PsychPress

Talent Management Psychologists

Neuropsych Catalogue

Welcome to PsychPress

Talent Management Psychologists

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

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

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

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

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

We look forward to our next contact with you!

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Alzheimer's Disease Caregiver's Questionnaire™ (ADCQ™)

Paul R. Solomon, PhD, ADCQ User's Manual by Paul R. Solomon, PhD and Cynthia A. Murphy

Because of the projected increase in the prevalence of Alzheimer's disease, the need for appropriate measures for screening and subsequent diagnosis grows increasingly vital within both medical and social contexts. The ADCQ is a new screening instrument that evaluates the likelihood that an individual has a dementia suggestive of Alzheimer's disease. This scientifically developed measure provides an essential link to early detection and treatment.

The ADCQ is an 18-item symptom checklist that is completed by a concerned family member or someone who has sufficient knowledge about the individual. Once the caregiver has completed the checklist, a Caregiver's Report is generated that determines the *likelihood* that the rated individual has a dementia suggestive of Alzheimer's disease. The Caregiver's Report contains a summary of the behavioural problems/changes observed by the caregiver in six categories: Memory, Confusion and Disorientation, Geographic Disorientation, Behaviour, Reasoning and Judgment, and Language Abilities. It also provides recommendations regarding whether further evaluation may be warranted.

- Takes 5-10 minutes to complete.
- Ages 40 years or older.
- Requires no participation from office staff, physician, or other health care professional(s).
- Requires no cooperation or participation from the individual being rated.

Reliability/Validity

- Internal consistency reliability of .87.
- Test-retest reliability of .71 (using a smaller sample of caregivers).
- Initial validation of the ADCQ revealed a sensitivity and specificity >.87.

Requirements: Windows® 95/NT with Internet Explorer 4.0 or higher, Windows® 98/Me/2000/XP, 1.44MB 3.5" disk drive

Behavior Rating Inventory of Executive Function™ (BRIEF™)

by Gerard A. Gioia, Ph.D., Peter K. Isquith, Ph.D., Steven C. Guy, Ph.D., and Lauren Kenworthy, Ph.D

These new parent and teacher questionnaires assess children's executive function in home and school environments. The BRIEF is useful in evaluating 5- through 18-year-olds with developmental and acquired neurological conditions such as learning disabilities, ADHD, traumatic brain injury, low birth weight, Tourette's Disorder, and autism.

Each BRIEF questionnaire includes 86 items on 8 nonoverlapping clinical scales and 2 validity scales:

Clinical Scales

Inhibit	Initiate	Organization of Materials
Shift	Working Memory	Monitor
Emotional Control	Plan/Organize	

Validity Scales

Negativity	Inconsistency of Responses

These scales form two broader indexes: Behavioral Regulation and Metacognition.

Norms are based on ratings from 1,419 parents and 720 teachers from rural, suburban, and urban areas, reflecting the U.S. population in regard to SES, ethnicity, and gender distribution. Separate norm tables for teacher and parent ratings provide *T*-scores, percentiles, and 90% confidence intervals for four developmental age groups, by gender.

Requiring just 10 to 15 minutes to complete, the BRIEF is an efficient way to evaluate impairment of executive function in children and adolescents with neurological conditions.

Behaviour Rating Inventory of Executive Function - Adult Version (BRIEF-A)

by Robert M. Roth, Ph.D., Peter K. Isquith, Ph.D., and Gerard A. Gioia, Ph.D.

This version of the BRIEF assesses executive control and self-regulation in adults, 18 to 90 years of age. Using both a Self-Report and an Informant Report, it provides a comprehensive view of an individual's daily functioning.

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

- Inhibit
- Self-Monitor
- Plan/Organize
- Shift
- Initiate
- Task Monitor
- Emotional Control
- Working Memory
- Organization of Materials

These scales form two broad indexes -- Behavioural Regulation and Metacognition -- which combine to produce an overall score, the Global Executive Composite. Three validity scales (Negativity, Inconsistency, and Infrequency) are also provided. Normative data, based on a broad sample of men and women (aged 18 to 90), reflect U.S. Census data in terms of race, ethnicity, education, and geographic region.

Both the Self-Report and the Informant Report can be completed in just 10 to 15 minutes. Most adults are able to respond to the Self-Report -- including those with developmental, systemic, neurological, and psychiatric disorders. However, if the individual has limited awareness of his or her own difficulties, the Informant Report can be used alone. Typically, both forms are administered in order to gain two perspectives on the individual's functioning.

