PsychPress

Talent Management Psychologists

Cognitive Catalogue

PsychPress

Talent Management Psychologists

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!

Gavin Didsbury, PhD. (MAPS)   Daniel Fruchter, MPsych Ind&Org (MAPS)
Director   General Manager
gavindidsbury@psychpress.com.au   danielfruchter@psychpress.com.au

PsychPress
Talent Management Psychologists

AAMR Adaptive Behavior Scale-School: 2nd Ed. (ABS-S:2)
Nadine M. Lambert, PhD, Kazuo Nihira, PhD, Henry Leland, PhD
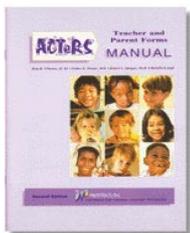
This observational rating scale assesses behavior and social adjustment of children ages 3-21 years whose adaptive behavior suggests possible mental retardation, emotional disturbance, or other learning handicaps. It reveals areas where special program planning could be required.

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 behavior domains and 18 subdomains. Part 2 measures personality and behavior 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 behavior of children in Grades K-8 on four factors:

- Attention
- Hyperactivity
- Social Skills
- Oppositional Behavior

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.

PsychPress
Talent Management Psychologists

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 behavior 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 Behavior. 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 behavior. In addition to the original four subscales, a fifth scale focuses on early childhood behavior

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 Behavior 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 behavior and includes 8 domains that relate to the manifestation of personality and behavioral 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, behavior 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.
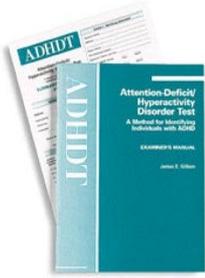
The 50 yes/no items that make up the ASDS were drawn from five specific areas of behavior: cognitive, maladaptive, language, social, and sensorimotor. All of the items represent behaviors that are symptomatic of Asperger syndrome. The ASDS provides an "AS Quotient" that indicates the likelihood that 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 behavioral 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

PsychPress
Talent Management Psychologists

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 behavior, motor skills, and adaptive behavior. 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 behavior) are conducted using parent questionnaires.

- Caregiver Report--Helps examiners provide information about test results to parents and caregivers.

- Behavior 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.

PsychPress
Talent Management Psychologists

New to the Bayley-III

- Two new subtests--Social-emotional and adaptive behavior 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/behavior.

- 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 behavior 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

PsychPress
Talent Management Psychologists

- 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.

PsychPress
Talent Management Psychologists

- 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.

PsychPress
Talent Management Psychologists

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

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.

PsychPress
Talent Management Psychologists

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.

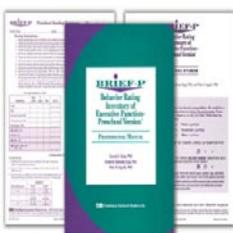The BRIEF-A is composed of 75 items on 9 nonoverlapping clinical scales:

- 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.

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.

PsychPress
Talent Management Psychologists

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   Global Executive
Metacognition   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.

PsychPress
Talent Management Psychologists

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.

Psych*Press*
Talent Management Psychologists

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 II*) 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 II* 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 II* 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 II* 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

PsychPress
Talent Management Psychologists

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.

PsychPress
Talent Management Psychologists

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

PsychPress
Talent Management Psychologists

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.

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.
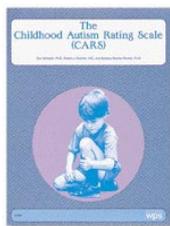
The Brown ADD Scales are effective tools for monitoring treatment responses, making them especially useful in managed care settings. They are also useful as components of a comprehensive assessment for diagnosis of ADD and comorbidities. The Brown Diagnostic Form for adolescents and adults provides guidelines 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.

PsychPress
Talent Management Psychologists

Childhood Autism Rating Scale (CARS)
Eric Schopler, PhD, Robert J. Reichler, MD, Barbara Rochen Renner, PhD

The CARS is a 15-item behavioral 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 behavior 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 behavior. 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 behavior 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.

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.

PsychPress
Talent Management Psychologists

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 behavior 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.

PsychPress
Talent Management Psychologists

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.

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 behaviors, 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.
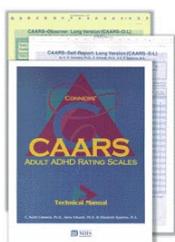
Scoring Options

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)
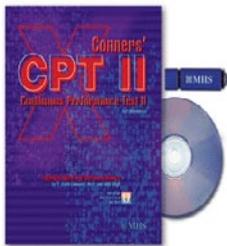**C. Keith Conners, PhD, Drew Erhardt, PhD, Elizabeth Sparrow, MA**

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.
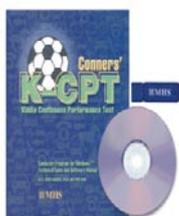
The CPT II V.5 program produces a Conners' Multimodal Integrated Report that combines CPT II results with those obtained from the CRS-R V.5 software. You also can generate a Single Administration Report and a Multi-Administration Report, which is ideal for monitoring treatment efficacy because it compares 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

Conners' Continuous Performance Test®: Kiddie Version (K-CPT)
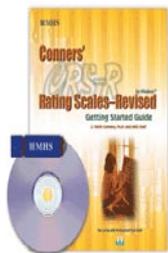**C. Keith Conners, PhD, MHS Staff**

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

PsychPress
Talent Management Psychologists

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 behaviors 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 behaviors. 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 behaviors reported by parents. Normative data for these revised scales come from the ratings of more than 2,000 parents.

PsychPress
Talent Management Psychologists

Both Long (CTRS-R:L) and Short (CTRS-R:S) Forms have been developed to assess behaviors 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 behaviors. 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 behavior 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.

