interviews with parents, siblings, relatives, and peers. Data were collected from 2,438 youth in three countries. The 19 different samples of adolescents included institutionalized offenders (detained in correctional or inpatient facilities); offenders on probation or in open custody or arrested youth referred for outpatient evaluation; and youth in the community (including conduct-disordered youth attending a treatment program).

Overall, the PCL: YV showed sound psychometric properties, based on samples across a variety of settings. The internal consistency of the PCL: YV was .85-.94 across the settings.

Inventory of Offender Risk, Needs, and Strengths™ (IORNS™)
Holly A. Miller, PhD

The IORNS is a 130-item self-report measure that assesses static risk, dynamic risk/need, and protective strength factors as they relate to recidivism, treatment need, and management.

The IORNS provides index and scale scores that are internally consistent and stable over time, in addition to content subscales that aid in interpretive specificity. The IORNS indexes, scales, and subscales demonstrate good convergent and discriminant validity with self-report, interview, and objective criminal history measures of antisocial behaviour, psychopathy, personality pathology, substance use, depression, and anxiety among numerous male and female offender samples.

The IORNS consists of the four IORNS indexes, 10 scales, 14 subscales, and two validity scales. *T* scores, percentiles, confidence intervals, and qualitative classifications (i.e., low, average, high, very high) are provided for the normative samples. Given low or high endorsement of certain items, percentiles and percentile classifications are recommended for interpretation.

Special Features

- Is the only instrument that assesses all three types of factors (static, dynamic, and protective factors) important to recidivism by providing a more comprehensive risk assessment than is currently available through concomitant assessment.

- Can be group administered at offender intake, thereby reducing clinician burden.

- Can be administered and scored by persons who do not have training in forensic or clinical psychology or psychiatry, with supervision and interpretation by a licensed or certified professional.

- Written at a 3rd-grade reading level.

- Standardized and validated with offenders (men ages 18-75 years and women ages 18-60 years). Offender samples included incarcerated and probated general and sexual offenders.
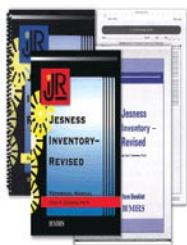
- Community adult/college normative sample also provided (men and women ages 18-75 years). The community adult/college normative group approximates U.S. Census proportions (U.S. Bureau of the Census, 2003) for race/ethnicity and educational status.

- The validity of the IORNS is based on multiple sources of evidence, including content validity, convergent and discriminant validity, and internal structure of the measure via factor analysis.

- Constructs of interest were chosen based on their relationship between recidivism, desistance, or protection and criminal behaviour.

- The IORNS demonstrated significant correlations with self-reported criminal history variables, including number of nonviolent and violent crimes and number of times in jail/prison among male and female offenders. The IORNS also was significantly related to numerous self-reported criminal, familial, and substance use history variables (e.g., past physical and sexual abuse) among female offenders.

- Evidence for construct validity of the IORNS was further demonstrated through significant correlations with the following measures within various offender groups:
  - Level of Service Inventory-Revised (LSI-R)
    - Sexual Offender Needs Assessment Rating Scale (SONAR)
    - Personality Assessment Inventory™ (PAI®)
    - Psychopathy Checklist-Revised (PCL-R)
    - Psychopathic Personality Inventory™-Revised (PPI™-R)
    - Levenson's Self-Report Psychopathy Scale (LSRP)
    - Self-Report Psychopathy Scale-II (SRP-II)
    - Substance Abuse Subtle Screening Inventory-3 (SASSI-3)
    - Center for Epidemiologic Studies Depression Scale (CES-D)
    - State-Trait Anxiety Inventory (STAI)
    - Factor analysis supports separate Dynamic Need and Protective Strength factors

  IORNS Materials

  The IORNS materials consist of the Professional Manual, the Carbonless Response Form, and the Scoring Summary/Profile Form.

Jesness Inventory--Revised (JI-R)
Carl F. Jesness, PhD

The JI-R is a restandardized version of the Jesness Inventory (JI) with new norms based on large and diverse samples of approximately 3,500 general population individuals and 1,000 offenders/delinquents (ages 8 years to adult). An easy-to-understand, 160-item true/false

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questionnaire, the JI-R provides valuable information about functioning across a variety of different areas. It has 11 personality subtype scales that measure key traits and attitudes, including Social Maladjustment, Manifest Aggression, Value Orientation, Withdrawal-Depression, Immaturity, Social Anxiety, Autism, Repression, Alienation, Denial, and Asocial Index.

The JI-R also provides subtype evaluation with nine distinct subtype areas. The subtype system not only helps you understand the individuals being assessed, but also leads to specific suggestions about treatment and risk. The nine subtypes are Undersocialized/Active, Undersocialized/Passive, Conformist, Group-Oriented, Pragmatist, Autonomy-Oriented, Introspective, Inhibited, and Adaptive.

This revision to the JI includes two new scales: the Conduct Disorder and Oppositional Defiant Disorder scales. These new scales are fully normed and add to the clinical diagnostic utility of the Jesness scale. The JI-R also contains validity scales to assess potentially invalid response patterns. There is a Lie scale, as well as a Random Response scale that can be easily scored and interpreted when using the inventory.

The JI-R Technical Manual describes the development of the scales, new norms and validation, and provides information on administration, use, and interpretation. Scoring time is greatly reduced using the JI-R Scoring Templates.

Level of Service Inventory-Revised (LSI-R)
Don Andrews, Ph.D. & James Bonta, Ph.D.

The LSI–R™ is a quantitative survey of attributes of offenders and their situations relevant to level of supervision and treatment decisions. Designed for ages 16 and older, the LSI–R helps predict parole outcome, success in correctional halfway houses, institutional misconducts, and recidivism. The 54 items are based on legal requirements and include relevant factors needed for making decisions about risk and treatment. The LSI–R Manual explains the use of the LSI–R and summarizes research studies on its reliability and validity.

The LSI–R can be used by probation and parole officers and correctional workers at jails, detention facilities, and correctional halfway houses to assist in the allocation of resources, help make decisions about probation and placement, make appropriate security level classifications, and assess treatment progress.

Profile Reports provide security classification information based on the overall assessment score.

Comparative Reports show progress over time. Free option with Profile Reports.

Group Reports provide summary information for a group of offenders. Free option with Profile Reports

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Level of Service Inventory-Revised: Screening Version (LSI-R:SV)
Don Andrews, Ph.D. & James Bonta, Ph.D.

The LSI–R: SV is a screening instrument ideal for use when a complete LSI–R™ assessment may not be feasible, due to time constraints or insufficient staff resources. The LSI–R: SV consists of eight items selected from the full LSI–R (see page 108). It provides a brief summary of dynamic risk areas that may require further assessment and possible intervention.

Research with the LSI–R: SV shows it is predictive of a variety of outcomes important to offender management. Among probation samples, the LSI–R: SV scores predicted violent recidivism and violations while under community supervision. Among incarcerated offenders, scores have predicted success in correctional halfway houses and institutional misconduct.

Profile Reports summarize the addressed items and indicate whether a full LSI-R assessment is necessary.

Level of Service/Case Management Inventory (LS/CMI)
Don Andrews, Ph.D., James Bonta, Ph.D., & J. Stephen Wormith, Ph.D.

Meet the fourth generation of risk assessment and the most comprehensive and current product of its kind.

The Level of Service/Case Management Inventory (LS/CMI) is the next step from the LSI–R inventory. It combines risk assessment and case management into one evidence-based system. All the necessary tools are here in one single application.

The LS/CMI helps probation officers, psychologists, and correctional workers to assess offenders' rehabilitation needs. The interview guide allows you to survey the offender's attributes and life situation, enabling you to assess his or her risk of recidivism and produce a quantitative assessment of the factors most relevant to the level of service, supervision, and programming required.

A case management plan provides a summary of the criminogenic and noncriminogenic needs, as well

as special responsivity considerations to be targeted during supervision. A progress record provides a running log of activities designed to measure changes in the client's situation resulting from case management strategies. A discharge summary sums up the offender's status at discharge and any recommendations for the future.

The LS/CMI was normed on 157,947 North American youth and adult offenders—60,156 U.S. adult and youth offenders from 10 jurisdictions, and 97,791 Canadian community and institutionalized adult and youth offenders.
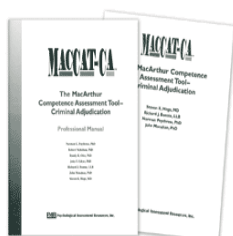
Profile Reports provide security classification information based on the overall assessment score.

Comparative Reports compare results of two to four assessments. They are useful in determining risk/need changes over time. Free option with Profile Reports.

Case Management Reports provide an administrative summary of the criminogenic and noncriminogenic needs of the offender. These reports also list special responsivity considerations and a discharge summary where applicable. Free option with Profile Reports.

MacArthur Competence Assessment Tool-Criminal Adjudication (MacCAT-CA™)
Steven K. Hoge, MD, Richard J. Bonnie, LLB, Norman G. Poythress, PhD, John Monahan, PhD

The MacCAT-CA is a 22-item structured interview for the pretrial assessment of adjudicative competence. This instrument uses a vignette format and objectively scored questions to standardize the measurement of three competence-related abilities.

- Understanding capacity for factual understanding of the legal system and the adjudication process.

- Reasoning ability to distinguish more relevant from less relevant factual information and ability to reason about the two legal options: pleading guilty or not guilty.

- Appreciation capacity to understand his or her own legal situation and circumstances.

The MacCAT-CA begins with the presentation of a brief vignette describing a hypothetical crime upon which the eight Understanding and the eight Reasoning items are based. The 16 items involve queries about prosecution of the hypothetical defendant. This approach was designed to introduce legal issues in a way that distances the defendant from the specifics of his/her own case. The six

Appreciation items query defendants about their attitudes and beliefs concerning the legal process involved in their own cases.

The format of the MacCAT-CA Interview Booklet facilitates easy administration, recording, and scoring of the defendant's responses. Items appear on the right-hand page of the Booklet. The facing page contains scoring criteria for that item. The examiner assigns a value of 0, 1, or 2 based on the scoring criteria. The final page of the Booklet is a Scoring Summary form for transferring and summing the item scores for Understanding, Reasoning, and Appreciation. The MacCAT-CA Professional Manual presents guidelines for the clinical interpretation of these three measures based on a national norming study of 729 defendants. Score ranges are provided for three levels of impairment (none or minimal, mild, or clinically significant) for each measured ability. The MacCAT-CA Interview Booklet also provides space for examiners to record case-specific observations that may be relevant for follow-up.

The professional manual presents important findings from the MacArthur "field studies" and the NIMH "norming" study that support the use of the MacCAT-CA in clinical evaluations of adjudicative competence. The MacCAT-CA has been validated with three groups of criminal defendants with the following characteristics: (a) randomly selected jail inmates whose competence was not in doubt, most of whom had neither active nor prior mental health problems ($n = 197$), (b) jail inmates whose competence was not in doubt, but who were currently receiving treatment for a variety of mental disorders ($n = 249$), and (c) adjudicated incompetent to proceed as a result of mental illness ($n = 283$).

The MacCAT-CA is considered appropriate for use with both felony and misdemeanor defendants ages 18 years and older. It may be used in inpatient, outpatient, forensic, and correctional settings both prior to, and subsequent to, adjudication of competence to proceed with the criminal process. It may also be used to assess treatment progress with respect to restoration of competency.

Manson Evaluation, Revised (ME)
by Morse P. Manson, Ph.D. and George J. Huba, Ph.D.

This widely used test (more than 350,000 administered) identifies maladjusted individuals, including alcoholics. It measures seven personality characteristics: Anxiety, Depressive Fluctuations, Emotional Sensitivity, Resentfulness, Incompleteness, Aloneness, and Interpersonal Relations. In addition, it tells you how likely it is that the respondent belongs to a population prone to alcohol abuse.

Written at a fourth-grade reading level and administered to individuals or groups in just 5-10 minutes, the *Manson Evaluation* has high reliability and validity. It is an excellent instrument for personnel screening, diagnosis, therapy, research, and alcohol abuse programs.

Maryland Addictions Questionnaire (MAQ)

by William E. O'Donnell, Ph.D., MPH, Clinton B. DeSoto, Ph.D., and Janet L. DeSoto, Ed.D.

Brief, economical, and easy to administer and score, the MAQ is one of the best treatment planning tools you'll find. Administered at intake, it quickly tells you how severe the addiction is, how motivated the patient is, which treatment approach is most likely to work, what the risk of relapse is, and whether treatment may be complicated by cognitive difficulties, anxiety, or depression.

Find out if the patient will benefit from treatment.

The MAQ can be used with anyone aged 17 or older who can read at a fifth-grade level. It is a self-report inventory composed of 111 items on the following scales:

Substance Abuse Scales
  Alcoholism Severity
  Drug Abuse Severity
  Craving
  Control
  Resentment

Summary Scores
  Emotional Distress
  Resistance to Treatment
  Admission of Problems

Treatment Scales
  Motivation for Treatment
  Social Anxiety
  Antisocial Behaviour
  Cognitive Impairment
  Affective Disturbance

Validity Scales
  Inconsistent Responding
  Defensiveness

The test gives you standard scores and percentiles for each of these scales. Based on the relative elevation of the Summary Scores, it also assigns the patient one of six Summary Codes, indicating his or her ability to benefit from treatment.

Determine treatment readiness, treatment approach, and relapse risk.

The MAQ can be completed in just 15 to 20 minutes. (A 30-item Short Form, which includes the scales Alcoholism Severity, Drug Abuse Severity, Craving, Control, and Affective Disturbance, can be completed in only 5 minutes.) While the AutoScore™ Answer Sheet makes

hand scoring quick and easy, the test can also be computer scored using WPS TEST REPORT Mail-In Answer Sheets, CD, or FAX Service. All of these computer options give you an interpretive report full of concrete, specific information about the most productive treatment approach, the patient's treatment readiness, relapse risk, and related problems.

   Norms are based on a large sample of people receiving substance abuse treatment at outpatient clinics, residential facilities, or halfway house programs.

   The MAQ is brief yet multidimensional, the items are easy to complete, the scales are easy to interpret, and the results facilitate treatment planning. All of this makes it the ideal intake measure for patients entering an addiction treatment program.

Miller Forensic Assessment of Symptoms Test™ (M-FAST™)
Holly A. Miller, PhD

The M-FAST is a brief 25-item screening interview for individuals ages 18 years and older that provides preliminary information regarding the probability that he/she is feigning psychiatric illness. Most malingering and symptom validity instruments assess malingered cognitive and/or neuropsychological deficits. The M-FAST focuses exclusively on malingered psychiatric illness.

The brief interview format saves valuable clinical time and provides considerable flexibility for the clinician to determine when, where, and to whom the M-FAST should be administered. The M-FAST may be integrated into a larger evaluation with minimal difficulty.

The M-FAST also facilitates rapid identification of individuals who require additional assessment. When the M-FAST results indicate a probability of feigning, a more comprehensive assessment instrument (e.g., the Structured Interview of Reported Symptoms) can be administered to obtain more detailed and definitive information.

The seven M-FAST scales operationalize response styles and interview strategies that have been demonstrated to successfully identify individuals who are attempting to feign psychology: Reported vs. Observed (symptoms) (RO), Extreme Symptomatology (ES), Rare Combinations (RC), Unusual Hallucinations (UH), Unusual Symptom Course (USC), Negative Image (NI), and Suggestibility (ES).

The M-FAST Professional Manual provides information about administration, scoring, and interpretation (with illustrative case examples). M-FAST results provide interpretive information at three distinct levels:

- The M-FAST Total score provides an estimate of the likelihood that the respondent is malingering psychopathology.
- M-FAST scale scores provide information about the nature of the individual's response styles that can help to explain *how* he/she is attempting to malinger mental illness. The UH, RC, RO,

and ES scales have been found to consistently differentiate malingerers (both simulators and known or suspected malingerers) from honest responders.

- Responses to individual items also provide valuable interpretive information.

The M-FAST was developed and validated with both simulation and known-groups samples. The validity of the instrument also has been demonstrated across genders, ethnic groups (Caucasian and African American), and settings (e.g., V.A. hospitals, correctional institutions, and inpatient/outpatient treatment facilities).

Multiscale Dissociation Inventory™ (MDI™)
John Briere, PhD

The MDI is a standardized, multidimensional test of dissociative symptoms, such as depersonalization and derealization, as well as less common responses, such as psychogenic amnesia and Dissociative Identity Disorder. Because dissociation typically arises in response to a traumatic event and can be an associated feature of posttraumatic stress disorder (PTSD), the MDI is a valuable tool in the assessment of clients with a history of childhood abuse or adult traumas (ages 18 years and older).

The MDI requires a 6th-grade reading level and consists of 30 items that reflect dissociative symptoms. The respondent rates the frequency of the symptom occurrence during the past month on a 5-point Likert-type scale ranging from 1 (Never) to 5 (Very Often). The clinician sums the responses to obtain six MDI scale scores: Disengagement, Depersonalization, Derealization, Emotional Constriction, Memory Disturbance, and Identity Dissociation.

The MDI was standardized on a group of more than 440 adults with histories of at least one *DSM-IV-TR*™ "Criterion A" traumatic event. As a result, the individual's MDI scores can be compared to the scores from a large group of men and women with a known trauma history. The MDI Profile Form allows the conversion of raw scores to *T* scores relative to the scores of the standardization sample.

The MDI scales have high internal consistency/reliability with mean Cronbach alphas of .87, .77, and .92, respectively, in general population, university, and clinical samples. Convergent, discriminant, and overall construct validity of the MDI has been demonstrated in a variety of samples. MDI scales are strongly correlated with other measures of dissociation, including the Dissociative Experiences Scale. Individuals who have been diagnosed with PTSD have significantly higher MDI scores than those without a PTSD diagnosis. Moreover, individuals who have been exposed to interpersonal trauma have substantially higher MDI scores than those without such trauma. A cutoff score of 15 or higher on the MDI Identity Dissociation (IDDIS) scale has high specificity (92%) and sensitivity (93%) for identifying individuals with a Dissociative Identity Disorder (DID) diagnosis.

Personality Assessment Inventory (PAI)

Leslie C. Morey, Ph.D.

This objective inventory of adult personality assesses psychopathological syndromes and provides information relevant for clinical diagnosis, treatment planning, and screening for psychopathology. Since it was first introduced in 1991, the PAI has been heralded as one of the most important innovations in the field of clinical assessment.

The 344 items constitute 22 nonoverlapping full scales covering the constructs most relevant to a broad-based assessment of mental disorders: 4 validity scales, 11 clinical scales, 5 treatment scales, and 2 interpersonal scales. To facilitate interpretation and cover the full range of complex clinical constructs, 10 full scales contain conceptually derived subscales (click on link below for more information).

No Scoring Keys Needed...

Clients with 4th-grade reading skills can usually complete the PAI in less than 1 hour, rating each of the 344 items on a 4-point scale ranging from false, not at all true, to very true. Responses are entered on a 2-

part carbonless Answer Sheet. The bottom page of the Answer Sheet provides scores for all 344 items. Full scales and subscales can be scored in only 15-20 minutes.

For situations where no desk or table top is available, the PAI Administration Folio holds both the Item Booklet and Answer Sheet and provides a hard surface so your clients can easily complete the inventory.

To provide interpretation relative to the standardization sample of 1,000 community-dwelling adults, PAI scale and subscale raw scores are translated to T scores. Transformed T scores have a mean of 50 and a standard deviation of 10, so that T-score values greater than 50 lie above the mean in comparison to scores of individuals in the standardization sample. Therefore, T scores greater than or equal to 70 (2 standard deviations above the mean) will quickly alert you to a pronounced deviation from typical responses of adults in the normative sample. PAI Profile Forms allow you to rapidly translate raw scores to T scores and plot the pattern of test results. The Adult Profile Form also contains a blue line demarcating the distribution of scores for a large sample of clinical cases. This feature facilitates comparison of an individual's scores with those in the clinical sample.

The Critical Items Form (CIF) lists 27 items (distributed across 7 content areas) that suggest behavior or psychopathology that may demand immediate attention.

Reliability and validity are based on data from a census-matched normative sample of 1,000 community-dwelling adults (matched on the basis of gender, race, and age), a sample of 1,265 patients from 69 clinical sites, and a college sample of 1,051 students.

Because the PAI was normed on adults in a variety of clinical and community settings, profiles can be compared with both normal and clinical populations. Combined-sex normative data are provided. Reliability studies indicate that the PAI has a high degree of internal consistency across samples: results are stable over periods of 2 to 4 weeks (median alphas and test-retest correlations exceed .80 for the 22 full scales). Validity studies demonstrate convergent and discriminant validity with more than 50 other measures of psychopathology.

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PAI®-CS On-Site Scanning Module
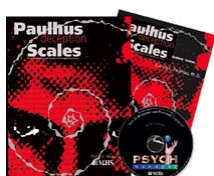
John F. Edens, PhD, Mark A. Ruiz, PhD, and PAR Staff

- Requires prior installation of the PAI®-SP (V.3.0 or higher) and the PAI-CS.

- Administer the PAI-CS using the PAI-CS scannable Answer Sheet.

- Scan the Answer Sheet (requires compatible Pearson Assessments "pencil-read" optical scanner) and the PAI-CS software will generate the report.

Requirements: Prior installation of the PAI-SP and the PAI-CS Module (V.3.0 or higher); OpScan® or iNSIGHT™ OMR scanner (autofeeder recommended)

PLEASE NOTE: There are various other reporting and software structure options available for the PAI. Please contact a consultant at Psych Press via email at info@psychpress.com or 61 (3) 9670-0590 to discuss other report or software formats.

Paulhus Deception Scales (PDS)

Delroy L. Paulhus, Ph.D.

The PDS is a 40-item instrument that identifies individuals who, when administered instruments, distort their responses. It is designed to be administered concurrently with other instruments. Items are phrased in contemporary, gender-neutral language.

The PDS was normed on 1,457 subjects—441 from the general North American population, 289 college students, 603 prison entrants, and 124 military recruits.

PDS for Windows Reports provide statistical, textual, and graphical interpretations of a respondent's results.

Personal Experience Inventory (PEI)
A Measure of Substance Abuse in Adolescents

by Ken C. Winters, Ph.D. and George A. Henly, Ph.D.

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The PEI helps you identify, refer, and treat teenagers with drug and alcohol problems. It is particularly useful because it covers all forms of substance abuse, assesses both chemical involvement and related psychosocial problems, and documents the need for treatment.

This convenient self-report inventory, used with more than 100,000 adolescents in facilities throughout the country, documents chemical involvement in 12- to 18-year-olds and identifies personal risk factors that may precipitate or sustain substance abuse.

Problem Severity Scales

Personal Involvement With Chemicals
Effects From Drug Use
Social Benefits of Drug Use
Personal Consequences of Drug Use
Polydrug Use
Transituational Drug Use
Psychological Benefits of Drug Use
Social-Recreational Drug Use
Preoccupation With Drugs
Loss of Control

Psychosocial Scales

Negative Self-Image
Psychological Disturbance
Social Isolation
Uncontrolled
Rejecting Convention
Deviant Behaviour
Absence of Goals
Spiritual Isolation
Peer Chemical Involvement
Sibling Chemical Use
Sibling Chemical Use
Family Pathology
Family Estrangement

Drug Use, Frequency, Duration, and Age of Onset

Alcohol

Amphetamines
Marijuana or Hashish
Quaaludes

Barbiturates
LSD
Other Psychedelics

Tranquilizers
Cocaine/Crack
Inhalants
Heroin
Other Opiates

Problem Screens

Family Chemical Dependency
Sexual Abuse
Physical Abuse
Eating Disorder
Suicide Potential
Psychiatric Referral

In addition, five validity scales alert you to response distortion, including defensiveness, "faking bad," and inattentive responding. Norms, based on nearly 2,000 adolescents, are provided by age and sex for both drug clinic populations and regular high school samples. So you can see where the teenager stands in relation not only to the most extreme cases but also to average adolescents.

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The PEI is routinely used in substance abuse treatment programs, student assistance programs, juvenile rehabilitation centers, and private practice. Reinforcing the trend toward earlier intervention, the PEI makes it easier to evaluate the many adolescents who are entering the health care system at younger ages, with more poorly defined problems. It permits more specialized treatment. And it documents the need for treatment--for insurance companies, the juvenile justice system, and parents.

Psychopathic Personality Inventory™-Revised (PPI™-R)
Scott O. Lilienfeld, PhD

The PPI-R is a 154-item self-report measure of both global psychopathy and the component traits of psychopathy. Like the original PPI, the PPI-R is construct valid, time efficient, and can detect response styles potentially relevant to psychopathy (i.e., positive or negative impression management, random or careless responding). Rather than focusing exclusively on antisocial or criminal behaviours, the PPI-R measures the continuum of psychopathic personality traits present in a range of individuals and can be used in both clinical (e.g., forensic) and nonclinical (e.g., student, community) settings.

Special Features

- Self-report measure with 4th-grade reading level.

- Focuses on psychopathic personality traits and behaviours rather than antisocial and criminal behaviours exclusively.

- Provides both offender and community/college normative samples.

- Takes less time to administer than other published psychopathy measures.

- Cost-effective to use in correctional and forensic settings and for both individual and group assessments.

The PPI-R was standardized and validated for use with men and women from ages 18-86 years. Community adults in the community/college sample reflect 2002 U.S. Census data (U.S. Bureau of the Census, 2002) for race/ethnicity, educational background, and geographic area. In addition, the PPI-R includes normative data for a male offender sample, should users wish to compare respondents to incarcerated offenders (e.g., for management purposes). The instrument is useful in a variety of settings, particularly correctional facilities, forensic practice, substance abuse treatment centers, and research.

Reliability and Validity

- Internal consistency is adequate for the PPI-R Total score and the PPI-R Content scale scores, with coefficient alpha ranging from .78-.92 for the community/college sample. For the offender sample, internal consistency estimates for the Total and Content scale scores ranged from .72-.84.

- Temporal stability of PPI-R Total and Content Scale scores ranged from .82-.93 for a subset of the community/college sample over an average test-retest period of 19.94 days.

- Evidence for construct validity of the PPI-R also was obtained via significant correlations with Hare's Self-Report Psychopathy Scale-II (SRP-II) Total score and Levenson's Self-Report Psychopathy Scale primary and secondary psychopathy scores in the community/college and offender samples.

- Evidence of construct validity was also obtained via significant correlations between the PPI-R and self-report measures of pathological and nonpathological personality functioning, *DSM-IV*™ Antisocial Personality Disorder, interpersonal problems, sensation-seeking, substance use, and offense variables.

- Exploratory factor analyses using the community/college sample yielded a three-factor model of psychopathology: Self-Centered Impulsivity, Fearless Dominance, and Coldheartedness.

Risk-Sophistication-Treatment Inventory™ (RSTI™)
Randall T. Salekin, PhD

One of the major challenges within the juvenile justice system is tailoring psychological assessment services to the specific needs of the court. Clinicians working within the court system are frequently called upon to evaluate children and adolescents and to provide the court with recommendations regarding rehabilitation, delinquency, and transfer. The RSTI helps the clinician to address important juvenile justice issues and to provide vital information to juvenile court judges, child and adolescent forensic psychotherapists, parole officers, and other correctional authorities for making important legal decisions.

The RSTI is a semistructured interview and rating scale designed to help clinicians assess juvenile offenders ages 9-18 years in three important areas: risk for dangerousness, sophistication-maturity, and treatment amenability. Each of these areas is measured by a scale that is composed of 15 items. Additionally, each scale contains three content areas or clusters.

- The Risk for Dangerousness scale consists of the Violent and Aggressive Tendencies, Planned and Extensive Criminality, and Psychopathic Features clusters.
- The Sophistication-Maturity scale consists of the Autonomy, Cognitive Capacities, and Emotional Maturity clusters.
- The Treatment Amenability scale consists of the Psychopathology-Degree and Type, Responsibility and Motivation to Change, and Consideration and Tolerance of Others clusters.

The RSTI materials include the Professional Manual, the semistructured Interview Booklet, and the Rating Form. The Professional Manual provides detailed information regarding the reliability and

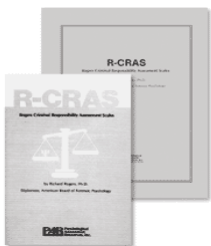PsychPress
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validity of the instrument and includes six case studies that provide examples of appropriate scoring and interpretation of the results.

The questions in the 32-page Interview Booklet are designed to help obtain background, clinical, and historical information, as well as a sample of the juvenile's behavioural and psychological functioning. Optional probes are provided throughout the interview in case the juvenile gives incomplete responses. The clinician takes detailed notes throughout the interview and data collection process and uses this information when rating and scoring the inventory. The Rating Form enables the clinician to score the items by reviewing and synthesizing information from the entire interview, as well as from other collateral sources (e.g., school records, police records, detention records, previous treatment records, consultations with parents/guardians). Each item is rated on a 3-point scale reflecting the extent to which the individual demonstrates the specific characteristic. Proper administration and coding of the RSTI requires considerable professional knowledge and skill with juvenile offenders.

Data for the RSTI normative sample was collected so that the sample would represent young offenders (ages 9-18 years) across a variety of juvenile justice settings. The sample included detained and nondetained youth; juveniles who were transferred to adult court; youth who remained in juvenile court; violent and nonviolent offenders; and first-time and chronic offenders. Normative data are provided by gender in the Appendixes of the Professional Manual. Using these data, scale raw scores are converted to T scores and percentiles. Additionally, within each scale, the three cluster raw scores are converted to percentile ranges.

Rogers Criminal Responsibility Assessment Scales (R-CRAS)
Richard Rogers, PhD, ABPP

The R-CRAS provides the forensic psychologist or psychiatrist with an empirically based approach to evaluating criminal responsibility. This instrument allows you to quantify the impairment at the time of the crime, to relate the impairment to the appropriate legal standard, and to render an expert opinion with respect to that legal standard. Part I establishes the degree of impairment on psychological variables significant to the determination of insanity. Part II aids in rendering an accurate opinion on criminal responsibility with the ALI standard, and also includes experimental decision models for guilty-but-mentally-ill (GBMI) and M'Naghten standards.

The average alpha coefficient of the R-CRAS summary scales is .60. The mean reliability coefficient for individual variables is .58, with each variable achieving significance. Overall percentage of agreement for the decision variables is 91% with an average kappa coefficient of .81.

Validation studies indicate a high level of accuracy for classifying sane and insane subjects. The R-CRAS is designed for use by professionals with experience in forensic evaluations or those who will be supervised by a qualified professional.

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Rorschach® Interpretation Assistance Program: Version 5 Forensic Edition (RIAP5™ FE)

Irving B. Weiner, PhD, PAR Staff

The unlimited-use RIAP5 FE is an addition to the Rorschach Interpretation Assistance Program: Version 5 (RIAP5™). The RIAP5 provides both an Interpretive Report and a Client Report. The RIAP5 FE adds a considerable amount of flexibility by providing a specialized Forensic Report. This report is not intended to replace the basic RIAP5 Interpretive Report. Clinicians are advised to draw on both the Interpretive Report and the Forensic Report to arrive at their conclusions.

The Forensic Report is focused on the forensic issues of criminal responsibility and competency to stand trial, personal injury, and parental fitness/child custody. The three types of Forensic Reports are: Criminal Case Issues, Personal Injury Case Issues, and Family Law Case Issues. Each report begins with a section on validity and malingering. The software allows clinicians to select which sections of the Forensic Report to include for a specific individual.

This software was developed to assist clinicians in using the Rorschach when conducting specific types of forensic evaluations, including:

Criminal Case Issues

- Competency to stand trial.

- Sanity at the time of an alleged offense.

- Advisability of probation or parole (including consideration of dangerousness, suicide risk, and amenability to treatment).

Personal Injury Case Issues

- Posttraumatic stress disorder and other anxiety disturbances.

- Affective and cognitive features of depression.

- Psychotic loss of contact with reality.

Family Law Case Issues

- Effective parenting with regard to psychological disturbance, coping skills, and interpersonal accessibility.

In addition to the Forensic Report, the RIAP5 FE also includes a reference list that allows clinicians to review a selected category of references organized according to forensic issues. Clinicians can print out specific sections of the reference list in order to help them further evaluate the applicability of their findings and to prepare testimony based in part on the Rorschach data. The reference list primarily

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includes articles and chapters focusing on the Rorschach Inkblot Method, but additional references regarding basic forensic psychology issues are listed.

Special Features

- The RIAP5 FE Forensic Report was written by leading Rorschach scholar, Irving B. Weiner, PhD. He has published extensively on the use of the Rorschach in forensic assessments.

- The software includes a categorized, on-screen reference list.

- Rorschach Response Recording Forms facilitate and document Rorschach responses.

- The RIAP5 FE includes unlimited-use software on CD-ROM, on-screen Software Manual, and RIAP5 FE Manual Supplement.

Requirements: Windows® 2000/XP/Vista™; NTFS file system; 15-30MB hard drive space; CD-ROM drive for installation; Internet connection or telephone for software activation

Self-Appraisal Questionnaire (SAQ)
Wagdy Loza, Ph.D.

The SAQ is the first multidimensional self-administered questionnaire designed to predict violent and nonviolent offender recidivism among correctional and forensic populations. It assists with the assignment of these populations to appropriate treatment/correctional programs and institutional security levels. It can be used as a pre- and post-treatment measure to help you gage progress and make decisions. With its short administration time, the SAQ is ideal for inmates with short sentences who would not normally warrant a lengthy assessment.

The SAQ is an empirically based, theoretically and rationally derived assessment. From a Total score, risk is assessed as Low, Low-Moderate, High-Moderate, or High. Scale scores flag case management or program concerns, and responses to certain items indicate specific needs. Normative data consisted of inmates from American and Canadian institutions.

SASSI-3: Substance Abuse Subtle Screening Inventory (SASSI-3)
Franklin G. Miller, James Roberts, Marlene K. Brooks, Linda E. Lazowski

The SASSI-3 is a brief and easily administered screener that helps to identify individuals ages 18 years and older who have a high probability of having a substance abuse disorder and provides information to help select appropriate treatment. The SASSI-3 subscales also provide clinically useful information regarding an individual's attitude toward the assessment, as well as defensiveness, emotional pain, ability to acknowledge problems, and risk of legal problems.

- Accurate, inexpensive, and simple to administer.
- Effective even when individuals are unable or unwilling to acknowledge relevant behaviours.
- Appropriate for individuals or group administration to both genders.
- Useful in a variety of settings including addiction treatment centers; criminal justice programs; employee assistance programs; and education, mental health, medical, and vocational programs.
- Produces reliable results using both test-retest and internal consistency methodologies; corresponds closely with independent clinical diagnoses (94% for overall accuracy).
- No significant gender difference was found in SASSI-3 accuracy; additionally, an individual's level of functioning did not have a significant impact on the accuracy of the SASSI-3.

Spanish SASSI Version

The Spanish SASSI requires a 5th-grade reading level and takes only 15 minutes to administer and score. The samples used to validate the Spanish SASSI were comprised primarily of males 18 years and older. The Administration and Scoring Instructions provide information on the development of the Spanish SASSI, detailed instructions on administration and scoring, and guidelines for interpreting the results. The Development and Validation of the Spanish SASSI provides information on the accuracy of Decision Rule results, demographic characteristics of the sample, and identification of substance dependence versus abuse.

Sexual Violence Risk-20 (SVR-20)
Douglas R. Boer, PhD, Stephen D. Hart, PhD, P. Randall Kropp, PhD, Christopher D. Webster, PhD

The SVR-20 is a 20-item checklist of risk factors for sexual violence that were identified by a review of the literature on sex offenders. The checklist was developed to improve the accuracy of assessments for the risk of future sexual violence. Sexual violence is defined broadly as "actual, attempted, or threatened sexual contact with a person who is nonconsenting or unable to give consent." The goals of the SVR-20 guidelines include the following:

- Make risk assessments more systematic.
- Increase agreement among evaluators.
- Provide detailed guidelines grounded in the scientific literature.
- Assist in the planning and delivery of interventions (treatment and supervision).
- Objectively evaluate the adequacy of risk assessments.

Risk assessment does not fall exclusively within the domain of any profession or discipline. Risk assessments are routinely conducted by correctional, psychological, and medical professionals, as well as by multidisciplinary teams. Evaluators need to understand the factors associated with general crime and violence as well as those associated with sexual violence. The SVR-20 manual provides information about how and when to conduct sexual violence risk assessments, research on which the basic risk factors are based, and key questions to address when making judgments about risk.
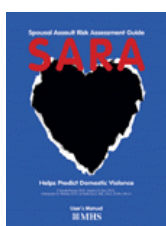
The SVR-20 specifies which risk factors should be assessed and how the risk assessment should be conducted. The list of risk factors is: (a) empirically related to future sexual violence; (b) useful in making decisions about the management of sex offenders; (c) nondiscriminatory; and (d) reasonably comprehensive without being redundant. The 20 factors essential in a comprehensive sexual violence risk assessment fall into three main categories: Psychosocial Adjustment, History of Sexual Offenses, and Future Plans. The actual risk for sexual violence depends on the combination (not just the number) of risk factors present in a specific case. Coding of the SVR-20 involves determining the presence/absence of each factor and whether there has been any recent change in the status of the factor. This item-level information is integrated into a summary judgment of the level of risk (Low, Moderate, or High), which can easily be translated into an action plan.

Developed primarily for use in criminal and civil forensic contexts, the SVR-20 is appropriate for use in cases where an individual has committed, or is alleged to have committed, an act of sexual violence:

- Pretrial release decisions.
- Presentence assistance to judges.
- Development of treatment programs at correctional intake.
- Prior to discharge to assist in post-release management.
- Custody/access assessment.
- Determination of need for a community warning.
- Quality assurance or critical incident reviews.
- Education and training.

Spousal Assault Risk Assessment Guide (SARA)
P. Randall Kropp, Ph.D., Stephen D. Hart, Ph.D., Christopher D. Webster, Ph.D., & Derek Eaves, M.B.

Key Areas Measured:
Criminal History
Psychosocial Adjustment
Spousal Assault Risk
Alleged/Most Recent Offense

The Spousal Assault Risk Assessment Guide (SARA) helps criminal justice professionals predict the likelihood of domestic violence. The tool is a quality-control checklist that determines the extent to which a professional has assessed risk factors of crucial predictive importance according to clinical and empirical literature.

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With 20 items, the SARA assessment screens for risk factors in individuals suspected of or being treated for spousal or family-related assault. The SARA can help determine the degree to which an individual poses a threat to his/her spouse, children, another family member, or another person involved.

The instrument can be used by members of various boards or tribunals (e.g., parole and review boards, professional ethics committees, etc.), lawyers, victims' rights advocates, and also prisoners' rights advocates.

The SARA was normed on 2,309 adult male offenders—1,671 probationers and 638 inmates.

Structured Assessment of Violence Risk in Youth™ (SAVRY™)
Randy Borum, PsyD, Patrick Bartel, PhD, and Adelle Forth, PhD

The SAVRY is composed of 24 items in three risk domains (Historical Risk Factors, Social/Contextual Risk Factors, and Individual/Clinical Factors), drawn from existing research and the professional literature on adolescent development as well as on violence and aggression in youth. Each risk item has a three-level rating structure with specific rating guidelines (*Low, Moderate,* or *High*). In addition to the 24 risk factors, the SAVRY also includes six Protective Factor items that are rated as either *Present* or *Absent*.

The SAVRY is useful in the assessment of either male or female adolescents between the ages of 12 and 18 years. It may be used by professionals in a variety of disciplines who conduct assessments and/or make intervention/supervision plans concerning violence risk in youth.

The SAVRY is not designed to be a formal test or scale; there are no assigned numerical values nor are there any specified cutoff scores. Based on the structured professional judgment (SPJ) model, the SAVRY helps assist in structuring an assessment so that the important factors will not be missed and, thus, will be emphasized when formulating a final professional judgment about a youth's level of risk.

Features of the SAVRY

- Systematic--The primary domains of known risk and protective factors are addressed, with clear operational definitions provided.

- Empirically Grounded--Items are based on the best available research and guidelines for juvenile risk assessment practice.

- Developmentally Informed--Risk and protective factors are based on their relationship to adolescents, not to children or adults.

- Treatment-Oriented--Items have direct implications for treatment, including the consideration of dynamic factors that can be useful targets for intervention in risk reduction.

- Flexible--Allows consideration of case-specific factors, along with those factors derived from research.

- Practical--Time-efficiency of the instrument offers the evaluator essential information for a competent and complete assessment.

Reliability

- Interrater reliability for the SAVRY, using trained student raters (intraclass correlation coefficient [ICC]) was .81 for the SAVRY Risk Score and .77 for the Summary Risk Rating.