Behavior Rating Inventory of Executive Function Preschool Version (BRIEF-P)

by Gerard A. Gioia, Ph.D., Kimberly Andrews Espy, Ph.D., and Peter K. Isquith, Ph.D.

The assessment of executive function in preschool children is often difficult for several reasons: the variable nature of behaviour in this age range; limitations in motor and verbal proficiency in preschoolers; and the many neuropsychological, psychological, developmental, and medical conditions that begin to manifest during the preschool years. The BRIEF-P is the first standardized rating scale designed to measure behavioural manifestations of executive function in preschool children. As such, it permits intervention at earlier stages of development.

The BRIEF-P is a single form used by parents, teachers, and day care providers to rate a child's executive functions within the context of his or her everyday environments--both home and preschool. Completed in just 10 to 15 minutes, the hand-scorable BRIEF-P Rating Form consists of 63 items that measure various aspects of executive functioning:

Inhibit	Emotional Control	Plan/Organize
Shift	Working Memory	

The clinical scales form 3 broad indexes and one composite score:

Inhibitory Self-Control	Flexibility
Emergent Metacognition	Global Executive Composite

The BRIEF-P also provides 2 validity scales, Inconsistency and Negativity.

Normative data are based on ratings of children, aged 2.0 through 5.11, from 460 parents and 302 teachers from urban, suburban, and rural areas, reflecting U.S. Census estimates for race/ethnicity, gender, socioeconomic status, and age. Clinical samples included children in the following diagnostic groups: ADHD, prematurity, language disorders, autism spectrum disorders, and mixed clinical.

The BRIEF-P is useful in assessing preschool-aged children with conditions such as prematurity, emerging learning disabilities and attention disorders, language disorders, traumatic brain injuries, lead exposure, and pervasive developmental disorders/autism.

Behaviour Rating Inventory of Executive Function, Self-Report Version (BRIEF-SR)

by Steven C. Guy, Ph.D., Peter K. Isquith, Ph.D., and Gerard A. Gioia, Ph.D.

The BRIEF-SR is useful in evaluating and treating adolescents (11 to 18 years of age) who have executive control problems--difficulties with reasoning, self-awareness, flexibility, organization, self-monitoring, memory capacity, or behavioral regulation. Complementing the *Behavior Rating Inventory of Executive Function* (BRIEF) Parent and Teacher Forms, this standardized, 80-item self-report scale captures an adolescent's view of his or her own purposeful, goal-directed, problem-solving behavior. This information can help you determine how much external support an adolescent needs and how you can best build a collaborative working relationship with him or her.

In just 10 to 15 minutes, the BRIEF-SR can be completed by any teen who can read at a 5th-grade-or-higher level, including those with attention disorders, language disorders, traumatic brain injury, lead exposure, learning disabilities, high-functioning autism, or other developmental, psychiatric, or medical conditions.

The inventory is composed of eight nonoverlapping clinical scales: Inhibit, Shift, Emotional Control, Monitor, Working Memory, Plan/Organize, Organization of Materials, and Task Completion. These scales form two broader indexes--the Behavioral Regulation Index and the Metacognition Index--and yield an overall summary score, the Global Executive Composite. Two validity scales, Inconsistency and Negativity, are also included.

Quick and convenient, the BRIEF-SR gives you another perspective on the self-regulatory strengths and weaknesses of adolescents.

Behavioural and Psychological Assessment of Dementia™ (BPAD™)

Kara S. Schmidt, PhD and Jennifer L. Gallo, PhD

The BPAD is a standardized informant report that assesses the changes in both behaviour and mood that are associated with the onset and course of various dementia syndromes. This 78-item assessment categorizes symptoms into three clusters (i.e., Psychopathological, Behavioural, Biological) and further, into seven domains (i.e., Perceptual/Delusional, Positive Mood/Anxiety, Negative Mood/Anxiety, Aggressive, Perseverative/Rigid, Disinhibited, Biological Rhythms). The BPAD Response Booklet is large-print to simplify completion by individuals with vision difficulties.

During administration, the respondent is asked about symptoms the patient has exhibited both within the past 4 weeks and 5 years ago. To differentiate symptoms associated with long-standing psychiatric illness from symptoms associated with the onset of behavioural disturbance related to dementia, the BPAD assesses the symptoms over these two time periods and computes a change score that captures information about changes in mood and behaviour specific to the onset and course of dementia. The BPAD was standardized and validated on a sample of men and women ages 30-90 years; these rated adults came from a wide range of racial/ethnic and educational backgrounds and geographic regions, and the sample was matched to U.S Census proportions.