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.

Psych*Press*
Talent Management Psychologists

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 behavior. The five subtests (one for each of the domains) can be administered separately or as a comprehensive battery in about 10-20 minutes.
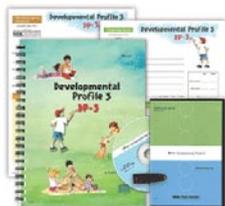
The DAYC can be used: (a) to differentiate children who are developing normally and those who are significantly below their peers in cognitive, communication, social/emotional, physical, or adaptive behavior; (b) to determine a child's specific strengths and weaknesses in developmental abilities; (c) 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 Behavior, 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.

PsychPress
Talent Management Psychologists

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 Behavior, 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.

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.

- **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

PsychPress
Talent Management Psychologists

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.

Developmental Test of Visual Perception-Adolescent and Adult (DTVP-A)
Cecil R. Reynolds, PhD, Nils A. Pearson, PhD, Judith K. Voress

PsychPress
Talent Management Psychologists

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.

PsychPress
Talent Management Psychologists

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 chilld'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
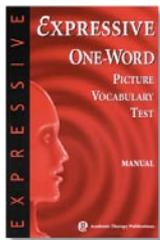- Math Calculation
- Phonemic Analysis

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.

PsychPress
Talent Management Psychologists

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 behavioral 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 behavior characteristics of Asperger's Disorder necessary for diagnosis. It can be used in the assessment process to document behavioral 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 behavioral disorders.
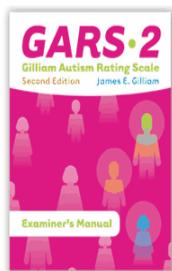
The GADS has the following characteristics:

- Thirty-two clearly stated items divided into four subscales describe specific, observable, and measurable behaviors.

- 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.
- Behaviors 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 behaviors of persons with autism. The items are grouped into three subscales - Stereotyped Behaviors, 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 behavioral 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.

- 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 behaviors for each item on the GARS-2. The discreet behaviors 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.

PsychPress
Talent Management Psychologists

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.

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.

- 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.

PsychPress
Talent Management Psychologists

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

PsychPress
Talent Management Psychologists

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 behavior 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
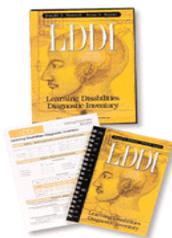
visual processing (e.g., determining that a child with difficulty identifying appropriate mathematical operations has a visual-spatial processing deficit). The Professional Manual provides a chapter on clinical interpretation that demonstrates the way appropriate academic interventions can be developed 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.
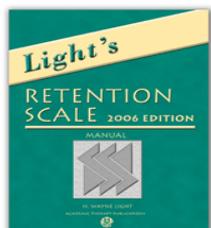
The LDDI is a rating scale designed to help you identify intrinsic processing disorders and LDs in students between the ages of 8.0-17.11 years. A reliable and valid norm-referenced inventory, the LDDI is composed of six independent scales-Listening, Speaking, Reading, Writing, Mathematics, and Reasoning. 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

PsychPress
Talent Management Psychologists

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 Behavior 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.

- 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.

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.

PsychPress
Talent Management Psychologists

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 behaviors described in the text.

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).
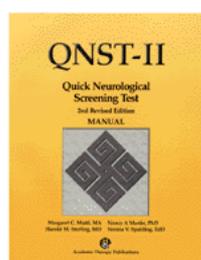
The PEP-3 now includes a Caregiver Report. This report utilizes parent input and is completed prior to the administration of the assessment. The form asks the parent or caregiver to estimate the child's developmental level compared with typical children. This form has been shown to help orient teachers 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:

PsychPress
Talent Management Psychologists

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.

Quick Neurological Screening Test-II (QNST-II)
Margaret C. Mutti, MA, Harold M. Sterling, MD, Nancy A. Martin, PhD, Norma V. Spalding, EdD
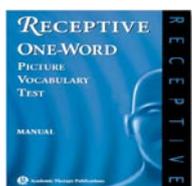

The QNST-II identifies whether behaviors seen in the classroom have physiological (organic) or emotional origins. The detailed scoring provides invaluable information for planning appropriate remediation. The 15 areas of neurological development assessed include manual dexterity, visual tracking, spatial 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

PsychPress
Talent Management Psychologists

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

The RBPC is used to rate problem behaviors 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 Behavior, and Motor Tension-Excess.

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

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

Overview of the RBPC Scales

- **Conduct Disorder (CD/22)**--Items focus on behavior alproblems of physical aggression, difficulty controlling anger, and open disobedience, defiance, and oppositionality.
- **Socialized Aggression (SA/17)**--Items tap behaviors associated with Adolescent Conduct Disorder. Items focus on the commission of conduct-disordered behaviors 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 behavioral 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 Behavior (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

PsychPress
Talent Management Psychologists

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, behavior 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 Behavior 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.

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.

Student-Teacher Relationship Scale™ (STRS™)
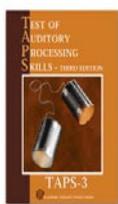**Robert C. Pianta, PhD**

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.
- 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.
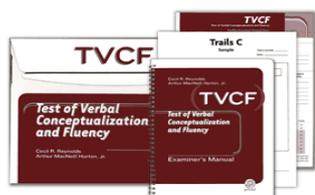
These tests were developed to measure attentional and impulse control processes in four areas: inattention or omissions; impulse control or commissions; response time; and response time variability. They are non-language based, computerized tests that require no left-right discrimination or sequencing 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

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

PsychPress
Talent Management Psychologists

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.

PsychPress
Talent Management Psychologists