Validity

- In the initial validation study, the SAVRY Risk Total correlated significantly with the Youth Level of Service/Case Management Inventory (YLS/CMI) and the Hare Psychopathy Checklist: Youth Version (PCL:YV) among offenders .89 and .78, respectively. The SAVRY Protective Factors, as a whole, were negatively correlated with both of these measures.

- Significant correlations have been found in other studies between the SAVRY Risk Total scores and measures of violence among young male offenders in Canada (.32 in one study and .25 in another) and among high-risk Native American youth (.56 for sample, .72 for females; Fitch, 2002).

Structured Interview of Reported Symptoms (SIRS)
Richard Rogers, PhD, ABPP, R. Michael Bagby, PhD, Susan E. Dickens, MA

The SIRS is a structured interview designed to detect malingering and other forms of feigning of psychiatric symptoms. It may be used in inpatient or outpatient settings to address both clinical and forensic issues. Appropriate for ages 18 years and older.

Description

The SIRS consists of eight primary and five supplementary scales for the assessment of feigning, including a scale to assess defensiveness; the content of each scale varies so that endorsement of items on a particular scale does not reflect any specific mental disorder.

The 16-page Interview Booklet contains 172 items, 32 of which are Repeated Inquiries to detect inconsistency of responding. The content covers a wide range of psychopathology, as well as symptoms that are unlikely to be true. The SIRS is designed to detect 13 response styles commonly associated with feigning, and allows for classification as feigning (definite or probable) or honest, as well as identification of inconsistent and other problematic response styles that have implications for therapeutic dynamics and other treatment considerations.

Reliability/Validity

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The SIRS has been validated with clinical, community, and correctional populations. Classification rates generalize across sociodemographic and diagnostic groups. Construct validity is demonstrated through factor analyses and correlational evidence of convergent and discriminant validity with MMPI validity scales and *M* test scales. Interrater reliability estimates range from .89-1.00. Internal consistency reliability coefficients for subscales range from .66-.92.

Administration

The SIRS may be administered by any mental health professional with formal training in structured interviews. Administration and scoring can be completed in under one hour. Primary scale scores are plotted on the front page of the booklet.

Structured Inventory of Malingered Symptomatology™ Software Portfolio (SIMS™-SP)

Michelle R. Widows, PhD, Glenn P. Smith, PhD, and PAR Staff

The SIMS-SP is used to score and interpret the Structured Inventory of Malingered Symptomatology ™ (SIMS™). The software provides an Interpretive Report based on either an on-screen administration of the SIMS or hand entry of an individual's item responses or scale raw scores (entered by the clinician). Program functionality includes navigation tools (e.g., menu system, Quickstart dialog box, Toolbar, Status Bar), file handling, and report editing.

On-screen administration of the SIMS-SP is simple and convenient. Step-by-step instructions guide the respondent through the entire process. The software also provides the option for the respondent to view and/or hear the instructions as well as each of the 75 items.

Special Features of the SIMS-SP

- Provides an overall score (i.e., SIMS Total score) for likely feigning, along with scale scores within five domains: Psychosis (*P*), Neurologic Impairment (*NI*), Amnestic Disorders (*AM*), Low Intelligence (*LI*), and Affective Disorders (*AF*).

- Interpretive report provides profile of the SIMS Total score as well as the five scale scores.

- Interpretive text discusses the likelihood of feigning based on the SIMS Total score and the scale scores, with recommendation for further evaluation of feigning/malingering.

- Provides visual and/or audible on-screen administration for clients who may have reading difficulties.

- Includes built-in, easy-to-use report editing features and an optional password feature to ensure the privacy and security of client data during on-screen administration and for general security of data.

Requirements: Windows® 2000/XP/Vista™; NTFS file system; CD-ROM drive for installation; Internet connection or telephone for software activation and counter update.

Structured Inventory of Malingered Symptomatology™ (SIMS™)
Glenn P. Smith, PhD, Professional Manual by Michelle R. Widows, PhD, and Glenn P. Smith, PhD

The SIMS is a 75-item, true/false screening instrument that assesses for both malingered psychopathology and neuropsychological symptoms. The instrument reduces clinician burden and increases assessment efficiency by serving as a screen for malingering and by reducing hands-on administration time. In addition to serving as a screening measure, the SIMS can be used as part of a battery of tests providing convergent evidence of malingering, rather than relying on a single instrument for diagnosis. The SIMS also is recommended as part of a comprehensive approach to the evaluation in which alternative hypotheses for response patterns are to be considered.

The SIMS is an excellent tool for forensic clinicians working with competency and Not Guilty by Reason of Insanity (NGRI) evaluations, forensic researchers, clinicians who evaluate disability and workers' compensation issues, as well as mental health providers in inpatient settings. It demonstrates sensitivity, specificity, and efficiency across both simulation and known-groups designs with honest responders, psychiatric patients, and clinical malingerers. The SIMS is written at a 5th-grade reading level and is appropriate for ages 18 years and older.

The SIMS consists of a Professional Manual and the SIMS Response Form (a two-part carbonless form). The clinician compares raw scores to empirically derived and validated clinical cutoff scores indicative of likely malingering. Interpretations for each scale score and the Total score are provided in the Professional Manual. Based on the comparison to the clinical cutoff scores, the individual may be referred for more extensive evaluation.

The SIMS provides five scale domains as well as an overall score for probable malingering (i.e., Total score):

- Psychosis (*P*)

- Neurologic Impairment (*NI*)

- Amnestic Disorders (*AM*)

- Low Intelligence (*LI*)

- Affective Disorders (*AF*)

Reliability and Validity

- Internal consistency alpha coefficients for all SIMS scales range from .82 (*P* scale) to .88 (Total score).

- Test-retest reliability was adequate (*r* = .72) for the Total score over a 3-week interval.

- The SIMS demonstrated moderate to high correlations with other indexes of malingering, including the MMPI-2 validity scales (*r* range = -.47-.50), the SIRS Scales (*r* range = .43-.80), and the M Test (*r* range = .58-.67).

- The SIMS has demonstrated very good utility in identifying malingering across multiple studies. In the SIMS cross-validation sample, efficiency was .95, while sensitivity was .96 and specificity was .88.

Test of Memory Malingering (TOMM)
Tom N. Tombaugh, Ph.D.

Based on research in neuropsychology and cognitive psychology, the TOMM is a visual recognition test designed to help psychologists and psychiatrists distinguish between malingered and true memory impairments. Research has found the TOMM to be sensitive to malingering and insensitive to a wide variety of neurological impairments, which makes it very reliable. It is not transparent as a malingering test.

Extensive data has been collected on a number of groups that include cognitively intact individuals (aged 16 to 84) and clinical samples that include individuals with no cognitive impairment, as well as those with cognitive impairment, aphasia, traumatic brain injury, and dementia.

TOMM for Windows Reports present scores and summarizer results for each TOMM administration.

Trauma Symptom Checklist for Children™ (TSCC™)
John Briere, PhD

The TSCC is a self-report measure of posttraumatic stress and related psychological symptomatology in children ages 8-16 years who have experienced traumatic events (e.g., physical or sexual abuse, major loss, natural disaster, or witness violence).

The 54-item TSCC includes two validity scales (Underresponse and Hyperresponse), six clinical scales (Anxiety, Depression, Anger, Posttraumatic Stress, Dissociation, and Sexual Concerns), and eight critical items. The alternate 44-item version (TSCC-A) is identical to the TSCC, except it makes no reference to sexual issues (and has no Sexual Concerns scale) and includes seven Critical Items.

This instrument is suitable for individual or group administration. Item responses on a 4-point scale are entered on the top page of the carbonless test booklet. Item responses are automatically transferred to the scoring page underneath, allowing for easy hand scoring. Profile Forms allow for conversion of raw scores to age- and sex-appropriate *T* scores and graphing the results.

The TSCC scales are internally consistent (alpha coefficients for clinical scales range from .77-.89 in the standardization sample) and exhibit reasonable convergent, discriminant, and predictive validity in normative and clinical samples. The TSCC was standardized on a group of over 3,000 inner-city, urban, and suburban children and adolescents from the general population. Data from trauma and child abuse centers are also provided.

The comprehensive Professional Manual provides information on test materials, administration, scoring, interpretation, psychometric characteristics, and normative data.

Trauma Symptom Checklist for Young Children™ (TSCYC™)
John Briere, PhD

Because exposure to traumatic events (e.g., child abuse, peer assaults, community violence) is an unfortunate part of many children's lives, psychological tests for trauma effects have become an important part of the child-focused assessment battery. Following the success of the Trauma Symptom Checklist for Children™ (TSCC™) in evaluating older children (ages 8 to 16 years), the new Trauma Symptom Checklist for Young Children (TSCYC) is the first fully standardized and normed broadband trauma measure for children as young as 3 years of age.

Eight years in the making, and tested by clinicians and researchers throughout North America, the TSCYC is a 90-item caretaker-report instrument, with separate norms for males and females in three age groups: 3-4 years, 5-9 years, and 10-12 years. Caretakers rate each symptom on a 4-point scale according to how often the symptom has occurred in the previous month. Unlike most other caretaker-report measures, the TSCYC contains specific scales to ascertain the validity of caretaker reports (Response Level and Atypical Response), as well as providing norm-referenced data on the number of waking hours the caretaker spends with the child in the average week (*0-1 hours* to *Over 60 hours*).

The TSCYC contains eight Clinical scales: Anxiety, Depression, Anger/Aggression, Posttraumatic Stress-Intrusion, Posttraumatic Stress-Avoidance, Posttraumatic Stress-Arousal, Dissociation, and Sexual Concerns, as well as a summary posttraumatic stress scale (Posttraumatic Stress-Total). These scales provide a detailed evaluation of posttraumatic stress, as well as information on other symptoms found in many traumatized children. The PTSD Diagnosis Worksheet incorporates information from the TSCYC to assist the user in evaluating PTSD criteria in younger children, and provides a possible PTSD diagnosis in children 5 years of age or older (sensitivity = .72, specificity = .75). The TSCYC is appropriate for English-speaking caretakers, including those who have a relatively low reading level (Flesch-Kincade score = 6.8).

The TSCYC materials consist of the Professional Manual, Item Booklet, Answer Sheet, and age- and gender-specific Profile Forms. Once the TSCYC is administered to the caretaker, the Answer Sheet is hand-scored by the examiner using the Scoring Sheet and the PTSD Diagnosis Worksheet. Resulting raw scores are converted and plotted as *T* scores, depending on the child's gender and age. The PTSD Diagnosis Worksheet aids the user in ascertaining the PTSD status of the child according to the *DSM-IV-TR*™. The Professional Manual includes several examples of how to score and interpret the TSCYC.

- Norms are based on a stratified national standardization sample of 750 children.

- Internal consistency for the Clinical scales in the standardization sample ranged from .78-.92, with an average clinical alpha coefficient of .86. Similar results were found in clinical and child abuse treatment samples.

- Homogeneity-corrected test-retest correlation coefficients for TSCYC scales ranged from .68-.96, with a median coefficient of .88.

- Discriminant, predictive, and construct validity have been demonstrated for the TSCYC in multiple samples and studies.

- Different TSCYC scale patterns have been found to predict different forms of trauma exposure in a published study of traumatized children.

Trauma Symptom Checklist™ Software Portfolio (TSC™-SP)
John Briere, PhD and PAR Staff

The unlimited-use TSC-SP software automatically scores the TSCC™, the TSCC-A™, or the TSCYC™ when the client's responses are entered by the clinician. It will generate a score report and

graphic profile of the results, which can be printed by any Windows®-compatible printer or exported for word processing. For convenient ordering, the TSC-SP software is sold as 3 separate CD-ROMs-- (1) TSCC only, (2) TSCYC only, and (3) TSCC and TSCYC combined.

Requirements: Windows® 2000/XP/Vista™; NTFS file system; CD-ROM drive for installation; Internet connection or telephone for software activation

Trauma Symptom Inventory™ Scoring Program (TSI-SP™)
John Briere, PhD, PAR Staff

This unlimited-use software, now available on CD-ROM:

Scores and profiles the 13 TSI scales (10 clinical and 3 validity scales).

Provides three additional summary factor scales that indicate the relative extent to which the respondent is experiencing reduced or insufficient internal resources, general posttraumatic distress, and dysphoric affect.

Enables exporting of the TSI profile into a Windows® Bitmap image format; the Score Summary Report uses Windows fonts, enhancing the appearance of the report. Enter item responses and the computer automatically scores the test and produces a Score Summary Report that includes raw scores and T scores for each scale, as well as a profile of all 13 scales.

Requirements: Windows® 2000/XP/Vista™; NTFS file system; CD-ROM drive for installation; Internet connection or telephone for software activation

Trauma Symptom Inventory™ (TSI™)
John Briere, PhD

The TSI, a 100-item test, is designed to evaluate posttraumatic stress and other psychological sequelae of traumatic events, including the effects of rape, spouse abuse, physical assault, combat, major accidents, natural disasters, and the lasting sequelae of childhood abuse.

It includes 10 clinical scales that measure the extent to which the respondent endorses trauma-related symptoms. These, in turn, can be subsumed under three broad categories of distress (trauma, self, and dysphoria). These scales include:

- Anxious Arousal
- Dissociation Behavior
- Depression
- Sexual Concerns
- Anger/Irritability
- Dysfunctional Sexual Behavior
- Intrusive Experiences
- Impaired Self-Reference
- Defensive Avoidance
- Tension Reduction

Additionally, in contrast to other trauma measures, the TSI contains three validity scales (Response Level, Atypical Response, and Inconsistent Response), which assess the respondent's tendency to deny symptoms that others commonly endorse, to overendorse unusual or bizarre symptoms, and to respond to items in an inconsistent or random manner.

The 12 critical items also help you identify potential problems, such as suicidal ideation or behavior, substance abuse, psychosis, and self-mutilatory behavior, that may require immediate follow-up.

TSI-A Version
The alternate item version (TSI-A) is identical to the TSI except it makes no references to sexual issues. It has no Sexual Concerns scale and includes only the critical items.

Reliability/Validity
The TSI is highly reliable. The 10 clinical scales are internally consistent (mean alpha coefficients of .86, .87, .84, and .85 in standardization, clinical, university, and U.S. Navy samples, respectively), and exhibit reasonable convergent, predictive, and incremental validity. In the standardization sample, TSI scales predicted independently assessed posttraumatic stress disorder status in over 90% of cases. Similarly, in the psychiatric inpatient sample, TSI scales correctly identified 89% of those independently diagnosed with Borderline Personality Disorder.

Administration/Scoring
The TSI Professional Manual is comprehensive and contains information on materials, administration, scoring, interpretation, psychometric characteristics, and normative data. Norms were derived from a nationally representative sample of over 800 adults from the general population and over 3,500 Navy recruits. Separate norms for males and females, ages 18-54 and 55+ years, make the TSI appropriate for all adult sex-by-age combinations.

Responses to the 100 items are entered on the carbonless, hand-scorable answer sheet. Profile forms for males and females allow conversion of raw scores to *T* scores. A graph of the profile may be drawn to portray the respondent's scores relative to general population scores.

Uniform Child Custody Evaluation System (UCCES)

Harry L. Munsinger, JD, PhD, Kevin W. Karlson, JD, PhD

The UCCES was developed by two forensic psychologists with law degrees and extensive experience in child custody evaluation to meet the need for a uniform custody evaluation procedure for mental health professionals. The UCCES consists of a Manual and 25 forms that provide a systematic method for gathering data necessary to determine the child's best interest, organizing information, presenting relevant data in an organized and logical manner, writing logical evaluation reports, and testifying in court.

The 25 forms are organized into three categories.

1) General Data and Administrative Forms-One of each of these 10 forms should be completed for each custody evaluation.

- UCCES Checklist contains a list of all the steps involved in completing a UCCES evaluation. It serves as a time-management and quality control tool; helps to organize, manage, and record all major events; documents all procedures; and verifies that all important steps were taken.
- Initial Referral Form provides a convenient and systematic way to maintain records of all parties and issues as well as the billing schedule.
- Chronological Record of all Case Contacts Form.
- Case Notes Form.
- Consent for Psychological Services to Child(ren) Form.
- Authorization to Release Information Form.
- Suitability for Joint Custody Checklist.
- Collateral Interview Form.
- Consent for Evaluation of Minor(s) Form.
- UCCES Summary Chart for noting significant entries from other completed forms.

2) Parent Forms-One of each of these nine forms should be completed for each parent.

- Parent's Family/Personal History Questionnaire.
- Parent Interview Form.
- Parenting Abilities Checklist.
- Suitability for Joint Custody Interview.
- Analysis of Response Validity Checklist.
- Behavioural Observations of Parent-Child Interaction Form.
- Home Visit Observation Form.
- Agreement Between Parent and Evaluator Form.
- Explanation of Custody Evaluation Procedures for Parents and Attorneys.

3) Child Forms-These six forms should be completed for each child.

- Child History Questionnaire (one for each parent to complete).
- Child Interview Form.
- Child Abuse Interview Form.
- Abuse/Neglect Checklist.
- Child's Adjustment to Home and Community Checklist.
- Parent-Child Goodness of Fit Observation Form and Checklist.

The Manual presents an overview of child custody evaluation research, discusses the requirements for a comprehensive custody evaluation, describes each of the 25 forms, and provides helpful suggestions for testifying as an expert witness.

Victoria Symptom Validity Test (VSVT™)
Daniel Slick, PhD, Grace Hopp, MA, Esther Strauss, PhD, Garrie B. Thompson, PhD
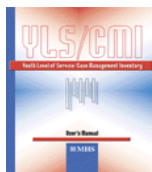

Suitable for use in both outpatient and inpatient settings, the VSVT is a computerized test that uses a forced-choice (two-alternative) model to assess possible exaggeration or feigning of cognitive impairments.

- The VSVT unlimited-use software administers the test, calculates all scores, and produces a 6-page report of the test results.

- Large, full-page graphs of your client's VSVT performance, as well as graphs of the performance of relevant comparison groups, can be easily viewed or printed for display.

- The 48 VSVT items are presented in three blocks of 16 items each; items are classified as either Easy or Difficult, depending on whether the study number and the foil share any common digits.

- The Total Items Correct score is used to classify a respondent's performance; the type and number of items answered correctly, the response latency, and the right-left preference provide information that also can be used to help interpret VSVT performance.

- Test interpretation compares the respondent's performance to what is expected to occur on the basis of chance alone; this binomial-based approach to respondent classification minimizes the risk of false positives.

- Results confirm the clinical and forensic utility of the VSVT for identifying respondents who are attempting to exaggerate or feign cognitive impairments.

Requirements: Windows® 2000/XP/Vista™; NTFS file system; CD-ROM drive for installation; Internet connection or telephone for software activation

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Youth Level of Service/Case Management Inventory (YLS/CMI)

R. D. Hoge, Ph.D. & D. A. Andrews, Ph.D.

Key Areas Measured:
Prior and Current Offense
Family
Education
Peers
Substance Abuse
Leisure/Recreation
Personality/Behaviour
Attitudes/Orientation

The YLS/CMI, derived from the LSI–R, helps probation officers, youth workers, psychologists, and social workers identify the youth's major needs, strengths, barriers, and incentives; select the most appropriate goals for him or her; and produce an effective case management plan.

Profile Reports provide classification information based on the overall assessment score.

Neuropsych products

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Alzheimer's Disease Caregiver's Questionnaire™ (ADCQ™)

Paul R. Solomon, PhD, ADCQ User's Manual by Paul R. Solomon, PhD and Cynthia A. Murphy

Because of the projected increase in the prevalence of Alzheimer's disease, the need for appropriate measures for screening and subsequent diagnosis grows increasingly vital within both medical and social contexts. The ADCQ is a new screening instrument that evaluates the likelihood that an individual has a dementia suggestive of Alzheimer's disease. This scientifically developed measure provides an essential link to early detection and treatment.

The ADCQ is an 18-item symptom checklist that is completed by a concerned family member or someone who has sufficient knowledge about the individual. Once the caregiver has completed the checklist, a Caregiver's Report is generated that determines the *likelihood* that the rated individual has a dementia suggestive of Alzheimer's disease. The Caregiver's Report contains a summary of the behavioural problems/changes observed by the caregiver in six categories: Memory, Confusion and Disorientation, Geographic Disorientation, Behaviour, Reasoning and Judgment, and Language Abilities. It also provides recommendations regarding whether further evaluation may be warranted.

- Takes 5-10 minutes to complete.
- Ages 40 years or older.
- Requires no participation from office staff, physician, or other health care professional(s).
- Requires no cooperation or participation from the individual being rated.

Reliability/Validity

- Internal consistency reliability of .87.
- Test-retest reliability of .71 (using a smaller sample of caregivers).
- Initial validation of the ADCQ revealed a sensitivity and specificity >.87.

Requirements: Windows® 95/NT with Internet Explorer 4.0 or higher, Windows® 98/Me/2000/XP, 1.44MB 3.5" disk drive

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Behavior Rating Inventory of Executive Function™ (BRIEF™)

by Gerard A. Gioia, Ph.D., Peter K. Isquith, Ph.D., Steven C. Guy, Ph.D., and Lauren Kenworthy, Ph.D

These new parent and teacher questionnaires assess children's executive function in home and school environments. The BRIEF is useful in evaluating 5- through 18-year-olds with developmental and acquired neurological conditions such as learning disabilities, ADHD, traumatic brain injury, low birth weight, Tourette's Disorder, and autism.

Each BRIEF questionnaire includes 86 items on 8 nonoverlapping clinical scales and 2 validity scales:

Clinical Scales

Inhibit	Initiate	Organization of Materials
Shift	Working Memory	Monitor
Emotional Control	Plan/Organize	

Validity Scales

Negativity	Inconsistency of Responses

These scales form two broader indexes: Behavioral Regulation and Metacognition.

Norms are based on ratings from 1,419 parents and 720 teachers from rural, suburban, and urban areas, reflecting the U.S. population in regard to SES, ethnicity, and gender distribution. Separate norm tables for teacher and parent ratings provide *T*-scores, percentiles, and 90% confidence intervals for four developmental age groups, by gender.

Requiring just 10 to 15 minutes to complete, the BRIEF is an efficient way to evaluate impairment of executive function in children and adolescents with neurological conditions.

Behaviour Rating Inventory of Executive Function - Adult Version (BRIEF-A)

by Robert M. Roth, Ph.D., Peter K. Isquith, Ph.D., and Gerard A. Gioia, Ph.D.

This version of the BRIEF assesses executive control and self-regulation in adults, 18 to 90 years of age. Using both a Self-Report and an Informant Report, it provides a comprehensive view of an individual's daily functioning.

The BRIEF-A is composed of 75 items on 9 nonoverlapping clinical scales:

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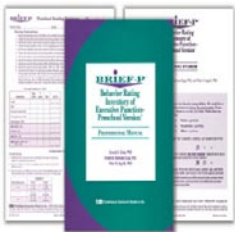Talent Management Psychologists

- Inhibit
- Self-Monitor
- Plan/Organize
- Shift
- Initiate
- Task Monitor
- Emotional Control
- Working Memory
- Organization of Materials

These scales form two broad indexes -- Behavioural Regulation and Metacognition -- which combine to produce an overall score, the Global Executive Composite. Three validity scales (Negativity, Inconsistency, and Infrequency) are also provided. Normative data, based on a broad sample of men and women (aged 18 to 90), reflect U.S. Census data in terms of race, ethnicity, education, and geographic region.

Both the Self-Report and the Informant Report can be completed in just 10 to 15 minutes. Most adults are able to respond to the Self-Report -- including those with developmental, systemic, neurological, and psychiatric disorders. However, if the individual has limited awareness of his or her own difficulties, the Informant Report can be used alone. Typically, both forms are administered in order to gain two perspectives on the individual's functioning.

Behavior Rating Inventory of Executive Function Preschool Version (BRIEF-P)
by Gerard A. Gioia, Ph.D., Kimberly Andrews Espy, Ph.D., and Peter K. Isquith, Ph.D.

The assessment of executive function in preschool children is often difficult for several reasons: the variable nature of behaviour in this age range; limitations in motor and verbal proficiency in preschoolers; and the many neuropsychological, psychological, developmental, and medical conditions that begin to manifest during the preschool years. The BRIEF-P is the first standardized rating scale designed to measure behavioural manifestations of executive function in preschool children. As such, it permits intervention at earlier stages of development.

The BRIEF-P is a single form used by parents, teachers, and day care providers to rate a child's executive functions within the context of his or her everyday environments--both home and preschool. Completed in just 10 to 15 minutes, the hand-scorable BRIEF-P Rating Form consists of 63 items that measure various aspects of executive functioning:

Inhibit   Emotional Control   Plan/Organize
Shift   Working Memory

The clinical scales form 3 broad indexes and one composite score:

Inhibitory Self-Control   Flexibility
Emergent Metacognition   Global Executive Composite

The BRIEF-P also provides 2 validity scales, Inconsistency and Negativity.

Normative data are based on ratings of children, aged 2.0 through 5.11, from 460 parents and 302 teachers from urban, suburban, and rural areas, reflecting U.S. Census estimates for race/ethnicity, gender, socioeconomic status, and age. Clinical samples included children in the following diagnostic groups: ADHD, prematurity, language disorders, autism spectrum disorders, and mixed clinical.

The BRIEF-P is useful in assessing preschool-aged children with conditions such as prematurity, emerging learning disabilities and attention disorders, language disorders, traumatic brain injuries, lead exposure, and pervasive developmental disorders/autism.

Behaviour Rating Inventory of Executive Function, Self-Report Version (BRIEF-SR)
by Steven C. Guy, Ph.D., Peter K. Isquith, Ph.D., and Gerard A. Gioia, Ph.D.

The BRIEF-SR is useful in evaluating and treating adolescents (11 to 18 years of age) who have executive control problems--difficulties with reasoning, self-awareness, flexibility, organization, self-monitoring, memory capacity, or behavioral regulation. Complementing the *Behavior Rating Inventory of Executive Function* (BRIEF) Parent and Teacher Forms, this standardized, 80-item self-report scale captures an adolescent's view of his or her own purposeful, goal-directed, problem-solving behavior. This information can help you determine how much external support an adolescent needs and how you can best build a collaborative working relationship with him or her.

In just 10 to 15 minutes, the BRIEF-SR can be completed by any teen who can read at a 5th-grade-or-higher level, including those with attention disorders, language disorders, traumatic brain injury, lead exposure, learning disabilities, high-functioning autism, or other developmental, psychiatric, or medical conditions.

The inventory is composed of eight nonoverlapping clinical scales: Inhibit, Shift, Emotional Control, Monitor, Working Memory, Plan/Organize, Organization of Materials, and Task Completion. These scales form two broader indexes--the Behavioral Regulation Index and the Metacognition Index--and yield an overall summary score, the Global Executive Composite. Two validity scales, Inconsistency and Negativity, are also included.

Quick and convenient, the BRIEF-SR gives you another perspective on the self-regulatory strengths and weaknesses of adolescents.

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Behavioural and Psychological Assessment of Dementia™ (BPAD™)

Kara S. Schmidt, PhD and Jennifer L. Gallo, PhD

The BPAD is a standardized informant report that assesses the changes in both behaviour and mood that are associated with the onset and course of various dementia syndromes. This 78-item assessment categorizes symptoms into three clusters (i.e., Psychopathological, Behavioural, Biological) and further, into seven domains (i.e., Perceptual/Delusional, Positive Mood/Anxiety, Negative Mood/Anxiety, Aggressive, Perseverative/Rigid, Disinhibited, Biological Rhythms). The BPAD Response Booklet is large-print to simplify completion by individuals with vision difficulties.

During administration, the respondent is asked about symptoms the patient has exhibited both within the past 4 weeks and 5 years ago. To differentiate symptoms associated with long-standing psychiatric illness from symptoms associated with the onset of behavioural disturbance related to dementia, the BPAD assesses the symptoms over these two time periods and computes a change score that captures information about changes in mood and behaviour specific to the onset and course of dementia. The BPAD was standardized and validated on a sample of men and women ages 30-90 years; these rated adults came from a wide range of racial/ethnic and educational backgrounds and geographic regions, and the sample was matched to U.S Census proportions.

Administration is done using the large-print Response Booklet and pencil, takes 15 minutes to complete, and should be completed by family members, paraprofessionals, or other professionals ages 18-90 who have regular contact with individuals who have suspected or diagnosed dementia. The items are written at a sixth-grade reading level. The BPAD can be employed in a wide range of settings (e.g., outpatient clinics, assisted living settings, clinical research settings) with heterogeneous groups of individuals with suspected or diagnosed dementia (e.g., patients diagnosed with Alzheimer's disease, patients with vascular dementia, psychiatric patients with suspected dementia).

The BPAD Software Portfolio Makes Scoring Easy

After hand-entry of raw scores, the easy-to-use BPAD™ Software Portfolio (BPAD™-SP) generates scores that represent current impairment (i.e., CURRENT), past impairment (i.e., PAST), and change in impairment over time (i.e., CHANGE). The Score Report also provides T scores and percentiles for the BPAD Total and domain scores and graphical presentation of BPAD T scores. The BPAD-SP is included in the BPAD Introductory Kit.

Requirements: Windows® 2000/XP/Vista™; NTFS file system; CD-ROM drive for installation; Internet connection or telephone for software activation

Bender Visual-Motor Gestalt Test, Second Edition (Bender Gestalt II)
by Gary Brannigan and Scott Decker

Originally published in 1938 by Lauretta Bender, M.D., the *Bender Visual-Motor Gestalt Test* is one of the most widely used psychological tests. The Second Edition (*Bender Gestalt //*) updates this classic assessment and continues its tradition as a brief test of visual-motor integration that can provide useful information about an individual's development and psychological functioning.

Appropriate for ages 3 to 85+ years, the *Bender Gestalt //* is a reliable way to assess visual-motor development. It is also a useful introduction to any battery of educational, psychological, or neuropsychological tests. The *Bender Gestalt //* provides helpful information in preschool screening as well as geriatric assessment. And it can offer insight into many conditions, including ADHD, mental retardation, giftedness, learning disabilities, autism, and Alzheimer's Disease.

The *Bender Gestalt //* consists of a series of stimulus cards, each displaying a unique figure. The individual is asked to draw each figure as he or she observes it. The stimulus card is not removed until the drawing is complete.

This edition of the test adds items and extends the range of ability assessed. New recall procedures to measure visual-motor memory ensure a more comprehensive assessment of visual-motor skills. And supplemental tests of simple motor and perceptual ability help identify specific visual-motor deficits. An optional timing component allows the examiner to time each drawing, and scoring is now quicker and easier.

Co-normed with the *Stanford-Binet Intelligence Scales*, Fifth Edition, the *Bender Gestalt II* was standardized on more than 4,000 individuals ranging in age from 4 through 85+ years. The composition of the standardization sample corresponds to the 2000 U.S. population.

The *Bender Gestalt II* is an ideal way to start an extended psychological test battery. With its simple design and administration, the test is a nonthreatening way to warm up to more challenging assessments.

Benton Laboratory of Neuropsychology: Selected Tests
Arthur L. Benton, PhD

These tests have demonstrated validity and provide additional substantive data in the evaluation of brain-damaged patients. Each test is designed to be quickly and easily administered, minimizing

patient fatigue and maximizing the collection of reliable neuropsychological test data. Normative and validity data are described in the Manual, *Contributions to Neuropsychological Assessment*, which may be purchased separately.

Temporal Orientation

This brief test assesses the accuracy of an individual's temporal orientation with relation to the day of the week, day of the month, month, year, and time of day. The test provides a standardized procedure, based on empirically established norms, for interpreting an individual's performance.

Right-Left Orientation

This 20-item test requires an individual to point to lateral body parts on verbal command. Form B is a mirror image of Form A in which the commands are reversed. Administration time is 5 minutes.

Serial Digit Learning

This test consists of the presentation of either eight or nine randomly selected single digits for a varying number of trials up to a maximum of 12. Three alternate versions are provided for each form. Administration requires 5-10 minutes.

Facial Recognition

A three-part standardized measure of the ability to match unfamiliar faces. Contains a 27-item short form and a 54-item long form.

Judgment Of Line Orientation

This is a standardized measure of visuospatial judgment in two alternate forms. The spiral-bound booklet contains 35 stimuli, five of which are practice items.

Visual Form Discrimination

This measure of ability to discriminate between complex visual configurations provides comparative data on clients with brain disease. Composed of 16 items ranging in level of difficulty, this brief, convenient procedure has proven utility because of its sensitivity to effects of brain disease.

Pantomime Recognition

This test requires the client to point to drawings of objects; the pretended uses of the objects are shown in a series of 30 videotaped pantomimes.

Motor Impersistence

This battery consists of eight tests requiring the maintenance of a movement or posture: keeping eyes closed, protruding tongue (blindfolded and eyes open), fixation of gaze in lateral visual fields, keeping mouth open, central fixation during confrontation testing of visual fields, head turning during sensory testing, and saying "ah."

Booklet Category Test, 2nd Edition (BCT™)

Nick A. DeFilippis, PhD, Elizabeth McCampbell, PhD

This portable version of the widely used Halstead Category Test (CT) allows you to distinguish individuals ages 15 years and older with brain damage from normal individuals. The BCT contains 208 visual stimuli that assess complex concept formation and abstract reasoning.

Description

The two portable BCT easel binders contain all 208 Category Test designs. The task demands of the BCT are essentially equivalent to those of the CT. The BCT eliminates the need for expensive, complex projection equipment. Administration instructions are now incorporated on the backs of the Stimulus Plates and in the Response Form to aid in standardization of the BCT administration. The BCT Response Form has also been updated to enhance its ease of use. The stimuli for each subtest are presented on a single page to aid in test administration and to facilitate the review of patient responses. The new Score Summary section of the form facilitates the use of the demographically corrected normative data which are now included in the expanded BCT Professional Manual for improved diagnostic accuracy and interpretation of error scores. The revised manual also provides information about current research findings related to the clinical utility of the BCT.

Administration/Scoring

The BCT is administered by presenting the Stimulus Plates and having the respondent point to the number on the BCT Response Strip that corresponds to the pattern on each Stimulus Plate. The examiner records the individual responses and then tallies the incorrect responses to obtain the error score.

Reliability/Validity

Regarded as the most sensitive indicator of brain dysfunction in the Halstead-Reitan Neuropsychological Test Battery, the CT is nearly as valid as the complete battery in detecting brain damage. In a cross-validation study, the BCT correlated with the CT at the same statistical level as the CT correlates with itself, suggesting that the BCT retains the high reliability and validity of the original instrument.

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Boston Diagnostic Aphasia Examination, 3rd Ed. (BDAE)

Harold Goodglass, PhD, Edith Kaplan, PhD, Barbara Barresi, PhD

Since 1972, the BDAE has been the benchmark for the diagnosis of aphasia and related disorders. The text, *Assessment of Aphasia and Related Disorders*, addresses the nature of aphasia; its definition and characteristics; the normative basis for the BDAE scoring system; a specific explanation of how to administer and interpret the exam; a Severity Rating Scale that provides a meaningful standard for measuring your client's communicative ability; and a Visuospatial Quantitative Battery to test visuospatial and quantitative skills after brain injury. (This 135-page book is only available as part of the Kit.)

New to the 3rd Edition:

- A Short Form of the BDAE--takes only 30-45 minutes to complete and provides you with the option to perform a brief, no frills assessment.
- Extended tools for more in-depth study and recording of results--the regular exam has been augmented with extended tools that test syntax comprehension, locate category-specific difficulties in word comprehension and word production, and assess grapho-phonemic processing.
- The **Boston Naming Test (BNT),** which helps determine the extent of an individual's visual confrontation naming abilities, has been incorporated into the BDAE. This requires using the separately bound BNT Stimulus Cards and Record Booklets. New options for the BNT are provided and include new methods for eliciting disclosure, new approaches to scoring, and new tests for analyzing reading disorders.
- Also includes a new 90-minute videotape, *Examining for Aphasia with the BDAE*, in which Drs. Goodglass, Kaplan, and Barresi demonstrate the test materials, examiner/patient interactions, and scoring techniques through real-life examinations of three aphasic patients.

Brief Neuropsychological Cognitive Examination (BNCE)

Joseph M. Tonkonogy, M.D., Ph.D.

Suitable for: ages 18 and up

This convenient test assesses the cognitive functions targeted in a typical neuropsychological exam. In less than 30 minutes, it gives you a general cognitive profile that can be used for screening, diagnosis, or follow-up. More efficient than a neuropsychological battery and more thorough than a screener, BNCE is an ideal way to evaluate the cognitive status of patients with psychiatric disorders or psychiatric manifestations of neurological diseases.   Appropriate for individuals 18 years of age and older, the BNCE assesses working memory, gnosis, praxis, language, orientation, attention, and

executive functions. It is composed of 10 subtests, none requiring more than minimal reading skills. Five of these subtests measure the ability to process conventional, frequently used information, while the remaining five measure the ability to process novel or incomplete information. The test focuses on processing skills needed for everyday functioning, and is sensitive to mild impairment often missed by other brief cognitive screeners. The BNCE is an excellent way to start a process-oriented neuropsychological exam—It quickly reveals specific cognitive abnormalities that may warrant more detailed evaluation. And it can be used to monitor the course of both psychiatric and neurological disease. It has been found especially useful in evaluating patients with sequelae of head injury, stroke, encephalitis, and primary degenerative disorders such as Alzheimer's, Huntington's, Parkinson's and Pick's diseases and those suffering from seizure disorders, schizophrenia, mood disorders, and alcohol and drug abuse.

Brief Visuospatial Memory Test Revised (BVMT)
Ralph H. B. Benedict, Ph.D., ABCN

User Qualification: Psychologist

Suitable for: Adults Aged 18 to 79 Years
Time: Timed, 45 minutes

The BVMT-R is designed for use as a criterion measure of visuospatial memory within a large battery of neuropsychological tests, as a screening measure within a brief neuropsychological battery, and as a repeat measure to document changes in neurocognitive skills over time.

Each of the six equivalent, alternate BVMT-R stimulus forms consists of 6 geometric figures printed in a 2 x 3 array on a separate page of the Recall Stimulus Booklet. In the three Learning Trials, the respondent views the Recall Stimulus page for 10 seconds and then is asked to draw as many of the figures as possible in their correct location on a page in the Response Booklet. After a 25-minute delay which includes primarily verbal activities, the task is repeated. Then the respondent is asked to identify which of the 12 figures in the Recognition Stimulus Booklet were included in the 6 geometric figures on the original Recall Stimulus page. As a final step, an optional Copy trial may be administered to screen for severe visuoconstructive deficits and to help in scoring recall responses.

Brief Visuospatial Memory Test-Revised (BVMT-R™)
Ralph H. B. Benedict, PhD, ABCN

The BVMT-R is designed for use as a criterion measure of visuospatial memory within a large battery of neuropsychological tests, as a screening measure within a brief neuropsychological battery, and as a repeat measure to document changes in neurocognitive skills over time. It has been standardized and normed for use with adults ages 18-79 years.

BVMT-R materials were designed to be handled and transported easily, so that the test can be administered in a clinic setting or at the bedside using a clipboard. The materials include the Professional Manual, the Recall Stimulus Booklet, the Recognition Stimulus Booklet (easel format), and the Response Form. Administration requires a pencil and a stopwatch.

Each of the six equivalent, alternate BVMT-R stimulus forms consists of six geometric figures printed in a 2 x 3 array on a separate page of the Recall Stimulus Booklet. In the three Learning Trials, the respondent views the Recall Stimulus page for ten seconds and then is asked to draw as many of the figures as possible in their correct location on a page in the Response Booklet. After a 25-minute delay which includes primarily verbal activities, the task is repeated. Then, the respondent is asked to identify which of the 12 figures in the Recognition Stimulus Booklet were included in the six geometric figures on the original Recall Stimulus page. As a final step, an optional Copy trial may be administered to screen for severe visuoconstructive deficits and to help in scoring recall responses.

Normative data for the BVMT-R were derived from a sample of 588 normal participants that included 171 college students and 417 community respondents. Normative data are also provided for a 377-member subset of this normative sample, selected to reflect the age distribution of the U.S. population.

Reliability coefficients range from .96-.97 for the three Learning trials, .97 for Total Recall, and .97 for Delayed Recall. Test-retest reliability coefficients range from .60 for Trial 1 to .84 for Trial 3. The BVMT-R correlates most strongly with other tests of visual memory and less strongly with tests of verbal memory.