Administration is done using the large-print Response Booklet and pencil, takes 15 minutes to complete, and should be completed by family members, paraprofessionals, or other professionals ages 18-90 who have regular contact with individuals who have suspected or diagnosed dementia. The items are written at a sixth-grade reading level. The BPAD can be employed in a wide range of settings (e.g., outpatient clinics, assisted living settings, clinical research settings) with heterogeneous groups of individuals with suspected or diagnosed dementia (e.g., patients diagnosed with Alzheimer's disease, patients with vascular dementia, psychiatric patients with suspected dementia).

The BPAD Software Portfolio Makes Scoring Easy

After hand-entry of raw scores, the easy-to-use BPAD™ Software Portfolio (BPAD™-SP) generates scores that represent current impairment (i.e., CURRENT), past impairment (i.e., PAST), and change in impairment over time (i.e., CHANGE). The Score Report also provides *T* scores and percentiles for the BPAD Total and domain scores and graphical presentation of BPAD *T* scores. The BPAD-SP is included in the BPAD Introductory Kit.

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

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

by Gary Brannigan and Scott Decker

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

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

The *Bender Gestalt //* consists of a series of stimulus cards, each displaying a unique figure. The individual is asked to draw each figure as he or she observes it. The stimulus card is not removed until the drawing is complete.

This edition of the test adds items and extends the range of ability assessed. New recall procedures to measure visual-motor memory ensure a more comprehensive assessment of visual-motor skills. And supplemental tests of simple motor and perceptual ability help identify specific visual-motor deficits. An optional timing component allows the examiner to time each drawing, and scoring is now quicker and easier.

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

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

Benton Laboratory of Neuropsychology: Selected Tests

Arthur L. Benton, PhD

These tests have demonstrated validity and provide additional substantive data in the evaluation of brain-damaged patients. Each test is designed to be quickly and easily administered, minimizing patient fatigue and maximizing the collection of reliable neuropsychological test data. Normative and validity data are described in the Manual, *Contributions to Neuropsychological Assessment*, which may be purchased separately.

Temporal Orientation

This brief test assesses the accuracy of an individual's temporal orientation with relation to the day of the week, day of the month, month, year, and time of day. The test provides a standardized procedure, based on empirically established norms, for interpreting an individual's performance.

Right-Left Orientation

This 20-item test requires an individual to point to lateral body parts on verbal command. Form B is a mirror image of Form A in which the commands are reversed. Administration time is 5 minutes.

Serial Digit Learning

This test consists of the presentation of either eight or nine randomly selected single digits for a varying number of trials up to a maximum of 12. Three alternate versions are provided for each form. Administration requires 5-10 minutes. **Facial Recognition**

A three-part standardized measure of the ability to match unfamiliar faces. Contains a 27-item short form and a 54-item long form.

Judgment Of Line Orientation

This is a standardized measure of visuospatial judgment in two alternate forms. The spiral-bound booklet contains 35 stimuli, five of which are practice items.

Visual Form Discrimination

This measure of ability to discriminate between complex visual configurations provides comparative data on clients with brain disease. Composed of 16 items ranging in level of difficulty, this brief, convenient procedure has proven utility because of its sensitivity to effects of brain disease.

Pantomime Recognition

This test requires the client to point to drawings of objects; the pretended uses of the objects are shown in a series of 30 videotaped pantomimes.

Motor Impersistence

This battery consists of eight tests requiring the maintenance of a movement or posture: keeping eyes closed, protruding tongue (blindfolded and eyes open), fixation of gaze in lateral visual fields, keeping mouth open, central fixation during confrontation testing of visual fields, head turning during sensory testing, and saying "ah."

Booklet Category Test, 2nd Edition (BCT™)

Nick A. DeFilippis, PhD, Elizabeth McCampbell, PhD

This portable version of the widely used Halstead Category Test (CT) allows you to distinguish individuals ages 15 years and older with brain damage from normal individuals. The BCT contains 208 visual stimuli that assess complex concept formation and abstract reasoning.

Description

The two portable BCT easel binders contain all 208 Category Test designs. The task demands of the BCT are essentially equivalent to those of the CT. The BCT eliminates the need for expensive, complex projection equipment. Administration instructions are now incorporated on the backs of the Stimulus Plates and in the Response Form to aid in standardization of the BCT administration. The BCT Response Form has also been updated to enhance its ease of use. The stimuli for each subtest are presented on a single page to aid in test administration and to facilitate the review of patient responses. The new Score Summary section of the form facilitates the use of the demographically corrected normative data which are now included in the expanded BCT Professional Manual for improved diagnostic accuracy and interpretation of error scores. The revised manual also provides information about current research findings related to the clinical utility of the BCT.