The BVMT-R Professional Manual contains information about the test materials and their development, administration and scoring, the normative standardization sample, and validity and reliability, as well as guidelines for interpretation. The Appendixes provide scoring examples, normative tables for the U.S. census age-matched sample, demographically corrected norm tables based on the entire sample, and information on the base rate of impairment of BVMT-R scores in various clinical samples. For most diagnostic purposes, the use of demographically corrected normative scores is recommended.

Any trained person with a background in psychological testing may administer and score the BVMT-R in less than one hour. Interpretation requires training and expertise in clinical psychology and/or neuropsychology.

HVLT-R/BVMT-R Professional Manual Supplement
The HVLT-R/BVMT-R Professional Manual Supplement provides information on the development, use, and interpretation of several new scores, including Reliable Change scores and Discrepancy scores.

You can assess verbal learning and memory with the HVLT-R, a companion to the BVMT-R.

California Verbal Learning Test®, 2nd Ed (CVLT®-II)

Dean C. Delis, PhD, ABPP, Joel H. Kramer, PsyD, Edith Kaplan, PhD, ABPP/CN, and Beth A. Ober, PhD

The CVLT-II, a revision of the classic test of verbal learning and memory, now provides even more comprehensive information than the original CVLT. New features of the CVLT-II include additional items, increased flexibility in administration with new standard and short forms, an expanded age range for broader usage, and correlation with the Wechsler Abbreviated Scale of Intelligence™ (WASI™) for valuable comparative data.

More Comprehensive Information

Additional items provide more comprehensive information. Examinees are read a list of words (selected after careful study of their frequency of use across multiple demographic variables) and asked to recall them in a series of trials. The CVLT-II includes forced-choice items useful in detecting malingering, thereby helping to reduce false results. In addition to recall and recognition scores, the CVLT-II measures:

- Encoding strategies

- Error types

- Learning rates

- Other processing data

Flexible Administration

New options provide flexibility in test administration:

- The Short Form (nine words in three categories) is useful when examination time is limited or when the clinician requires less detailed test information.

- The Short Form also is useful when examinee fatigue is a concern (or severe memory or cognitive deficits make the Standard or Alternate Forms impractical).

- The new Alternate Form prevents artificially inflated scores when retesting is necessary.

Expanded Sample

Extensive clinical data are available, as well as new norms on a national sample of adults selected to represent the U.S. population. Norms are provided now for individuals from ages 16-89 years, thus increasing the utility of the new edition.

Correlated with the WASI™

The CVLT-II is correlated with the WASI, providing valuable comparative information about the effect of cognitive ability on verbal learning and memory. The CVLT-II offers a technologically advanced computer scoring system, the CVLT-II Comprehensive Scoring System, which provides rich

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information not available through typical hand scoring. The most technologically advanced scoring system yet, the CVLT-II Scoring System offers multiple scoring options, varying from brief to highly detailed information.

Requirements: Windows® 95/98/NT 4.0/200/Me/XP; CD-ROM drive and 1.44MB 3.5" disk drive for installation

California Verbal Learning Test®-Children's Version (CVLT®-C)
Dean C. Delis, PhD, ABPP, Joel H. Kramer, PsyD, Edith Kaplan, PhD, ABPP/CN, and Beth A. Ober, PhD

The CVLT-C assesses verbal learning through an everyday memory task in which the child is asked to recall a list. An interference task is given, followed by a short delay free recall and cued recall trials. Free recall, cued recall, and a word recognition trial also are administered after a 20-minute delay. In this way, the CVLT-C generates measures of short- and long-term memory performance, including eight recall and four recognition measures. It also provides data on encoding strategies and errors, such as intrusions and perseveration, together with indicating the degree to which stimuli may interfere with a profile of learning characteristics.

The CVLT-C can be used in a variety of settings to identify learning and memory difficulties, to isolate deficient learning strategies, and to assist in designing remediation programs. The CVLT-C standardization sample consisted of 920 children that were representative of the U.S. population of children for age, gender, race/ethnicity, geographic region, and parent education level, based on data from the U.S. Bureau of the Census (1988). Because the CVLT-C was co-normed with the Children's Category Test (CCT), it allows clinicians to compare a child's memory and learning performance with higher executive functioning.

The CVLT-C can be hand scored or scored using the CVLT-C Scoring Assistant software. The scoring software tabulates and prints numerous raw scores and age-referenced standard scores, thus making the scoring process cost-effective for both clinical and educational practices.

Requirements: Windows® 95/98/2000/Me/XP/NT 4.0, Pentium® 100 processor or higher; 16MB RAM, 14MB free hard drive space; CD-ROM and 3.5" disk drive

Canter Background Interference Procedure (BIP) for the Bender Gestalt Test
Arthur Canter, Ph.D

This widely used measure assesses performance characteristics of individuals with brain pathology. It compares results from the standard Bender Gestalt Test to those from a second administration of the Bender Gestalt in which the subject reproduces the designs on a special sheet with intersecting sinusoidal lines. These lines provide background "noise" or interference during the copying task.

Clinical Assessment Scales for the Elderly™ (CASE™)

Cecil R. Reynolds, PhD, Erin D. Bigler, PhD

The CASE is designed to assist the clinician in the diagnosis of *DSM-IV* Axis I clinical disorders in individuals from ages 55 to 90 years. The CASE consists of a self-rating form (Form S) and an other-rating form (Form R) that can be completed by a knowledgeable caregiver (e.g., a spouse, child, home health care worker, and sibling). Form R is especially useful to verify the information provided by the patient, or when the patient is unable to complete the assessment due to physical or cognitive difficulties.

- Developed specifically to assess for the most prominent *DSM-IV* disorders among the elderly.
- Normed on a U.S. census-matched sample of 2,000 adults, ages 55-90 years.
- Consists of 10 clinical scales: Anxiety (ANX), Cognitive Competence (COG), Depression (DEP), Fear of Aging (FOA), Obsessive-Compulsive (OCD), Paranoia (PAR), Psychoticism (PSY), Somatization (SOM), Mania (MAN), and Substance Abuse (SUB).
- Includes a valuable Fear of Aging scale that assesses an individual's level of apprehension about the aging process.
- CASE items are free of gender or ethnic bias.
- Contains three validity scales especially useful to identify feigning and for forensic assessments.

Administration and Scoring

Patients and knowledgeable caregivers can complete the CASE in 40 minutes or less. Scoring and profiling are easy. CASE raw scores are converted to *T* scores using the age-appropriate normative tables. The *T* scores are then plotted on the CASE Profile Form to provide a graphic overview of the patient's clinical status or a comparison of multiple profiles when available.

Reliability/Validity

- Total normative group of 2,000 adults, matched to U.S. census data for gender, geographic region, educational level, and ethnicity (normative data are based on 1,000 each of Form S and Form R).
- Construct validity of CASE Form S is demonstrated by correlations with the MMPI-2, Beck Depression Inventory (BDI), Beck Hopelessness Scale (BHS), and both the State and Trait scales of the State-Trait Anxiety Inventory (STAI). A group of dementia patients were evaluated using the CASE Form R and the Cognitive Behavior Rating Scales (CBRS).
- Studies of gender and ethnic bias indicate no clinically significant differences as a function of gender or of ethnicity among Caucasians, African Americans, and Hispanics.
- Validity scales for Forms S and R include measures of positive and negative distortion and dissimulation (L scale), infrequently endorsed items (F scale), and detection of random responding, failure to comprehend the items, and lack of cooperation (V scale).

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Clinical Assessment Scales for the Elderly™ Short Form (CASE-SF™)
Cecil R. Reynolds, PhD, Erin D. Bigler, PhD

The CASE-SF is designed to provide you with a rapid assessment of elderly adults (ages 55-90 years) to determine whether a more comprehensive evaluation of psychopathology or a referral for a different type of examination might be needed (e.g., referral to a neuropsychologist). The CASE-SF consists of a self-rating test booklet (Form S) and an other-rating test booklet (Form R) that can be completed by a knowledgeable caregiver such as a spouse, child, home health-care worker, or sibling.

- Derived from the CASE, the CASE-SF includes all 10 CASE clinical scales and two of the CASE validity scales (*Lie* and *Validity*).

CASE-SF Scales

Clinical Scales
Anxiety (*ANX*)
Cognitive Competence (*COG*)
Depression (*DEP*)
Fear of Aging (*FOA*)
Mania (*MAN*)
Obsessive-Compulsive (*OCD*)
Paranoia (*PAR*)
Psychoticism (*PSY*)
Somatization (*SOM*)
Substance Abuse (*SUB*)

Validity Scales
Lie (*L*)
Validity (*V*)

- The CASE-SF Form R provides independent information about the patient from caregivers for verification of patient status or when the patients are unable to complete the assessment themselves due to physical or cognitive difficulties.
- Designed to help you track treatment effectiveness or monitor a patient's clinical status over time.
- Enables you to quickly evaluate large numbers of seniors in a variety of settings such as assisted living facilities, nursing homes, and community care centers.
- Normative data derived from the CASE sample.
- CASE-SF items are free of gender or ethnic bias.
- The CASE/CASE-SF Professional Manual provides all of the necessary information for the administration and scoring of both the CASE and the CASE-SF.
- Patients and knowledgeable caregivers can complete the CASE-SF in 20 minutes or less; scoring and profiling are quick and easy.

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Cognistat - Neurobehavioral Cognitive Status Examination
by Ralph J. Kiernan, Ph.D., Jonathan Mueller, M.D., and J. William Langston, M.D

Cognistat gives you a quick way to assess the intellectual functioning of adults in five major areas:

Language
> Spontaneous
> Speech
> Comprehension
> Recognition
> Naming

Constructions
Memory
Calculations
Reasoning
> Similarities
> Judgment

In addition, Attention, Level of Consciousness, and Orientation are assessed independently.

All but the Memory items are administered in a screen and metric format. Within each of the five sections, patients are first screened with a demanding test item. If they fail the screen, they are tested further with the metric, a series of increasingly difficult items. However, if they pass the screen, their functioning in the particular area is assumed to be normal, and the examiner moves on to the next section. In this way, intact areas are briefly tested, while impaired areas are examined in some detail. Testing time is about 5 minutes for normals, and about 20 minutes for individuals who are cognitively impaired.

Scores are plotted on a clear-cut profile form, which illustrates the patient's overall strengths and deficits. For interpretive guidance, the Manual presents five sample profiles and a list of specific cautions. Norms are based on two groups of 58 volunteers (20 to 39 and 40 to 66 years old), a geriatric group of 59 volunteers (70 to 92 years old), and 30 neurosurgical patients (25 to 88 years old).

Sensitive, specific, and easy to interpret, *Cognistat* quickly alerts you to potential cognitive problems. It provides a sound basis for referral, further testing, and treatment.

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Cognitive Symptom Checklists (CSC)
Christiane O'Hara, PhD, Minnie Harrell, MS, LPC, Eileen Bellingrath, MS, Katherine Lisicia, MEd, CCC-SLP

The CSC is a series of five checklists designed to pinpoint the areas where individuals (ages 16 years and older) who have impaired cognitive functioning may be having difficulties in everyday activities. It can be used as a screening tool to supplement formal neuropsychological or other cognitive testing.

These checklists are designed for use with individuals ages 16 and older. Items are written at a 7th-grade reading level. The client completes the specific checklists the clinician feels necessary to determine potential problems in five basic cognitive areas:

- Attention/Concentration
- Visual Processes
- Executive Functions
- Memory
- Language

The client checks each problem he/she experiences and circles those that seem most important for treatment. The clinician inquires about each specific item checked by the client and uses this information to identify baseline cognitive problem areas, develop treatment plans, provide information to clients and their families, and measure posttreatment progress. These five checklists provide a framework for clinicians to gather additional information about the nature of specific problems and to assist the client and clinician in prioritizing problems to target for treatment.

Colour Trails Test (CTT)
Louis F. D'Elia, Ph.D., Paul Satz, Ph.D., Graig Lyons Uchiyama, Ph.D. and Travis White, Ph.D.

The Color Trails Test was developed to meet the need for a test with the sensitivity and specificity of the standard Trail Making Test, but one that was as free as possible from the influences of language and cultural bias. The CTT retains the psychometric properties of the standard TMT, but it substitutes the use of color for the use of English alphabet letters, making it more suitable in cross-cultural and other special-needs contexts. Instructions may be presented either verbally or with visual cues. Respondents must be able to recognize Arabic numerals from 1 to 25 and to distinguish between the colors pink and yellow.

The CTT uses numbered colored circles and universal sign language symbols. The circles are printed with vivid pink or yellow backgrounds that are perceptible to colorblind individuals. During the test the examiner uses a stopwatch to record the length of time to complete each trial along with qualitative features of performance indicative of brain dysfunction.

Comprehensive Trail-Making Test (CTMT)
by Cecil R. Reynolds, Ph.D.

Based on time-tested techinques, the CTMT is a standardized set of five visual search and sequencing tasks that are heavily influenced by attention, concentration, resistance to distraction, and cognitive flexibility (or set-shifting). It is highly useful in the evaluation and diagnosis of brain injury; frontal lobe deficits; problems with psychomotor speed, visual search and sequencing, and attention; and impairments in set-shifting.

The CTMT is for individuals ages 11 through 74. Administration is timed and takes from 5 to 12 minutes. Scoring typically requires just a few minutes more. Normative scores, derived from a nationwide sample of 1,664 people, are provided as percentile ranks and T-scores with a mean of 50 and a standard deviation of 10.

The basic task of trail-making is to connect a series of stimuli (numbers and letters) in a specified order as fast as possible. The score derived for each trail is the number of seconds required to complete the task. The composite score is obtained by pooling T-scores from the individual trails. Although similar, the test's five trails differ from each other in some significant way. For example, Trail 1 requires the examinee to draw a line connecting the numbers 1 through 25 in order, while Trail 2 presents the same task with 29 distracters on the same page.

The CTMT is extremely sensitive to neurological insult, disease, injury, or dysfunction, including the subtle neuropsychological problems often present in individuals with learning disabilities

The Clock Test (CT)
H. Tuokko, Ph.D., T. Hadjistavropoulos, Ph.D., J.A. Miller, Ph.D., A. Horton, M.D., & B.L. Beattie, M.D.

User Qualification: Psychologist
Suitable for: Adults Aged 65 Years and Over
Time: Untimed, approximately 5-10 minutes for each of three components
The Clock Test is designed to quickly assess visual-spatial construction, visual perception, and abstract conceptualization. Using three subtests: Clock Drawing, Clock Setting, and Clock Reading, the Clock Test measures an individual's level of cognitive impairment and helps differentiate between normal elderly and those suffering from dementia.

The Clock Test provides you with well-defined, specific scoring criteria that ensures greater efficiency and reliability. Errors are broken down into the following components: omissions, distortions, misplacements, perseverations, substitutions, additions and rotations

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Continuous Visual Memory Test (CVMT)
Donald E. Trahan, Ph.D. and Glenn J. Larrabee, Ph.D.

The CVMT uses complex, ambiguous designs and a recognition format to measure visual learning and memory. Studies suggest that these features may increase task sensitivity and reduce the confounding influence of verbal encoding strategies. This format also eliminates the motor responses required by drawing tasks and restricts the verbal labeling required by tests that use simplistic geometric figures and common objects.

The CVMT includes 3 tasks for assessing visual memory, (1) the Acquisition Task tests recognition memory; (2) the Delayed Recognition Task measures retrieval from long-term storage after a 30-minute delay; and (3) a Visual Discrimination Task distinguishes visual discrimination deficits from visual memory problems. The clinical sensitivity of the CVMT has been demonstrated in patients with unilateral right hemisphere CVA, individuals with Alzheimer's disease, as well as patients who have suffered severe head trauma.

Delis-Kaplan Executive Function System™ (D-KEFS™)
Dean C. Delis, PhD, Edith Kaplan, PhD, Joel H. Kramer, PsyD

With nine new stand-alone tests, the D-KEFS comprehensively assesses the key components of executive functions believed to be mediated primarily by the frontal lobe. Incorporating principles from cognitive science, the D-KEFS™ evaluates higher-level cognitive functions in both children and adults.

The D-KEFS has multiple uses. It can be used to assess the integrity of the brain; to determine how deficits in abstract, creative thinking may impact daily life; and to help plan coping strategies and rehabilitation programs tailored to each patient's profile of executive function strengths and weaknesses.

Normed on over 1,500 individuals demographically and regionally matched with the U.S. population, the D-KEFS is individually administered. Its game-like format is designed to be interesting and engaging for examinees, encouraging optimal performance without providing "right/wrong" feedback that can create frustration in some children and adults.

The Standard Record Forms include all nine D-KEFS tests (each test is available for individual ordering as well); the Alternate Record Forms include alternate versions of D-KEFS Sorting, Verbal Fluency, and 20 Questions Tests. An alternate set of Sorting Cards also is available.

The D-KEFS is correlated with the Wechsler® Abbreviated Scale of Intelligence™ (WASI™) and the California Verbal Learning Test®, 2nd Ed. (CVLT®-II), providing information concerning the role of

intellectual ability and memory on D-KEFS performance. The scoring process is enhanced with the convenient D-KEFS™ Scoring Assistant® that reduces your scoring time. The scoring software enables you to quickly and easily generate score reports in either a tabular or graphic format.

The scoring process is enhanced with the convenient D-KEFS™ Scoring Assistant™ that reduces your scoring time. The scoring software enables you to quickly and easily generate score reports in either a tabular or graphic format.

Requirements: Windows® 95/98/2000/Me/XP/NT 4.0, 100 MHz processor (166 MHz recommended), 32MB of RAM (64MB recommended), 2MB video card capable of 800x600 resolution (16-bit color), 75MB free hard disk space

Note: The Trail Making Test and the Design Fluency Test require separate response booklets. If you are ordering either of these tests, or are ordering the Standard Record Forms and intend to administer either of these tests, be sure you also order the corresponding response booklets.

Dementia Rating Scale - 2 (DRS - 2)
Steven Mattis, Ph.D.

Research conducted after the publication of the original Dementia Rating Scale (DRS) showed that both age and education contribute significantly to DRS subscale and Total Scores. This finding, along with several other factors, provided the impetus for the development of the DRS-2.

The DRS-2 measures cognitive function at lower ability levels where some other evaluation instruments are limited by floor effects. The DRS-2 also can be used to track changes in cognitive status over time. By design, the DRS-2 measures deficits in a large range of higher cortical functions and differentiates deficits of varying severity levels.

The DRS-2 incorporates the original 36 DRS tasks and 32 stimuli, yielding five subscale scores, and an assessment of the patient's overall level of cognitive functioning. The five DRS-2 subscales provide additional information on specific abilities including Attention (8 items), Initiation/Perseveration (11 items), Construction (6 items), Conceptualization (6 items), and Memory (5 items). Stimulus items consist of material familiar to most individuals.

The DRS-2 tasks are presented in a fixed order. Within each subscale the most difficult tasks are presented first. Generally, if the first one or two tasks in a subscale are performed well, subsequent tasks in the subscale are credited with a correct performance and the examiner proceeds to the next subscale. This procedure significantly shortens the total testing time for individuals with relatively intact cognitive functioning.

The DRS-2 Includes the Following Features:

- A newly designed 12-page DRS-2 Scoring Booklet that facilitates administration and scoring.
- A new Profile Form helps to create a graphical representation for interpretation.
- An expanded age range (55-89 years and older).

- Age-corrected normative tables for all DRS-2 subscales with age- and education-corrected normative data for the DRS-2 Total Score.
- The 32 Stimulus Cards and the 36 tasks of the original DRS.
- Expanded literature review with a discussion of DRS reliability and validity studies.
- Validity studies comparing the DRS with WMS® and WAIS-R® subtests and the MMSE™.

DRS-2 test materials include the Professional Manual, one set of Stimulus Cards, 50 Scoring Booklets, and 50 Profile Forms. The 32 Stimulus Cards are contained in a separate binder for ease of administration. The Scoring Booklet provides prompts for administration of the items and complete instructions for scoring the patient's responses.

Digit Vigilance Test (DVT)
Ronald F. Lewis, Ph.D.

The DVT, included in Robert K. Heaton's expanded HRB normative system, is a simple task designed to measure vigilance during rapid visual tracking and accurate selection of target stimuli. It is sensitive to subtle changes in neuropsychological status, but relatively insensitive to the effects of either repeated administrations or practice. The DVT appears to isolate alertness and vigilance while placing minimal demands on two other components of attention: selectivity and capacity.

Time to complete the task is recorded using a stopwatch. The 4 scoring templates (one for 6s and one for 9s in each of the colors) allow the test administrator to count and record errors of commission and omission.

Interpretation within the context of a comprehensive neuropsychological evaluation requires training in clinical psychology or neuropsychology. Normative data are not provided in the Professional User's Guide, but are presented in Comprehensive Norms for an Expanded Halstead-Reitan Battery.

Dementia Rating Scale-2™: Alternate Form (DRS-2™: Alternate Form)
Kara S. Schmidt, PhD

The DRS-2 is a widely used instrument for the assessment of neurocognitive status. Because it is appropriate for use by professionals across multiple disciplines (e.g., neuropsychology, psychiatry, neurology, gerontology), an equivalent form was needed, and subsequently, the DRS-2: Alternate Form was developed.

The DRS-2: Alternate Form reduces the practice effects that occur with serial administrations of the original DRS-2. This issue is particularly important in the assessment of older adults (ages 55-89 years

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and older) with neuro-psychiatric illness. Accurate documentation of cognitive changes is crucial to arrive at a precise diagnosis. Often, it is necessary to administer mental status measures multiple times over a relatively brief period. Thus, having two DRS-2 forms available allows for a better characterization of declining cognitive status and an improvement in the evaluation of treatment efficacy.

The DRS-2: Alternate Form test materials include the Professional Manual Supplement, 1 set of Stimulus Cards, Scoring Booklets, and Profile Forms. The Professional Manual Supplement is an adjunct to the original DRS-2 Professional Manual, which provides all normative tables and data as well as interpretive guidelines for both forms of the DRS-2. The item content in the newly designed DRS-2: Alternate Form Scoring Booklet and the stimuli in the DRS-2: Alternate Form Stimulus Cards are structured to mirror their respective original forms. The DRS-2: IR software also has been updated to include the use of either or both forms.

Reliability and Equivalency Studies
Test-retest reliability of the DRS-2: Alternate Form is strong. In addition, alternate form reliability between the original DRS-2 and the DRS-2: Alternate Form is strong, with a correlation coefficient of .82 for the Total Score, and correlation coefficients ranging from .66 to .80 for the subscales. Several other studies, including a generalizability and equipercentile equating, were utilized to determine the equivalency between the two forms.

The Dean-Woodcock Neuropsychological Battery

The *Dean-Woodcock Neuropsychological Battery* (DW) is a comprehensive assessment of sensory-motor functioning that also includes a structured interview and an emotional status exam. The DW adds standardized procedures and normative information to typically unstandardized measures used in neuropsychology.

Appropriate for ages 4 and up (including the geriatric population), the DW can be administered in just 40 to 45 minutes. It measures simple and complex sensory and motor functioning and both cortical and subcortical functions. First, a structured interview is used to determine an individual's medical and family background. This is followed by an emotional status exam, during which the clinician records psychiatric signs and symptoms--covering most major disorders found in the DSM-IV--as well as clinical impressions. The third part of the battery assesses sensory-motor functioning on the following subtests:

Lateral Preference Scale	Object Identification	Construction Test (Cross and Clock)
Near Point Visual Acuity	Finger Identification	Mime Movements
Visual Confrontation	Simultaneous	Left-Right Movements

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	Localization	
Naming Pictures of Objects	Gait and Station	Finger Tapping
Auditory Perception	Romberg Test	Expressive Speech
Palm Writing	Coordination Test	Grip Strength

Scores indicate functional ranges of impairment: Within Normal Limits; Mildly Impaired; Moderately Impaired; or Severely Impaired. Several levels of interpretation are offered, allowing various professionals--from school psychologists to neurologists--to benefit from battery results.

Developmental Test of Visual-Motor Integration (VMI) 5th Edition
by Keith E. Beery, Ph.D. and Norman A. Buktenica, and Natasha A. Beery

This highly acclaimed test measures visual-motor integration in children and adults. Backed by decades of research and clinical use, the VMI, in its fifth revision, offers a convenient and economical way to screen for visual-motor deficits that can lead to learning and behavior problems. While it is used primarily with young children, the VMI can also be administered to adolescents and adults.

The Fifth Edition extends the norms downward to 2 years of age, offers five new teaching tools, and includes a fully revised Manual, with approximately 600 age-specific norms, from birth through age 6. These norms reflect developmental "stepping stones" identified by research. They have proven useful in helping parents understand their child's current level of development.

The Fifth Edition was standardized on a national sample of 2,512 individuals aged 2 to 18.

The test presents the examinee with drawings of 24 geometric forms, arranged in developmental sequence, from less to more complex. The examinee simply copies these forms in the Test Booklet. The test can be individually or group administered in just 10 to 15 minutes. A Short Form, composed of 15 drawings, is often used with 3- to 8-year-old children.

Two supplemental test--the VMI Visual Test and the VMI Motor Test--can each be administered in 5 minutes or less. They are generally given if full- or short-form VMI results indicate a need for further testing. The supplemental tests use the same VMI stimulus forms, so it's easy to compare results from all three tests, using a profile form provided in the Test Booklet.

A revised scoring system permits finer discrimination between performances, especially at older age levels. The Manual presents very clear scoring criteria, standard scores, percentiles, and teaching suggestions. It also reports recent medical and neuropsychological applications of the VMI.

Five teaching tools, new to the Fifth Edition, offer activities and exercises that help teachers respond to VMI results. These are described below.

The Adult Version, for use with individuals aged 19 to 100, facilitates the identification of neurological and related problems in the adult population.

One of the most well researched instruments of its kind, the VMI is useful in assessing learning, neuropsychological, and emotional disorders.

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Developmental Scoring System for the Rey-Osterrieth Complex Figure (DSS-ROCF)
Jane Holmes Berenstein, Ph.D. and Deborah Waber, Ph.D.

The DSS-ROCF allows the examiner to objectively evaluate ROCF performance within a developmental context and to determine the age-appropriateness of the child's Copy and Recall productions. The DSS-ROCF measures not only the child's ability to accurately reproduce the figure, but also the child's qualitative, organizational, and stylistic approaches to the figure. Clinical experience has shown that children's responses to the ROCF often predict their responses in comparable situations where novel, complex material is presented.

The DSS-ROCF measures four parameters of ROCF performance: Organization, Style, Accuracy, and Errors. Age-referenced norms for these four parameters provide guidelines for determining the developmental appropriateness of a child's production.

Digit Vigilance Test (DVT)
Ronald F. Lewis, PhD

Sensitive to subtle changes in neuropsychological status, but relatively insensitive to the effect of repeated administrations, the DVT is a simple task designed to measure vigilance during rapid visual tracking and accurate selection of target stimuli. It appears to isolate alertness and vigilance while placing minimal demands on two other components of attention: selectivity and capacity.

- Four color-coordinated Scoring Keys.

- Administration and scoring can be accomplished by individuals with no formal training under the supervision of a qualified psychologist. Interpretation within the context of a comprehensive neuropsychological evaluation requires training in clinical psychology or neuropsychology.

- Respondents are asked to find and cross out either "6s" or "9s," which appear randomly within 59 rows of single digits.

- The 59 rows of digits are printed in red on the first stimulus page and in blue on the second.

The Dot Counting Test (DCT)
Kyle Boone, Ph.D., Po Lu, Psy.D., and David Herzberg, Ph.D.

The *Dot Counting Test* (DCT) is a brief task that assesses test-taking effort in individuals ages 17 and older. This convenient instrument allows you to detect lack of effort on cognitive measures, whether it is intentional (malingering) or unintentional (unconscious). The DCT measures an "overlearned" skill that is preserved in all but the most severe brain injuries. Because of this, a poor performance on the DCT suggests lack of effort. A validity study reported in the manual compared the DCT scores of 85 "suspect effort" patients (previously identified as "under attempters" by rigorous inclusion and exclusion criteria) to those of patients in seven "normal effort" diagnostic groups: Depression, Schizophrenia, Head Injury, Stroke, Learning Disability, Mild Dementia, and Nonclinical. This study verified the ability of the DCT to discriminate among patients based on their effort status. In interpreting DCT results, you can select a cut off score that minimizes false positives while maintaining adequate sensitivity to "suspect effort." Simply compare the patient's performance to that of a similar reference group. The DCT is highly useful in any setting where examinees have external incentives to fabricate or exaggerate cognitive problems—personal injury litigation, disability evaluations, and criminal cases, for example. The test's usefulness, however, reaches far beyond these situations. Routine assessment of effort often reveals unexpected features of other clinical complaints. For instance, patients who fail effort tests are sometimes found to have factitious or somatoform disorders. Even patients who have legitimate brain injuries sometimes exaggerate existing problems or fabricate new symptoms to ensure that their complaints are taken seriously. Administered and scored in less than 10 minutes, the DCT can easily be added to routine assessment practice, rather than limited to forensic and disability cases. Its value in research is also apparent, especially in studies focusing on disorders that can't be independently confirmed through laboratory or imaging tests.

Ecologically Oriented Neurorehabilitation of Memory (EON-MEM)
by Anthony Y. Stringer, Ph.D.

The EON-MEM is a systematic, structured, and detailed cognitive rehabilitation program designed to help patients overcome memory impairment. Incorporating the author's 20 years of experience in cognitive rehabilitation and best empirical practices, the EON-MEM is ideal for adults with mild to moderate memory impairments caused by neurological conditions, including stroke, traumatic brain injury, and brain tumors.

Incorporating mnemonic strategies and written aids, the EON-MEM introduces a simple, practical way to improve memory. Using the **W**rite-**O**rganize-**P**icture-**R**epeat (WOPR) method, along with an ingenious rhyming technique, EON-MEM helps patients recall information they need to function in their daily lives.

The program includes a Therapist Guide and a Patient Workbook. The Therapist Guide provides step-by-step instructions, making it easy for both novice and experienced clinicians to use. It walks you through the program, explaining what to say and do with the patient in each session. The EON-MEM system is consistent across patients, quickly mastered by clinicians, and useful for outcome evaluation studies of cognitive rehabilitation.

Each patient receives a Patient Workbook, in which he or she practices skills taught by the therapist. Homework assignments save the therapist time, as substantial progress can be made between sessions. Included in the Patient Workbook is *The Memory Strategies and Concerns Questionnaire*, a self-report inventory that allows the therapist to collect information on the kinds of everyday memory problems a patient is experiencing, the subjective severity of those problems, and the strategies that the patient

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currently uses to compensate for his or her impairment. Administered before and after treatment, this questionnaire allows you to demonstrate and monitor the efficacy of the program, create individualized treatment plans, monitor change in the patient's subjective experience of his or her everyday memory, and increase the patient's knowledge of memory improvement strategies.

Implemented in 21 sessions of 1 to 2 hours each, the program allows for considerable flexibility and individualization and actively solicits input from the patient in order to address his or her treatment needs. Session topics include learning numbers and appointments, remembering future tasks and locations of objects, and recalling names, faces, and biographical information. The program can be easily shortened to focus on the areas most critical to the individual. With a strong emphasis on oral and written information, the EON-MEM is useful, practical, and designed to improve necessary skills and everyday functioning.

Electronic Tapping Test

Here is an accurate, easy-to-use finger or foot tapping measure for neuropsychological evaluation. This redesigned, compact electronic tapper automatically starts a 10-second timer as soon as the first tap is made. The digital display shows a dash (--) until 10 seconds are up—at which point it shows the number of taps made during that interval. Additional taps, made after the 10-second period has elapsed, are not recorded. Measuring 4½" x 2¾" x 1" high, this pocket-size unit comes in a sturdy but lightweight plastic housing. It operates on a single 9-volt battery (not included) and requires no adapter. Normative data confirm that results obtained using this tapper is comparable to those obtained from mechanical tappers. Norms included with the Electronic Tapping Test are based on a sample of 184 individuals, ages 16 and up. They are provided separately for males and females, for various age groups, and for preferred and non-preferred hands.

Executive Control Battery (ECB)
E. Goldberg, K.Podell, R. Bilder and J. Jaeger

The Executive Control Battery has been designed to document the presence and the extent of the "executive dyscontrol" or "frontal lobe" syndrome. It was created as a result of the work done by Alexander Luria and Elkhonon Goldberg whilst studying patients with focal prefrontal lesions.

The battery is one of a kind amongst other similar tests in the area showing much greater sensitivity and specificity in measuring deficits resulting from the "frontal lobe" syndrome.

The battery consists of four subtests: (1) the Graphical Dequences Test; (2) the Competing Programs Test; (3) the Manual Postures Test; and (4) the Motor Sequences test each of which can be administered on its own or altogether. Distinct patterns of performance on each subtest indicate various aspects of the executive dyscontrol syndrome.

Extended Complex Figure Test (ECFT)
Philip Fastenau, Ph.D.

The *Extended Complex Figure Test* (ECFT) retains the strengths and overcomes the limitations of the *Rey-Osterrieth Complex Figure Test (*CFT), a standard measure of perceptual organization and visual memory in brain-injured individuals. By adding Recognition and Matching Trials to the CFT's design copying task, the ECFT allows clinicians to distinguish perceptual operations from constructional skills, and encoding processes from retrieval processes. This gives the ECFT greater diagnostic sensitivity. The ECFT is useful not only in evaluating the effects of head injury, stroke, seizure, various medical conditions, and exposure to neurotoxins, but also in differentiating depression from dementia; distinguishing dementia-related memory deficits from normal, age-related memory lapses; and identifying aspects of memory functioning relevant to rehabilitation.

Facial Recognition
Arthur L. Benton, PhD

A 3-part standardized measure of the ability to match unfamiliar faces. Contains a 27-item short form and a 54-item long form.
This test has demonstrated validity and provides additional substantive data in the evaluation of brain-damaged patients.

Frontal Systems Behaviour Scale™ (FrSBe™)
Janet Grace, PhD, Paul F. Malloy, PhD

The FrSBe, formerly known as the Frontal Lobe Personality Scale (FLoPS), provides a brief, reliable, and valid measure of three frontal systems behavioural syndromes: apathy, disinhibition, and executive dysfunction. It also quantifies behavioural changes over time by including both baseline (retrospective) and current assessments of behaviour.

Research has demonstrated that many individuals with frontal lobe damage are capable of normal performance on traditional neuropsychological measures. However, their behaviour in natural settings is often disordered, resulting in severe impairment in social and occupational functioning. The FrSBe fills a gap in the assessment of frontal systems behavioural syndromes by providing a means to identify and quantify these behavioural problems so that they may be targeted for treatment.

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The FrSBe includes a Total Score, as well as scores on three subscales related to the three frontal systems behavioural syndromes: Apathy (14 items), Disinhibition (15 items), and Executive Dysfunction (17 items). This 46-item, paper-and-pencil behaviour rating scale is much easier and less time-consuming to administer than a neuropsychological test battery. Two hand-scorable, carbonless test booklets are available: one for self-rating and one for rating by a family member or caregiver. Each item is rated on a 5-point Likert scale. Items are written at a 6th-grade reading level. Two profile forms (Self and Family) allow comparisons of behaviours pre- and post-injury/illness.

The Professional Manual provides normative data for a community-based sample of 436 men and women for two levels of education (i.e., $\leq$12 years and >12 years). Data also provided for several clinical groups, including patients with frontotemporal dementia, frontal lesions, nonfrontal stroke, head injury, Alzheimer's disease, Huntington's disease, and Parkinson's disease.

The FrSBe is particularly useful to neuropsychologists, clinical psychologists, rehabilitation psychologists and counselors, behavioural neurologists, neuropsychiatrists, and occupational therapists and speech pathologists who provide cognitive rehabilitation services.

The FrSBe can be administered to individuals or groups (ages 18-95 years) in 10 minutes. Scoring takes 10-15 minutes.

Halstead Russell Neuropsychological Evaluation System, Revised (HRNES-R)
Elbert W. Russell, Ph.D., and Regina I. Starkey
This convenient computer scoring system, available on an unlimited-use disk or CD, makes it easier to tailor your neuropsychological exam to the patient's particular needs.

Hooper Visual Organisation Test (VOT)
H. Elston Hooper, Ph.D.

This brief screening test measures the individual's ability to organise visual stimuli - a task that is particularly sensitive to neurological impairment. It taps both general and specific cognitive functions, including: Arousal, Visual analysis and synthesis, Concept formation, Short and long term memory, Written or oral labelling of familiar objects.

The test consists of 30 line drawings, each showing a common object - such as an apple or a ball - that has been cut into several pieces. The pieces are scattered on the page like parts of a puzzle. The client's task is to identify what the object would be if the pieces were put back together correctly.

The VOT minimizes situational factors, such as low motivation or inattention on the client's part, which can lead to diagnostic error. It is relatively independent of distractibility or verbal ability and doesn't require a motor response. The test is non-threatening and it usually engages even the most reluctant clients. Those who can't come up with the correct answers can still respond to the items in

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some way. This allows the clinician to successfully test individuals who might refuse to co-operate on an intellectual task where failure is more obvious.

Hopkins Verbal Learning Test-Revised™ (HVLT-R™)
Jason Brandt, PhD, Ralph H. B. Benedict, PhD

THE HVLT-R offers a brief assessment of verbal learning and memory (recognition and recall) for individuals 16 years and older. It is easy to administer and score and is well-tolerated even by significantly impaired individuals. Its use has been validated with brain-disordered populations (e.g., Alzheimer's disease, Huntington's disease, amnestic disorders).

The Professional Manual provides information on administration and scoring, interpretation (including four case examples), development and psychometric characteristics, reliability, and validity of the instrument. Raw score to T-score conversions by age group are provided in the Appendix.

Six distinct forms of the HVLT-R are available, eliminating practice effects on repeated administrations. Each form consists of a list of 12 nouns (targets) with four words drawn from each of three semantic categories. The semantic categories differ across the six forms, but the forms are very similar in their psychometric properties. Each form is printed in a different colour.

The HVLT-R tasks include three learning trials, a delayed recall trial (20-25 minute delay), and a yes/no delayed recognition trial. This latter trial consists of a randomized list that includes the 12 target words and 12 nontarget words, six of which are drawn from the same semantic categories as the targets. Raw scores are derived for Total Recall, Delayed Recall, Retention (% retained), and a Recognition Discrimination Index.

The HVLT-R has high test-retest reliability, and its construct, concurrent, and discriminant validity have been well established. The normative sample included 1,179 community residents (300 men, 879 women), who reported being free of neurological or psychiatric disorders. Their ages ranged from 16-92 years (M = 59 years), and their educational backgrounds ranged from 2-20 years (M = 13.5 years).

The HVLT-R was intentionally designed to be methodologically similar to the Brief Visual Memory Test-Revised (BVMT-R; Benedict, 1997). Both tests share the same administration procedures (three learning trials, delayed recall, and delayed recognition). The HVLT-R assesses verbal learning and memory while the BVMT-R measures visual learning and memory.

HVLT-R/BVMT-R Professional Manual Supplement
The HVLT-R/BVMT-R Professional Manual Supplement provides information on the development, use, and interpretation of several new scores, including Reliable Change scores and Discrepancy scores.

Hopkins Verbal Learning Test-Revised™/Brief Visuospatial Memory Test-Revised™ Software Portfolio (HVLT-R™/BVMT-R™ SP)

Ralph H. B. Benedict, PhD, Jason Brandt, PhD, and PAR Staff

Because of their brief and complementary nature, the HVLT-R and BVMT-R are often administered together. The new HVLT-R/BVMT-R SP provides unlimited scoring and reporting for both instruments after hand entry of an individual's raw scores. Several new scores have been developed, including:

- *T* scores for Trials 1, 2, and 3 of the HVLT-R.

- Reliable Change Scores (evaluates change in scores over time for the HVLT-R and BVMT-R Total Recall and Delayed Recall scores).

- Discrepancy Scores (compares a client's auditory/verbal [HVLT-R] and visual/spatial [BVMT-R] memory test performances; also calculated for Total Recall and Delayed Recall scores).

The software generates up to five reports:

- **HVLT-R Score Report**--provides raw scores, *T* scores, percentiles and profiles; also includes new *T* scores for Trials 1, 2, and 3.

- **HVLT-R Longitudinal Report**--includes the new Reliable Change Score.

- **BVMT-R Score Report**--provides raw scores, *T* scores, percentiles and profiles.

- **BVMT-R Longitudinal Report**--includes the new Reliable Change Score.

- **HVLT-R/BVMT-R Discrepancy Report**--includes the new Discrepancy Score.

HVLT-R/BVMT-R Professional Manual Supplement

The Professional Manual Supplement provides information on the development, use, and interpretation of new scores. In addition, normative data are included for all new scores.

Requirements: Windows® 2000/XP/Vista™; NTFS file system; CD-ROM drive for installation; Internet connection or telephone for software activation

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Intermediate Booklet Category Test (IBCT)
Paul B. Byrd, Ph.D.

This booklet version of the Halstead Category Test (CT) can be used to help discriminate normal students from those with learning and behavior disorders. Equivalency studies reported in the manual support using the IBCT as an alternative form of the CT.

The IBCT consists of 168 stimulus items in 6 subtests. Presented in the same format as the Booklet Category Test, the white designs on black backgrounds duplicate the designs used in the original slide version.

Interference Learning Test (ILT)
Michael M. Schmidt, Ph.D., and Frederick L. Coolidge, Ph.D
.

This multiple-trial verbal learning and memory test offers innovative design and psychometric sophistication. Ongoing interference with the learning process is embedded into the test procedure. This interference taxes source memory, invites intrusion errors, and impedes efforts to organize the material to be learned. In doing so, it frees the ILT from the ceiling effects that limit many other neuropsychological tests—making the ILT ideal for detecting mild and moderate as well as severe impairment. In addition, this ongoing interference establishes learning conditions more similar to those encountered in everyday life. The ILT is composed of two word lists. List 1 includes 20 target words and 24 distracters. List 2 presents 16 targets and no distracters. Each word is printed on a separate card—targets on white cards, distracters on blue. The examinee is instructed to read all the words aloud while trying to learn the targets and ignore the distracters. Four trials are administered for List 1, then two trials for List 2. The examinee is then asked to recall List 1 targets. After a 30-minute interval filled with nonverbal tests, the examinee is again asked to recall List 1 targets. This is followed by a category cued recall trial, a recognition memory trial, and an indirect memory task.

Integrated Visual and Auditory Continuous Performance Test (IVA)
by Joseph A. Sandford, Ph.D. and Ann Turner, M.D.

In just 13 minutes, this unique continuous performance test assesses impulsivity, inattention, and hyperactivity in individuals ages 6 to 96. And the computer does almost all the administration, scoring, and test-retest comparisons.

The IVA is the only continuous performance test to combine visual and auditory stimuli. And it's the first to provide an objective measure of fine motor hyperactivity. The IVA is an excellent way to differentiate ADHD Predominantly Inattentive Type, ADHD Predominantly Hyperactive-Impulsive Type, and ADHD Combined Type.

The client sits at the computer, instructed to click the mouse only when he or she sees or hears a "1" and not to click when he or she sees or hears a "2." Some portions of the test "pull for" errors of commission (impulsivity), while others pull for errors of omission (inattention). Administration and scoring are fully automated, and test instructions are presented both visually and aurally by the computer.

The IVA produces quotient scores for impulsivity and inattention. These identify performances outside the norm. In addition, it gives you a separate scale of fine motor

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hyperactivity based on impulsive and off-task behavior with the mouse. Twenty-two other scale scores help you pinpoint differences in auditory and visual processing related to impulsivity, attention, focus, stamina, motivation, consistency, speed, and learning problems.

Normative information is based on a sample of more than 1,700 individuals from 6 to 96 years of age, screened to rule out attention, learning, neurological, and psychological problems. Norms are separated by sex and age.

Because the IVA assesses auditory and visual modalities for both inattention and impulsivity, it functions as four CPTs in one. It provides immediate analysis, and stores data for future comparisons. An automated test-retest analysis lets you quickly assess the effects of treatment or medication. IVA has demonstrated 92% sensitivity (i.e., an 8% rate of false negatives) and 90% specificity (i.e., a 10% rate of false positives) in differentiating ADHD and normal children. Also, recent research has shown the test 97% accurate in differentiating individuals with mild traumatic brain injury from normals (with age and education controlled).

IVA now comes with The Investigator, an unlimited-use program that lets you analyze your client's performance. Comparing performance test by test, quintile by quintile, or response by response, you can use The Investigator to titrate medication more accurately, evaluate treatment effectiveness, judge the client's stamina, demonstrate progress to parents or insurance companies, or export data into statistical programs for further study.

Hardware requirements: *Pentium 166 or higher PC compatible processor, DirectX 7 (Included on IVA CD), 100 MB available hard drive program space, 32 MB RAM, Windows ME/2000/XP/Vista, VGA Color Monitor, 4X CD ROM, External Speakers or Headphones, USB Mouse, Sound Card.*

Judgment Of Line Orientation
Arthur L. Benton, PhD

This is a standardized measure of visuospatial judgment in two alternate forms. The spiral-bound booklet contains 35 stimuli, five of which are practice items.

This test has demonstrated validity and provides additional substantive data in the evaluation of brain-damaged patients. This test is designed to be quickly and easily administered, minimizing patient fatigue and maximizing the collection of reliable neuropsychological test data. Normative and validity data are described in the manual, *Contributions to Neuropsychological Assessment*, which must be purchased separately.

Kent Visual Perceptual Test (KVPT)

Lawrence E. Melamed, PhD

The KVPT is an integrated battery of interrelated tests that demonstrate impairment and distinguish skill levels among three visual processes related to the development of basic reading, early mathematics, and written expression. These tests are particularly effective in both individualized neuropsychological assessment and psychoeducational assessment.

The KVPT-D (Discrimination) requires the individual to select (from a set of alternatives) the item that matches a standard form. Stimuli are presented in a binder for ease of administration.

The KVPT-C (Copy) consists of three increasingly difficult subtests that require the individual to reproduce forms of the same type as the KVPT-D items.

The KVPT-M (Immediate Memory) requires the individual to locate a target form within a set of alternatives immediately following a brief exposure to the form. Stimuli are presented in a binder for ease of administration.

For neuropsychological assessment, the KVPT can be used as the core visual processing battery to characterize visual-perceptual deficits and distinguish them from visual memory or visual motor problems. Use the KVPT to distinguish visual-spatial errors or to distinguish a deficit due to errors in processing the spatial features of forms from errors in reproducing (copying) the forms. The KVPT is sensitive to stroke-related deficits.

In a school setting, the KVPT can help professionals in school psychology and/or special education to predict early achievement and to identify and remediate reading, mathematics, and written expression difficulties due to visual processing (e.g., determining that a child with difficulty identifying appropriate mathematical operations has a visual-spatial processing deficit). The Professional Manual provides a chapter on clinical interpretation that demonstrates the way appropriate academic interventions can be developed based on a child's KVPT profile.

All three tests come from a common pool of two-dimensional items based on form perception literature, assuring both construct validity and comparability in processing difficulty. Although the KVPT was normed with all three tests administered, it is possible to use only one or two of the tests so long as the tests are presented in the following order: KVPT-D, KVPT-C, KVPT-M.

Specific scoring criteria and examples are provided for each test. Standard scores and percentile ranks are provided by gender for all three KVPT tests for children ages 5-11 years. Additional normative data are provided by gender for KVPT-D and KVPT-M scores for adults ages 18-22 years and for all three KVPT tests for older adults ages 55-91 years. Comprehensive norms are provided for both level of performance and error analysis, facilitating both brief and in-depth analysis of deficits in visual processing. Normative data for the KVPT-D and the KVPT-M allow for quantitative evaluation of rotation (spatial) errors, nonrotation (patterns of organization or content) errors, and errors due to the complexity of the item.

Koppitz Developmental Scoring System for the Bender Gestalt Test -- Second Edition (KOPPITZ-2)
by Cecil R. Reynolds, Ph.D.

This revision of Elizabeth Koppitz's Bender Gestalt scoring system retains the developmental approach that made the original so popular while adding new norms, an expanded age range, and improved reliability. These changes give clinicians and educators a highly useful measure of visual-motor integration across the life span.

Using the Bender Gestalt II Stimulus Cards, the KOPPITZ-2 requires the examinee to draw increasingly complex figures on a plain sheet of white paper. This relatively unstructured task assesses the individual's ability to relate visual stimuli to motor responses and to organize the effort independently.

Individually administered in just 5 to 10 minutes, the KOPPITZ-2 includes the following key features:

- New norms based on a nationally representative sample of 3,600 people
- An expanded age range -- from 5 to 85 years (which allows evaluation of special education students up to age 21)
- Separate scoring systems for young children (ages 5 to 7 years) and older children and adults (ages 8 to 85+ years)
- The addition of two- and three-dimensional drawings for older children and adults -- drawings that can reveal subtle visual-motor integration deficits
- A completely nonverbal format that makes the test appropriate for individuals from all cultural and ethnic backgrounds
- High reliability across age, gender, and ethnicity
- Detailed scoring guidelines that insure high interscorer reliability
- A variety of scores -- standard scores, percentile ranks, specialized scores, and age equivalents -- to meet the needs of all practitioners
- A separate section of the Manual explaining how to use Koppitz Emotional Indicators (EIs) and a specialized form for this purpose

More clinically useful than ever, the KOPPITZ-2 can help you determine the presence and degree of visual-motor problems; identify candidates for remediation or visual-motor training; monitor progress in cases of acute injury or degenerative disease; and evaluate the effectiveness of intervention efforts.

Learning and Memory Battery (LAMB)
James P. Schmidt, Ph.D. and Tom N. Tombaugh, Ph.D.

The Learning and Memory Battery (LAMB) assesses both specificity and sensitivity to diverse memory problems. With the use of test administration methods already familiar to practitioners who evaluate memory functioning, LAMB provides a uniform format for unambiguous test interpretations. The LAMB evaluates learning and retention across several dimensions, including initial versus repeated trial learning, immediate versus delayed recall, and free versus cued versus recognition recall. It also evaluates verbal, visual, and numerical learning and retention.

The LAMB consists of the following subtests: (1) Paragraph Learning; (2) Word List Learning; (3) Simple Figures (drawn); (4) Word Pair Learning; (5) Complex Figure; and (6) Digit Span and Supraspan Learning.

Luria-Nebraska Neuropsychological Battery (LNNB)
Charles J. Golden, Ph.D., Arnold D. Purisch, Ph.D., and Thomas A. Hammeke, Ph.D.

This widely used battery takes the clinical procedures of neuropsychologist A. R. Luria and adds standardized administration and scoring to produce a comprehensive but convenient measure of neuropsychological functioning. The LNNB is used to diagnose cognitive deficits, including lateralization and localization of focal brain impairments. Unlike other neuropsychological tests, which give only a global measure of cerebral dysfunction, the LNNB also detects very specific problems, as well as mild impairment that might otherwise go unnoticed. Designed for individuals ages 15 and older, the LNNB has also been used successfully with 13- and 14-year-olds. It assesses a wide range of cognitive functions. In addition, 28 factor scales reflect more specific sensory and cognitive functions. The LNNB can be administered in only 1.5 to 2.5 hours. Depending on the patient's condition, it can be given in a single session or in a series of brief sessions. Completely portable, it can even be given at bedside if necessary. The battery is available in two equivalent forms: Form I (269 items) and Form II (279 items). Although they yield similar information, Form II features improved Stimulus Cards that are much easier to use. They are spiral bound, rather than loose, and are arranged in the proper sequence. Also, Form II includes one additional scale, Intermediate Memory, which permits more detailed memory assessment. In addition, Form II is computer scored only, while Form I can be scored by hand or computer.

Luria-Nebraska Neuropsychological Battery Children's Revision (LNNB-C)
Charles J. Golden, Ph.D

This Children's Revision of the widely used Luria-Nebraska Neuropsychological Battery (LNNB) offers the same comprehensiveness and flexibility of the adult version, in a form designed for 8- to 12-year-olds. It assesses cognitive deficits. The LNNB-C uses the same stimulus materials as Form I of the adult version, with the addition of three extra cards and an audiotape. Like the adult version, the LNNB-C is comparatively easy to administer and score. Typically, it takes about 2.5 hours to give the complete battery, which can then be hand or computer scored.

MATRICS™ (Measurement and Treatment Research to Improve Cognition in Schizophrenia) Consensus Cognitive Battery (MCCB™)

Keith H. Nuechterlein, PhD and Michael F. Green, PhD

Cognitive deficits, including impairments in such areas as memory, attention, and executive function, are a major determinant and predictor of long-term disability in schizophrenia. Unfortunately, available antipsychotic medications are relatively ineffective for improving cognition. Scientific discoveries during the past decade suggest that there may be opportunities for developing medications that will be effective for improving cognition in schizophrenia. To aid in that process, the MATRICS (Measurement and Treatment Research to Improve Cognition in Schizophrenia) Consensus Cognitive Battery (MCCB) has been developed to help researchers and clinicians measure cognition in individuals diagnosed with schizophrenia and related disorders.

The MCCB is a standardized battery that is intended for use with adults with schizophrenia and related disorders. It consists of 10 individually administered tests to measure cognitive performance in the following seven domains: Speed of processing, Attention/Vigilance, Working memory, Verbal learning, Visual learning, Reasoning and problem solving, and Social cognition.

Special Features of the MATRICS Consensus Cognitive Battery

- The MCCB is the result of a unique broad-based consensus process that included the academic community, the National Institutes of Health (NIH), the U.S. Food and Drug Administration (FDA), and the pharmaceutical industry.

- It assesses the key separable cognitive deficits of schizophrenia, using tests that experts selected as best suited for this purpose.

- Standardized battery with co-norming of 10 component tests, the MCCB exhibits high test-retest reliability and has high utility as a repeated measure.

- The MCCB has a demonstrated relationship to functional outcome and high tolerability by respondents.

- The MCCB provides convenient administration, scoring and conversion to standardized scores, and creation of a computer data file of summary scores.

Materials
The MATRICS Consensus Cognitive Battery (MCCB) Kit includes materials for 25 administrations of the entire battery. The MCCB Retest Packet includes the materials needed for 25 additional administrations. For situations in which practice effects with repeated administration can occur, alternate forms are available as part of the Retest Packet.

The MCCB Manual contains information about the development, reliability and validity, standardization, administration, and scoring of the battery. The MCCB Administrator's Form is to be used by test administrators to record results for one respondent. In some cases (for HVLT-R™ and NAB® Mazes), there is a separate booklet or form to use, which then gets attached to the MCCB Administrator's Form. For three of the tests in the battery, the respondent marks in the MCCB Respondent's Booklet. For one test (CPT-IP), the responses are made via a computer program. For all the other tests, administrators record the responses.

Uses of the MATRICS Consensus Cognitive Battery
This battery is intended to provide a relatively brief evaluation of key cognitive domains that are relevant to schizophrenia and related disorders. It was designed for the following purposes:

- As an outcome measure for clinical trials of cognition-enhancing drugs for schizophrenia,

- As an outcome measure for studies of cognitive remediation,

- As a sensitive measure of cognitive change in other repeated testing applications, and

- As a cognitive reference point for non-intervention studies of schizophrenia and other severe psychiatric disorders.

Administration and Scoring
Each of the 10 tests should be individually administered. Testing can usually be completed in one session lasting approximately 1 to 1.5 hours. A template is provided in the Kit to use in scoring the BACS Symbol-Coding test. Results for MSCEIT Managing Emotions and CPT-IP are computer-generated. The front of the Administrator's Form has places to record the raw scores.

Normative data for the battery allow age and gender correction; age, gender, and education correction; or no demographic correction. Both *T* scores and percentiles are available. The MCCB Computer Scoring Program allows entry of the primary raw scores on a PC and then provides the corresponding *T* scores and percentiles and a graphic profile of the *T* scores for each of the seven cognitive domains. This Scoring Program also produces a data file for entry of data into statistical programs for group analyses.

Mini-Mental State Examination (MMSE)
by Marshal F. Folstein, M.D., Susan E. Folstein, M.D., and Paul R. McHugh, M.D

The MMSE is a brief, quantitative measure of cognitive status in adults. It can be used to screen for cognitive impairment, estimate the severity of cognitive impairment at a given time, monitor cognitive change over time, and document response to treatment.
    Individually administered in just 5 to 10 minutes, the MMSE involves brief tasks or questions assessing orientation to time, orientation to place, registration, attention and calculation, recall,

naming, repetition, comprehension, reading, writing, and drawing. A convenient new "all-in-one" test form includes a detachable sheet with stimuli for the comprehension, reading, writing, and drawing tasks.

Every package of test forms contains a new pocket-sized User's Guide with detailed administration and scoring instructions plus recommended cutoff scores for classifying the severity of cognitive impairment. This handy User's Guide also provides population-based normative data (by age and years of education). These norms allow you to compare an individual's MMSE Score with the appropriate reference group, and they make it easier to interpret the scores of individuals who are illiterate, older than 80, or lacking more than 9 years of formal education.

A new Clinical Guide to the MMSE describes the development, validation, administration, and interpretation of the exam. It provides in-depth information about using the MMSE in diagnosis and treatment. In addition, a convenient laminated Pocket Norms Card gives you raw score to T-score conversions for 14 age and education groups--making it ideal for use in clinical settings.

Motor-Free Visual Perception Test--Vertical (MVPT-V)
by Louisette Mercier, OT, M.A., Jean Hebert, Ph.D., Ronald P. Colarusso, Ed.D., and Donald D. Hammill, Ed.D.

Adapted from the widely used MVPT-3 for use with adults, this version of the test presents all stimuli vertically, at visual midline, rather than horizon- tally across the page. This modification reduces the effect of hemifield visual neglect (HVN), a common result of brain injury. HVN interferes with the patient's ability to attend to a portion of the horizontal visual field, even though his or her vision, per se, may be normal. Patients with HVN may score low on tests with horizontally presented stimuli not because of visual perception problems but because of visual attentional difficulties.

The MVPT-V lessens the effect of HVN by presenting all stimuli at visual midline. This is helpful not only in planning rehabilitation for brain-injured adults but also in assessing individuals with learning disabilities, who often have similar visual attentional deficits.

The test provides separate norms for adults with and without head injury. Because visual perception is considered mature by age 10, the MVPT-V can be used with anyone over that age.

Memory Assessment Scales™ (MAS®)

J. Michael Williams, PhD

The MAS is a comprehensive battery that assesses short-term, verbal, and visual (nonverbal) memory functioning in individuals ages 18-90 years. Verbal and visual tasks use both recall and recognition formats and assess memory immediately after stimulus presentation as well as after a delay period.

The MAS has been designed for use by clinical and consulting psychologists, as well as researchers. Its self-contained easel format increases ease of use and greatly simplifies administration.

The MAS consists of 12 subtests based on the following seven memory tasks: Verbal Span, List Learning, Prose Memory, Visual Span, Visual Recognition, Visual Reproduction, and Names-Faces.

The 16-page record form contains instructions for the clinician to use during administration of the seven memory tasks. Three of the tasks are administered entirely from the record form. The Visual Span, Visual Recognition, Visual Reproduction, and Names-Faces tasks require the accompanying stimulus card set for administration.

MAS administration requires only the stimulus card set (contained in an easel format) and the record form.

The MAS can be scored in 10-15 minutes. The resulting Global Memory and Summary Scale scores provide measures of overall memory performance, short-term memory, verbal memory, and visual memory. All measures have a mean of 100 and a standard deviation of 15.

Subtest scale scores have been derived to have a mean of 10 and a standard deviation of three. They can be profiled by functional memory area to facilitate scale comparison. Process scores from subtests using the List Learning task can be calculated to examine cognitive learning strategies and problems involving encoding and retrieval.

The MAS normative sample is based on data collected from 843 adults. Normative tables facilitate interpretation for a variety of clinical questions: norms based on 843 adults by age decade, norms based on 843 adults by age and education levels, and norms based on 467 adults selected to match the U.S. census on the basis of age, education, and gender.

Reliability/Validity

Generalizability coefficients (reliability estimates), calculated for all three sets of norms, ranged from .70-.95 for MAS subtests, .86-.92 for the Summary Scales, and .94-.95 for the Global Memory Scale. Validity data demonstrate that MAS scores distinguish normal from neurologically impaired subjects and produce expected profiles for criterion groups of patients with neurological disorders, such as dementia, closed head injury, left-hemisphere lesions, and right-hemisphere lesions.

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Multilingual Aphasia Examination, 3rd Edition (MAE)

Arthur L. Benton, PhD, Kerry deS. Hamsher, PhD, Abigail B. Sivan, PhD. MAE Spanish Version by Gustavo J. Rey, PhD, Abigail B. Sivan, PhD, Arthur L. Benton, PhD

The MAE is a relatively brief test battery designed to evaluate the presence, severity, and qualitative aspects of aphasic disorder. Three tests assess different aspects of oral expression--naming, sentence repetition, and verbal associative capacity; three tests assess oral verbal understanding; one test assesses reading comprehension; and three tests assess oral, written and block spelling. Speech articulation and the fluency-nonfluency dimension of expressive speech are rated, but not systematically sampled. Writing is evaluated from performance on the test of written spelling.

As a comprehensive aphasia battery, the MAE complements the use of other tests of neuropsychological function developed at the Benton Laboratory of Neuropsychology. The Manual includes new normative standards for elderly individuals, data on the discriminative value of each test, and recent clinical research results.

Most of the tests were standardized on a sample of 360 subjects, ranging in age from 16-69 years, whose native language was English, and who showed no evidence or history of hemispheric brain disease. The MAE was also standardized on 229 children, ages 6-12 years, who were within the normal range of intelligence.

MAE Tests Include:

Visual Naming
Oral Spelling
MAE Token Test
Reading Comprehension of Words and Phrases
Sentence Repetition
Written Spelling
Aural Comprehension of Words and Phrases
Controlled Word Association
Block Spelling
Rating of Articulation
Rating of Praxic Features of Writing

Neuropsychological Assessment Battery® (NAB®)

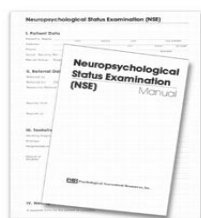Robert A. Stern, PhD, Travis White, PhD

The NAB is a comprehensive, integrated, modular battery of 33 new neuropsychological tests developed to assess a wide array of neuropsychological skills and functions in adults (ages 18-97 years) who have known or suspected disorders of the central nervous system. The individual tests are grouped into six modules: Attention, Language, Memory, Spatial, Executive Functions, and Screening (which allows the clinician to determine which of the other five domain-specific modules are appropriate to administer to an individual patient).

The NAB has excellent psychometric properties, includes extensive normative and validation data, provides clinical information that meets the needs of a broad range of modern referral sources, and offers two equivalent forms that reduce practice effects and facilitate reevaluation. The examiner can administer the entire NAB for a comprehensive evaluation of neuropsychological functioning in less than 4 hours.

The NAB was created and developed over a 7-year period and was funded, in part, through grants from the National Institute of Mental Health. Decisions pertaining to the content and format of the NAB were guided by the results of the publisher's national survey of neuropsychological assessment practices and needs, as well as by the feedback and guidance of members of the NAB Advisory Council (a group of experts recognized nationally in the field of clinical neuropsychology) and numerous other consultants and contributors.

Neuropsychological Status Examination (NSE)

John A. Schinka, PhD

The NSE provides the format for comprehensive data collection as well as a detailed outline for generation of a complete clinical report. Designed to ensure ease of use and rapid accumulation of a comprehensive data base, the neuropsychological activities range from screening procedures to extensive workups and preparation for expert witness testimony. The Neuropsychological Symptom Checklist (NSC) is a 2-page screening instrument, which can be completed by the clinician, the patient, or a significant other in the event that the patient is not capable.

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Neitz Test of Colour Vision

Jay Neitz, Ph.D., Phyllis Summerfelt, and Maureen Neitz, Ph.D.

The *Neitz Test of Colour Vision* is a revolutionary new approach to testing for colour blindness. Developed at the Eye Institute of the Medical College of Wisconsin, the *Neitz Test* is accurate, quick, and inexpensive. It identifies the type and severity of colour vision deficiency in just a few minutes. It can be used with people of any age, including very young children. And it can be administered in fluorescent light, daylight, or a combination of the two—making it much more convenient than competing instruments.

Neuropsychological Impairment Scale (NIS)

William E. O'Donnell, Ph.D., M.P.H., Clinton B. DeSoto, Ph.D., Janet L. DeSoto, Ed.D., and Don McQ. Reynolds, Ph.D.

Here is a quick and convenient way to screen adults for neuropsychological symptoms. This brief self-report questionnaire addresses both global impairment and specific symptom areas, eliciting diagnostically relevant information that might otherwise go unreported. The NIS brings up symptoms that patients often fail to mention in an informal clinical interview. A useful addition to any general psychological evaluation, it is an efficient way to screen for organic problems. Serving as an "early warning system," the NIS can identify areas for inquiry, focus treatment efforts and help determine whether the patient will benefit from therapy. It has proven particularly useful in assessing age- and AIDS-related dementia. Composed of 95 items, the NIS provides three very helpful summary scores, plus subscale scores and validity checks. Written at a fifth-grade reading level, the scale can be completed in just 15 to 20 minutes by anyone over the age of 17. Nonclinical norms, based on a sample of 1,000 adults (18 to 88 years old), are stratified by age (young adult, adult, middle-aged, and elderly). Clinical norms, drawn from a sample of 534 neuropsychiatric patients, are separated by diagnostic group (neurological, psychiatric, alcohol/drug, learning disability, and physical trauma). A second form of the NIS—the Observer Report—presents items in the third person. This nonstandardized form, which can be completed by a relative or close friend of the patient, provides a different perspective on the patient's symptoms. Comparisons of Self and Observer Reports can help the patient understand the impact of his or her deficits and help family members adopt realistic expectations. A third form of the test—the Senior Interview—is useful with older patients who can't complete the NIS Self-Report due to poor vision, strength, or manual dexterity. The Senior Interview consists of 40 questions that are read to the patient by the examiner. The patient indicates his or her response on a large-print visual cue card. This form provides a Global Measure of Impairment and scores for Defensiveness, Affective Disturbance, and Inconsistency. A Subjective Distortion Index can also be calculated if WAIS-R Digit Span and Similarities scores are available.

Philadelphia Head Injury Questionnaire

Lucille M. Curry, Ph.D., Richard G. Ivins, Ph.D., and Thomas L. Gowen, J.D.

This convenient questionnaire answers the need for a detailed history-gathering instrument designed specifically for individuals who have sustained head injuries. It can be used by all

professionals— neuropsychologies, psychologists, neurologists, attorneys, and others—who are involved with head trauma patients. Although it is not a diagnostic tool, this questionnaire is an extremely efficient way to gather and organize information about head trauma. Attorneys will find it useful in screening potential head injury cases, referring clients for diagnosis and treatment, and documenting the injury for purposes of litigation. Medical and mental health professionals will find it equally helpful because it provides an organized record of symptoms.

Portable Tactual Performance Test (P-TPT)
PAR Staff

This portable version of the Tactual Performance Test offers a convenient alternative to the original for use with the Halstead-Reitan Neuropsychological Test Battery. Its unique design, as an attractive wooden carrying case with a handle that doubles as a portable testing easel, facilitates easy storage, handling, and set-up for test administration. The P-TPT Kit includes both 6-hole and 10-hole boards. Appropriate for ages 5 years to adult.

Note: The P-TPT Kit does not include norms. However, norms are available in *A Compendium of Neuropsychological Tests: Administration, Norms, and Commentary, 3rd Ed.* for ages 5-85 years and in the *Revised Comprehensive Norms for an Expanded Halstead-Reitan Battery: Demographically Adjusted Neuropsychological Norms for African American and Caucasian Adults (HRB)* for ages 20 years and older.

Quick Neurological Screening Test II (QNST-II) Second Revised Edition
by Margaret Mutti, M.A., Harold M. Sterling, M.D., N. Martin, and Norma V. Spalding, Ed.D

Here is a rapid and reliable way to identify possible neurological interference in learning. Individually administered to children in grades K--12, the QNST-II assesses 15 areas of neurological integration in approximately 20 minutes. This revision includes the latest research findings concerning the soft neurological signs that may accompany learning disabilities. The test alerts special education professionals to physical problems (in dexterity, visual tracking, spatial orientation, tactile perceptual abilities, and motor skills) that often co-occur with learning disabilities.

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The QNST-II requires the examinee to perform a series of motor tasks adapted from neurological pediatric examinations and from neuropsychological and developmental scales. These nonthreatening tasks sample maturity of motor development, skill in controlling large and small muscles, motor planning and sequencing, sense of rate and rhythm, spatial organization, visual and auditory perceptual skills, balance and cerebellar-vestibular function, and disorders of attention. This revision features clearer instructions, simplified scoring, and a protocol sheet with a handy summary of all subtest scores and classifications as well as the overall score and functional category determination.

Normative data on more than 1,200 regular classroom students and 1,000 learning-disabled subjects are presented in the Manual. Scores are easily recorded as the test is administered. The QNST-II is an excellent way to screen students for suspected learning disabilities.

Recognition Memory Test (RMT)
Elizabeth K. Warrington

This measure of visual and verbal memory allows clinicians to quickly distinguish between right- and left- hemisphere brain damage—and to make judgments about localization. Sensitive enough to detect minor degrees of memory deficit, the *Recognition Memory Test* (RMT) does not tap, and is therefore not diluted by, cognitive skills as is the *Wechsler Memory Scale*. The test consists of two simple subtests, Recognition Memory for Words and Recognition Memory for Faces. It takes less than 15 minutes to administer and is easily scored. Standardization is based on more than 300 individuals, including normal and patients suspected of having neurological disease, brain damage, or head injury. Norms are provided for ages 18–70 years. The RMT is easy-to-use and it provides clinically relevant information for those treating organic neurological disease or dysfunction.

Rey Auditory Verbal Learning Test: A Handbook
Michael Schmidt, Ph.D., ABPP, ABPN

Here is a comprehensive manual for the *Rey Auditory Verbal Learning Test* (RAVLT). This handbook brings together everything the clinician needs to know about this widely used neuropsychological test. Originally developed in the 1940s, the RAVLT has evolved over the years, and several variations of the test have emerged. The standard RAVLT format starts with a list of 15 words, which an examiner reads aloud at the rate of one per second. The patient's task is to repeat all the words he or she can remember, in any order. This procedure is carried out a total of five times. Then the examiner presents a second list of 15 words, allowing the patient only one attempt at recall. Immediately following this, the patient is asked to remember as many words as possible from the first list. The RAVLT has proven useful in evaluating verbal learning and memory, including proactive inhibition, retroactive inhibition, retention, encoding versus retrieval, and subjective organization. Because the test is brief, straightforward, easy to understand, and appropriate for both children and adults (ages 7 through 89), it has gained widespread acceptance. However, until now, data about the RAVLT-norms, validity studies, different administration and scoring procedures-have been scattered in various sources.   What this handbook provides is a definitive guide to the RAVLT-in a single volume. It describes the test, its development, and its use.

Repeatable Battery for the Assessment of Neuropsychological Status (RBANS™)

Christopher Randolph

The RBANS is a brief, individually administered test that helps determine the neuropsychological status of adults ages 20-89 years who have neurological injury or disease such as dementia, head injury, or stroke. You can get a quick sampling of important cognitive areas using content and a format familiar to clinicians who use the Wechsler™ Scales. The overall battery length is less than 30 minutes, in order to maximize patient cooperation and to minimize the effect of fatigue on performance. In addition, the RBANS has two parallel forms, ideal for measuring change in the client's neuropsychological status over time.

The RBANS Can Be Used in a Variety of Ways

- As a stand-alone 'core' battery for the detection and characterization of dementia in the elderly.
- As a neuropsychological 'screening battery' when lengthier standardized assessments are either impractical or inappropriate.
- For repeat evaluations when an alternate form is needed to control for content practice effects.

The RBANS Is Useful in a Variety of Settings

Because the RBANS is a brief, portable, and hand scorable instrument, it is appropriate for use in a variety of settings. You can administer the RBANS for screening for deficits in acute-care settings, for tracking recovery during rehabilitation, for tracking progression in degenerative diseases, or as a neuropsychological screening for non-neuropsychologists who must make referrals to neuropsychologists. Although the RBANS was originally developed with a primary focus on assessment of dementia, it has potential utility for screening neurocognitive status in younger patients.

The RBANS enables you to examine areas of cognitive functioning and profile impairment across domains with 12 subtests, including: List Learning, Story Memory, Figure Copy, Line Orientation, Digit Span, Coding, Picture Naming, Semantic Fluency, List Recall, List Recognition, Story Recall, and Figure Recall.

Reynolds Intellectual Assessment Scales™ (RIAS™)
Cecil R. Reynolds, PhD, Randy W. Kamphaus, PhD

Ruff 2&7 Selective Attention Test (RUFF)
Ronald M. Ruff, Ph.D. and Christopher Allen, Ph.D.

The Ruff 2 & 7 Test was developed to measure two aspects of visual attention: sustained attention (ability to maintain consistent performance level over time) and selective attention (ability to select relevant stimuli while ignoring distractors). The test consists of a visual search and cancellation task. The respondent detects and marks through all occurrences of the two target digits, "2" and "7." In the 10 Automatic Detection trials, the target digits are embedded among alphabetical letters that serve as distractors. In the 10 Controlled Search trials, the target digits are embedded among other numbers that serve as distractors. Correct hits and errors are counted for each trial and serve as the basis for scoring the test. Speed scores reflect the total number of correctly identified targets (hits). Accuracy scores evaluate the number of targets identified in relation to the number of possible targets. A stopwatch is required for administration.

Rivermead Behavioural Memory Test, Third Edition (RBMT-3) Including the Implicit Memory Test (IMT)
by Barbara A. Wilson, Eve Greenfield, Linda Clare, Alan Baddeley, Janet Cockburn, Peter Watson, Robyn Tate, Sara Sopena, and Rory Nannery

(Note: Product will be available for purchase December 2008)

Over the past two decades, the *Rivermead Behavioural Memory Test* has become a preferred measure for assessing everyday memory problems in people with acquired, non-progressive brain injury. This updated edition expands and refines the test's coverage, making it even more clinically useful.

Replacing both the RBMT-II and the RBMT-E, this version covers the full range of memory impairment, from mild to severe. In addition, it adds a separate measure of implicit memory and a new subtest, the Novel Task, which assesses the ability to learn new skills. The other RBMT-3 subtests measure immediate and delayed recall and recognition, plus orientation. All are listed below:

- First and Second Names
- Belongings
- Appointments
- Picture Recognition
- Story
- Face Recognition
- Route
- Messages
- Orientation and Date
- Novel Task

In addition to these subtests, the RBMT-3 provides a completely new measure, the *Implicit Memory Test* (IMT). The first standardized test of implicit memory, the IMT assesses the ability to learn something without necessarily being aware of what has been learned. For example, implicit memory is at work when people acquire certain motor skills, conditioned responses, or habits. The IMT includes two subtests, Fractionated Pictures and Stem Completion, both of which provide information that is useful in planning individualized rehabilitation.

Norms for the RBMT-3 are based on a sample much larger than those used for previous editions of the test. Because the RBMT-3 and IMT were normed together, results from the two tests can be compared.

With expanded coverage and increased sensitivity, the RBMT-3 is an excellent way to measure memory stability, improvement, or deterioration.

Screening Test for the Luria-Nebraska Neuropsychological Battery (ST-LNNB): Adult and Children's Forms
Charles J. Golden, Ph.D.

This convenient screener requires less than 20 minutes, yet accurately predicts overall performance on the *Luria-Nebraska Neuropsychological Battery* (LNNB)—in many cases eliminating the need to administer the full 2.5-hour battery. Like the LNNB, the Screening Test includes both an Adult Form, for individuals 13 years of age or older, and a Children's Form for 8- to 12-year-olds. Each form is composed of 15 items that can be administered and scored by a technician or paraprofessional with minimal training in neuropsychology. Because testing can be discontinued as soon as the client reaches the critical score, administration time often amounts to no more than a few minutes. Items on the Screening Test were selected from the LNNB on the basis of research with more than 500 adults and 350 children. Original screening cut points were independently cross-validated on a second sample of the same size. The test is designed to accurately predict overall LNNB scores and should be used only for that purpose. It should not be used as a separate measure of neuropsychological impairment, but should instead be administered only as a means of identifying those who need further evaluation with the LNNB. Test materials include an Administration and Scoring Booklet and a set of sturdy, spiral bound Stimulus Cards with a convenient built-in stand. These materials can be easily carried or slipped into a briefcase.

Shipley Institute of Living Scale
Walter C. Shipley, Ph.D

This popular measure of intellectual ability and impairment has been used with millions of individuals 14 years of age and older. The Scale is composed of two brief subtests: (1) a 40-item Vocabulary Test that requires the respondent to choose which of four listed words "means the same or nearly the same" as a specified target word; and (2) a 20-item Abstract Thinking Test, which requires the respondent to fill in numbers or letters that logically complete a given sequence. The Manual provides standard scores, updated norms (ages 16 and up), a new impairment index with empirically derived corrections for age and education, age-adjusted norms for estimating WAIS and WAIS-R IQs, and a complete review of the Shipley literature.

Short Category Test, Booklet Format
Linda Wetzel, Ph.D. and Thomas J. Boll, Ph.D.

The *Short Category Test, Booklet Format* (SCT) reduces the length and complexity of the Halstead-Reitan Category Test, one of the most sensitive indicators of brain damage. The SCT includes five subtests, each in a 5" x 7" booklet of 20 Stimulus Cards. As in the original Category Test, the cards show various geometric shapes, lines, colours, and figures. All the cards within each booklet are organized around a single principle.

Symbol Digit Modalities Test (SDMT)
Aaron Smith, Ph.D.

The SDMT has demonstrated remarkable sensitivity in detecting not only the presence of brain damage, but also changes in cognitive functioning over time and in response to treatment.

The SDMT involves a simple substitution task that normal children and adults can easily perform. Using a reference key, the examinee has 90 seconds to pair specific numbers with given geometric figures. Individuals with cerebral dysfunction perform poorly on the SDMT, in spite of normal or above average intelligence.

Studies documented in the SDMT Manual have shown the test effective in a wide range of clinical applications, including: differentiation of brain damaged from psychotic patients, differentiation of organics from depressives, early detection of senile dementia and Huntington's disease, differential diagnosis of children with learning disorders, early identification of children likely to have reading problems, assessment of change in cognitive functioning over time and/or with therapy in individuals with traumatic, vascular, neoplastic and other brain insultsm and assessment of recovery from closed-head injury.

Shipley Institute of Living Scale (SILS)
Walter C. Shipley, Ph.D.

The SILS is a popular measure of intellectual ability and impairment which has been used with millions of individuals 14 years of age and older. The Scale is a quick yet accurate measure of general intellectual functioning and is composed of two brief subtests: 40-item Vocabulary Test that requires the respondent to choose which of four listed words means "the same or nearly the same" as a specified target word and
a 20-item Abstract Thinking Test, which requires the respondent to fill in numbers or letters that logically complete a given sequence.

The SILS is based on clinical and research findings suggesting that intellectual impairment differentially affects various cognitive abilities - vocabulary has proven relatively resistant to change, whereas abstract thinking has been shown to be more susceptible to cognitive deterioration associated with brain dysfunction, mental disorders or normal aging.

This standardized version of the Stroop consists of 2 parts. In the Color Task, the individual reads aloud a list of 112 color names in which no name is printed in its matching color. In the Color-Word Task, the individual names the color of ink in which the color names are printed.

The SNST may be administered and scored by individuals with limited training. Interpretation of the resulting Color and Color-Word scores requires professional training in psychology, psychiatry, or educational testing. A stopwatch is required to administer each 2-minute test.

Serial Digit Learning
Arthur L. Benton, PhD

This test consists of the presentation of either eight or nine randomly selected single digits for a varying number of trials up to a maximum of 12. Three alternate versions are provided for each form. Administration requires 5-10 minutes.

This test has demonstrated validity and provides additional substantive data in the evaluation of brain-damaged patients. This test is designed to be quickly and easily administered, minimizing patient fatigue and maximizing the collection of reliable neuropsychological test data. Normative and validity data are described in the manual, *Contributions to Neuropsychological Assessment*, which may be purchased separately.

Severe Cognitive Impairment Profile™ (SCIP™)
Guerry M. Peavy, PhD

The SCIP is a reliable and valid measure of overall dementia severity, as well as a patient's relative strengths and weaknesses in all the basic areas of cognitive functioning. This assessment tool is designed for patients previously diagnosed with dementia (ages 42-90 years and older) and can provide important information about the degree to which the individual's symptoms are consistent with those of patients with a progressive dementia at various levels of severity. In addition, information about relative strengths and weaknesses in cognitive functioning can lead to ideas concerning the individual patient's care, management, and treatment planning.

One important advantage of this measure over many other neuropsychological tests is that the SCIP items span a wide range of difficulty relevant to severely impaired adults, thus avoiding both floor and ceiling effects in this population. The SCIP is an excellent companion instrument to the Dementia Rating Scale-2™ (DRS-2™)--it picks up where the DRS-2 leaves off. Because of the growing number of severely demented individuals, the increasing survival time for Alzheimer's disease patients in the late stages of dementia, and the challenges these individuals present to caregivers and health professionals, an accurate assessment of cognitive functioning has become increasingly important.