Administration/Scoring

The BCT is administered by presenting the Stimulus Plates and having the respondent point to the number on the BCT Response Strip that corresponds to the pattern on each Stimulus Plate. The examiner records the individual responses and then tallies the incorrect responses to obtain the error score.

Reliability/Validity

Regarded as the most sensitive indicator of brain dysfunction in the Halstead-Reitan Neuropsychological Test Battery, the CT is nearly as valid as the complete battery in detecting brain damage. In a cross-validation study, the BCT correlated with the CT at the same statistical level as the CT correlates with itself, suggesting that the BCT retains the high reliability and validity of the original instrument.

Boston Diagnostic Aphasia Examination, 3rd Ed. (BDAE)

Harold Goodglass, PhD, Edith Kaplan, PhD, Barbara Barresi, PhD

Since 1972, the BDAE has been the benchmark for the diagnosis of aphasia and related disorders. The text, *Assessment of Aphasia and Related Disorders*, addresses the nature of aphasia; its definition and characteristics; the normative basis for the BDAE scoring system; a specific explanation of how to administer and interpret the exam; a Severity Rating Scale that provides a meaningful standard for measuring your client's communicative ability; and a Visuospatial Quantitative Battery to test visuospatial and quantitative skills after brain injury. (This 135-page book is only available as part of the Kit.)

New to the 3rd Edition:

- A Short Form of the BDAE--takes only 30-45 minutes to complete and provides you with the option to perform a brief, no frills assessment.
- Extended tools for more in-depth study and recording of results--the regular exam has been augmented with extended tools that test syntax comprehension, locate category-specific difficulties in word comprehension and word production, and assess grapho-phonemic processing.
- The **Boston Naming Test (BNT),** which helps determine the extent of an individual's visual confrontation naming abilities, has been incorporated into the BDAE. This requires using the separately bound BNT Stimulus Cards and Record Booklets. New options for the BNT are provided and include new methods for eliciting disclosure, new approaches to scoring, and new tests for analyzing reading disorders.
- Also includes a new 90-minute videotape, *Examining for Aphasia with the BDAE*, in which Drs. Goodglass, Kaplan, and Barresi demonstrate the test materials, examiner/patient interactions, and scoring techniques through real-life examinations of three aphasic patients.

Brief Neuropsychological Cognitive Examination (BNCE)

Joseph M. Tonkonogy, M.D., Ph.D.

Suitable for: ages 18 and up

This convenient test assesses the cognitive functions targeted in a typical neuropsychological exam. In less than 30 minutes, it gives you a general cognitive profile that can be used for screening, diagnosis, or follow-up. More efficient than a neuropsychological battery and more thorough than a screener, BNCE is an ideal way to evaluate the cognitive status of patients with psychiatric disorders or psychiatric manifestations of neurological diseases. Appropriate for individuals 18 years of age and older, the BNCE assesses working memory, gnosis, praxis, language, orientation, attention, and executive functions. It is composed of 10 subtests, none requiring more than minimal reading skills. Five of these subtests measure the ability to process conventional, frequently used information, while

the remaining five measure the ability to process novel or incomplete information. The test focuses on processing skills needed for everyday functioning, and is sensitive to mild impairment often missed by other brief cognitive screeners. The BNCE is an excellent way to start a process-oriented neuropsychological exam—It quickly reveals specific cognitive abnormalities that may warrant more detailed evaluation. And it can be used to monitor the course of both psychiatric and neurological disease. It has been found especially useful in evaluating patients with sequelae of head injury, stroke, encephalitis, and primary degenerative disorders such as Alzheimer's, Huntington's, Parkinson's and Pick's diseases and those suffering from seizure disorders, schizophrenia, mood disorders, and alcohol and drug abuse.

Brief Visuospatial Memory Test Revised (BVMT)

Ralph H. B. Benedict, Ph.D., ABCN

User Qualification: Psychologist

Suitable for: Adults Aged 18 to 79 Years
Time: Timed, 45 minutes

The BVMT-R is designed for use as a criterion measure of visuospatial memory within a large battery of neuropsychological tests, as a screening measure within a brief neuropsychological battery, and as a repeat measure to document changes in neurocognitive skills over time.