- Provides detailed information about a wide variety of cognitive areas.

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- Eight subtests include measures of Comportment, Attention, Language, Memory, Motor Functioning, Conceptual Reasoning, Arithmetic, and Visuospatial Abilities.
- Scores can be used to identify relative strengths and weaknesses in specific cognitive areas - a key to developing successful strategies for enhancing communication and interactions in clinical and institutional settings.
- Scaled scores facilitate within-subject comparisons of performance across different subtests.
- Total or subtest scores can serve as outcome measures for efficacy studies.
- Total scores yield four levels of impairment: Moderately Severe, Severe, Very Severe, and Profound.

Test results can be used to inform caregivers about the patient's individual needs and to adjust the type and level of care provided throughout the course of the illness. The SCIP also facilitates empirically based estimates of both the capacity for activities required in daily living (ADLs) and the likelihood of psychiatric and/or behavioural difficulties.

Research has shown that the SCIP is reliable with respect to both interrater scoring and temporal stability across a brief retest interval. Highly significant correlations with traditional measures of dementia severity provide strong evidence of construct validity. The SCIP was standardized on a group of 92 well-characterized severely impaired AD patients, and SCIP standardized scores reflect an individual patient's performance relative to this sample. Patients with very severe dementia who scored at or near the floor on standard mental status examinations (e.g., Mini-Mental™ State Examination) obtained meaningful scores on the SCIP.

The Professional Manual provides detailed information about the test materials and procedures for administration and scoring, standardization and descriptive information, psychometric and technical information (including development, reliability, and validity), scoring criteria, scoring examples, and three case illustrations.

Smell Identification Test™ (SIT™)
Richard L. Doty, PhD

The SIT, also known as the University of Pennsylvania Smell Identification Test (UPSIT), consists of four self-administered test booklets, each containing ten stimuli for smell. Respondents (ages 4-99 years) pick from one of four multiple choices. By incorporating microencapsulation technology and sound psychometric principles into a simple test format, the SIT provides a rapid, easy means of quantifying smell functioning.

Sensitive to smell deficits caused by a wide range of medical, neurological, and psychiatric disorders, the SIT is useful in a variety of clinical, laboratory, and industrial settings. It has been

used in occupational settings to screen persons working in hazardous manufacturing areas for their ability to smell; to evaluate the effect of occupational exposure to airborne chemicals on the ability to smell; to select members for sensory panels within the food and beverage industries; and to screen firemen, municipal gas works employees, plumbers, and others who are in potential danger from smoke or leaking natural gas. In addition, the SIT has been shown to be an excellent measure of frontal lobe dysfunction and has gained interest in the area of Schizophrenia, as it is one of a few neuropsychological measures that tracks the progression of the disease.

The SIT focuses on the comparative abilities of individuals to identify a number of odorants at the suprathreshold level. Test stimuli include a number of odorous components mimicking the types of stimuli usually experienced by individuals in the general population. An individual's test scores are compared to scores from normal persons of equivalent age and gender using tables provided in the manual. The resulting percentile score provides a measure of the individual's performance that is easy to interpret. The test-retest reliability of the SIT exceeds .90 and correlates well with other olfactory tests, including detection threshold tests.

One of the strengths of this unique test is its normative data base of nearly 4,000 individuals of all ages. Another strength is its means for detecting malingerers.

Stroop Color and Word Test: Children's Version
Charles J. Golden, PhD, Shawna M. Freshwater, Zarabeth Golden

The children's version of the Stroop Color and Word Test was developed in response to the demand for a Stroop test that is similar to the adult version, but is specifically normed and interpreted for children. The Stroop Color and Word Test: Children's Version Manual details specific administration, scoring, and interpretive strategies for use with children ages 5-14 years.

The interpretation of a child's score is affected by developmental trends, possible learning disabilities, attentional problems, emotional problems, and overall maturity--therefore, it is more difficult to interpret a child's score than it is to interpret an adult's score. The children's version of the Stroop has been designed to avoid measurement issues that exist in attempting to apply the scoring approach of the adult Stroop to children's data. Interpretive strategies also differ between younger children (ages 5-10) and older children (ages 11-14). Therefore, interpretive strategies for each age group are presented separately in the Manual.

Each Stroop Test Booklet consists of three basic sections:

- Word Page-names of colors are printed in black ink;
- Color Page-semantically meaningless symbols are printed in various colors of ink; and

- Color-Word Page-composed of words from the first page (i.e., Word Page) printed in the colors from the second page (i.e., Color Page).

The task consists of moving down five columns on each page as quickly as possible, and reading words or naming colors. The test yields three scores (i.e., Raw Word score, Raw Color score, and Raw Color-Word score), based on the number of items completed. Raw scores are then converted to *T* scores by age using the Appendixes in the Manual. In addition, an Interference score is derived from the difference between the Color-Word *T* score and the Color *T* score.

Stroop Color and Word Test
Charles Golden, PhD

The Stroop Color and Word Test has long been a standard measure in neuropsychological assessment. It measures cognitive processing and provides valuable diagnostic information on brain dysfunction, cognition, and psychopathology. The 2002 Examiner's Manual provides updated scoring, norms, and interpretations for ages 15-90 years.

The Stroop Color and Word Test is based on the observation that individuals can read words much faster than they can identify and name colours. The cognitive dimension tapped by the Stroop is associated with cognitive flexibility, resistance to interference from outside stimuli, creativity, and psychopathology--all of which influence the individual's ability to cope with cognitive stress and process complex input. Whether the test is used as a screener or as part of a general battery, its quick and easy administration, validity, and reliability make it a highly useful instrument.

The Stroop Color and Word Test consists of a Word Page with colour words printed in black ink, a Color Page with 'Xs' printed in colour, and a Color-Word Page with words from the first page printed in colours from the second page (the colour and the word do not match). The test-taker looks at each sheet and moves down the columns, reading words or naming the ink colours as quickly as possible within a time limit. The test yields three scores based on the number of items completed on each of the three stimulus sheets. In addition, an Interference score, which is useful in determining the individual's cognitive flexibility, creativity, and reaction to cognitive pressures also can be calculated. A **stopwatch** is required to administer each test.

Stroop Neuropsychological Screening Test (SNST)
Max R. Trenerry, PhD, Bruce Crosson, PhD, James DeBoe, PhD, William R. Leber, PhD

This standardized version of the Stroop consists of two parts. In the Color Task, the individual reads aloud a list of 112 color names in which no name is printed in its matching color. In the Color-Word Task, the individual names the color of ink in which the color names are printed.

The SNST may be administered and scored by individuals with limited training. Interpretation of the resulting Color and Color-Word scores requires professional training in psychology, psychiatry, or educational testing. A stopwatch is required to administer each 2-minute test.

Reliability/Validity

The SNST was standardized on 156 adults ages 18-79 years. Norms are provided for two age groups, 18-49 years and 50 years and older. The test correctly differentiates 79%-92% of brain-damaged from normal adults. Test-retest reliability is .90.

Short Category Test, Booklet Format
by Linda Wetzel, Ph.D. and Thomas J. Boll, Ph.D.

The *Short Category Test, Booklet Format* (SCT) reduces the length and complexity of the Halstead-Reitan Category Test, one of the most sensitive indicators of brain damage.

Brief, portable, and easy to administer, the SCT uses less than half the items on the original test and presents them in convenient, spiralbound booklets. It eliminates entirely the expensive and cumbersome equipment required by the Category Test. Yet this practical new format retains the diagnostic power of the original test, effectively assessing cognitive deterioration in adults age 20 and older.

Compact, Convenient Test Materials

The SCT includes five subtests, each in a 5" x 7" booklet of 20 Stimulus Cards. As in the

original Category Test, the cards show various geometric shapes, lines, colours, and figures. All the cards within each booklet are organized around a single principle.

The client is shown the cards, one at a time. In order to respond correctly, he or she must discern the principle underlying each series of cards. This requires specific mental abilities: abstract concept formation, learning capacity, adaptive skill, and cognitive flexibility. By testing these abilities, the SCT uncovers the important, but often subtle, deficits that are frequently present in brain-damaged individuals.

Although the SCT measures a complex set of abilities, it is quite easy to administer and score. Under appropriate supervision, a paraprofessional can administer all five subtests in just 15 to 30 minutes. The only materials required are the SCT Answer Sheet and the five subtest booklets.

The test can be given to anyone who can see clearly and is alert enough to give a simple one-word response. (Individuals who are language impaired can respond by pointing to numbers on a special card provided with each subtest booklet.) And because the test materials are compact and portable, the SCT is easy to administer at bedside.

Scoring the test requires only a few minutes. Errors are totaled to produce raw scores, which are then converted to T-scores and percentile equivalents.

Diagnostic Power of the Category Test

The SCT functions in a manner very similar to the Category Test--in terms of psychometric properties, discriminative ability, and correlation with other neuropsychological tests. It serves as a sensitive screening device in a variety of medical and mental health settings. Typically, the test is used to:

- Detect the subtle effects of closed-head injuries
- Isolate the organic components of psychiatric illness
- Identify the early stages of dementia related to Alzheimer's disease, multiple infarcts, drug and alcohol   abuse, or drug toxicity
- Assess the effects of chronic conditions, such as renal failure and diabetes
- Measure cognitive status following neurosurgery or rehabilitation
- Confirm suspected deficits in abstract concept formation

The SCT gives you the diagnostic power of the Category Test--without its practical limitations.

Stroop Color and Word Test
by Charles J. Golden, Ph.D. and Shawna M. Freshwater

Here is a standardized version of the *Stroop Color and Word Test*, which maximizes the benefits of this popular measure of cognitive processing.

The Stroop is based on the observation that individuals can read words much faster than they can identify and name colors. The cognitive dimension tapped by the *Stroop* is associated with

cognitive flexibility, resistance to interference from outside stimuli, creativity, and psychopathology--all of which influence the individual's ability to cope with cognitive stress and process complex input. Whether the test is used as a screener or as part of a general battery, its quick and easy administration, validity, and reliability make it an especially attractive instrument.

The test features a three-page test booklet. On the first page, the words "RED," "GREEN," and "BLUE," are printed in black ink and repeated randomly in columns. On the second page, the item "XXXX" appears repeatedly in columns, printed in red, green, or blue ink. On the third page (referred to as the interference page), the words "RED, "GREEN," and "BLUE" are printed in red, green, or blue ink--but in no case do the words and the colors in which they are printed match. For example, the word "BLUE" appears in either red or green ink.

The subject's task is to look at each page and move down the columns, reading words or naming the ink colors as quickly as possible, within a given time limit. The test yields three scores, based on the number of items completed on each of the three stimulus sheets. In addition, you can calculate an interference score, which is useful in determining the individual's cognitive flexibility, creativity, and reaction to cognitive stress.
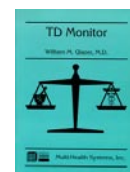Administration time is just 5 minutes.
While the adult version of the test is appropriate for individuals 15 years of age and up, a new children's version can be used with 5- to 14-year-olds. Specifically designed for, normed on, and interpreted for children, this version generates T-scores, by age, based on means and standard deviation. (Adult T-scores are based on multiple regression equations, using age and education.)

Stroop results can be used in the diagnosis of brain dysfunction and in the evaluation of stress, personality, cognition, ADHD, and psychopathology. Because it is brief, requires very little education, and is not culturally biased, this unique test is an ideal way to screen for neuropsychological deficits.

Tardive Dyskinesia Monitor (TD Monitor)
William M. Glazer, M.D.

The TD Monitor assists you in systematically monitoring patients receiving chronic neuroleptic maintenance and in developing your approach towards the Risk Benefit Ratio of Neuroleptic Exposure. It centers around the use of the modified Abnormal Involuntary Movement Scale (AIMS) and assists in generating a diagnosis and classifying the course of the movement disorder once it has appeared. The TD Monitor measures the presence and severity of the tardive dyskinesia movements either at first neuroleptic exposure or when the clinician first decides to monitor TD.

The TD Monitor includes the Modified Webster and the Modified Aims. You are provided with descriptive case examples that will provide further explanations of key points and prove beneficial as a point of reference.

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The b Test

Kyle Boone, Ph.D., Po Lu, Psy.D., and David Herzberg, Ph.D.

Like the *Dot Counting Test* (DCT), *The b Test* assesses test-taking effort in individuals ages 17 and older. Unlike the DCT, *The b Test* offers entirely new and unfamiliar stimuli, making it ideal for forensic use.

Because *The b Test* assesses "overlearned" skills, individuals with cerebral dysfunction who try hard on the task will not be mistakenly classified as non-cooperative. Similarly, examinees who are feigning symptoms may be tempted to display their "impairment," in which case the test will flag their effort as suspect.

The b Test performance of 91 "suspect effort" patients (previously identified as "under attemptors" by rigorous inclusion and exclusion criteria) was compared to that of patients in 6 "normal effort" diagnostic groups: Depression, Schizophrenia, Head Injury, Stroke, and Learning Disability. Results verified the ability of *The b Test* to discriminate among patients based on their effort status.

In interpreting test scores, you can select a cutoff that minimizes false positives while maintaining adequate sensitivity to "suspect effort." Simply compare the patient's performance to that of a similar reference group.

Like the DCT, *The b Test* is useful in any setting where examinees have external incentives to fabricate or exaggerate cognitive problems--personal injury litigation, disability evaluations, and criminal cases, for example. However, it need not be limited to these applications. There is increasing consensus among psychologists that effort tests should be a standard component of assessment practice.

Administered in less than 15 minutes, *The b Test* is a quick, cost-effective way to routinely assess test-taking effort.

Test of Everyday Attention (TEA)

by Ian H. Robertson, Tony Ward, Valerie Ridge

Here is a norm-referenced, broad-based measure of the most important clinical aspects of attention. The TEA assesses selective attention, sustained attention, attentional switching, and divided attention, using everyday materials that are relevant to the daily problems that patients encounter following brain damage.

The TEA includes eight subtests:

Map Search, which requires the patient to search for symbols on a large, color map of the Philadelphia   area

Elevator Counting, which asks the patient to count a series of tones, presented on audio CD, that   represent floors reached on an elevator

Elevator Counting With Distraction, which asks the patient to count the low tones in the imagined   elevator while ignoring the high tones

Visual Elevator, in which the patient must count up and down as he or she follows a series of visually   presented "floors" in the elevator

Elevator Counting With Reversal, which is the same as the previous subtest except that it is   presented at a fixed speed on audio CD

Telephone Search, in which patients must look for key symbols in a simulated telephone directory

Telephone Search While Counting, which requires the patient to search the telephone directory while simultaneously counting tones presented on audio CD

Lottery, in which patients must listen for their "winning number" on an audio CD and write down the two   letters preceding all numbers ending in given digits

The entire battery can be administered in just 45 to 60 minutes. (Some of the subtests are timed.) Available in three parallel versions, it yields nine percentile scores that are useful in predicting recovery of function and likelihood of everyday attention problems following brain damage. The normative sample, composed of 154 normal individuals ranging from 18 to 80 years of age, is stratified by age and education.

The TEA can be used with a wide range of people, from normal young adults to patients in the early stages of Alzheimer's disease. Broad-based and relevant to everyday functioning, it is an ideal way to identify patterns of attentional deterioration.

Test of Memory and Learning: Second Edition (TOMAL-2)
by Cecil R. Reynolds and Judith K. Voress

The second edition of the *Test of Memory and Learning* features an expanded age range, shorter administration time, and easier scoring. The TOMAL-2 provides the most comprehensive coverage of memory assessment in children and adults currently available in a standardized battery.

The TOMAL-2 includes 8 core subtests, 6 supplementary subtests, and 2 delayed recall tasks that provide highly interpretable and relevant scores, scaled to a familiar metric. Individually administered, the core battery that provides 3 Core Index scores can be completed in just 30 minutes, or you can administer both core and supplementary tests in 60 minutes. The subtests give information on specific and general aspects of memory and are used to derive the following indexes:

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Core Indexes

- Verbal Memory
- Nonverbal Memory
- Composite Memory

Supplementary Indexes

- Verbal Delayed Recall
- Learning
- Attention and Concentration
- Sequential Memory
- Free Recall
- Associate Recall

Standardized on a nationally representative sample of more than 1,900 children, adolescents, and adults aged 5-0 through 59-11, and evaluated at the item and subtest levels for gender and ethnic bias, the TOMAL-2 can be administered with confidence to both males and females, across U.S. ethnic populations.

Test of Memory Malingering (TOMM)
by Tom N. Tombaugh, Ph.D.

Based on research in both neuropsychology and cognitive psychology, the TOMM offers a systematic way to discriminate between malingered and real memory impairments in adults.

Completed in 15 to 20 minutes, the TOMM is particularly effective in detecting malingering for several reasons. First, it looks like a memory test, not a malingering test--patients do not suspect that they are being evaluated for malingering. Second, the test appears more difficult than it is, which leads malingerers to intentionally perform poorly while non-malingerers exert their full effort and do well. Third, though the TOMM is sensitive to malingering, it is insensitive to neurological impairments. The TOMM offers a norm-based criterion to detect malingering, which supplements the more traditional procedure of using below-chance performance as the criterion for malingering.

Norms are provided for individuals aged 16 to 84. In addition, extensive data has been collected from cognitively intact normals and clinical samples with cognitive impairment, aphasia, traumatic brain injury, dementia, and no impairment at all.

The TOMM provides a reliable, economical first step in judging whether a patient is malingering.

Test of Variables of Attention (T.O.V.A.)

by Lawrence Greenberg, M.D., Robert A. Leark, Ph.D., Tammy R. Dupuy, M.S., Clifford L. Corman, M.D., Carol L. Kindschi, R.N., M.S.N., and Michael Cenedela

This set of computerized continuous performance tests was designed specifically for screening, diagnosis, and treatment of children and adults with attention disorders, both congenital and acquired. It includes both visual and auditory tests, and it is provided in two formats. The Screening Version, intended for use by schools and learning centers, provides a user-friendly report that includes referral recommendations when appropriate. The Clinical Version, for physicians and clinical psychologists, generates a report that refers to DSM-IV diagnostic categories and includes medication suggestions. The two versions use identical test items and make identical calculations--they differ only in the language used to explain results.

Normed on over 4,100 children and adults (ages 4 to 80), these highly reliable, cost-effective, and easily administered tests provide relevant information about attention and impulsivity that is not otherwise available. In addition, the tests are very sensitive to the effects of treatment, including medication. They are commonly used to determine optimal dosage and monitor the course of treatment.

These tests are not language-based and have no practice effects. The visual test uses two simple geometric stimuli, while the auditory test uses two audible tones. With simple stimuli and considerable test length, practice effects are insignificant. The T.O.V.A. tests are intentionally long, easy, and boring in order to assess attentional variables. A nonsequential "go/no-go" response paradigm avoids confounding variables such as complex information processing and memory. A specially designed, highly accurate electronic microswitch eliminates inherent variability of keyboard and mouse responses.

The software automatically records the individual's responses, non-responses, and reaction times, and then calculates raw scores and percentages. Results are reported as standardized scores and standard deviations, presented in quarters, halves, and totals for the full 22 minutes of the test. The program instantly displays test results, including an ADHD score, in narrative and graphic formats. The ADHD score compares the examinee's performance to that of an identified ADHD sample.

Hardware requirements: PC with Windows 95, 98, 98SE, ME, 2000, or XP (also compatible: PC with MS-DOS 6.22, FreeDOS 0.9, or later), 5 MB free RAM, DOS-compatible parallel port (this does not include USB parallel port adapters), VGA or better graphics card, parallel (printer) port.

Test of Verbal Conceptualization and Fluency (TVCF)

by Cecil R. Reynolds, Ph.D., and Arthur MacNeill Horton, Jr., Ph.D.

The new TVCF eliminates the shortcomings associated with other measures of executive functioning:

- It is well-standardized, appropriately normed, and objectively scored.
- It measures multiple, rather than limited, aspects of executive functioning.
- It involves both verbal and nonverbal assessment.

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These features, along with quick administration and a wide age range (8 to 89 years), make the TVCF highly useful in both clinical and educational settings. It can help you detect brain injury and track rehabilitation progress, assess language functions, determine disability under IDEA, and evaluate academic difficulties in regular classrooms.

Because executive functioning involves planning and purposeful action in response to external demands, the TVCF requires the individual to perform a range of tasks. It is composed of four subtests:

- **Categorical Fluency**
  Ability to retrieve words within a category (e.g., animals, foods) and fluency of ideation
- **Classification**
  A verbal measure of set shifting and rule induction (a language-based analog to the *Wisconsin Card Sorting Test*)
- **Letter Naming**
  Word retrieval by initial sound and fluency of ideation
- **Trails C**
  Sequencing, visual search, ability to coordinate high attentional demands, and ability to shift rapidly between numerals and words representing numbers (a variation of other "trail-making" tasks, renormed with the TVCF subtests above)
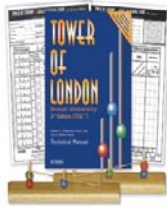
These subtests are easy to administer. Several are timed, and most people can complete all four in just 20 to 30 minutes.

For each subtest, the TVCF generates raw scores, normalized *T*-scores, and percentile ranks. Quotient scores, *z*-scores, and stanines are also provided for the convenience of researchers and others with specialized assessment needs. Norms are based on a sample of 1,788 individuals, aged 8 to 89, approximating the U.S. population in terms of geographic region, gender, ethnicity, education, and disability.

The TVCF is a quick, cost-effective way to identify people who may have executive functioning deficits. In educational settings, such deficits are associated with academic difficulties due to weak study skills, test-taking problems, and poor time management. Because these problems exist in both regular and special education classrooms, the TVCF is useful for pre-referral evaluation as well as assessment of students with identified learning disabilities or ADHD. In clinical settings, the test offers an efficient way to detect brain injury or evaluate executive functioning in people with CNS disease, drug addiction, aphasia, or dementia. Because it is brief, the TVCF is also ideal for monitoring treatment progress.

Tower of LondonDX 2nd Edition (TOLDX 2nd Edition)
William C. Culbertson, PsyD, Eric A. Zillmer, PsyD

The TOL^{DX} 2nd Edition measures higher order problem-solving ability. The information it provides is not only useful when assessing frontal lobe damage but also when evaluating attention disorders and executive functioning difficulties. This new edition includes a Stimulus-bound score that is particularly useful when assessing older adults. The score is rarely produced by healthy older adults, but, when apparent, suggests significant cognitive impairment consistent with dementia or seriously compromised frontally mediated executive control. New normative data for older adults also is included in this new edition, along with recent research findings.

The 2nd Edition eliminates repeated trials for failed problems, thereby maintaining task novelty; introduces 6- and 7-move test problem configurations, increasing sensitivity to executive functioning across age levels; and presents an empirical selection of test problem configurations, which allows assessment of the range of executive planning abilities that characterize child and adult populations.

The TOL^{DX} 2nd Edition is an easily transportable test with minimal set-up time. Scoring can be completed within 5-10 minutes. The Examiner's Manual is appropriate for use with children and adults. The Child Record Forms are suitable for children ages 7-15 years; the Adult Record Forms are suitable for individuals ages 16-80 years and older.

Telephone Interview for Cognitive Status™ (TICS™)
Jason Brandt, PhD, Marshal F. Folstein, MD

The TICS is a brief, standardized test of cognitive functioning that was developed for use in situations where in-person cognitive screening is impractical or inefficient (e.g., large-scale population screening, epid emiological surveys, or with patients who are unable to appear in person for clinical follow-up).

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Although the TICS is designed to be administered via the telephone, it also may be administered face-to-face. Because it does not require vision, the TICS is particularly useful for examining visually impaired individuals and individuals who are unable to read or write. The test was standardized and validated for use with English-speaking adults, ages 60-98 years.

Research has demonstrated that psychological data obtained over the telephone are as reliable and valid as those obtained through face-to-face interaction. The TICS correlates highly with the Mini-Mental™ State Examination (MMSE™). It has high test-retest reliability and excellent sensitivity and specificity for the detection of cognitive impairment. Among elderly populations, TICS scores approximate a normal distribution and are not subject to the ceiling effects that limit the usefulness of many mental status examinations.

Before administering the telephone interview, the examiner must speak with someone at the same location (e.g., family member, caregiver) who will serve as a proctor to ensure that the environment is appropriate for testing and that the examinee is able to hear spoken language at a conversational volume.

The test materials consist of the Professional Manual and the Record Form. To assist in test administration, the Record Form provides specific instructions for administration, the exact instructions for both the examinee and the proctor, and the scoring criteria for each TICS item.

The 11 test items usually take less than 10 minutes to administer and score. All examinee responses are recorded verbatim. The individual item scores are summed to obtain the TICS Total score. The TICS Total score provides a measure of global cognitive functioning and can be used to monitor changes in cognitive functioning over time.

The impairment ranges have been shown to adequately distinguish between normal participants and patients with cognitive impairment. The appropriate normative reference group for interpretation will depend on the reason for the evaluation, and the examinee's age and level of education.

TICS results are reported using a qualitative impairment range and *T* scores.

Qualitative Impairment Range

> The TICS Total score can be interpreted by means of four qualitative impairment ranges: Unimpaired, Ambiguous, Mildly Impaired, and Moderately to Severely Impaired (based on the results from six nondemented and six cognitively impaired elderly groups representing diverse race/ethnicity).

T **Scores**

> For individuals ages 60-89 years with at least 12 years of education, TICS *T* scores are provided based on the results from a normative sample of 6,338 participants.
> For individuals ages 65 years or less with less than 12 years of education (based on the results from a sample of 388 participants), *T* scores may be obtained through a process of equating TICS and MMSE Total scores.

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The TICS is designed to provide a brief overall assessment of cognitive status; it should not be used alone to diagnose any specific neurological or psychiatric disorder. Specifying the precise nature and cause of cognitive impairment requires a comprehensive assessment that includes diagnostic testing and a complete medical and neuropsychiatric history. In addition to measuring an individual's overall cognitive functioning with the TICS Total score, clinicians also may wish to examine an individual's performance on specific items.

The Professional Manual provides information about the development, reliability, and validity of the instrument, as well as data based on both normative and clinical groups. Two case studies are presented to illustrate appropriate uses of the instrument.

Note: The Mini-Mental™ State Examination (MMSE™) is a brief and valid measure for assessing cognitive function in adults, making it a useful companion to the TICS.

Visual Search and Attention Test (VSAT)
Max R. Trennerry, Ph.D., Bruce Crosson, Ph.D., James DeBoe, Ph.D. and William R. Leber, Ph.D.

This norm-referenced test quickly measures attentional processes commonly disrupted in acute and chronic brain damage or disease. The VSAT consists of 4 visual cancellation tasks that require the respondent to cross out letters and symbols that are identical to a target. It yields an overall attention score and provides separate scores for left- and right-side performance to assess visual field defects, unilateral spatial neglect, or syndromes that affect the perception of portions of the visual space.

Visual Analog Mood Scales™ (VAMS™)
Robert A. Stern, PhD

The VAMS are reliable and valid measures of eight specific mood states: Afraid, Confused, Sad, Angry, Energetic, Tired, Happy, and Tense. These simple, brief scales place minimal cognitive or linguistic demands on the respondent and are appropriate for neurologically impaired individuals or those who are unable to complete more verbally or cognitively demanding instruments (ages 18-94 years). The scales have a "Neutral" schematic face (and accompanying word) at the top of a 100 mm vertical line and a specific "mood" face (and word) at the bottom of the line.

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Because of their standardized approach and the existing normative data from 425 healthy adults as well as from 290 psychiatric inpatients and outpatients, the VAMS can be used for a variety of applications including repeated assessment of mood states to monitor treatment efficacy, screening for mood disorder in primary care settings, and screening for mood disorder in patients with neurologic illness.

Test materials include the Professional Manual, the VAMS Response Booklet, and a metric ruler. A pen or pencil is also required for administration. Respondents indicate the point along the vertical line that best describes how they are currently feeling. The score for each mood ranges from 0-100, with 100 representing a maximal level of that mood and zero representing a minimal level (or absence) of that mood. The Response Booklet includes instructions to the respondent, the eight mood scales, and a profile for plotting the *T* scores for each of the eight scales.

The Professional Manual provides information about the development, administration, and scoring of the VAMS; guidelines for interpretation; normative data; summaries of reliability and validity studies; and *T* score conversion tables by age and gender.

Visual Motor Assessment (ViMo)
by Gerald B. Fuller, Ph.D.

Formerly known as the Minnesota Percepto-Diagnostic Test, the ViMo identifies visual-motor problems in both children and adults -- in just 5 to 10 minutes. It assesses visual input, integration, and execution in order to differentiate individuals with normal perception from those with impaired perception due to brain damage, schizophrenia, emotional disturbance, or personality disorder. Because it is completely nonverbal, the ViMo is ideal for use with people from all socioeconomic, cultural, and educational backgrounds.

The test consists of two sets of six Gestalt designs that the examinee is asked to reproduce. His or her drawings are scored for rotation and configuration errors, and scores are adjusted for age and IQ -- a feature that distinguishes the ViMo from other visual-motor tests and ensures accurate results. If scores indicate that the examinee's perception is not normal, he or she is given an opportunity to recognize and correct earlier errors. This process further refines test results.

Based on 35 years of diagnostic data and research on visual-motor performance, the ViMo features updated norms based on a national sample of more than 12,000 children and adults. Included in this sample are several distinct clinical groups: children with special education needs, emotional disturbance, schizophrenia, or brain damage; and adults with personality disorders, brain damage, schizophrenia, alcoholism, or medical problems.

ViMo scores indicate the presence and type of visual-motor impairment and the likelihood of a learning or behavioral problem, emotional or personality disturbance, brain damage, or schizophrenia. Following a clear, four-step interpretive process, you can compare the examinee's rotation and configuration scores (including separations and distortions) to those obtained from various diagnostic groups. This process clarifies the nature of the examinee's impairment and helps you determine what kind of additional testing may be needed.

Simple, brief, and effective, the ViMo is a reliable and cost-effective way to screen for visual-

motor problems.

Wide Range Assessment of Memory and Learning, Second Edition (WRAML2)
by David Sheslow, Ph.D. and Wayne Adams, Ph.D.

Revised in 2003, this test makes it easier to assess memory functions in children, adolescents, and--with this edition--adults as well. The WRAML2 gives clinicians a single, integrated collection of relevant memory tests that can be used across the life span.

Appropriate for individuals from 5 through 90 years of age, the WRAML core battery produces a General Memory Index, plus three more specific index scores and six subtest scores:

Verbal Memory Index
    Verbal Learning Subtest
    Story Memory Subtest

Visual Memory Index
    Design Memory Subtest
    Picture Memory Subtest

Attention and Concentration Index
    Number/Letter Subtest
    Finger/Windows Subtest

Several subtests from the original WRAML are now optional (e.g., Sentence Memory) or limited to a specific age group (e.g., Sound-Symbol for 5- through 8-year-olds).

The WRAML2 also adds supplementary subtests and indexes that reflect current interests in working memory and rapid memory decline:

Working Memory Index
    Verbal Working Memory Subtest
    Symbolic Working Memory Subtest

Delayed Memory Measures
    Recall
    Story Memory Delayed Recall
    Verbal Learning Delayed Recall

Recognition
    Story Memory Recognition
    Picture Memory Delayed Recognition

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Verbal Learning Recognition
Design Memory Recognition

The delayed recall tasks can provide critical information about rapid decay of memory, an important indicator of possible dementia.

All of the subtest and index scores can be converted to standard scores and percentiles for age-based performance comparisons. The core battery can be individually administered in well under an hour, and a Memory Screening Form, composed of four subtests, requires just 10 to 15 minutes, yet correlates highly with the full test.

Given the important part that memory plays in academic success, WRAML2 is highly useful in evaluating learning and school-related problems. It can clarify the role of memory deficits in learning disabilities and attention disorders. WRAML2 is also an excellent tool for assessing memory impairment following head injury

Wisconsin Card Sorting Test (WCST)
David A. Grant, Ph.D. and Esta A. Berg, Ph.D.

The WCST is used primarily to assess perseveration and abstract thinking and has gained increasing popularity as a neuropsychological instrument. Unlike other measures of abstraction, it provides objective measures of overall success and identifies particular sources of difficulty on the task.

The WCST is sensitive to frontal lobe dysfunction. When used with more comprehensive ability testing, the WCST is helpful in discriminating frontal from nonfrontal lesions.

This untimed test uses stimulus cards and response cards containing various forms in different numbers and colors. Respondents are required to sort the cards according to different principles (color, form, or number) and to alter their approach as unannounced shifts in the sorting principle occur during the test administration. The revised and expanded manual provides demographically corrected normative data for ages 6.5-89 years. Compare scores to the cutoff to assess degree of perseveration.

Wisconsin Card Sorting Test--64 Card Version (WCST-64)
by Susan K. Kongs, Laetitia L. Thompson, Ph.D., Grant L. Iverson, Ph.D., and Robert K. Heaton, Ph.D

This shortened version of the WCST was developed in response to concerns for patient comfort, managed care restrictions, and tighter research budgets. It uses only the first 64 WCST cards, thereby reducing administration time while retaining the task requirements of the standard version. The WCST-64 also eliminates variability in the number of cards administered, allowing the user to easily compare test-retest stability and individual test results with normative and validity data.

In developing the shortened version, WCST protocols were re-scored for the first 64 cards administered. The normative sample includes both adults (18 to 89 years of age) and children (6 to 17 years of age).

Administered in just 10 to 15 minutes, the WCST is an excellent option for clinicians and researchers working within budgetary or time constraints.

Wisconsin Card Sorting Test®Computer Version 4 Research Edition (WCST:CV4™)
Robert K. Heaton, PhD, PAR Staff

This unlimited-use software is designed to assist you in administering and scoring the Wisconsin Card Sorting Test® (WCST). The reports are more visually attractive and easier to read than those reports generated by earlier versions of the software.

- Clinicians have the option of administering the test on-screen (clients enter their responses via either the keyboard or the mouse), or by entering the client's item responses from a previous WCST administration.

- The client record feature allows the clinician to save basic demographic information and to store test response data for each test associated with a particular client. This helps the clinician track the client's progress and monitor changes over time.

Entry of Item Responses

- If the clinician chooses to enter the client's item responses from the Record Form of a previous WCST administration, the data-entry screen presents only the possible valid responses for each card; this prevents certain errors in data entry.

- The clinician can either select all the valid dimensions, or simply click on one of the valid dimensions to which the client was matching; the software will automatically record any other dimension matches.

On-Screen Administration
The software automatically tells the respondent (by both an audible response in English and an on-screen message in one of 10 user-definable languages) whether the choice was correct or incorrect.

- For on-screen administration, keyboard response entry utilizes four predefined alphanumeric keys.

- A set of colored keytops representing the four WCST Stimulus Cards can be attached to these keys.

WCST: CV4 Report

The software program automatically scores the responses according to Dr. Heaton's scoring system and then generates a report which includes the following information and features:

- Demographic information and test performance variables.

- WCST raw scores and corresponding age- and education-corrected standard scores, *T* scores, and percentile scores for major WCST variables for clients ages 6.5-89 years.

- Scores for individuals ages 20-89 years also are compared to normative scores derived from an adult sample matched by age to 1995 U.S. Census data.

- Reports may be printed or saved in Rich Text Format (which is compatible with most word processing programs).

Requirements: Windows® 2000/XP/Vista™; NTFS file system; CD-ROM drive for installation; Internet connection or telephone for software activation

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AAMR Adaptive Behaviour Scale-School: 2nd Ed. (ABS-S:2)

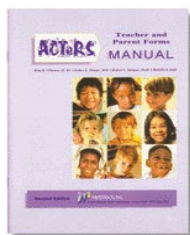Nadine M. Lambert, PhD, Kazuo Nihira, PhD, Henry Leland, PhD

This observational rating scale assesses behaviour and social adjustment of children ages 3-21 years whose adaptive behaviour suggests possible mental retardation, emotional disturbance, or other learning handicaps. It reveals areas where special program planning could be required.

The ABS-S:2 is divided into two parts. Part 1 is designed to evaluate coping skills considered important to personal independence and responsibility in daily living and is grouped into 9 behaviour domains and 18 subdomains. Part 2 measures personality and behaviour disorders and is grouped into 7 domains.

The ABS-S:2 was normed on two public school groups: 2,074 students with developmental disabilities and 1,254 students without developmental disabilities. The Examiner's Manual contains interpretive information, percentile norms tables, and instructions for administering the ABS-S:2.

ADD-H: Comprehensive Teacher's Rating Scale-2nd Edition (ACTeRS)

Rina K. Ullmann, MEd, Esther K. Sleator, MD, Robert L. Sprague, PhD

This 24-item rating instrument describes classroom behaviour of children in Grades K-8 on four factors:
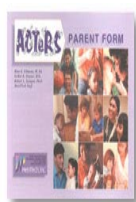
- Attention
- Hyperactivity

- Social Skills
- Oppositional Behaviour

Results are reported by percentiles and can be plotted on profile sheets for easy evaluation. The ACTeRS can be used to monitor medication effects or as a screening tool to differentiate ADD-H and Learning Disability. Internal consistency of the four factors ranges from .93-.97. Test-retest reliability ranges from .78-.82.

ADD-H: Comprehensive Teacher's Rating Scale: Parent Form (ACTeRS)
Rina K. Ullmann, MEd, Esther K. Sleator, MD, Robert L. Sprague, PhD, Metritech Staff

The ACTeRS: Parent Form helps improve diagnostic accuracy by offering a second, objective perspective of the child's behaviour obtained from the parents. Uniquely parallel in structure and content to the Teacher version of the ACTeRS, the Parent Form provides scores for the same four subscales reported in the original ACTeRS: Attention, Hyperactivity, Social Skills, and Oppositional Behaviour. Each subscale includes 5 of the original ACTeRS items that have been enhanced with additional descriptive information to help parents make accurate, informed observations about their children. This approach not only ensures that teachers and parents are providing ratings on the same factors, but that they are considering the same types of behaviour. In addition to the original four subscales, a fifth scale focuses on early childhood behaviour

ADHD Symptoms Rating Scale (ADHD-SRS)
Melissa Lea Holland, PhD, Gretchen A. Gimpel, PhD, Kenneth W. Merrell, PhD

The ADHD-SRS is a standardized, norm-referenced ADHD rating scale that may be used either for clinical assessment or research purposes. It was developed to aid in symptom identification, diagnosis, treatment planning, and monitoring treatment progress in children and adolescents ages 5-18 years.

Raters need only 10-15 minutes to complete the rating scale, which is available in both English and Spanish.

Features of the ADHD-SRS

- The ADHD-SRS contains 56 items, providing a thorough, complete assessment based on the *DSM-IV*™. It provides two subscales: Hyperactive-Impulsive (HI) and Inattention (IN).

- Raters may be selected from either the child's home or school setting, depending on the type of information needed.

- Normed on a national sample of more than 2,800 individuals ages 5-18 years and stratified by age, gender, ethnicity, and geographic region.

- Highly reliable and valid

Adaptive Behaviour Scale-Residential and Community: 2nd Ed. (ABS-RC:2)
Kazuo Nihira, PhD, Henry Leland, PhD, Nadine M. Lambert, PhD

The ABS-RC:2 is divided into two parts. Part 1 focuses on personal independence and is designed to evaluate important coping skills for daily living. Part 2 deals with social behaviour and includes 8 domains that relate to the manifestation of personality and behavioural disorders.

The ABS-RC:2 was standardized on 4,103 examinees (ages 18-79 years) with developmental disabilities. Internal consistency and test-retest reliability coefficients for Part 1 and Part 2 domains and factors exceed .80. Complete validity and reliability data are provided in the Examiner's Manual.

Asperger Syndrome Diagnostic Scale (ASDS)
Brenda Myles, Stacy Jones-Bock, Richard Simpson

Diagnosis of Asperger syndrome is difficult because the characteristics of the disorder often resemble those of autism, behaviour disorders, Attention-Deficit/Hyperactivity Disorder, and learning disabilities. The ASDS is a quick, easy-to-use rating scale that helps you determine

whether a child or adolescent is likely to have Asperger syndrome. Anyone who knows the child or adolescent well can complete the form in 10-15 minutes.

The 50 yes/no items that make up the ASDS were drawn from five specific areas of behaviour: cognitive, maladaptive, language, social, and sensorimotor. All of the items represent behaviours that are symptomatic of Asperger syndrome. The ASDS provides an "AS Quotient" that indicates the likelihood that an individual has Asperger syndrome. Low AS Quotients are indicative of persons with little or no known pathology, whereas higher scores are increasingly more indicative of Asperger syndrome.