Each of the six equivalent, alternate BVMT-R stimulus forms consists of 6 geometric figures printed in a 2 x 3 array on a separate page of the Recall Stimulus Booklet. In the three Learning Trials, the respondent views the Recall Stimulus page for 10 seconds and then is asked to draw as many of the figures as possible in their correct location on a page in the Response Booklet. After a 25-minute delay which includes primarily verbal activities, the task is repeated. Then the respondent is asked to identify which of the 12 figures in the Recognition Stimulus Booklet were included in the 6 geometric figures on the original Recall Stimulus page. As a final step, an optional Copy trial may be administered to screen for severe visuoconstructive deficits and to help in scoring recall responses.

Brief Visuospatial Memory Test-Revised (BVMT-R™)

Ralph H. B. Benedict, PhD, ABCN

The BVMT-R is designed for use as a criterion measure of visuospatial memory within a large battery of neuropsychological tests, as a screening measure within a brief neuropsychological battery, and as a repeat measure to document changes in neurocognitive skills over time. It has been standardized and normed for use with adults ages 18-79 years.

BVMT-R materials were designed to be handled and transported easily, so that the test can be administered in a clinic setting or at the bedside using a clipboard. The materials include the Professional Manual, the Recall Stimulus Booklet, the Recognition Stimulus Booklet (easel format), and the Response Form. Administration requires a pencil and a stopwatch.

Each of the six equivalent, alternate BVMT-R stimulus forms consists of six geometric figures printed in a 2 x 3 array on a separate page of the Recall Stimulus Booklet. In the three Learning Trials, the respondent views the Recall Stimulus page for ten seconds and then is asked to draw as many of the figures as possible in their correct location on a page in the Response Booklet. After a 25-minute delay which includes primarily verbal activities, the task is repeated. Then, the respondent is asked to identify which of the 12 figures in the Recognition Stimulus Booklet were included in the six geometric figures on the original Recall Stimulus page. As a final step, an optional Copy trial may be administered to screen for severe visuoconstructive deficits and to help in scoring recall responses.

Normative data for the BVMT-R were derived from a sample of 588 normal participants that included 171 college students and 417 community respondents. Normative data are also provided for a 377-member subset of this normative sample, selected to reflect the age distribution of the U.S. population.

Reliability coefficients range from .96-.97 for the three Learning trials, .97 for Total Recall, and .97 for Delayed Recall. Test-retest reliability coefficients range from .60 for Trial 1 to .84 for Trial 3. The BVMT-R correlates most strongly with other tests of visual memory and less strongly with tests of verbal memory.

The BVMT-R Professional Manual contains information about the test materials and their development, administration and scoring, the normative standardization sample, and validity and reliability, as well as guidelines for interpretation. The Appendixes provide scoring examples, normative tables for the U.S. census age-matched sample, demographically corrected norm tables based on the entire sample, and information on the base rate of impairment of BVMT-R scores in various clinical samples. For most diagnostic purposes, the use of demographically corrected normative scores is recommended.

Any trained person with a background in psychological testing may administer and score the BVMT-R in less than one hour. Interpretation requires training and expertise in clinical psychology and/or neuropsychology.

HVLT-R/BVMT-R Professional Manual Supplement

The HVLT-R/BVMT-R Professional Manual Supplement provides information on the development, use, and interpretation of several new scores, including Reliable Change scores and Discrepancy scores.

You can assess verbal learning and memory with the HVLT-R, a companion to the BVMT-R.

California Verbal Learning Test®, 2nd Ed (CVLT®-II)

Dean C. Delis, PhD, ABPP, Joel H. Kramer, PsyD, Edith Kaplan, PhD, ABPP/CN, and Beth A. Ober, PhD

The CVLT-II, a revision of the classic test of verbal learning and memory, now provides even more comprehensive information than the original CVLT. New features of the CVLT-II include additional items, increased flexibility in administration with new standard and short forms, an expanded age range for broader usage, and correlation with the Wechsler Abbreviated Scale of Intelligence™ (WASI™) for valuable comparative data.

More Comprehensive Information
Additional items provide more comprehensive information. Examinees are read a list of words (selected after careful study of their frequency of use across multiple demographic variables) and asked to recall them in a series of trials. The CVLT-II includes forced-choice items useful in detecting malingering, thereby helping to reduce false results. In addition to recall and recognition scores, the CVLT-II measures:

- Encoding strategies
- Error types
- Learning rates
- Other processing data

Flexible Administration
New options provide flexibility in test administration:

- The Short Form (nine words in three categories) is useful when examination time is limited or when the clinician requires less detailed test information.
- The Short Form also is useful when examinee fatigue is a concern (or severe memory or cognitive deficits make the Standard or Alternate Forms impractical).
- The new Alternate Form prevents artificially inflated scores when retesting is necessary.

Expanded Sample
Extensive clinical data are available, as well as new norms on a national sample of adults selected to represent the U.S. population. Norms are provided now for individuals from ages 16-89 years, thus increasing the utility of the new edition.

Correlated with the WASI™
The CVLT-II is correlated with the WASI, providing valuable comparative information about the effect of cognitive ability on verbal learning and memory. The CVLT-II offers a technologically advanced

computer scoring system, the CVLT-II Comprehensive Scoring System, which provides rich information not available through typical hand scoring. The most technologically advanced scoring system yet, the CVLT-II Scoring System offers multiple scoring options, varying from brief to highly detailed information.

Requirements: Windows® 95/98/NT 4.0/200/Me/XP; CD-ROM drive and 1.44MB 3.5" disk drive for installation

California Verbal Learning Test®-Children's Version (CVLT®-C)

Dean C. Delis, PhD, ABPP, Joel H. Kramer, PsyD, Edith Kaplan, PhD, ABPP/CN, and Beth A. Ober, PhD

The CVLT-C assesses verbal learning through an everyday memory task in which the child is asked to recall a list. An interference task is given, followed by a short delay free recall and cued recall trials. Free recall, cued recall, and a word recognition trial also are administered after a 20-minute delay. In this way, the CVLT-C generates measures of short- and long-term memory performance, including eight recall and four recognition measures. It also provides data on encoding strategies and errors, such as intrusions and perseveration, together with indicating the degree to which stimuli may interfere with a profile of learning characteristics.

The CVLT-C can be used in a variety of settings to identify learning and memory difficulties, to isolate deficient learning strategies, and to assist in designing remediation programs. The CVLT-C standardization sample consisted of 920 children that were representative of the U.S. population of children for age, gender, race/ethnicity, geographic region, and parent education level, based on data from the U.S. Bureau of the Census (1988). Because the CVLT-C was co-normed with the Children's Category Test (CCT), it allows clinicians to compare a child's memory and learning performance with higher executive functioning.

The CVLT-C can be hand scored or scored using the CVLT-C Scoring Assistant software. The scoring software tabulates and prints numerous raw scores and age-referenced standard scores, thus making the scoring process cost-effective for both clinical and educational practices.

Requirements: Windows® 95/98/2000/Me/XP/NT 4.0, Pentium® 100 processor or higher; 16MB RAM, 14MB free hard drive space; CD-ROM and 3.5" disk drive

Canter Background Interference Procedure (BIP) for the Bender Gestalt Test

Arthur Canter, Ph.D

This widely used measure assesses performance characteristics of individuals with brain pathology. It compares results from the standard Bender Gestalt Test to those from a second administration of the Bender Gestalt in which the subject reproduces the designs on a special sheet with intersecting sinusoidal lines. These lines provide background “noise” or interference during the copying task.

Clinical Assessment Scales for the Elderly™ (CASE™)

Cecil R. Reynolds, PhD, Erin D. Bigler, PhD

The CASE is designed to assist the clinician in the diagnosis of *DSM-IV* Axis I clinical disorders in individuals from ages 55 to 90 years. The CASE consists of a self-rating form (Form S) and an other-rating form (Form R) that can be completed by a knowledgeable caregiver (e.g., a spouse, child, home health care worker, and sibling). Form R is especially useful to verify the information provided by the patient, or when the patient is unable to complete the assessment due to physical or cognitive difficulties.

- Developed specifically to assess for the most prominent *DSM-IV* disorders among the elderly.
- Normed on a U.S. census-matched sample of 2,000 adults, ages 55-90 years.
- Consists of 10 clinical scales: Anxiety (ANX), Cognitive Competence (COG), Depression (DEP), Fear of Aging (FOA), Obsessive-Compulsive (OCD), Paranoia (PAR), Psychoticism (PSY), Somatization (SOM), Mania (MAN), and Substance Abuse (SUB).
- Includes a valuable Fear of Aging scale that assesses an individual's level of apprehension about the aging process.
- CASE items are free of gender or ethnic bias.
- Contains three validity scales especially useful to identify feigning and for forensic assessments.

Administration and Scoring

Patients and knowledgeable caregivers can complete the CASE in 40 minutes or less. Scoring and profiling are easy. CASE raw scores are converted to *T* scores using the age-appropriate normative tables. The *T* scores are then plotted on the CASE Profile Form to provide a graphic overview of the patient's clinical status or a comparison of multiple profiles when available.