Normed on 115 children, the ASDS has several uses:

- Identify individuals who have Asperger syndrome (ages 5-18 years).
- Document behavioural progress as a consequence of special intervention programs.
- Target goals for change and intervention on a student's Individual Education Program (IEP).
- Measure Asperger syndrome for research purposes.

Attention Deficit/Hyperactivity Disorder Test (ADHDT)
James E. Gilliam, EdD

The ADHDT was designed for use in schools and clinics. The test is easily completed by teachers, parents, or others familiar with the individual. The 36 items are based on the *DSM-IV™* criteria for ADHD. The three subtests represent the core symptoms necessary for ADHD diagnosis: hyperactivity, impulsivity, and inattention.

Normed on a representative national sample of more than 1,200 persons who were diagnosed with attention-deficit disorders (ages 3-23 years). Studies of internal consistency and test-retest reliability produced high (.90+) coefficients. Additional studies confirmed the content, construct, and criterion-related validity.

Bayley Scales of Infant and Toddler Development™-Third Edition (BAYLEY-III™)

Nancy Bayley, PhD

The Bayley-III is recognized internationally as one of the most comprehensive tools for assessing children as young as one month old. With the Bayley-III, it is possible to obtain detailed information even from children who are not yet verbally functioning. Children are assessed in the five key developmental domains: Cognition, language, social-emotional behaviour, motor skills, and adaptive behaviour. The battery identifies infant and toddler strengths and competencies, as well as weaknesses. It also provides a valid and reliable measure of a child's abilities, in addition to giving comparison data for children with high-incidence clinical diagnoses. Growth scores can be used to chart intervention progress, and the instrument can be used in program evaluation, ongoing progress monitoring, and outcome measurement.

Features of the Bayley-III

- Core battery of five scales--Three scales (i.e., cognitive, motor, language) are administered with child interaction and two scales (i.e., social-emotional, adaptive behaviour) are conducted using parent questionnaires.

- Caregiver Report--Helps examiners provide information about test results to parents and caregivers.

- Behaviour Observation Inventory--Provides a separate scale for validating examiner and parent perceptions of the child's responses.

- New norms based on 1,700 children stratified according to age and based on the 2000 U.S. Census.

- Ideal for team-testing or multidisciplinary teams where a professional in each area may assess the child.

- Flexibility--Individually administer one or more domain subtests.

New to the Bayley-III

- Two new subtests--Social-emotional and adaptive behaviour subtests, both for parental input.

- Caregiver Report--Includes suggestions to help parents plan for their child.

- Growth Scores and Growth Charts--Chart a child's growth over time.

- Screening Test--To determine if further testing is indicated.

Improvements to the Bayley-III

- Easier to administer and more user-friendly with easy-to-follow record forms, easel-back stimulus book, child-appealing manipulatives, and play-based items to facilitate assessment.

- Easier to determine if the child has performed to the target skill/behaviour.

- Floor and ceiling have been extended so that the clinician can more easily identify lower functioning infants and toddlers.

- Clinical studies presented have been improved (e.g., special data collected and presented on children with high-incidence clinical diagnoses).

- More parent/caregiver input with the addition of new test items.

Beery™-Buktenica Developmental Test of Visual-Motor Integration, 5th Ed. (Beery™ VMI)
Keith E. Beery, PhD, Norman A. Buktenica, PhD, Natasha A. Beery

Internationally respected and backed by decades of research and clinical use, the Beery VMI, now in its fifth edition, offers a convenient and economical way to screen for visual-motor deficits that can lead to learning, neuropsychological, and behaviour problems.

The Beery VMI, 5th Ed. helps assess the extent to which individuals can integrate their visual and motor abilities. The Short Form and Full Form tests present drawings of geometric forms arranged in order of increasing difficulty that the individual copies.

The newly revised Beery VMI, 5th Ed. provides supplemental visual perception and motor coordination tests that use the same stimulus forms as the Short Form and Full Form tests. These optional assessments are designed to be administered if results from either the Short Form or Full Form test shows the need for further testing, and to help compare an individual's test results with relatively pure visual and motor performance. (One or both of the supplemental tests may be used.) A statistical comparison of results from all three tests can be quickly and easily made on the graphic profile provided in the test booklets.

The Beery VMI, 5th Ed. was standardized on a national sample of 2,512 individuals ages 2-18 years and has proven reliability and validity. Updates of medical, neuropsychological, international, and other studies are reported in this edition.

Test Uses

- Identify individuals who may be encountering difficulties in visual-motor integration.
- Make appropriate referrals for needed services.
- Test the effectiveness of educational and other interventions.
- Conduct research.

Special Features of the Beery VMI, 5th Ed.

- Provides standard scores for children as young as 2 years 0 months.
- Provides approximately 600 age-specific norms from birth through age 6 years in the Manual. These consist of basic gross motor, fine motor, visual, and visual fine motor developmental stepping stones that have been identified by research criteria. The Beery VMI is scored using the Manual; results are reported as standard scores, percentiles, or other equivalents.
- Offers a culture-free, nonverbal assessment that is useful with individuals of diverse environmental, educational, and linguistic backgrounds.
- Provides time-efficient screening tools, with the Short Form and Full Form tests taking only 10-15 minutes to complete and the supplemental tests taking only 5 minutes each.
- The Short Form and Full Form tests can be administered individually or to groups. Individual administration is recommended for the supplemental tests.

New Beery VMI Materials
Authors Keith and Natasha Beery have developed the following visual, motor, and visual-motor teaching activities for use with children from birth to elementary school age:

- ***Beery VMI Developmental Teaching Activities:*** This booklet contains more than 250 activities for teachers to use with children from birth through age 6 years to develop foundations for art, academics (including pre-reading and pre-writing), and athletic skills. At each level, activities are included for gross motor, fine motor, visual, and visual-motor development.
- ***Beery VMI My Book of Shapes:*** This booklet contains 100 geometric paper-and-pencil exercises designed to focus on early prevention of problems. These exercises are designed to help students refine their motor, visual, and visual-motor development. They provide a foundation for the later teaching of letter and numeral shapes during the first semester of kindergarten.
- ***Beery VMI My Book of Letters and Numbers:*** This booklet focuses on alphanumeric exercises for students in the second semester of kindergarten. The 100 exercises use numeral and letter shapes so that the motor, visual, and visual-motor skills that children learn with geometric shape exercises can be successfully transferred to the letter and numeral shapes they will use in school.
- ***Beery VMI Developmental Wall Chart for Visual-Motor Integration:*** This laminated, full-color wall chart of basic gross motor, fine motor, visual, and visual-motor developmental stepping stones serves as a handy reminder for parents and professionals.
- ***Beery VMI Stepping Stones Parent Checklist:*** This consumable checklist provides parents with more than 200 key developmental stepping stones for making home observations that

can be shared with teachers as an important means for planning and identifying developmental progress.

Now Available!
Adult Norms and Adult Versions for the BEERY VMI

Updated for Adults
The Beery-VMI, the widely-used and well-respected test to identify difficulties children have integrating their visual-perception and motor abilities, now has norms for adults up to 100 years of age. The U.S. population is aging, and thus has created the need for better identification of possible neurological problems.

A Valuable Indicator
Studies have indicated that visuoconstructional deficits are an early indicator of dementia, such as Alzheimer's disease. Considered by clinicians and researchers as more robust and better statistically, the Beery VMI Adult Norms contain supplemental tests of visual perception and motor coordination that provide much needed information to help form a confident diagnosis.

Unlike other tests of visual motor integration that can be too intimidating, inconsistent, or insensitive to many adults, the Beery VMI has been found to be both comfortable and effective for this population.

- Can be administered in 10-15 minutes.

- Supplemental tests of visual perception and motor coordination available.

- Provides an early indicator of dementia.

Supplemental Tests
In addition to the initial test, the Beery VMI offers two optional tests that follow the administration of the Beery VMI. These tests are standardized on the same sample as the Beery VMI.

Test of Visual Perception

- 30 items.

- Involve choosing which of three geometric forms is identical to the stimulus.

- Motor tasks are reduced to a minimum.

Test of Motor Coordination

- 30 items.

- Require tracing the stimulus forms with a pencil, without going outside the double lines.

- Visual perception demands are reduced by providing strong visual guide.

Alzheimer's Disease Caregiver's Questionnaire™ (ADCQ™)
Paul R. Solomon, PhD, ADCQ User's Manual by Paul R. Solomon, PhD and Cynthia A. Murphy

Because of the projected increase in the prevalence of Alzheimer's disease, the need for appropriate measures for screening and subsequent diagnosis grows increasingly vital within both medical and social contexts. The ADCQ is a new screening instrument that evaluates the likelihood that an individual has a dementia suggestive of Alzheimer's disease. This scientifically developed measure provides an essential link to early detection and treatment.

The ADCQ is an 18-item symptom checklist that is completed by a concerned family member or someone who has sufficient knowledge about the individual. Once the caregiver has completed the checklist, a Caregiver's Report is generated that determines the *likelihood* that the rated individual has a dementia suggestive of Alzheimer's disease. The Caregiver's Report contains a summary of the behavioural problems/changes observed by the caregiver in six categories: Memory, Confusion and Disorientation, Geographic Disorientation, Behaviour, Reasoning and Judgment, and Language Abilities. It also provides recommendations regarding whether further evaluation may be warranted.

- Takes 5-10 minutes to complete.
- Ages 40 years or older.
- Requires no participation from office staff, physician, or other health care professional(s).
- Requires no cooperation or participation from the individual being rated.

Reliability/Validity

- Internal consistency reliability of .87.
- Test-retest reliability of .71 (using a smaller sample of caregivers).
- Initial validation of the ADCQ revealed a sensitivity and specificity >.87.

Requirements: Windows® 95/NT with Internet Explorer 4.0 or higher, Windows® 98/Me/2000/XP, 1.44MB 3.5" disk drive

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Behavior Rating Inventory of Executive Function™ (BRIEF™)

by Gerard A. Gioia, Ph.D., Peter K. Isquith, Ph.D., Steven C. Guy, Ph.D., and Lauren Kenworthy, Ph.D

These new parent and teacher questionnaires assess children's executive function in home and school environments. The BRIEF is useful in evaluating 5- through 18-year-olds with developmental and acquired neurological conditions such as learning disabilities, ADHD, traumatic brain injury, low birth weight, Tourette's Disorder, and autism.

Each BRIEF questionnaire includes 86 items on 8 nonoverlapping clinical scales and 2 validity scales:

Clinical Scales

Inhibit	Initiate	Organization of Materials
Shift	Working Memory	Monitor
Emotional Control	Plan/Organize	

Validity Scales

Negativity	Inconsistency of Responses

These scales form two broader indexes: Behavioral Regulation and Metacognition.

Norms are based on ratings from 1,419 parents and 720 teachers from rural, suburban, and urban areas, reflecting the U.S. population in regard to SES, ethnicity, and gender distribution. Separate norm tables for teacher and parent ratings provide *T*-scores, percentiles, and 90% confidence intervals for four developmental age groups, by gender.

Requiring just 10 to 15 minutes to complete, the BRIEF is an efficient way to evaluate impairment of executive function in children and adolescents with neurological conditions.

Behaviour Rating Inventory of Executive Function - Adult Version (BRIEF-A)

by Robert M. Roth, Ph.D., Peter K. Isquith, Ph.D., and Gerard A. Gioia, Ph.D.

This version of the BRIEF assesses executive control and self-regulation in adults, 18 to 90 years of age. Using both a Self-Report and an Informant Report, it provides a comprehensive view of an individual's daily functioning.

The BRIEF-A is composed of 75 items on 9 nonoverlapping clinical scales:

- Inhibit
- Self-Monitor
- Plan/Organize
- Shift
- Initiate
- Task Monitor
- Emotional Control
- Working Memory
- Organization of Materials

These scales form two broad indexes -- Behavioural Regulation and Metacognition -- which combine to produce an overall score, the Global Executive Composite. Three validity scales (Negativity, Inconsistency, and Infrequency) are also provided. Normative data, based on a broad sample of men and women (aged 18 to 90), reflect U.S. Census data in terms of race, ethnicity, education, and geographic region.

Both the Self-Report and the Informant Report can be completed in just 10 to 15 minutes. Most adults are able to respond to the Self-Report -- including those with developmental, systemic, neurological, and psychiatric disorders. However, if the individual has limited awareness of his or her own difficulties, the Informant Report can be used alone. Typically, both forms are administered in order to gain two perspectives on the individual's functioning.

Behaviour Rating Inventory of Executive Function Preschool Version (BRIEF-P)

by Gerard A. Gioia, Ph.D., Kimberly Andrews Espy, Ph.D., and Peter K. Isquith, Ph.D.

The assessment of executive function in preschool children is often difficult for several reasons: the variable nature of behaviour in this age range; limitations in motor and verbal proficiency in preschoolers; and the many neuropsychological, psychological, developmental, and medical

conditions that begin to manifest during the preschool years. The BRIEF-P is the first standardized rating scale designed to measure behavioural manifestations of executive function in preschool children. As such, it permits intervention at earlier stages of development.

The BRIEF-P is a single form used by parents, teachers, and day care providers to rate a child's executive functions within the context of his or her everyday environments--both home and preschool. Completed in just 10 to 15 minutes, the hand-scorable BRIEF-P Rating Form consists of 63 items that measure various aspects of executive functioning:

Inhibit   Emotional Control   Plan/Organize
Shift   Working Memory

The clinical scales form 3 broad indexes and one composite score:

Inhibitory Self-Control   Flexibility
Emergent Metacognition Global Executive Composite

The BRIEF-P also provides 2 validity scales, Inconsistency and Negativity.

Normative data are based on ratings of children, aged 2.0 through 5.11, from 460 parents and 302 teachers from urban, suburban, and rural areas, reflecting U.S. Census estimates for race/ethnicity, gender, socioeconomic status, and age. Clinical samples included children in the following diagnostic groups: ADHD, prematurity, language disorders, autism spectrum disorders, and mixed clinical.

The BRIEF-P is useful in assessing preschool-aged children with conditions such as prematurity, emerging learning disabilities and attention disorders, language disorders, traumatic brain injuries, lead exposure, and pervasive developmental disorders/autism.

Behaviour Rating Inventory of Executive Function, Self-Report Version (BRIEF-SR)
by Steven C. Guy, Ph.D., Peter K. Isquith, Ph.D., and Gerard A. Gioia, Ph.D.

The BRIEF-SR is useful in evaluating and treating adolescents (11 to 18 years of age) who have executive control problems--difficulties with reasoning, self-awareness, flexibility, organization, self-monitoring, memory capacity, or behavioral regulation. Complementing the *Behavior Rating Inventory of Executive Function* (BRIEF) Parent and Teacher Forms, this standardized, 80-item self-report scale captures an adolescent's view of his or her own purposeful, goal-directed, problem-solving behavior. This information can help you determine how much external support an adolescent needs and how you can best build a collaborative working relationship with him or her.

In just 10 to 15 minutes, the BRIEF-SR can be completed by any teen who can read at a 5th-grade-or-higher level, including those with attention disorders, language disorders, traumatic brain injury, lead exposure, learning disabilities, high-functioning autism, or other developmental, psychiatric, or medical conditions.

The inventory is composed of eight nonoverlapping clinical scales: Inhibit, Shift, Emotional Control, Monitor, Working Memory, Plan/Organize, Organization of Materials, and Task Completion. These scales form two broader indexes--the Behavioral Regulation Index and the Metacognition Index--and yield an overall summary score, the Global Executive Composite. Two validity scales, Inconsistency and Negativity, are also included.

Quick and convenient, the BRIEF-SR gives you another perspective on the self-regulatory strengths and weaknesses of adolescents.

Behavioural and Psychological Assessment of Dementia™ (BPAD™)
Kara S. Schmidt, PhD and Jennifer L. Gallo, PhD

The BPAD is a standardized informant report that assesses the changes in both behaviour and mood that are associated with the onset and course of various dementia syndromes. This 78-item assessment categorizes symptoms into three clusters (i.e., Psychopathological, Behavioural, Biological) and further, into seven domains (i.e., Perceptual/Delusional, Positive Mood/Anxiety, Negative Mood/Anxiety, Aggressive, Perseverative/Rigid, Disinhibited, Biological Rhythms). The BPAD Response Booklet is large-print to simplify completion by individuals with vision difficulties.

During administration, the respondent is asked about symptoms the patient has exhibited both within the past 4 weeks and 5 years ago. To differentiate symptoms associated with long-standing psychiatric illness from symptoms associated with the onset of behavioural disturbance related to dementia, the BPAD assesses the symptoms over these two time periods and computes a change score that captures information about changes in mood and behaviour specific to the onset and course of dementia. The BPAD was standardized and validated on a sample of men and women ages 30-90 years; these rated adults came from a wide range of racial/ethnic and educational backgrounds and geographic regions, and the sample was matched to U.S Census proportions.

Administration is done using the large-print Response Booklet and pencil, takes 15 minutes to complete, and should be completed by family members, paraprofessionals, or other professionals ages 18-90 who have regular contact with individuals who have suspected or diagnosed dementia. The items are written at a sixth-grade reading level. The BPAD can be employed in a wide range of settings (e.g., outpatient clinics, assisted living settings, clinical research settings) with heterogeneous groups of individuals with suspected or diagnosed dementia (e.g., patients diagnosed with Alzheimer's disease, patients with vascular dementia, psychiatric patients with

suspected dementia).

The BPAD Software Portfolio Makes Scoring Easy
After hand-entry of raw scores, the easy-to-use BPAD™ Software Portfolio (BPAD™-SP) generates scores that represent current impairment (i.e., CURRENT), past impairment (i.e., PAST), and change in impairment over time (i.e., CHANGE). The Score Report also provides *T* scores and percentiles for the BPAD Total and domain scores and graphical presentation of BPAD *T* scores. The BPAD-SP is included in the BPAD Introductory Kit.

Requirements: Windows® 2000/XP/Vista™; NTFS file system; CD-ROM drive for installation; Internet connection or telephone for software activation

Bender Visual-Motor Gestalt Test, Second Edition (Bender Gestalt II)
by Gary Brannigan and Scott Decker

Originally published in 1938 by Lauretta Bender, M.D., the *Bender Visual-Motor Gestalt Test* is one of the most widely used psychological tests. The Second Edition (*Bender Gestalt //*) updates this classic assessment and continues its tradition as a brief test of visual-motor integration that can provide useful information about an individual's development and psychological functioning.

Appropriate for ages 3 to 85+ years, the *Bender Gestalt //* is a reliable way to assess visual-motor development. It is also a useful introduction to any battery of educational, psychological, or neuropsychological tests. The *Bender Gestalt //* provides helpful information in preschool screening as well as geriatric assessment. And it can offer insight into many conditions, including ADHD, mental retardation, giftedness, learning disabilities, autism, and Alzheimer's Disease.

The *Bender Gestalt //* consists of a series of stimulus cards, each displaying a unique figure. The individual is asked to draw each figure as he or she observes it. The stimulus card is not removed until the drawing is complete.

This edition of the test adds items and extends the range of ability assessed. New recall procedures to measure visual-motor memory ensure a more comprehensive assessment of visual-motor skills. And supplemental tests of simple motor and perceptual ability help identify specific visual-motor deficits. An optional timing component allows the examiner to time each drawing, and scoring is now quicker and easier.

Co-normed with the *Stanford-Binet Intelligence Scales*, Fifth Edition, the *Bender Gestalt II* was standardized on more than 4,000 individuals ranging in age from 4 through 85+ years. The composition of the standardization sample corresponds to the 2000 U.S. population.

The *Bender Gestalt II* is an ideal way to start an extended psychological test battery. With its simple design and administration, the test is a nonthreatening way to warm up to more challenging assessments.

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Benton Laboratory of Neuropsychology: Selected Tests

Arthur L. Benton, PhD

These tests have demonstrated validity and provide additional substantive data in the evaluation of brain-damaged patients. Each test is designed to be quickly and easily administered, minimizing patient fatigue and maximizing the collection of reliable neuropsychological test data. Normative and validity data are described in the Manual, *Contributions to Neuropsychological Assessment*, which may be purchased separately.

Temporal Orientation

This brief test assesses the accuracy of an individual's temporal orientation with relation to the day of the week, day of the month, month, year, and time of day. The test provides a standardized procedure, based on empirically established norms, for interpreting an individual's performance.

Right-Left Orientation

This 20-item test requires an individual to point to lateral body parts on verbal command. Form B is a mirror image of Form A in which the commands are reversed. Administration time is 5 minutes.

Serial Digit Learning

This test consists of the presentation of either eight or nine randomly selected single digits for a varying number of trials up to a maximum of 12. Three alternate versions are provided for each form. Administration requires 5-10 minutes.

Facial Recognition

A three-part standardized measure of the ability to match unfamiliar faces. Contains a 27-item short form and a 54-item long form.

Judgment Of Line Orientation

This is a standardized measure of visuospatial judgment in two alternate forms. The spiral-bound booklet contains 35 stimuli, five of which are practice items.

Visual Form Discrimination

This measure of ability to discriminate between complex visual configurations provides comparative data on clients with brain disease. Composed of 16 items ranging in level of

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difficulty, this brief, convenient procedure has proven utility because of its sensitivity to effects of brain disease.

Pantomime Recognition

This test requires the client to point to drawings of objects; the pretended uses of the objects are shown in a series of 30 videotaped pantomimes.

Motor Impersistence

This battery consists of eight tests requiring the maintenance of a movement or posture: keeping eyes closed, protruding tongue (blindfolded and eyes open), fixation of gaze in lateral visual fields, keeping mouth open, central fixation during confrontation testing of visual fields, head turning during sensory testing, and saying "ah."

Booklet Category Test, 2nd Edition (BCT™)
Nick A. DeFilippis, PhD, Elizabeth McCampbell, PhD

This portable version of the widely used Halstead Category Test (CT) allows you to distinguish individuals ages 15 years and older with brain damage from normal individuals. The BCT contains 208 visual stimuli that assess complex concept formation and abstract reasoning.

Description

The two portable BCT easel binders contain all 208 Category Test designs. The task demands of the BCT are essentially equivalent to those of the CT. The BCT eliminates the need for expensive, complex projection equipment. Administration instructions are now incorporated on the backs of the Stimulus Plates and in the Response Form to aid in standardization of the BCT administration. The BCT Response Form has also been updated to enhance its ease of use. The stimuli for each subtest are presented on a single page to aid in test administration and to facilitate the review of patient responses. The new Score Summary section of the form facilitates the use of the demographically corrected normative data which are now included in the expanded BCT Professional Manual for improved diagnostic accuracy and interpretation of error scores. The revised manual also provides information about current research findings related to the clinical utility of the BCT.

Administration/Scoring

The BCT is administered by presenting the Stimulus Plates and having the respondent point to the number on the BCT Response Strip that corresponds to the pattern on each Stimulus Plate. The

examiner records the individual responses and then tallies the incorrect responses to obtain the error score.

Reliability/Validity

Regarded as the most sensitive indicator of brain dysfunction in the Halstead-Reitan Neuropsychological Test Battery, the CT is nearly as valid as the complete battery in detecting brain damage. In a cross-validation study, the BCT correlated with the CT at the same statistical level as the CT correlates with itself, suggesting that the BCT retains the high reliability and validity of the original instrument.

Boston Diagnostic Aphasia Examination, 3rd Ed. (BDAE)
Harold Goodglass, PhD, Edith Kaplan, PhD, Barbara Barresi, PhD

Since 1972, the BDAE has been the benchmark for the diagnosis of aphasia and related disorders. The text, *Assessment of Aphasia and Related Disorders*, addresses the nature of aphasia; its definition and characteristics; the normative basis for the BDAE scoring system; a specific explanation of how to administer and interpret the exam; a Severity Rating Scale that provides a meaningful standard for measuring your client's communicative ability; and a Visuospatial Quantitative Battery to test visuospatial and quantitative skills after brain injury. (This 135-page book is only available as part of the Kit.)

New to the 3rd Edition:

- A Short Form of the BDAE--takes only 30-45 minutes to complete and provides you with the option to perform a brief, no frills assessment.
- Extended tools for more in-depth study and recording of results--the regular exam has been augmented with extended tools that test syntax comprehension, locate category-specific difficulties in word comprehension and word production, and assess grapho-phonemic processing.
- The **Boston Naming Test (BNT),** which helps determine the extent of an individual's visual confrontation naming abilities, has been incorporated into the BDAE. This requires using the separately bound BNT Stimulus Cards and Record Booklets. New options for the BNT are provided and include new methods for eliciting disclosure, new approaches to scoring, and new tests for analyzing reading disorders.
- Also includes a new 90-minute videotape, *Examining for Aphasia with the BDAE*, in which Drs. Goodglass, Kaplan, and Barresi demonstrate the test materials, examiner/patient interactions, and scoring techniques through real-life examinations

of three aphasic patients.

Brief Neuropsychological Cognitive Examination (BNCE)
Joseph M. Tonkonogy, M.D., Ph.D.

Suitable for: ages 18 and up

This convenient test assesses the cognitive functions targeted in a typical neuropsychological exam. In less than 30 minutes, it gives you a general cognitive profile that can be used for screening, diagnosis, or follow-up. More efficient than a neuropsychological battery and more thorough than a screener, BNCE is an ideal way to evaluate the cognitive status of patients with psychiatric disorders or psychiatric manifestations of neurological diseases.   Appropriate for individuals 18 years of age and older, the BNCE assesses working memory, gnosis, praxis, language, orientation, attention, and executive functions. It is composed of 10 subtests, none requiring more than minimal reading skills. Five of these subtests measure the ability to process conventional, frequently used information, while the remaining five measure the ability to process novel or incomplete information. The test focuses on processing skills needed for everyday functioning, and is sensitive to mild impairment often missed by other brief cognitive screeners. The BNCE is an excellent way to start a process-oriented neuropsychological exam—It quickly reveals specific cognitive abnormalities that may warrant more detailed evaluation. And it can be used to monitor the course of both psychiatric and neurological disease. It has been found especially useful in evaluating patients with sequelae of head injury, stroke, encephalitis, and primary degenerative disorders such as Alzheimer's, Huntington's, Parkinson's and Pick's diseases and those suffering from seizure disorders, schizophrenia, mood disorders, and alcohol and drug abuse.

Brief Visuospatial Memory Test Revised (BVMT)
Ralph H. B. Benedict, Ph.D., ABCN

The BVMT-R is designed for use as a criterion measure of visuospatial memory within a large battery of neuropsychological tests, as a screening measure within a brief neuropsychological battery, and as a repeat measure to document changes in neurocognitive skills over time.

Each of the six equivalent, alternate BVMT-R stimulus forms consists of 6 geometric figures printed in a 2 x 3 array on a separate page of the Recall Stimulus Booklet. In the three Learning Trials, the respondent views the Recall Stimulus page for 10 seconds and then is asked to draw as many of the figures as possible in their correct location on a page in the Response Booklet. After a 25-minute delay which includes primarily verbal activities, the task is repeated. Then the respondent is asked to identify which of the 12 figures in the Recognition Stimulus Booklet were included in the 6 geometric figures on the original Recall Stimulus page. As a final step, an optional Copy trial may be administered to screen for severe visuoconstructive deficits and to help in scoring recall responses.

Brief Visuospatial Memory Test-Revised (BVMT-R™)

Ralph H. B. Benedict, PhD, ABCN

The BVMT-R is designed for use as a criterion measure of visuospatial memory within a large battery of neuropsychological tests, as a screening measure within a brief neuropsychological battery, and as a repeat measure to document changes in neurocognitive skills over time. It has been standardized and normed for use with adults ages 18-79 years.

BVMT-R materials were designed to be handled and transported easily, so that the test can be administered in a clinic setting or at the bedside using a clipboard. The materials include the Professional Manual, the Recall Stimulus Booklet, the Recognition Stimulus Booklet (easel format), and the Response Form. Administration requires a pencil and a stopwatch.

Each of the six equivalent, alternate BVMT-R stimulus forms consists of six geometric figures printed in a 2 x 3 array on a separate page of the Recall Stimulus Booklet. In the three Learning Trials, the respondent views the Recall Stimulus page for ten seconds and then is asked to draw as many of the figures as possible in their correct location on a page in the Response Booklet. After a 25-minute delay which includes primarily verbal activities, the task is repeated. Then, the respondent is asked to identify which of the 12 figures in the Recognition Stimulus Booklet were included in the six geometric figures on the original Recall Stimulus page. As a final step, an optional Copy trial may be administered to screen for severe visuoconstructive deficits and to help in scoring recall responses.

Normative data for the BVMT-R were derived from a sample of 588 normal participants that included 171 college students and 417 community respondents. Normative data are also provided for a 377-member subset of this normative sample, selected to reflect the age distribution of the U.S. population.

Reliability coefficients range from .96-.97 for the three Learning trials, .97 for Total Recall, and .97 for Delayed Recall. Test-retest reliability coefficients range from .60 for Trial 1 to .84 for Trial 3. The BVMT-R correlates most strongly with other tests of visual memory and less strongly with tests of verbal memory.

The BVMT-R Professional Manual contains information about the test materials and their development, administration and scoring, the normative standardization sample, and validity and reliability, as well as guidelines for interpretation. The Appendixes provide scoring examples, normative tables for the U.S. census age-matched sample, demographically corrected norm tables based on the entire sample, and information on the base rate of impairment of BVMT-R scores in various clinical samples. For most diagnostic purposes, the use of demographically corrected normative scores is recommended.

Any trained person with a background in psychological testing may administer and score the BVMT-R in less than one hour. Interpretation requires training and expertise in clinical psychology and/or neuropsychology.
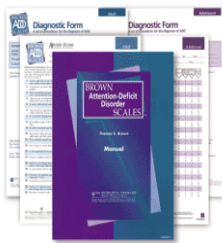
HVLT-R/BVMT-R Professional Manual Supplement
The HVLT-R/BVMT-R Professional Manual Supplement provides information on the development, use, and interpretation of several new scores, including Reliable Change scores and Discrepancy scores.

You can assess verbal learning and memory with the HVLT-R, a companion to the BVMT-R.

Brown Attention-Deficit Disorder Scales® (Brown ADD)
Thomas E. Brown, PhD

The Brown Attention-Deficit Disorder Scales are reliable, clinician-administered instruments that allow you to quickly screen for indications of Attention-Deficit Disorder (ADD) by examining a wide variety of factors believed to be associated with ADD. The Brown ADD Scales are offered in two forms: one for adolescents ages 12-18 years, and the other for adults. Obtain self-report information and scores with handy Ready Score® forms and quickly determine whether full evaluation for ADD is appropriate.

The Brown ADD Scales address the most recent developments in the understanding of ADD in an easily administered format and are among the first ADD assessment instruments to provide separate forms for assessing adults and adolescents. The Brown ADD Scales examine not only the ability to sustain attention, but also the ability to activate and organize work tasks, sustain energy and effort to complete tasks, regulate moods, utilize short-term working memory, and recall learned material. The Ready Score form gives you an immediate summary score, indicating overall impairment from a broad range of ADD symptoms. Results indicate whether the client appears to have ADD and would benefit from a full evaluation for the disorder. You can administer the 40-item self-report measure in 20-40 minutes, making it an efficient screening instrument.

Identify the following clusters frequently associated with ADD: activating and organizing to work, sustaining attention and concentration, sustaining energy and effort, managing affective interference, utilizing working memory, and assessing recall. *T* scores give you an indication of how much impairment the client is reporting on each of five clusters of ADD symptoms, relative to a nonclinical population of adults or adolescents.

The Brown ADD Scales are effective tools for monitoring treatment responses, making them especially useful in managed care settings. They are also useful as components of a comprehensive
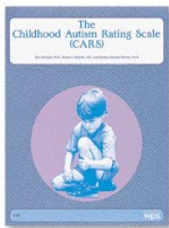
assessment for diagnosis of ADD and comorbidities. The Brown Diagnostic Form for adolescents and adults provides guidelines for comprehensive assessment of ADD and is suggested for use in conjunction with the Brown ADD Scales.

Brown ADD Diagnostic Form: Procedures for Diagnosing ADD

The Brown ADD Scales help you determine whether an individual is likely to meet diagnostic criteria for ADD. The Brown ADD Diagnostic Form helps you conduct a comprehensive evaluation by providing a set of procedures, tools, and worksheets. There are two Diagnostic Forms: one for adolescents and one for adults. The forms also include guidelines for using ability scales subtest data, often sensitive to cognitive impairments such as those exhibited by individuals with ADD. The Brown ADD Diagnostic Form components include a Protocol and Record Form for a semistructured clinical interview, a Scoring Summary, a Multirater Evaluation Form for complete *DSM-IV*" ADHD criteria, a Worksheet for analysis of IQ subtest data relevant to ADD, a Screener for Comorbid Disorders, an IQ Test Summary Form, and the Overall Diagnostic Summary Form.

Childhood Autism Rating Scale (CARS)
Eric Schopler, PhD, Robert J. Reichler, MD, Barbara Rochen Renner, PhD

The CARS is a 15-item behavioural rating scale developed to identify children ages 2 years and older with autism, and to distinguish them from developmentally handicapped children without the autism syndrome. It provides quantifiable ratings based on direct behaviour observation. The CARS is especially effective in discriminating between autistic children and those children who are considered trainable mentally retarded; it distinguishes children with autism in the mild to moderate range from children with autism in the moderate to severe range. It can also be used to evaluate adolescents or adults who have never received a diagnosis of autism.

Developed over a 15-year period, with more than 1,500 cases, the CARS includes items drawn from five of the most widely used systems for diagnosing autism. Each item covers a distinct characteristic, ability, or behaviour. After observing the child and examining relevant information from parent reports and other records, the examiner rates the child on each item, using a 7-point scale, that indicates the degree to which the child's behaviour deviates from that of a normal child of the same age. A total score is calculated by summing the individual ratings. Individuals who score above a given point are categorized as autistic. Scores falling within the autistic range are then divided into two categories: mild-to-moderate autism and severe autism. In addition to observations during formal testing sessions, the items can be rated from relevant medical records, classroom observations, and parent reports. Professionals such as special educators, school psychologists, speech pathologists, audiologists, and physicians, who have had only minimal exposure to autism, can easily be trained to administer the CARS.

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Children's Academic Intrinsic Motivation Inventory (CAIMI)
Adele E. Gottfried, PhD

For students in grades 4-8 with academic difficulties, the CAIMI is an excellent resource for differentiating motivation from achievement and ability factors. It is a valuable part of a psychodiagnostic battery for evaluating academic failure or delay. Distinguishing between motivation, achievement, and ability is of utmost importance to allow for a more complete and accurate assessment of school difficulties and for developing specific interventions. Clinical case examples employing the CAIMI are presented in the Interpretation section.

The CAIMI is also useful for the general population of students in addition to those with school difficulties. You can use the information derived from the CAIMI for counseling students with regard to academic interests and course selection; in instructional planning to stimulate motivation in weak areas and continue to facilitate intrinsic motivation in strong areas; in providing individualized program planning; and in program and educational evaluation by schools and school districts.

The 44 CAIMI questions comprise 122 items in five scales: Reading, Math, Social Studies, Science, and General. Results can be reported as *T* scores or percentiles, and the Profile Form allows a visual comparison of motivational strengths across scales. For students with academic difficulties, the CAIMI is an excellent resource for differentiating motivation from achievement and ability factors.

College ADHD Response Evaluation (CARE)
Joseph Glutting, PhD, David Sheslow, PhD, Wayne Adams, PhD

The CARE is an ADHD assessment designed specifically for college students ages 17-23 years. The CARE will establish the need for a more comprehensive psychological evaluation for those students who are concerned that symptoms of ADHD may be impacting their achievement and

may require educational accommodations. The instrument also can assist postsecondary disability service providers with students who have a documented history of ADHD.

The CARE consists of two rating scales: the Student Response Inventory (SRI), which is administered to college students, and the Parent Response Inventory (PRI), which is administered to the student's parents. Test items on these inventories that relate to anxiety disorders, mood disorders, somatic disorders, disruptive behaviour disorders, and substance abuse form the comorbidity screener.

Features of the CARE

- Reading levels are low: 6th grade for the SRI and 7th grade for the PRI.
- Examiners can use two normative standards to identify ADHD: Comparison to average college students and comparison to *DSM-IV™* diagnostic standards for adults.
- Conormed on 1,080 matched students and parents and stratified by age/grade level, gender, ethnicity, ability level, region, and classification status.
- Excellent reliability and validity.

Comprehensive Test of Phonological Processing (CTOPP)
Richard Wagner, PhD, Joseph K. Torgesen, MD, Carol Rashotte, PhD

The CTOPP test battery spans a wide range of ages and abilities. The first version, developed for individuals ages 5-6, contains seven core subtests and one supplemental test. The 2nd version, for individuals ages 7-24, contains six core subtests and eight supplemental tests. Both versions allow you to carefully assess specific phonological strengths and weaknesses. Both versions are individually administered, taking about 30 minutes to administer the core subtests. Percentiles, standard scores, and age and grade equivalents are provided.

The Phonological Awareness Quotient (PAQ) measures an individual's awareness and access to the phonological structure of oral language.
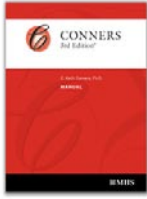
The Phonological Memory Quotient (PMQ) measures the examinee's ability to code information phonologically for temporary storage in working or short-term memory.

The Rapid Naming Quotient (RNQ) measures the examinee's efficient retrieval of phonological information from long-term or permanent memory, as well as the examinee's ability to execute a sequence of operations quickly and repeatedly.

The CTOPP was normed on more than 1,600 individuals ranging in age from 5-24 years and residing in 30 states. Internal consistency or alternate forms reliability coefficients exceed .80. The test-retest coefficients range from .70-.92.

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Conners 3rd Edition™ (Conners 3™)

C. Keith Conners, PhD

Based on the solid findings and key elements of its predecessor, the Conners' Rating Scales-Revised (CRS-R), the Conners 3rd Edition (Conners 3) offers a more thorough assessment of ADHD. The Conners 3 now addresses comorbid disorders such as Oppositional Defiant Disorder and Conduct Disorder. Each Parent, Teacher, and Self-Report Form is available in long and short versions. The Conners 3 was normed on a large sample of individuals that was representative of the general U.S. population in terms of ethnicity/race, gender, and parent education level.

What's New in the Conners 3?

- A large normative sample representative of the latest U.S. census data.
- A refined focus on ADHD in school-age children with a new age range (i.e., 6-18 years for parent and teacher scales; 8-18 years for self-report scales).
- Strengthened Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition Text Revision (DSM-IV-TR) connections.
- Clear applications in educational settings that help identify children with clinical symptoms.
- A manual that provides step-by-step guidance on how to use the tool in intervention planning and monitoring.

As with its predecessor, the new Conners 3 is a multi-informant assessment. It has a high level of consistency in the scales across raters, allowing for easy interpretation of multi-informant assessments. Users can critically examine any discrepancies between the informants, highlight certain behaviours, and easily compare results.

The Conners 3 includes two popular indexes: the Conners 3 ADHD Index (Conners 3AI) and the Conners 3 Global Index (Conners 3GI). The Conners 3AI items were taken from the Conners 3 long form and efficiently differentiate between youth with ADHD and youth without a clinical diagnosis. This brief index is ideal for users who need to quickly screen for ADHD, and works well for screening large groups of children and adolescents to see if further assessment of ADHD is warranted. The Conners 3GI is a fast and effective measure of general psychopathology. It includes the 10 best-predictive items from the CRS-R parent and teacher rating scales. The items have remained unchanged; however, the normative data has been updated.

Long Forms

The long form is a comprehensive assessment that can be used as part of the diagnostic process through direct links to the DSM-IV-TR. The Parent Form includes 110 items, the Teacher Form includes 115 items, and the Self-Report Form includes 99 items. These forms are excellent for identifying the specific needs of each youth as well as areas that require attention and focus.

- Three new validity scales (i.e., Positive Impression, Negative Impression, and Inconsistency Index) increase confidence in the informant's responses.
- An assessment of executive functioning has been added to Parent and Teacher Forms.
- Two new complete DSM-IV-TR symptom scales that measure Oppositional Defiant Disorder and Conduct Disorder have been added for all informants.
- New severe conduct critical items identify youth who require immediate attention and intervention.
- Screener items for both anxiety and depression have been added.
- Newly added impairment questions provide the ability to measure how problems are impacting a child's life at home, at school, and with friends.

Short Forms

The Conners 3 also gives clinicians the choice of using a short form. Consisting of 43 items on the Parent Form, 39 items on the Teacher Form, and 39 items on the Self-Report Form, the short form is an excellent tool for screening large groups of students who may require additional assessment. The short form includes the strongest items from the long form's empirical scales and includes Positive and Negative Impression Indexes for all informants. This form is beneficial when an assessment is repeated a number of times and/or when administration time is limited. It also is useful for monitoring the success of treatment programs over long periods.
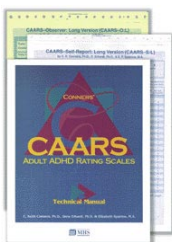
Scoring Options

The QuikScore forms convert raw scores to T scores, providing the user with a clear and easily understood profile of results, and are available for all Conners 3 forms. Computerized scoring also is available for all forms. The unlimited-use Conners 3 software enables the user to score the test and to generate Assessment Reports and Progress Reports.

Requirements: Windows 2000/XP/Vista; USB port

Conners' Adult ADHD Rating Scales (CAARS)
C. Keith Conners, PhD, Drew Erhardt, PhD, Elizabeth Sparrow, MA

The CAARS contains both self-report and observer forms, providing a balanced, multimodal assessment of adult ADHD symptoms at home, at work, and in peer interaction. Both self-report and observer forms use a 4-point Likert-style format and are written at a 6th-grade reading level. In addition, the CAARS contains a Long version, a Short version, and a Screening version. Scoring takes about 10 minutes with the handscorable, easy-to-use QuikScore™ Form.

The long versions of the Self-Report Form (CAARS-S:L) and Observer Form (CAARS-O:L) provide comprehensive information along clinically relevant dimensions. The short versions of the Self-Report Form (CAARS-S:S) and Observer Form (CAARS-O:S) were designed to be brief and display key dimensions. The screening versions of the Self-Report Form (CAARS-S:SV) and Observer Form (CAARS-O:SV) contain the scales most relevant to clinical assessment of ADHD and require only 10 minutes for administration.

Based on a large normative base of 2,000 community-based, nonclinical adults, the CAARS provides age- and gender-based norms that you can compare to the CAARS results of respondents, aged 18 years and older. It is appropriate for use by a variety of health care professionals including psychologists, social workers, and counselors, and suitable for use in a variety of settings including outpatient clinics, private practice offices, and managed care settings.

Conners' Continuous Performance Test II Version 5® (CPT II)
C. Keith Conners, PhD, MHS Staff

The CPT II V.5 is an updated version of the CPT II for Windows®. The respondents react to target letters on the screen, allowing the CPT II program to measure response time, errors, change in reaction time speed and consistency, signal detection theory statistics, and overall statistics. The unique Conners' paradigm, widely used in clinical practice and ADHD research, is still the basis for the program. The software contains large normative samples, including new ADHD clinical data and data on neurologically impaired adults.

The CPT II V.5 program produces a Conners' Multimodal Integrated Report that combines CPT II results with those obtained from the CRS-R V.5 software. You also can generate a Single Administration Report and a Multi-Administration Report, which is ideal for monitoring treatment efficacy because it compares the results of up to four administrations for the same client.

The CPT II V.5 comes with the MHS SmartLink™ client management software that offers faster report generation, enhanced client-searching capabilities, and flexible multi-user security.

Requirements: Windows® 2000 Professional or higher (not compatible with Windows XP Media Center Edition, Windows Server 2003, or Windows Vista™), CD-ROM drive, Pentium® or higher processor, 64MB RAM, USB 2.0 port, 120MB hard drive space, mouse/pointing device, Internet Explorer 4.01 SP2 or higher, VGA color monitor

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Conners' Continuous Performance Test®: Kiddie Version (K-CPT)

C. Keith Conners, PhD, MHS Staff

The K-CPT follows the same basic paradigm as the popular Conners' CPT II, but with some key differences that make it an ideal tool for the early identification of attention disorders in children ages 4-5 years. The K-CPT takes half as much time to administer as the CPT II (only 7 minutes), and pictures of objects rather than letters are presented on-screen. Young children are better able to recognize pictures rather than letters. Therefore, the K-CPT avoids the potentially confounding variable of letter recognition.

The K-CPT offers two report options: the Single Administration Report allows you to select sections for inclusion; the Multi-Administration Report allows you to compare the results of up to four administrations for the same child, making the K-CPT an ideal way to monitor treatment efficacy.

Requirements: Windows® NT 4.0 or higher, Pentium® or higher processor, CD-ROM drive, USB port, 64MB RAM, 120MB hard drive space, mouse/pointing device, Internet Explorer 4.01 SP2 or higher, 800x600 video resolution

Conners' Rating Scales-Revised Version 5 (CRS-R)

C. Keith Conners, PhD

The CRS-R Version 5 enables you to administer the CPRS-R:L, CPRS-R:S, CTRS-R:L, CTRS-R:S, CASS:L, and CASS:S on your computer, or you can enter the results from a paper-and-pencil administration for automated scoring and reporting.

The CRS-R software generates two reports: a Profile Report and an Interpretive Report. Both reports include demographic information on the first page. The Profile Report, available for all six main scales, provides a graph that displays the individual's T scores for each of the subscales and tips for interpretation. The Interpretive Report includes the graphs from the Profile Report, as well as a description of the Index score results and overall results, plus treatment suggestions. The Interpretive Report is only available for the three long scales: CPRS-R:L, CTRS-R:L, and CASS:L.

The CRS-R V.5 software offers fast report generation, detailed client searching capabilities, easy access from your Windows® desktop, flexible multi-user security, and scalability for growth to

networks of any size. This version includes Profile Reports for the CGI and CADS auxiliary scales. It also includes Rater Comparison Reports and Progress Reports at no additional charge. The CRS-R V.5 program works with the MHS SmartLink™ client management program.

Requirements: Windows® NT 4.0 or higher, Pentium® or higher processor, CD-ROM drive, 64MB RAM, 120MB hard drive space, USB port, mouse/pointing device, Internet Explorer 4.01, SP2 or higher

Conners' Rating Scales-Revised (CRS-R)
C. Keith Conners, PhD

This revision adds a number of enhancements to a set of measures that has long been one of the standard instruments for the assessment of attention deficit/hyperactivity disorder (ADHD) in children and adolescents ages 3-17 years. Items have been added that match the symptoms for ADHD outlined in the *Diagnostic and Statistical Manual of Mental Disorders-4th Edition* (*DSM-IV™*). Published using the QuikScore™ format, the CRS-R evaluates problem behaviours as reported by the teacher, parents or alternative caretakers, and adolescents. As with the original CRS, the new scales are valuable tools for measuring treatment changes as well as for program evaluation.

All three instruments (Parent, Teacher, and Self-Report) contain scales created through factor analyses to assess a broad range of significant problem behaviours. In addition, all three instruments contain rationally created scales (the ADHD/DSM-IV scales) that correspond with *DSM-IV™* criteria for ADHD; they also contain a new empirically created index for assessing children and adolescents at risk for a diagnosis of ADHD. The widely used Hyperactivity Index for parent or teacher ratings (renamed the Conners' Global Index) also is included on the parent and teacher forms.

Normative data for the revised forms come from 11,000 community-based children and adolescents throughout the United States and Canada.

Both Long (CPRS-R:L) and Short (CPRS-R:S) Forms have been developed to assess problem behaviours reported by parents. Normative data for these revised scales come from the ratings of more than 2,000 parents.

Both Long (CTRS-R:L) and Short (CTRS-R:S) Forms have been developed to assess behaviours reported by teachers. Normative data for these revised scales come from the ratings of approximately 2,000 teachers.

The Conners-Wells' Adolescent Self-Report Scale: Long (CASS:L) and Short (CASS:S) versions have been developed to assess self-reports of problem behaviours. Normative data for these new scales come from the ratings of over 3,000 adolescent respondents.

Note:

- The CRS-R scales are perfectly suited for use in managed care settings. The scales allow for the quantification and measurement of a variety of behaviour problems.
- CRS-R scores help to identify when treatment is necessary, whether treatment is effective, and when treatment should be terminated. The short scales are particularly useful for frequent monitoring of a child's status.
- QuikScore™ Forms are designed for easy administration, scoring, and profiling of results.
- Feedback Forms are designed to provide professional-looking assessment feedback and presentation of results.
- The User's Manual addresses administration, scoring, and interpretation of the CRS-R.
- The Technical Manual reports norm samples, psychometric properties, and validity, as well as administration, scoring, and interpretation information.

Das-Naglieri Cognitive Assessment System (CAS™)
Jack A. Naglieri, PhD, J. P. Das, PhD

The CAS is an assessment battery designed to evaluate cognitive processing. It was developed to integrate theoretical and applied areas of psychological knowledge using cognitive processing theory and tests designed to measure those processes--Planning, Attention, Simultaneous, and Successive (PASS)--in individuals ages 5-17 years.

- Measures the cognitive processes of Planning and Attention (important for evaluation of attention deficits and brain injuries).
- Also measures simultaneous processing (ability to integrate individual stimuli into a single whole/group and understand logical-grammatical relationships), and successive processing (involving working with things in a specific serial order sequence and the formation of sounds and movements in order).
- Predicts achievement and evaluates ability-achievement discrepancy.
- Facilitates the identification of attention-deficit/hyperactivity disorders, traumatic brain injury, learning disabilities, mental retardation, and giftedness.
- Provides flexible administration options: an 8-subtest Basic Battery and a 12-subtest Standard Battery.

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Organization:

To meet examiner need for flexibility, the CAS has two forms, a Standard Battery and a Basic Battery. Each of the two forms is composed of Planning, Attention, Simultaneous, and Successive (PASS) scales. In the Standard Battery, these scales are composed of three subtests each. In the Basic Battery, the scales are composed of two subtests each.

Interpretation:

Methods to evaluate the results obtained from the CAS are described in *The Interpretive Handbook*. The Planning, Attention, Simultaneous, and Successive (PASS) scale scores and the Full Scale score are reported as standard scores with a mean of 100 and *SD* of 15. Subtest scaled scores with a mean of 10 and *SD* of 3 are also provided.

For determining intraindividual differences, tables are provided to evaluate the significance of the differences between the four PASS scale standard scores. Similar tables are provided for evaluating the significance of differences between scaled scores for each subtest within a PASS scale.

To assess ability-achievement discrepancies, Simple-Difference and Predicted-Difference tables are provided. These tables are based on the sample that was administered both the CAS and WJ-R Tests of Achievement.

Methods for using the PASS scores to identify cognitive strengths and weaknesses, as well as related academic weaknesses, are also given. The unique information obtained from the CAS results is particularly helpful when assessing special populations.

The Interpretive Handbook that accompanies the CAS provides additional resources for examiners, including detailed interpretative strategies and implications for intervention based on CAS results. Several research-based programs of instruction directly linked to PASS Theory are also described. Two illustrative case reports, each presenting a written interpretation of CAS results, are also included.

Developmental Assessment of Young Children (DAYC)
Judith K. Voress, Taddy Maddox

The DAYC is a battery of five subtests that measure different but interrelated abilities. The battery, which is designed for use with children from birth through 5.11 years, was created to measure the five areas of assessment mandated by IDEA: cognition, communication, social/emotional

development, physical development, and adaptive behaviour. The five subtests (one for each of the domains) can be administered separately or as a comprehensive battery in about 10-20 minutes.

The DAYC can be used: (a) to differentiate children who are developing normally and those who are significantly below their peers in cognitive, communication, social/emotional, physical, or adaptive behaviour; (b) to determine a child's specific strengths and weaknesses in developmental abilities; (c) to document a child's developmental progress as a consequence of special intervention programs; and (d) to measure developmental abilities in research studies.

The DAYC format allows you to obtain information about a child's abilities through observation, interview of caregivers, and direct assessment.

The DAYC was normed on a national sample of 1,269 individuals, broken into 23 age groups. The reliability of the DAYC has been studied, and evidence relating to content-sampling and test-retest time sampling reliability is provided. Reliability coefficients range from .90-.99. Standard Error of Measure (*SEM*) ranges from 1.5-4.74, with the majority smaller than 3.0. Reliabilities for children identified as environmentally at-risk and biologically at-risk are .98 and .99.

Developmental Profile 3 (DP-3)
Gerald D. Alpern, PhD

Like previous versions, the new DP-3 evaluates children's functioning in five key areas (Physical, Adaptive Behaviour, Social-Emotional, Cognitive, Communication) in just 20-40 minutes. This edition adds norm-based standard scores, an expanded age range, updated item content, clearer interpretive guidelines, a nationally representative standardization sample, suggested remediation activities, and unlimited computer scoring and interpretation.

Designed to evaluate children from birth through 12 years, 11 months, the DP-3 includes 180 items, each describing a particular skill. The respondent simply indicates whether or not the child has mastered the skill in question. The DP-3 provides a General Development score as well as the following scale scores: Physical, Adaptive Behaviour, Social-Emotional, Cognitive, and Communication.

Administration Options
Typically, the DP-3 is administered as an interview, during which a parent or caregiver answers yes-or-no questions about the child. Within each scale, basals and ceilings are used, so it is not necessary to administer all 180 items. Start and stop points ensure that only age-appropriate questions are asked, making the interview focused and efficient. Because each scale has its own norms, each can be used individually.

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Although the Interview Form is the preferred method of administration, the DP-3 offers an alternative that's useful when time, research, or clinical needs make an interview unfeasible. A new Parent/Caregiver Checklist contains the same item content as the Interview Form (language has been altered slightly). Written at a sixth-grade reading level, the Checklist can be completed by the child's parent or caregiver without examiner supervision. It offers a convenient option when a face-to-face interview is not possible.

National Norms and Five Kinds of Scores
DP-3 norms are based on a sample of 2,216 typically developing children representative of the U.S. population in regard to ethnicity, geography, and socioeconomic status. Scores are available in five formats: standard scores, percentile ranks, stanines, age equivalents, and descriptive ranges.

What's New in the DP-3?

- Norm-based standard scores that are useful in determining eligibility for services.

- Expanded age range--up to 12 years, 11 months.

- A Parent/Caregiver Checklist, that can be used when an interview is not feasible.

- Updated item content reflecting recent cultural and technological changes.

- Improved interpretive guidelines.

- Suggested intervention activities for each skill measured.

- A General Development score for those who require an overall index of development.

- An unlimited-use scoring and interpretive program.

IDEA Compliance
Efficient and accurate, the DP-3 identifies developmental delays early in a child's life. Its norm-based standard scores allow you to compare children's functioning with that of their peers, to design interventions that meet their particular needs, and to monitor their progress over time.

Because the DP-3 meets federal criteria for evaluating children with developmental problems, it is useful for determining eligibility for special education, planning IEPs, and implementing periodic screening programs. Its five scales correspond to the five domains specified in IDEA for assessing developmental delays. In addition, the DP-3's interview format and provision of a parent report satisfy the federal requirement that parents be involved in their child's assessment.

Unlimited Computer Scoring and Interpretation
Provided on an unlimited-use CD-ROM, the DP-3 computer program saves time, reduces the chance of error, and gives you a wealth of information. It includes the following features:

- **Scoring and interpretation**--The program calculates all DP-3 scores (i.e., standard scores, percentile ranks, stanines, and age equivalents) and provides a ready-to-use interpretive analysis.

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- **Graphical representation of scores**--A clear-cut graphic profile makes it easy to spot advanced or delayed development across the five scales and the General Development score.

- **Scale pattern analysis and scale-by-scale item analysis**--These calculations--which are difficult or impossible in hand scoring--allow you to tease out subtle distinctions in a child's profile. Scale comparisons reveal statistical significance in the pattern of strengths and weaknesses, while item analysis pinpoints skills not yet mastered (i.e., items failed) below the child's ability level on each scale.

- **Individualized intervention activities**--For each scale, the program suggests teaching activities that address the child's specific weaknesses.

- **Clinician and parent reports**--The program generates both a thorough clinical report for professionals and an easy-to-understand summary for parents. Compatible with most word processing programs, these reports can be easily customized.

Requirements: Windows® 98/XP/2000/Me, CD-ROM drive

Developmental Test of Visual Perception-2nd Ed. (DTVP-2)
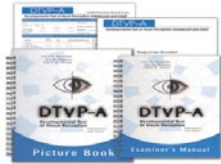Donald D. Hammill, EdD, Nils A. Pearson, PhD, Judith K. Voress

The DTVP-2 is a battery of eight subtests that measure different but interrelated visual-perceptual and visual-motor abilities. Each of the eight subtests measures a type of visual-perceptual ability that is easily classified as: Position in Space, Form Constancy, Spatial Relations, or Figure-Ground. In addition, each subtest is classified as either motor-reduced or motor-enhanced.

The battery, which is designed for use with children ages 4-10 years, has empirically established reliability and validity. Internal consistency reliabilities (i.e., alphas) and stability reliabilities (i.e., test-retest) for all scores exceed .80 at all ages. Standard scores, NCEs, percentiles, and age equivalents are provided in the Examiner's Manual. The normative sample consists of 1,972 children residing in 12 states. In addition, the DTVP-2 has demonstrated lack of bias relative to race, gender, and handedness.

The DTVP-2 can be used to document the presence and degree of visual-perceptual or visual-motor difficulties in children, to identify candidates for referral, to verify the effectiveness of intervention programs, and to serve as a research tool.

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Developmental Test of Visual Perception-Adolescent and Adult (DTVP-A)

Cecil R. Reynolds, PhD, Nils A. Pearson, PhD, Judith K. Voress

The DTVP-A is a battery of six subtests that measure different but interrelated visual-perceptual and visual-motor abilities. The DTVP-A subtests include: Copying, Figure-Ground, Visual-Motor Search, Visual Closure, Visual-Motor Speed, and Form Constancy.

The battery, which can be administered by psychologists, neuropsychologists, occupational therapists, physical therapists, regular and special educators, and diagnosticians who are interested in examining the visual-perceptual status and visual-motor integration skills of adolescents and adults ages 11.0-74.11 years, has empirically established reliability and validity. The normative sample included 1,664 adolescents and adults residing in 19 states; demographic characteristics approximate the current census data. Administration is individual and takes approximately 25 minutes.

The DTVP-A is especially useful in the evaluation of the neuropsychological integrity of TBI and stroke patients where right-hemisphere function may be at issue. Normed through age 75 years, the DTVP-A has sufficient floor (or easy items) to allow accurate assessment of individuals with severe TBI and other neurologically impaired individuals. The reliability of the various subtest and index scores indicates that the DTVP-A will be sensitive to improvement over the course of treatment. The subtest and index scores also will suggest areas of emphasis in cognitive and fine motor rehabilitation.

The DTVP-A is particularly useful in distinguishing true visual-perceptual deficits from problems solely with complex eye-hand or perceptual-motor actions. The DTVP-A may also assist in differential diagnosis of the various dementias in elderly patients, providing a baseline for normal aging changes in perception and perceptual-motor skills against which the referred patient may be referenced.

Composite Scores or Indexes:

The most reliable scores for the DTVP-A are the indexes. These scores are found by adding the standard scores of the subtests that comprise a composite and converting the sum to an index.

- **General Visual-Perceptual Index:** The GVPI is the best measure of what the majority of people mean when they say 'visual perception.' Data from six subtests, each of which measures a different type of visual perception in a different manner, contribute to the GVPI. When GVPIs are below 90, examiners need to pay more attention to the two clinically relevant indexes-the Motor-Reduced Visual Perceptual Index (MRVPI) and the Visual-Motor Integration Index (VMII). Examination of these indexes may help explain the causes for low GVPI scores.

- **Motor-Reduced Visual Perception Index:** Of all of the DTVP-A indexes, the MRVPI is the 'purest' and most direct measure of visual perception, in that only minimal motor skills (e.g., pointing) are required to show perceptual competence. This index is formed by combining the standard scores from the Figure-Ground, Visual Closure, and Form Constancy subtests.
- **Visual-Motor Integration Index:** To do well on this composite, individuals must perform complex eye-hand coordination tasks. Low scores do not necessarily indicate poor visual perception; they may mean that the individuals have awkward hand movements or that they have difficulty coordinating hand-to-eye movements. This index is formed by combining the standard scores of the Copying, Visual-Motor Search, and Visual-Motor Speed subtests.

Special Features of the DTVP-A

- Subtests were developed to be appropriate for adolescents and adults.
- The normative sample reflects the current population characteristics of the United States relative to race, ethnicity, gender, geographic region, parent education, and income.
- Internal consistency, stability, and interscorer reliability for all indexes are high.
- Validity evidence shows that all DTVP-A subtests and indexes are useful for measuring visual-perceptual and visual-motor integration skills.
- Evidence is provided to show that the test is unbiased with respect to gender and race.

Diagnostic Achievement Battery, 3rd Ed. (DAB 3)
Phyllis Newcomer, PhD

The DAB 3 is a cost-effective and culturally fair assessment tool that is quick and easy to administer. It uses 14 short subtests to determine a child's strengths and weaknesses across several areas of achievement. Scores from the subtests can be combined to form eight composites: Total Achievement, Listening, Speaking, Reading, Writing, Mathematics, Spoken Language, and Written Language. The subtests include the following:

- Story Comprehension
- Characteristics
- Synonyms
- Grammatic Completion
- Alphabet/Word Knowledge
- Reading Comprehension
- Capitalization

- Punctuation
- Spelling
- Contextual Language
- Story Construction
- Math Reasoning
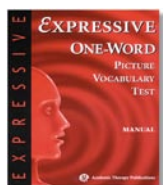- Math Calculation
- Phonemic Analysis

Many Improvements Were Made in This Updated Edition

- All new normative data that reflect the changing population characteristics of the U.S., collected from 1997-2000; the test was standardized on 1,534 students in 13 states (ages 6-14 years).
- Provides several new validity studies, including correlations with the Wechsler Intelligence Scales for Children-III® and the Stanford Achievement Test-9th Edition, plus studies showing the absence of gender, ethnic, and disability bias.
- Improved scoring criteria for the written composition that includes contextual language and story construction.
- More appealing and realistic color pictures, clearer administration procedures, and a new story audiotape.
- The DAB 3 includes a supplemental Manual enabling you to probe student responses on the standardized test to identify the thinking processes and problem solving strategies that result in both correct and incorrect responses.

The DAB 3 generates standard scores ($M = 10$, $SD = 3$ for the subtests, and $M = 100$, $SD = 15$ for the composites), percentile ranks, and age/grade equivalents. The test was standardized on 1,534 students in 13 states. The sample is representative of the national population with regard to gender, race, ethnicity, geographic region, and urban/rural residence.

Expressive One-Word Picture Vocabulary Test, 2000 Ed. (EOWPVT)
Edited by Rick Brownell

This is an individually administered, norm-referenced test of an individual's ability to name objects, actions, and concepts pictured in illustrations. The individual's performance, when compared to the normative group, gives an indication of his or her English-speaking vocabulary.

The EOWPVT has a number of specific uses, including assessing the extent of speaking vocabulary, assessing cognitive ability, diagnosing expressive aphasia, screening preschool and kindergarten children, evaluating an English learner's vocabulary, monitoring growth, and evaluating program effectiveness.

- All Test Plate illustrations have been newly rendered in full color with drawings that are easy to interpret and that better hold the examinee's interest.
- Norms are based on a representative sample of 2,327 school-age individuals ages 2-18.11 years in the United States; the sample was stratified by age, geographic region, ethnicity, level of parent education, community size, and gender.
- The test is conormed with the Receptive One-Word Picture Vocabulary Test for easy comparison of expressive and receptive vocabulary.
- Directions are included on each Record Form along with a list of item prompts.
- Instructions for using examiner prompts and cues are included to ensure assessment accuracy.
- Easy to use--The Manual provides detailed administration instructions, development procedures, and national norms; a series of Test Plates are bound in a spiral booklet with a fold-out easel.

Gilliam Asperger's Disorder Scale (GADS)
James E. Gilliam, EdD

The GADS is a norm referenced test designed to evaluate individuals with unique behavioural problems who may have Asperger's Disorder. Based on the most current and relevant definitions and diagnostic criteria of Asperger's Disorder, the GADS is useful for contributing valuable information toward the identification of individuals who have this disorder. Easily completed by a parent and professional who knows the individual, the GADS provides documentation about the essential behaviour characteristics of Asperger's Disorder necessary for diagnosis. It can be used in the assessment process to document behavioural progress, to target goals for IEPs, and for research purposes. The validity of the GADS was demonstrated by confirming that (a) the items of the test are directly related to the definitions of Asperger's Disorder, (b) the subscales are strongly related to each other and the overall diagnosis of Asperger's Disorder, and (c) the GADS scores discriminate persons with Asperger's Disorder from persons with autism and other behavioural disorders.
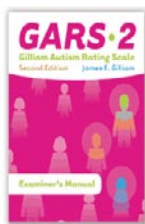
The GADS has the following characteristics:

- Thirty-two clearly stated items divided into four subscales describe specific, observable, and measurable behaviours.
- Eight additional items are included for parents to contribute data about their child's development during the first 3 years of life.
- Items are based on the most current definitions of Asperger's Disorder.

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- The test was normed on 371 representative individuals with Asperger's Disorder (ages 3-22 years) from 27 states, the District of Columbia, Canada, and Australia.
- Behaviours are rated using objective, frequency-based ratings.
- Standard scores and percentiles are provided.
- A table is provided for determining the likelihood that an individual has Asperger's Disorder.
- A list of books, journals, media, Internet sites, and organizations concerned about Asperger's Disorder are provided to give teachers, parents, and others information about Asperger's Disorder.

Gilliam Autism Rating Scale, 2nd Ed. (GARS-2)
James E. Gilliam, EdD

The GARS-2, a revision of the popular Gilliam Autism Rating Scale, is a norm-referenced instrument that assists teachers, parents, and clinicians in identifying and diagnosing autism in individuals ages 3-22 years, as well as estimating the severity of the individual's disorder. Items on the GARS-2 are based on the definitions of autism adopted by the Autism Society of America and the *DSM-IV-TR™*.

The instrument consists of 42 clearly stated items describing the characteristic behaviours of persons with autism. The items are grouped into three subscales - Stereotyped Behaviours, Communication, and Social Interaction. Using objective, frequency-based ratings, the entire scale can be completed and scored in 5-10 minutes. A structured interview form is included for gathering diagnostically important information from the individual's parents.

The GARS-2 was normed on a representative sample of 1,107 individuals with autism from 48 states within the U.S. The GARS-2 has strong psychometric characteristics that were confirmed through studies of the test's reliability and validity. Coefficients of reliability (internal consistency and test-retest) for the subscales and entire test are all large to very large in magnitude. The validity of the GARS-2 was demonstrated by confirming that (a) the items on the subscales are representative of the characteristics of autism; (b) the subscales are strongly related to each other and to the performance of other tests that screen for autism; (c) the GARS-2 standard scores discriminate persons with autism from persons with other severe behavioural disorders.

Improvements in the GARS-2

- A structured parent interview form replaces the Early Development subscale providing examiners with diagnostically significant information about the individual's development during early childhood.

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- Some items have been rewritten for clarity or to remove ambiguity.

- Demographic characteristics of the normative sample are keyed to the 2000 U.S. Census data.

- All new norms were created and the normative sample is more clearly described.

- The total score on the GARS-2 was changed from Autism Quotient to Autism Index.

- Guidelines for interpreting subscale scores and the Autism Index were changed.

- A separate chapter in the test manual provides multiple discreet target behaviours for each item on the GARS-2. The discreet behaviours are operationally defined and specific examples are given for applied research projects and other research purposes.

- A separate booklet, *Instructional Objectives for Children Who Have Autism*, is included in the test kit to assist in the formulation of instructional goals and objectives based on the results from the GARS-2.

Gray Diagnostic Reading Tests, 2nd Ed. (GDRT 2)

Brian R. Bryant, PhD, J. Lee Wiederholt, EdD, Diane P. Bryant

The GDRT 2 has been revised and updated to reflect current research in reading. The GDRT 2, along with the Gray Oral Reading Tests, 4th Ed. (GORT 4) and the Gray Silent Reading Tests (GSRT), form the Gray reading test battery. The GDRT 2 assesses students who have difficulty reading continuous print and who require an evaluation of specific abilities and weaknesses. Two parallel forms are provided to allow you to study a student's reading progress over time.

The GDRT 2 has four core subtests, each of which measures a significant reading skill: Letter/Word Identification, Phonetic Analysis, Reading Vocabulary, and Meaningful Reading. The three supplemental subtests--Listening Vocabulary, Rapid Naming, and Phonological Awareness-- measure skills that play an important role in the diagnosis or teaching of developmental readers or children with dyslexia.

The GDRT 2 was normed on a sample of 1,018 students, ages 6-13 years. The normative sample was stratified to correspond to key demographic variables (i.e., race, gender, geographic region).

The reliabilities of the test are high; all above average internal consistency reliabilities for the composites are .94 or above. Studies showing the absence of culture, gender, race, and disability

have been added; and several new validity studies have been conducted and are included in the Examiner's Manual.

KOPPITZ-2: Koppitz Developmental Scoring System for the Bender®Gestalt Test, 2nd Ed. (KOPPITZ-2)
Cecil R. Reynolds, PhD

The KOPPITZ-2 has been expanded to cover a broad age range with additional designs and a revised scoring system to add reliability at all levels. For the first time, the Koppitz Developmental Scoring System has been normed on a nationally stratified, census matched sample of children and adults from throughout the United States.

The KOPPITZ-2 is ideal for use by psychologists, educational diagnosticians, licensed professional counselors, Occupational Therapists, and others with proper training in the use of psychologically based tests of visual-motor integration. It is a highly reliable, valid measure of visual-motor integration skills that applies the developmental approach to scoring made so popular by its originator, Dr. Elizabeth Munsterberg Koppitz. The KOPPITZ-2 is true to Dr. Koppitz's original conceptualization but has been redeveloped to meet current psychometric standards. The age range has been extended to allow the evaluation of special education students through age 21 years and to assist in the evaluation of the visual-motor integration deficits of the growing population of seniors. For older children and adults, both 2 and 3 dimensional drawings are now required that reveal subtle deficits in visual-motor integration processes.

The Bender Gestalt Test has long been one of the most frequently administered of all psychological tests. The Koppitz Scoring System, with long outdated norms from the 1960s remained popular for 40 years due to its contribution to clinical assessment of individual children. The original Koppitz Scoring System was used in more than 500 published research studies on children with visual-motor integration problems, brain injury, learning problems, and various forms of emotional disturbance. This revision remains true to Dr. Koppitz' original views of the drawing of the Bender Gestalt figures and the reduction in errors in the execution of these drawings as a true developmental phenomenon. The figures are derived from theories of Gestalt psychology.

The KOPPITZ-2 requires the examinee to draw increasingly complex figures from a model (the Bender designs) on a plain sheet of white paper and to organize the task independently.

The KOPPITZ-2 assesses the ability to relate visual stimuli accurately to motor responses and to organize the drawing task independently. It does so using a less structured task than other tests of visual-motor integration, thereby providing a more ecologically sound approach to assessment of visual-motor integration skills relative to highly structured drawing tasks.

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Uses for the KOPPITZ-2

- To determine the presence and degree of any extant visual-motor problems.

- To identify candidates for remedial programs and visual-motor training.

- Evaluate the effectiveness of intervention programs and monitoring recovery following acute injury.

- Monitor the progress of progressive degenerative disease processes that affect visual-motor integration skills.

- To gather research regarding the visual-motor integration process.

Key Features:

- Time and cost efficient.

- Maintains a developmental view of visual-motor integration and provides separate scoring systems for young children (ages 5-7 years) and older children and adults (ages 8 -85 years and older).

- Completely nonverbal and useful with individuals from widely varied cultural and ethnic backgrounds.

- High reliability across age, gender, and ethnicity with reliability coefficients reported in the Manual for multiple subgroups, including individuals with various disorders.

- Designed for individual administration, the KOPPITZ-2 allows careful observation of the examinee to gain insights into the qualitative nature of any visual-motor integration problems evident.

- Detailed scoring guides and a clear template are provided for the developmental scoring systems that result in high levels of interscorer reliability.

- Provides standard scores and percentile ranks along with specialized scores and age equivalents to meet the needs of all practitioners.

- The total normative sample of 3,600 persons is matched to U.S. Bureau of the Census statistics on socioeconomic factors, ethnicity, geographic region, community size, and other critical variables to ensure representativeness of the United States population as a whole.

- Internal consistency (alpha) reliabilities for all but one age are greater than .80 (exception is the reliability for 5-year-old children = .77); the average of reliabilities across ages is .88. The test correlates highly with the WISC-III Performance Scale and Perceptual Organization Index.

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- A special chapter of the Manual is devoted to the Koppitz Emotional Indicators (EIs) and their proper use. A specialized scoring form is provided just for this purpose to make scoring of the Koppitz EIs easy and objective but also to maintain them as a separate record from the Developmental Scoring System.

Kaufman Assessment Battery for Children, 2nd Ed. (KABC-II)

Alan S. Kaufman, PhD, Nadeen L. Kaufman, EdD

Extensively redesigned and updated, the new KABC-II provides a detailed, accurate assessment of cognitive ability in children of different backgrounds and with diverse problems. With the KABC-II, you can choose from two theoretical models to meet the needs of each examinee. Administer the same subtests on four or five ability scales. Then, interpret the results using the Luria or Cattell-Horn-Carroll (CHC) model, based on the reason for referral or the child's background. In addition, a nonverbal option allows you to assess a child whose verbal skills are severely limited.

A range of scales and subtests gives you a detailed picture of cognitive ability. KABC-II scales include: Sequential Processing/Short-Term Memory, Simultaneous Processing/Visual Processing, Learning Ability/Long-Term Storage and Retrieval, Planning Ability/Fluid Reasoning, and Knowledge/Crystallized Ability.

Core subtests on each scale give you reliable scores. Fully normed and validated supplemental subtests let you explore your hypotheses.

KABC-II subtests are designed to minimize verbal instructions and responses. Test items also contain limited cultural content, so children of diverse backgrounds are assessed more fairly.

The KABC-II approach provides insights into how a child receives and processes information, helping you pinpoint cognitive strengths and weaknesses. Additionally, supplemental subtests are offered to allow hypothesis testing.

What's New in the KABC-II?

- A dual theoretical foundation--using the Luria neuropsychological model and the Cattell/Horn/Carroll (CHC) approach--helps you obtain the data you need for each individual you test.

- A new, optional Knowledge/Crystallized Ability scale, so you can use one test with all children.

- An expanded age range for ages 3-18 that allows you to use one test for preschool, elementary, and high school children.

Now Available! KABC-II Assist™ Computer Software
Quick and accurate, this software program makes scoring and reporting even simpler with four analysis options including Score Summary, Summary Profile, Achievement/Ability Comparison, and Additional Diagnostic Information for hypothesis generation.

Requirements: Windows® 98 SE or higher, CD-ROM drive, 200Mhz or higher speed processor, 40MB disk space

Kaufman Functional Academic Skills Test (K-FAST)
Alan S. Kaufman, PhD, Nadeen L. Kaufman, EdD

The K-FAST is composed of 2 subtests, Reading and Arithmetic, that assess aspects of adaptive behaviour involving the application of academically related acquired learning to the problems of daily living. The K-FAST items relate to everyday activities that occur outside school settings, such as the ability to:

- Understand labels on drug containers
- Follow directions in a recipe
- Budget monthly expenses
- Make price comparisons between products

Because this measure can help assess a person's capacity to function effectively in society, it can be used by schools, adult education programs, clinics, hospitals, prisons, the military, senior care facilities, and more (ages 15-85 years). Also, it can be administered and scored by a variety of personnel, although results should be interpreted only by qualified professionals.

Performance on the two subtests and the Functional Academic Skills Composite can be interpreted using standard scores. The K-FAST was normed on a representative sample of 1,424 people. All items were checked for cultural bias. Several studies support the K-FAST's reliability and validity, using both normal and clinical samples.

The K-FAST was developed, field-tested, and standardized with the Kaufman Adolescent and Adult Intelligence Test (KAIT), the Kaufman Brief Intelligence Test, 2nd Ed. (KBIT-2), and the Kaufman Short Neuropsychology Assessment Procedure (K-SNAP).

The two subtests are contained in a hard-cover, easel-type test booklet, which allows the examiner to see the test directions and scoring key on one side while the client sees the item stimulus on the other. The Manual includes information necessary for proper administration

and scoring, instructions and tables for obtaining derived scores, procedures for interpreting the scores, information about test standardization and development, and results of reliability and validity studies. The Individual Test Record includes a graph that permits a visual display of standard scores.

Kaufman Survey of Early Academic and Language Skills (K-SEALS)
Alan S. Kaufman, PhD, Nadeen L. Kaufman, EdD

This versatile instrument surveys both expressive and receptive vocabulary in an organized, systematic fashion. Children must identify objects, actions, numbers, letters, and words in expressive and receptive formats. They also must demonstrate verbal reasoning and understanding of quantitative concepts.

- May be used for a variety of purposes, from testing school readiness and identifying gifted children to evaluating program effectiveness and researching children's early development. It may be used in preschools, kindergartens, elementary schools, speech and language clinics, medical agencies, and any other setting in which young children are assessed.
- Offers several reliable scores that reflect many aspects of the child's language and early academic development.
- Subtests include Vocabulary, Number, and Articulation Survey.
- Scores can be profiled in a graph format on the Individual Test Record.
- Normed on a representative national sample of young children ages 3-6 years.
- Manual fully describes the instrument, its uses, administration, scoring, and interpretation in a step-by-step format.

Kent Visual Perceptual Test (KVPT)

Lawrence E. Melamed, PhD

The KVPT is an integrated battery of interrelated tests that demonstrate impairment and distinguish skill levels among three visual processes related to the development of basic reading, early mathematics, and written expression. These tests are particularly effective in both individualized neuropsychological assessment and psychoeducational assessment.

The KVPT-D (Discrimination) requires the individual to select (from a set of alternatives) the item that matches a standard form. Stimuli are presented in a binder for ease of administration.

The KVPT-C (Copy) consists of three increasingly difficult subtests that require the individual to reproduce forms of the same type as the KVPT-D items.

The KVPT-M (Immediate Memory) requires the individual to locate a target form within a set of alternatives immediately following a brief exposure to the form. Stimuli are presented in a binder for ease of administration.

For neuropsychological assessment, the KVPT can be used as the core visual processing battery to characterize visual-perceptual deficits and distinguish them from visual memory or visual motor problems. Use the KVPT to distinguish visual-spatial errors or to distinguish a deficit due to errors in processing the spatial features of forms from errors in reproducing (copying) the forms. The KVPT is sensitive to stroke-related deficits.

In a school setting, the KVPT can help professionals in school psychology and/or special education to predict early achievement and to identify and remediate reading, mathematics, and written expression difficulties due to visual processing (e.g., determining that a child with difficulty identifying appropriate mathematical operations has a visual-spatial processing deficit). The Professional Manual provides a chapter on clinical interpretation that demonstrates the way appropriate academic interventions can be developed based on a child's KVPT profile.
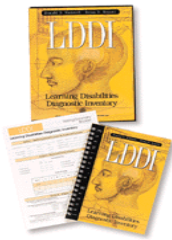
All three tests come from a common pool of two-dimensional items based on form perception literature, assuring both construct validity and comparability in processing difficulty. Although the KVPT was normed with all three tests administered, it is possible to use only one or two of the tests so long as the tests are presented in the following order: KVPT-D, KVPT-C, KVPT-M.

Specific scoring criteria and examples are provided for each test. Standard scores and percentile ranks are provided by gender for all three KVPT tests for children ages 5-11 years. Additional normative data are provided by gender for KVPT-D and KVPT-M scores for

adults ages 18-22 years and for all three KVPT tests for older adults ages 55-91 years. Comprehensive norms are provided for both level of performance and error analysis, facilitating both brief and in-depth analysis of deficits in visual processing. Normative data for the KVPT-D and the KVPT-M allow for quantitative evaluation of rotation (spatial) errors, nonrotation (patterns of organization or content) errors, and errors due to the complexity of the item.

Learning Disabilities Diagnostic Inventory (LDDI)
Donald D. Hammill, EdD, Brian R. Bryant, PhD

The LDDI was designed to help you identify learning disabilities (LD) in individuals. It assesses the extent to which the student's skill patterns in a particular area are consistent with those individuals known to have LD in that area. Thus, using the LDDI shifts the diagnostic emphasis away from interpreting norm-referenced ability test scores and toward studying an individual's skill patterns, especially those patterns that are indicative of people who are known to have specific LDs.

The LDDI is a rating scale designed to help you identify intrinsic processing disorders and LDs in students between the ages of 8.0-17.11 years. A reliable and valid norm-referenced inventory, the LDDI is composed of six independent scales-Listening, Speaking, Reading, Writing, Mathematics, and Reasoning. Each scale contains 15 easy-to-rate items. These items were generated after an extensive review of theoretical writings and empirical studies in LDs, especially the literature that is focused on the neuropsychological aspects of the disabilities.