Reliability/Validity

- Total normative group of 2,000 adults, matched to U.S. census data for gender, geographic region, educational level, and ethnicity (normative data are based on 1,000 each of Form S and Form R).
- Construct validity of CASE Form S is demonstrated by correlations with the MMPI-2, Beck Depression Inventory (BDI), Beck Hopelessness Scale (BHS), and both the State and Trait scales of the State-Trait Anxiety Inventory (STAI). A group of dementia patients were evaluated using the CASE Form R and the Cognitive Behavior Rating Scales (CBRS).
- Studies of gender and ethnic bias indicate no clinically significant differences as a function of gender or of ethnicity among Caucasians, African Americans, and Hispanics.
- Validity scales for Forms S and R include measures of positive and negative distortion and dissimulation (L scale), infrequently endorsed items (F scale), and detection of random responding, failure to comprehend the items, and lack of cooperation (V scale).

Clinical Assessment Scales for the Elderly™ Short Form (CASE-SF™)

Cecil R. Reynolds, PhD, Erin D. Bigler, PhD

The CASE-SF is designed to provide you with a rapid assessment of elderly adults (ages 55-90 years) to determine whether a more comprehensive evaluation of psychopathology or a referral for a different type of examination might be needed (e.g., referral to a neuropsychologist). The CASE-SF consists of a self-rating test booklet (Form S) and an other-rating test booklet (Form R) that can be completed by a knowledgeable caregiver such as a spouse, child, home health-care worker, or sibling.

- Derived from the CASE, the CASE-SF includes all 10 CASE clinical scales and two of the CASE validity scales (*Lie* and *Validity*).

CASE-SF Scales

Clinical Scales
Anxiety (*ANX*)
Cognitive Competence (*COG*)
Depression (*DEP*)
Fear of Aging (*FOA*)
Mania (*MAN*)
Obsessive-Compulsive (*OCD*)
Paranoia (*PAR*)
Psychoticism (*PSY*)
Somatization (*SOM*)
Substance Abuse (*SUB*)

Validity Scales
Lie (*L*)
Validity (*V*)

- The CASE-SF Form R provides independent information about the patient from caregivers for verification of patient status or when the patients are unable to complete the assessment themselves due to physical or cognitive difficulties.
- Designed to help you track treatment effectiveness or monitor a patient's clinical status over time.
- Enables you to quickly evaluate large numbers of seniors in a variety of settings such as assisted living facilities, nursing homes, and community care centers.
- Normative data derived from the CASE sample.
- CASE-SF items are free of gender or ethnic bias.
- The CASE/CASE-SF Professional Manual provides all of the necessary information for the administration and scoring of both the CASE and the CASE-SF.
- Patients and knowledgeable caregivers can complete the CASE-SF in 20 minutes or less; scoring and profiling are quick and easy.

Cognistat
Neurobehavioral Cognitive Status Examination

by Ralph J. Kiernan, Ph.D., Jonathan Mueller, M.D., and J. William Langston, M.D

Cognistat gives you a quick way to assess the intellectual functioning of adults in five major areas:

- **Language**
  - Spontaneous
  - Speech
  - Comprehension
  - Recognition
  - Naming
- **Constructions**
- **Memory**
- **Calculations**
- **Reasoning**
  - Similarities
  - Judgment

In addition, Attention, Level of Consciousness, and Orientation are assessed independently.

All but the Memory items are administered in a screen and metric format. Within each of the five sections, patients are first screened with a demanding test item. If they fail the screen, they are tested further with the metric, a series of increasingly difficult items. However, if they pass the screen, their functioning in the particular area is assumed to be normal, and the examiner moves on to the next section. In this way, intact areas are briefly tested, while impaired areas are examined in some detail. Testing time is about 5 minutes for normals, and about 20 minutes for individuals who are cognitively impaired.

Scores are plotted on a clear-cut profile form, which illustrates the patient's overall strengths and deficits. For interpretive guidance, the Manual presents five sample profiles and a list of specific cautions. Norms are based on two groups of 58 volunteers (20 to 39 and 40 to 66 years old), a geriatric group of 59 volunteers (70 to 92 years old), and 30 neurosurgical patients (25 to 88 years old).

Sensitive, specific, and easy to interpret, *Cognistat* quickly alerts you to potential cognitive problems. It provides a sound basis for referral, further testing, and treatment.

Cognitive Symptom Checklists (CSC)

Christiane O'Hara, PhD, Minnie Harrell, MS, LPC, Eileen Bellingrath, MS, Katherine Lisicia, MEd, CCC-SLP

The CSC is a series of five checklists designed to pinpoint the areas where individuals (ages 16 years and older) who have impaired cognitive functioning may be having difficulties in everyday activities. It can be used as a screening tool to supplement formal neuropsychological or other cognitive testing.