The test was normed on 2,152 students with LDs residing in 43 states and the District of Columbia. The demographic characteristics of the normative sample are representative of the population of U.S. students who have learning disabilities with regard to gender, race, ethnicity, urban/rural residence, family income, educational attainment of parents, and geographic distribution.

Numerous validity studies were conducted to ensure that the LDDI scores have content-description, criterion-   prediction, and construct-identification validity. Furthermore, the LDDI was built to minimize the effects of bias. Numerous steps were taken to detect and eliminate sources of cultural, gender, and racial bias.

Light's Retention Scale, 2006 Ed. (LRS 2006 Ed.) (LRS)

H. Wayne Light, PhD

Designed to be completed during a parent conference, the new LRS 2006 Edition is a powerful tool that assists school professionals when making the sensitive decision to promote or retain a child between the ages of 6-18 years. The LRS 2006 Edition includes an up-to-date review of the current findings on both sides of the issue, consideration of whether or not a student has preschool experience, a changed score structure for the items, revised item descriptions, and new cutoff scores.

This revised edition assures that the school professional and the parents will take into consideration all relevant factors prior to making a decision regarding retention or promotion. Each of the 20 factors assessed by the LRS 2006 Edition is scored to reflect the impact that factor exerts on possible retention or promotion. The sum of the ratings is compared to cutoff scores, which are provided in the Manual, to help determine if retention would be helpful or potentially harmful to the child.

The LRS 2006 Edition's comprehensive literature review provides summaries of numerous research reports as well as historical views of educational practices over the years. The Record Form is easy to use. The Light's Parent Guide explains each of the 20 factors in detail. The LRS 2006 Edition School Administrator's Kit contains Worksheets, Parent Consent Forms, and Appeal Forms that are useful when documenting the decision-making process.

Merrill-Palmer-Revised Scales of Development (Merrill-Palmer-R)

Gale H. Roid, PhD, Jackie L. Sampers, PhD

The Merrill-Palmer-R is the revision to the 1931 Merrill-Palmer Scale, and retains the types of engaging hands-on activities that hold the interest of even the youngest child. The Merrill-Palmer-R is innovative, and uses toy-based activities to assess visual-motor, learning, and

problem-solving skills. Choke-safe and colorful materials are included with the instrument. This revision follows the natural developmental progression of activities for children from birth to age 6.5 years, and is especially useful in assessing children born pre-term.

The Merrill-Palmer-R was designed specifically to assess the five domains required by the Individuals With Disabilities Education Act (IDEA), providing both a global assessment as well as individual scores for each IDEA-required domain. The instrument provides normative standard scores, percentiles, and age equivalence and criterion-referenced growth scores, that are sensitive to change for the five IDEA domains. Also provided is an Overall Developmental Index for all assessment scales related to intellectual functioning and additional measures of social-emotional functioning.

Recommended Uses for the Merrill-Palmer-R

- Developmental assessment of Cognitive, Language, Motor, Self-Help, and Social-Emotional Domains, required by federal and state regulations.
- Assessment of general cognitive development in English- and Spanish-speaking children.
- Screening of infants and children who have been referred for the evaluation of possible developmental delays or disabilities.
- Reevaluations of individuals previously identified as developmentally delayed.

The Merrill-Palmer-R materials consist of the Administration and Scoring Manual, the Growth Score Profile, Manipulatives, Record Forms, and Copying Response Sheets (A and B). There are separate Record Forms for each domain, and separate forms for the examiner and the parent within three of the domains. The Growth Score Profile allows the examiner to plot scores of individual IDEA Domains, relating each to Age Equivalence. Once these scores are plotted, specific deficit areas can be identified by test item and then can be used to develop an educational plan that targets these deficits.

The Manual provides national norms based on 1,400 cases (250 of which are atypical) corresponding to the 2000 U.S. Census for gender, ethnicity, socioeconomic level, and geographic region. The Merrill-Palmer-R exhibits high reliability (e.g., > .90 for IDEA-related composite scores). The instrument has been field tested extensively over a 5-year period for both content and construct validity as well as for fairness of assessment.

Motor-Free Visual Perception Test-3 (MVPT-3)
Ronald R. Colarusso, EdD, Donald D. Hammill, EdD

The MVPT-3 is a major revision of the MVPT-R, utilizing both the original Test Plates and new Test Plates that add more of a challenge for those over age 11. The MVPT-3 assesses an

individual's visual-perceptual ability with no motor involvement needed to make a response. It is especially useful with those who may have learning, motor, or cognitive disabilities (ages 4-95 years).

The MVPT-3 features new norms based on a nationally representative sample. An added, optional feature of the MVPT-3 is response time norms, often used in rehabilitation settings. It is designed to be used for screening, diagnostic, and research purposes by teachers, psychologists, occupational therapists, educational specialists, optometrists, and others who may need a quick, reliable, and valid measure of overall visual-perceptual ability in children and adults. The new manual provides reliability and validity studies and comparisons for clinical populations.

Administration and Scoring
The MVPT-3 takes approximately 25 minutes to administer. The horizontal, multiple-choice item format of earlier versions has been retained. Test Plates are contained in one easy-to-use book with an easel back. Test administration cues are provided on the Recording Forms to facilitate testing.

Scoring is extremely easy; no basals or ceilings are needed. Raw scores are quickly converted to standard scores and percentile ranks. Optional response time data identify whether an individual's responses are significantly delayed.

OWLS: Listening Comprehension (LC) and Oral Expression (OE) Scales (OWLS OE/LC)
Elizabeth Carrow-Woolfolk, PhD

The OWLS, consisting of the Listening Comprehension (LC) scales and the Oral Expression (OE) scales, provides an individually administered assessment of receptive and expressive language for children and young adults ages 3-21.11 years.

The LC is a measure of receptive language. Using a convenient easel, the examiner reads a verbal stimulus aloud. The examinee responds by indicating a picture on the examinee's side of the Easel. Correct responses are indicated on the examiner's side of the Easel and on the Record Form.

The OE is a measure of expressive language. The examinee answers a question, completes a sentence, or generates one or more sentences in response to a visual/verbal stimulus. Common correct and incorrect responses are included on the Record Form.

Administration is easy. Neither scale requires the examinee to read. Descriptive Analysis Worksheet Masters that allow you to categorize responses by item type (lexical, syntactic, pragmatic, and supralinguistic) are provided in each package of Record Forms.

Scoring is fast and reliable. The LC Easel and the Record Form contain correct responses for each item for on-the-spot scoring. For the OE, the examiner may do a preliminary tally and then consult the item-by-item scoring rules to determine scores of particular items.

Age-based norms can be used in learning disabilities assessments to meet requirements of P.L. 94-102 (IDEA, P.L. 101-476) for the areas of listening comprehension and oral expression. Raw scores can be converted to standard scores, percentile ranks, normal curve equivalents, stanines, and age equivalents.

The Manual reports correlations of OWLS scales with other measures of receptive and expressive language, as well as with tests of cognitive ability and academic achievement. Also, the score profiles of seven clinical groups are compared with matched control samples.

LC/OE Computer ASSIST™

The LC/OE Computer ASSIST is available on one CD-ROM for Windows® and Macintosh®. The program provides many report options, including a score profile, suggested exercises by grade range, a narrative report, and item responses.

Requirements: Windows® 3.1 or higher, CD-ROM drive, 8MB hard drive space; Macintosh® System 7.0 or higher, CD-ROM drive, 8MB hard drive space, 14-inch monitor or larger, and a 68020 CPU or higher

OWLS: Written Expression Scale (WE)

Elizabeth Carrow-Woolfolk, PhD

The OWLS WE provides an assessment of written language that may be administered individually or in small groups to persons ages 5.0-21.11 years. The scale's wide age range offers a broad-based record of growth. It is designed to measure the ability to use conventions (letter formation, spelling/incorrect words, punctuation, capitalization, conventional structures), to use linguistic forms (modifiers, phrases, question form, verb forms, sentences, complex sentence structures), and to communicate meaningfully (appropriate content, details, coherence, supporting ideas, word choice, unity).

The OWLS WE is easy to use and score. To administer the scale, the examiner reads aloud a verbal stimulus. The examinee responds by writing in the Response Booklet. Some items are

presented with pictures or print for the examinee's reference when responding.

The Manual features detailed scoring guidelines with samples of actual responses. The Record Form contains representations of score patterns, a record of item-by-item results, and a summary of score comparisons. The scale has high validity and reliability.

WE Computer ASSIST

The WE Computer ASSIST is available on one CD-ROM for Windows® and Macintosh®. The program provides a score profile, score narrative, suggested exercises, and a descriptive analysis.

PDD Behaviour Inventory™ (PDDBI™)

Ira L. Cohen, PhD, Vicki Sudhalter, PhD

The PDDBI is an informant-based rating scale that is designed to assist in the assessment of children from the age of 1 year 6 months to 12 years 5 months who have been diagnosed with a pervasive developmental disorder (PDD) as defined by the *DSM-IV™*. PDD is characterized by severe and pervasive impairments in several areas of development (e.g., communication skills, reciprocal social interaction skills, presence of stereotypical behaviours/activities). Unlike existing assessments for autism/PDD, the PDDBI was developed to assess both problem behaviours as well as appropriate social, language, and learning/memory skills. It was also designed to provide age-standardized scores for both parent and teacher ratings.

The PDDBI can be utilized across a variety of settings. For example, it can be used as a clinical tool for assisting in diagnosis and treatment recommendations and for assessing change over time. In addition, the PDDBI can be useful in educational settings (e.g., placement decisions, intervention planning, evaluating outcomes) and research applications (e.g., dependent measure for treatment intervention).

The PDDBI materials include the Professional Manual, the Parent Rating Form, the Teacher Rating Form, the Parent Score Summary Sheet, the Teacher Score Summary Sheet, and the Profile Form. Each of the Rating Forms includes an extended set of items (Parent = PDDBI-PX, with 188 items; Teacher = PDDBI-TX, with 180 items) and a standard set of items (Parent = PDDBI-P and Teacher = PDDBI-T, each with 124 items), allowing the clinician to decide on a case-by-case basis how he or she wishes to administer the items. The extended form is appropriate for use when the clinician wishes to assess other aspects of the child's behaviours beyond those that are specifically associated with autism. These other behaviours (e.g., fear, aggression) may be important to the clinician who is concerned with placement

issues and treatment recommendations. The standard form is appropriate if the primary concerns are specifically related to autism (e.g., whether treatment is specifically affecting targeted behaviours). The PDDBI Extended Rating Forms consist of 10 domains for both the parent and the teacher versions; the standard forms both consist of six domains. Each domain consists of a variable number of behavioural clusters that best represent that domain. The clusters help to identify those behaviours that contribute most to a child's score on a given domain. Domain scores are divided into two sections, Approach/Withdrawal Problems and Receptive-Expressive Social Communications Abilities.

Standardization, Reliability, and Validity
The PDDBI is appropriate with children from a broad range of racial/ethnic and socioeconomic contexts. The standardization sample consisted of 369 parents and 277 teachers of children with well-defined autism from a range of racial/ethnic backgrounds and geographic regions.

- Test-retest stability for the teacher ratings ranged from .65-.99 over an average 2-week interval. For the parent sample, test-retest stability ratings ranged from .38-.91 over a 12-month interval.

- Concurrent validity for the PDDBI was assessed via comparison with the Childhood Autism Rating Scale, the Nisonger Child Behaviour Scales, the Vineland Adaptive Behaviour Scales, and the Griffiths Mental Development Scales.

- Clinical validity was assessed via comparison with the Autism Diagnostic Observation Interview-Revised, the Autism Diagnostic Observation Schedule-Generic, and the Vineland Adaptive Functioning Level.

Peabody Developmental Motor Scales, 2nd Ed. (PDMS-2)
M. Rhonda Folio, Rebecca R. Fewell

The PDMS-2 is an early childhood motor development program that provides both in-depth assessment and training or remediation of gross and fine motor skills. The assessment is composed of six subtests that measure the interrelated motor abilities that develop early in life from birth through 5 years of age. Reliability and validity have been determined empirically. The normative sample consisted of 2,003 children residing in 46 states.

PDMS-2 Subtests:

Reflexes--8 items measure a child's ability to automatically react to environmental events.

Stationary--30 items measure a child's ability to sustain control of his or her body within its center of gravity and retain equilibrium.

Locomotion--89 items measure a child's ability to move from one place to another by crawling, walking, running, hopping, and jumping forward.

Object Manipulation--24 items measure a child's ability to manipulate balls by catching, throwing, and kicking. Because these skills are not apparent until a child has reached the age of 11 months, this subtest is only given to children ages 12 months and older.

Grasping--26 items measure a child's ability to use his or her hands. It begins with the ability to hold an object with one hand and progresses to actions involving the controlled use of the fingers of both hands.

Visual-Motor Integration--72 items measure a child's ability to use his or her visual-perceptual skills to perform complex eye-hand coordination tasks such as reaching and grasping for an object, building with blocks, and copying designs.

The PDMS-2 Has Been Improved in Several Ways

- Includes new normative data that has been stratified by age.
- Studies showing the absence of gender and racial bias have been added.
- New **Profile/Summary Forms** enable you to record the child's PDMS-2 scores to graphically display the child's performance and to compare that child's performance on the items he/she has mastered with that of the normative sample.
- New Examiner Record Booklets contain all of the items to be administered.
- New *Illustrated Guide to Administering and Scoring the PDMS-2 Items* provides a detailed description of every PDMS-2 item. The items are referenced by number within each subtest and each item description includes the age at which 50% of the children in the normative sample have mastered the item; the position the child should be in when the item is administered; the stimulus (if needed) for presenting the item; the procedure used to test the item; the criterion used to score the item; an illustration of a child performing the item.
- The **Peabody Motor Activities Program (P-MAP)** is the instruction/treatment program for the PDMS-2. It contains units organized developmentally by skill area. After a child's motor skills have been assessed and the examiner has completed all sections of the Profile/Summary Form, the examiner selects units from the P-MAP to use to facilitate the child's development in specific skill areas.
- The new **Peabody Motor Development Chart** provides the examiner with a convenient reference for the motor skills measured by the PDMS-2 and the ages at which 50% of the normative sample were able to perform the skill. Each of the subtests is represented along with numerous illustrations of children demonstrating the behaviours described in the text.

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Psychoeducational Profile, 3rd Ed. (PEP-3)

Eric Schopler, PhD, Margaret D. Lansing, Robert J. Reichler, MD, and Lee M. Marcus

The PEP-3 assesses the skills and behaviours of children with autism and communicative disabilities who function between the ages of 6 months to 7 years. The profile resulting from the PEP-3 graphically charts uneven and idiosyncratic development, emerging skills, and autistic behavioural characteristics. The PEP-3 meets the need for an assessment tool to assist in the educational programming for young children (ages 3 through 5) with disabilities and is particularly useful in planning for older students' Individualized Education Programs (IEPs).
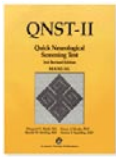
The PEP-3 now includes a Caregiver Report. This report utilizes parent input and is completed prior to the administration of the assessment. The form asks the parent or caregiver to estimate the child's developmental level compared with typical children. This form has been shown to help orient teachers to a student's developmental inconsistencies. The PEP-3 has included additional data that identify special learning strengths and teachable skills. Also, the third edition is improved by offering normative data both from a group of children in the autism spectrum as well as from a comparison group of children without autism.

Improvements to the PEP-3:

1. The function domains have been revised to reflect current research and clinical concerns, especially in the area of social and communication functions.
2. All of the toys and materials needed to administer the test (except food, drink, and a light switch) are now included with the test.
3. New items and subtests have been added; obsolete ones were deleted.
4. Normative data were collected from 2002 to 2003, with large national samples of children in the autism spectrum and of typical children ranging in ages from 2-7.5 years. These are the first normative data provided for comparison of a child's PEP results with children of either comparison group.
5. Reliability coefficients have been computed by age for subgroups within the normative sample (i.e., males, females, White, Black, and Hispanic Americans.)
6. Validity evidence is provided for children in the autism spectrum for all areas measured by the test.
7. The scoring has been quantified as 0, 1, and 2; and each score is clearly defined, making statistical comparisons more accurate. At the same time, the flexibility of the previous system, using pass, emerge, and fail, has been maintained.
8. A Caregiver Report has been added which includes Current Developmental Levels, Diagnostic Categories and Degree of Problem, and three subtests: Problem Behaviours, Personal Self-Care, and Adaptive Behaviour.

Quick Neurological Screening Test-II (QNST-II)

Margaret C. Mutti, MA, Harold M. Sterling, MD, Nancy A. Martin, PhD, Norma V. Spalding, EdD

The QNST-II identifies whether behaviours seen in the classroom have physiological (organic) or emotional origins. The detailed scoring provides invaluable information for planning appropriate remediation. The 15 areas of neurological development assessed include manual dexterity, visual tracking, spatial orientation, tactile perceptual abilities, and fine and gross motor movements.

- The Manual provides simple instructions for administrating and scoring each of the 15 subtests.
- Provides information for planning remediation.
- QNST-II protocol sheets include a handy summary of all subtest scores and classifications as well as the overall score and functional category determination.
- Appropriate for ages 5-18 years.

Receptive One-Word Picture Vocabulary Test, 2000 Ed. (ROWPVT)

Edited by Rick Brownell

This is an individually administered, norm-referenced test of an individual's ability to understand the meaning of single words. The individual's performance, when compared to the normative group, gives an indication of his or her English-hearing vocabulary.

The ROWPVT has a number of specific uses, including assessing the extent of hearing vocabulary, assessing cognitive ability, diagnosing reading difficulties, diagnosing expressive aphasia, screening preschool and kindergarten children, evaluating an English-learner's vocabulary, monitoring growth, and evaluating program effectiveness.

- All Test Plate illustrations have been rendered in full color with drawings that are easy to interpret and hold the examinee's interest.
- Norms are based on a representative sample of 2,327 school-age individuals ages 4.0-12.11 years in the U.S.; the sample was stratified by age, geographic region, ethnicity, level of parent education, community size, and gender.
- The test is conormed with the Expressive One-Word Picture Vocabulary Test for easy comparison of expressive and receptive vocabulary.

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- Directions are included on each Record Form along with a list of item prompts.
- Instructions for using examiner prompts and cues are included to ensure assessment accuracy.
- Easy to use--The Manual provides detailed administration instructions, development procedures, and national norms; the Test Plates are bound in a spiral booklet with a fold-out easel.

Revised Behaviour Problem Checklist-PAR Edition (RBPC)

Herbert C. Quay, PhD, Donald R. Peterson, PhD

The RBPC is used to rate problem behaviours observed in adolescents and young children ages 5-18 years. The six RBPC subscales measure Conduct Disorder, Socialized Aggression, Attention Problems-Immaturity, Anxiety-Withdrawal, Psychotic Behaviour, and Motor Tension-Excess.

The RBPC has been used for a wide variety of purposes:

- To screen for behavioural disorders in schools
- As an aid in clinical diagnosis
- To measure behavioural change associated with psychological or pharmacological interventions
- As part of a battery to classify juvenile offenders
- To select subjects for research on behavioural disorders in children and adolescents

Overview of the RBPC Scales

- **Conduct Disorder (CD/22)**--Items focus on behaviour alproblems of physical aggression, difficulty controlling anger, and open disobedience, defiance, and oppositionality.
- **Socialized Aggression (SA/17)**--Items tap behaviours associated with Adolescent Conduct Disorder. Items focus on the commission of conduct-disordered behaviours in the company of others, including stealing and substance use in the company of others, truancy from school, gang membership, stealing, and lying.
- **Attention Problems-Immaturity (AP/16)**--Items focus on symptoms associated with Attention Deficit Disorder (ADD), including short attention span, diminished concentration, distractibility, impulsivity, as well as the social and interpersonal correlates of ADD, including passivity, undependability, and childishness.
- **Anxiety-Withdrawal (AW/11)**--Items measure the behavioural components of internalizing disorders, including poor self-confidence and self-esteem, hypersensitivity to criticism and rejection, generalized fearfulness and anxiety, and reluctance to try new behaviours because of fear of failure.
- **Psychotic Behaviour (PB/6)**--Items tap psychotic symptoms, including speech

disturbance, bizarre ideation, delusions, and impaired reality testing.

- **Motor Tension-Excess (ME/5)**--Items focus on motoric symptoms of overactivity, including restlessness, tension, and "jumpiness."

Administration and Scoring

Administration and scoring are straightforward. Raters respond to the 89 items on the top page of the carbonless Test Booklet. Responses transfer to the bottom sheet, which contains scoring instructions and a scoring key. The RBPC Profile Sheet is used to record the obtained raw and *T* scores and to plot the pattern of the test results.

The Professional Manual contains information on the development of the RBPC, psychometric properties, additional reliability and validity studies, and tables for converting raw scores to *T* scores. Norms based on teacher ratings are provided for Grades K-12. Mean internal consistency reliabilities range from .73-.94 for the six subscales. Interrater reliabilities, based on teacher ratings, range from .52-.85.

The Rating Form is designed for use in conjunction with other measures (e.g., intelligence and achievement tests, behaviour observations, and interviews) as part of an overall assessment of the individual. The Rating Form can be completed by a parent, teacher, or other observer in about 20 minutes. Scoring and profiling take about 10 minutes.

Screening Assessment for Gifted Elementary and Middle School Students, 2nd Ed. (SAGES-2)
Susan K. Johnsen, Anne L. Corn

The SAGES-2 is helpful in identifying gifted students in kindergarten through eighth grade. Its three subtests assess aptitude and achievement to identify gifted students. Aptitude is measured via the Reasoning subtest. The student is asked to solve problems by identifying relationships among pictures and figures. The other two subtests (Mathematics/Science and Language Arts/Social Studies) assess achievement. Both of these subtests require the child to respond to questions in a multiple-choice format; items require recall, understanding, and application of ideas and basic concepts in the content areas. The subtests can be used to examine the relationships between aptitude and achievement.

The SAGES-2 can be used with students ranging in age from 5.0-14.11 years. Each untimed subtest requires approximately 20 minutes to administer. All of the SAGES-2 subtests can be administered individually or in small groups.

The SAGES-2 has several uses:

- To identify students as gifted in the areas of intellectual and academic ability.
- To screen entire pools of students for possible inclusion in gifted programs.
- To examine strengths and weaknesses in academic and reasoning abilities.
- To serve as a measurement device in research studies investigating intellectual and academic ability in gifted students.

The SAGES-2 was normed on two large samples tested in 1998 and 1999. Sample One (normal sample) consisted of 3,023 students who were in heterogeneous classrooms, and Sample Two (gifted sample) consisted of 2,290 students who were identified as gifted by their local school districts. The demographic characteristics of both samples were matched to those of the 1997 U.S. Census. The normative sample was stratified on the basis of age, gender, race, ethnic group membership, and geographic location. Standard scores and percentile ranks are provided for both samples.

The reliability coefficients for the test are high, ranging from .77-.95; 97% of these reach or exceed .80, and 74% reach or exceed .90. Test-retest studies show that the SAGES-2 is stable over time.

Extensive validity data are reported as well, documenting the test's relationship to the WISC®-III, OLSAT™, Stanford Achievement Test, and Gifted and Talented Evaluation Scale, and its efficiency in discriminating groups appropriately.

Note: The SAGES-2 is not intended for identifying children for classes emphasizing talents in creative, artistic, or leadership areas.

Social Behaviour Assessment Inventory (SBAI)
Thomas M. Stephens, DEd, Kevin D. Arnold, PhD

The SBAI measures the level of social behaviours exhibited by children and adolescents in classroom settings (grades K-9). It is appropriate for special education classes or any classroom where behaviour problems may exist.

The SBAI consists of 136 items that describe social skills commonly observed in the classroom. A teacher or other individual (such as a counsellor or parent) who has observed a student's behaviour rates each item on a 4-point scale describing both the presence and level of the behaviours exhibited by the student.

Results from the 4 behaviour scales (Environmental, Interpersonal, Self-Related, and Task-Related) and 30 subscales can be used to develop social skills instructional strategies.

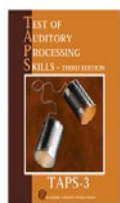## Student-Teacher Relationship Scale™ (STRS™)

Robert C. Pianta, PhD

The STRS can be used separately or as part of the Students, Teachers, and Relationship Support™ (STARS™) program to identify student-teacher relationships that could benefit from intervention and support. The STRS can be used (a) to evaluate changes in the quality of student-teacher relationships as a function of using the STARS intervention, (b) as part of an educational assessment battery to determine the extent to which relationship problems or strengths should be addressed in program planning, and (c) as a tool for researching classroom processes.

- Consists of 28 items rated on a 5-point Likert-type scale.
- Contains three subscales that measure Conflict, Closeness, and Dependency.
- Normative sample consisted of 275 teachers who rated at least one child from the 1,535 preschool through 3rd-grade group.

Test of Auditory Processing Skills (TAPS-3)

Nancy Martin and Rick Brownell

The TAPS-3 is a revision of the Test of Auditory Perceptual Skills. Intended to be used along with other test as part of a battery, the TAPS-3 measures what a child or adolescent does with what he or she hears. It is designed to be used by speech-language pathologists, audiologists, school psychologists, and other testing professionals.

The TAPS-3 now offers seamless coverage for ages 4-18 years. Other changes primarily involve the structure of the test (e.g., subtest order was amended to reflect a developmental progression of tasks, ranging from easiest to most difficult). Four new subtests have been added: Phonological Segmentation, Phonological Blending, Auditory Comprehension, and Auditory Reasoning. New items were developed for many subtests, some existing test items were retained, and the content of some subtests was completely revised. An optional Auditory Figure-Ground task also was added as a supplemental subtest presented via CD-

ROM to flag attention problems and give feedback about how the child's auditory processing system works in real-world situations.

There are also notable differences in how scores are derived and the types of scores obtained. The use of partial credit in some subtests more accurately reflects the child's auditory abilities. In addition to one overall score, individual subtest scores are combined to derive three cluster scores: Basic Auditory Skills, Auditory Memory, and Auditory Cohesion.

The TAPS-3 norms are now nationally stratified to closely match the demographics shown in the latest U.S. Census for gender, ethnicity, residence, geographic location, and parent educational level. Norms are based on data from more than 2,000 students. Individual subtests are reported as scaled scores; cluster scores and the overall score are reported as standard scores. Percentile ranks and age equivalents also are provided.

Test of Early Reading Ability, Third Ed. (TERA-3)
D. Kim Reid, Wayne P. Hresko, Donald D. Hammill, EdD

The TERA-3 is a unique, direct measure of the reading ability of young children ages 3.6-8.6 years. Rather than assessing children's readiness for reading, the TERA-3 assesses their mastery of early developing reading skills. This new edition has been redesigned to provide the examiner with three subtests: Alphabet (measures knowledge of the alphabet and its uses); Conventions (measures knowledge of the conventions of print); and Meaning (measures the construction of meaning from print). Standard scores are provided for each subtest. An overall Reading Quotient is computed using all three subtest scores.

The TERA-3 has many uses: (a) to identify those children who are significantly below their peers in reading development and may be candidates for early intervention; (b) to identify strengths and weaknesses of individual children; (c) to document a child's progress as a consequence of early reading intervention programs; (d) to serve as a measure in research studying reading development in young children; and (e) to serve as an adjunct to other assessments.

The TERA-3 has been improved in the following ways:

- All new normative data were collected during 1999 and 2000; the normative information is stratified by age relative to geography, gender, race, residence, and ethnicity.
- Studies showing the absence of gender, racial, disability, and ethnic bias have been added.
- Reliability is consistently high across all three types of reliability studied. All but 2 of the 32 coefficients reported approach or exceed .90.

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- New validity studies have been conducted; special attention has been devoted to showing that the test is valid for a wide variety of subgroups as well as for a general population.
- New items have been added to make the test more reliable and valid for the upper and lower ages covered by the test.
- Age and grade equivalents are provided.

Test of Irregular Word Reading Efficiency™ (TIWRE™)
Cecil R. Reynolds, PhD and Randy W. Kamphaus, PhD

By using the pronunciation of phonetically irregular words to measure reading comprehension, the TIWRE offers a rapid assessment of the examinee's reading vocabulary. Because phonetically irregular words cannot be pronounced correctly unless they are already a part of the reader's vocabulary, they are especially useful for measuring reading comprehension. The TIWRE is different from other reading comprehension assessments because it utilizes this concept and presents only phonetically irregular letters and words for pronunciation. This easy-to-administer measure is supported by validity evidence and is highly reliable. With three equivalent forms, the TIWRE provides its user with the ability to monitor changes in reading performance over relatively short periods of time with no detectable practice effect from testing itself.

Each form presents phonetically irregular letters (uppercase and lowercase) and words for a total of 50 items and takes approximately 2 minutes to administer. Because the three forms are based on a common normative sample and use the same normative table, frequent repeated testing is convenient and quick. Reliability coefficients for all forms are in the mid-to-high .90s. Change in reading comprehension is measured by comparing scores from two administrations and using the provided precalculated significance score ranges to determine statistically significant levels of change.

The TIWRE was normed using a large, nationally-drawn U.S. stratified sample consisting of 2,438 individuals ages 3 to 94 years. The Professional Manual provides a wide range of score conversions, including scores scaled to the metric commonly used with measures of aptitude and achievement (i.e., age-corrected deviation scaled scores with a mean of 100 and a standard deviation of 15) and additional supplementary scores that are commonly used in educational reporting and research. The Profile Form enables the examiner to plot scores of repeated administrations for easy, rapid identification of an individual's progress in reading performance. The reusable Stimulus Cards are color-coded for simple administration of each form.

The TIWRE was designed to have multiple applications in a variety of environments,

including educational, clinical, and rehabilitation settings. It can be used to assess current reading level, to measure response to intervention (RTI) in reading, to assess reading levels for completing self-reports or questionnaires, and to rapidly screen for individual reading difficulties. The TIWRE can enhance the accuracy and overall efficacy of progress monitoring and can lead to more frequent, accurate assessments of real reading skill in a variety of contexts.

Test of Reading Comprehension, 3rd Ed. (TORC-3)
Virginia Brown, Donald D. Hammill, EdD, J. Lee Wiederholt, PhD

The TORC-3 may be used to identify students whose reading comprehension scores are significantly below those of their peers and who might benefit from interventions designed to (a) improve reading comprehension, (b) determine areas of relative strength and weakness across reading comprehension abilities, (c) document overall progress in reading development as a result of intervention programs, and (d) serve as a measure for research efforts designed to investigate reading comprehension.

The TORC-3, developed for students ages 7.0-17.11 years, assesses the understanding of written language, focusing on the holistic, cognitive, and linguistic aspects of reading. The test comprises four subtests that are grouped under the General Reading Comprehension Core and four supplementary subtests that can be used to gain a clearer understanding of reading in terms of content-specific areas. The General Reading Comprehension Core yields the Reading Comprehension Quotient (RCQ) that can be compared to other measures of abstract thinking, oral language abilities, and achievement.

The TORC-3 yields six types of scores--raw scores, standard scores, grade equivalents, age equivalents, percentiles, subtest standard scores, and the Reading Comprehension Quotient (RCQ). The RCQ is derived through score transformation of the comprehensive core subtests: General Vocabulary, Syntactical Similarities, Paragraph Reading, and Sentence Sequencing. These four subtests best represent the construct of general reading comprehension. The RCQ is the most reliable, valid, and useful measure of reading comprehension derived from the TORC-3. The TORC-3 was standardized on 1,962 students from 19 states. Data are provided supporting test-retest and internal consistency reliability.

Special Features of TORC-3

- Information about the normative sample relative to geographic region, gender, residence, race, ethnicity, and disability status is reported.
- The normative information has been stratified by age.
- Characteristics of the normative sample are keyed to the 1990 U.S. Census data.

- Studies showing the absence of gender and racial bias have been added.
- Research supporting criterion-related validity has been updated and expanded.
- Discussion of content validity has been enhanced, especially for three of the four content-area subtests (i.e., Mathematics, Social Studies, and Science).
- Because they are required by many state and local school agencies, grade and age equivalents are provided.

Test of Variables of Attention (T.O.V.A.®/T.O.V.A.-A.®)

Lawrence Greenberg, MD, Robert A. Leark, PhD, Tammy R. Dupuy, MS, Clifford L. Corman, MD, Carol L. Kindschi, RN, MSN

The Tests of Variables of Attention are objective, standardized, extensively normed (2,200 respondents for T.O.V.A. and 2,500 for T.O.V.A.-A.), and highly accurate continuous performance tests (CPTs) that are used to assess attention in normal and clinical populations (ages 4-80 years). The T.O.V.A. is the visual version, and the T.O.V.A.-A. is the auditory version. They can be used in conjunction with other information gathering tools or diagnostic tests in neuropsychological or psychological evaluations. Free updates will be sent to you by the publisher.
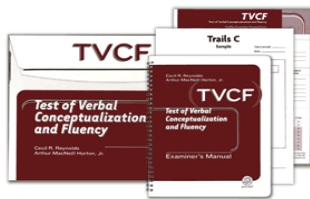
These tests were developed to measure attentional and impulse control processes in four areas: inattention or omissions; impulse control or commissions; response time; and response time variability. They are non-language based, computerized tests that require no left-right discrimination or sequencing and have no appreciable practice effects. Test responses are recorded with a specially designed electronic microswitch that eliminates inherent variability of keyboard and mouse response time.

The software automatically records an individual's responses, non-responses, and reaction times, and then calculates raw scores and percentages (eliminating examiner error). Data are reported by standardized scores and standard deviations, and are presented in quarters, halves, and totals for the full 21.6 minutes of the test. A full printable report instantaneously displays the test results in narrative and graphic form. A discriminant function measure, the ADHD Score, is provided for each individual. Unique test paradigms with stimulus infrequent and frequent conditions accurately measure attention and impulsivity. Test parameters can be modified for research and clinical applications.

Requirements:MS DOS 6.22/FreeDOS 0.9 or later with compatible parallel printer; Windows® 95/98 with DOS-compatible parallel printer; Windows® Me with DOS boot floppy disk or CD, DOS-compatible parallel printer; Windows 2000/XP with Windows-compatible printer; 4-bit VGA mode, DOS-compatible parallel port, x386 or better processor, 5MB disk space, 2MB RAM, CD-ROM drive, DVD player

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Test of Verbal Conceptualization and Fluency (TVCF)

Cecil R. Reynolds, PhD and Arthur MacNeill Horton, Jr., Ed

The TVCF is designed to measure multiple aspects of executive functions principally related to the integrity of the frontal lobes of the brain through the use of several verbally weighted tasks. The TVCF is useful in clinical neuropsychological examinations to detect brain injury and track rehabilitation progress, in the evaluation of language functions and verbal ability, for disability determination under the Individuals with Disabilities Education Act (IDEA), in psychoeducational testing, and in research on brain function, as well as in other applications.

The TVCF has four easy-to-administer subtests of primarily verbal and nonverbal tasks that emphasize multiple aspects of verbal fluency, set-shifting and rule induction, concept identification, sequencing, and visual search skills. The TVCF was designed and standardized for use with individuals ages 8-89 years. Standardized scores (or scaled scores) are provided in the form of normalized *T*-scores, along with their accompanying supplementary score conversions.

The TVCF subtests require a total administration time of 20-30 minutes for most individuals. The four TVCF subtests are listed below.

- *Categorical Fluency* measures an individual's ability to retrieve words that fit within a conceptual category (e.g., animals, things to eat) and fluency of ideation.

- *Classification* is a verbal measure of shifting and rule induction that is designed as a language-based analog to the well-known Wisconsin Card Sorting Test™ (Grant & Berg, 1948). Three scores are obtained: numbers of items correct, number of perseveration errors, and number of categories achieved.

- *Letter Naming* measures word retrieval by initial sound and fluency of ideation.

- *Trails C* measures the ability to coordinate high attentional demands, sequencing, visual search capacity, and the ability to shift rapidly between Arabic numerals and linguistic representations of numbers. The trails task is a variation of several other "trail-making" tasks and was taken from the previously published Comprehensive Trail-Making Test (Reynolds, 2003) and completely renormed with the other TVCF tasks.

Applications of the TVCF

Because the TVCF can be administered in 20-30 minutes, it is useful for large or small group screening of students and may be administered as part of a prereferral intervention strategy. The TVCF also is appropriate for individually assessing students with recognized disabilities and children suspected of having one or more learning disabilities. The brevity of the TVCF,

as well as the particular mental dimensions it assesses, also makes it useful in evaluating children suspected of having or known to have ADHD, emotional disturbances, and sensory or orthopedic impairments.

The TVCF also provides a well-standardized and efficient procedure to assess executive function deficits in clinical patients, whether those deficits are due to CNS disease, drug addiction, trauma, or specific forms of emotional disturbance such as schizophrenia. It is a time- and cost-efficient tool for assessing the executive functioning of individuals with traumatic brain injury, dementia, and speech/language impairment.

Test of Visual-Perceptual Skills (Non-motor), 3rd Ed. (TVPS-3)
Nancy A. Martin, PhD

The TVPS-3 assesses the following visual perceptual skills: Visual Discrimination, Visual Memory, Visual-Spatial Relationships, Form Constancy, Visual Sequential Memory, Visual Figure-Ground, and Visual-Closure. It is designed to be used by psychologists, occupational therapists, education diagnosticians, developmental optometrists, learning specialists, and other assessment professionals.

The TVPS-3 utilizes black and white designs as stimuli for all of the perceptual tasks. Within each area, the items are arranged in a developmental progression. The items are presented in a multiple-choice format; item responses are made vocally or by pointing. This format is ideal for children who may have impairments in motor, speech, hearing, neurological, or cognitive functioning. The TVPS-3 contains 16 plates for each perceptual area; each area is normed separately so that the clinician may reliably differentiate the various visual perceptual processes. The plates are spiral bound with fold-out easels to make presentation easy. The Manual includes a completed and scored protocol for instructional purposes.

Analysis of the subtest score patterns provides functional comparisons that enable the clinician to make a comprehensive diagnosis of a child's perceptual abilities separate from motor skills. The TVPS-3 also provides new, nationally stratified norms based on data from more than 2,000 children and adolescents.
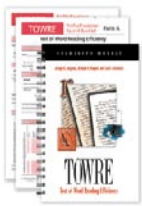
Administration and Scoring

The TVPS-3 may be administered to individuals or small groups. The test takes approximately 30-40 minutes to complete, depending on the age and the abilities of the individual being tested. No basals are needed and ceilings are used to minimize any fatigue effects.

Scoring is quick and easy and can be completed in approximately 5 minutes. The front of the Record Form provides a convenient graphic to display subtest scores.

Scores are presented as individual subtest scaled scores, and one overall standard score, enabling the TVPS-3 scores to be compared easily to scores from other standardized tests. Percentile ranks and age equivalents also are provided.

Test of Word Reading Efficiency (TOWRE)
Joseph Torgesen, PhD, Richard Wagner, PhD, Carol Rashotte, PhD

The TOWRE is a nationally normed measure of word reading accuracy and fluency. Because it can be administered very quickly, the test provides an efficient means of monitoring the growth of two kinds of word reading skills that are critical in the development of overall reading ability: the ability to accurately recognize familiar words as whole units or "sight words" and the ability to "sound out" words quickly.

The TOWRE contains two subtests: the Sight Word Efficiency (SWE) subtest assesses the number of real printed words that can be accurately identified within 45 seconds, and the Phonetic Decoding Efficiency (PDE) subtest measures the number of pronounceable printed nonwords that can be accurately decoded within 45 seconds. Each subtest has two forms (Forms A and B) that are of equivalent difficulty, and either one or both forms of each subtest may be given depending upon the purposes of the assessment.

Percentiles, standard scores, and age and grade equivalents are provided. Subtest standard scores have a mean of 100 and a standard deviation of 15. Age and grade equivalents show the relative standing of the individual's scores. The TOWRE was normed on more than 1,500 individuals ranging in age from 6.0-24.11 years and residing in 30 states. The sample characteristics were stratified by age and keyed to the demographic characteristics reported in the *1997 Statistical Abstract of the United States.*

Reliability of the TOWRE was investigated using estimates of content sampling, time sampling, and scorer differences. The average alternate forms reliability coefficients (content sampling) all exceed .90. The test/retest (time sampling) coefficients range from .83-.96. The magnitude of the coefficients reported from all the reliability studies suggests that there is little error in the TOWRE and that examiners can have confidence in the results. Extensive evidence of the validity of TOWRE test scores is provided for content-description validity, criterion-prediction validity, and construct-identification validity.

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