These checklists are designed for use with individuals ages 16 and older. Items are written at a 7th-grade reading level. The client completes the specific checklists the clinician feels necessary to determine potential problems in five basic cognitive areas:

- Attention/Concentration
- Visual Processes
- Executive Functions
- Memory
- Language

The client checks each problem he/she experiences and circles those that seem most important for treatment. The clinician inquires about each specific item checked by the client and uses this information to identify baseline cognitive problem areas, develop treatment plans, provide information to clients and their families, and measure posttreatment progress. These five checklists provide a framework for clinicians to gather additional information about the nature of specific problems and to assist the client and clinician in prioritizing problems to target for treatment.

Colour Trails Test (CTT)

Louis F. D'Elia, Ph.D., Paul Satz, Ph.D., Graig Lyons Uchiyama, Ph.D. and Travis White, Ph.D.

User Qualification: Psychologist
Suitable for: Adults
Time: Untimed, approximately 10 minutes, 2 trials

The Color Trails Test was developed to meet the need for a test with the sensitivity and specificity of the standard Trail Making Test, but one that was as free as possible from the influences of language and cultural bias. The CTT retains the psychometric properties of the standard TMT, but it substitutes the use of color for the use of English alphabet letters, making it more suitable in cross-cultural and other special-needs contexts. Instructions may be presented either verbally or with visual cues. Respondents must be able to recognize Arabic numerals from 1 to 25 and to distinguish between the colors pink and yellow.

The CTT uses numbered colored circles and universal sign language symbols. The circles are printed with vivid pink or yellow backgrounds that are perceptible to colorblind individuals. During the test the

examiner uses a stopwatch to record the length of time to complete each trial along with qualitative features of performance indicative of brain dysfunction.

Comprehensive Trail-Making Test (CTMT)

by Cecil R. Reynolds, Ph.D.

Based on time-tested techinques, the CTMT is a standardized set of five visual search and sequencing tasks that are heavily influenced by attention, concentration, resistance to distraction, and cognitive flexibility (or set-shifting). It is highly useful in the evaluation and diagnosis of brain injury; frontal lobe deficits; problems with psychomotor speed, visual search and sequencing, and attention; and impairments in set-shifting.

The CTMT is for individuals ages 11 through 74. Administration is timed and takes from 5 to 12 minutes. Scoring typically requires just a few minutes more. Normative scores, derived from a nationwide sample of 1,664 people, are provided as percentile ranks and T-scores with a mean of 50 and a standard deviation of 10.

The basic task of trail-making is to connect a series of stimuli (numbers and letters) in a specified order as fast as possible. The score derived for each trail is the number of seconds required to complete the task. The composite score is obtained by pooling T-scores from the individual trails. Although similar, the test's five trails differ from each other in some significant way. For example, Trail 1 requires the examinee to draw a line connecting the numbers 1 through 25 in order, while Trail 2 presents the same task with 29 distracters on the same page.

The CTMT is extremely sensitive to neurological insult, disease, injury, or dysfunction, including the subtle neuropsychological problems often present in individuals with learning disabilities

The Clock Test (CT)

H. Tuokko, Ph.D., T. Hadjistavropoulos, Ph.D., J.A. Miller, Ph.D., A. Horton, M.D., & B.L. Beattie, M.D.

User Qualification: Psychologist
Suitable for: Adults Aged 65 Years and Over
Time: Untimed, approximately 5-10 minutes for each of three components

The Clock Test is designed to quickly assess visual-spatial construction, visual perception, and abstract conceptualization. Using three subtests: Clock Drawing, Clock Setting, and Clock Reading, the Clock Test measures an individual's level of cognitive impairment and helps differentiate between normal elderly and those suffering from dementia.

The Clock Test provides you with well-defined, specific scoring criteria that ensures greater efficiency and reliability. Errors are broken down into the following components: omissions, distortions, misplacements, perseverations, substitutions, additions and rotations

Continuous Visual Memory Test (CVMT)

Donald E. Trahan, Ph.D. and Glenn J. Larrabee, Ph.D.

User Qualification: Psychologist
Suitable for: Adults
Time: Untimed, approximately 45-50 minutes, 112 items

The CVMT uses complex, ambiguous designs and a recognition format to measure visual learning and memory. Studies suggest that these features may increase task sensitivity and reduce the confounding influence of verbal encoding strategies. This format also eliminates the motor responses required by drawing tasks and restricts the verbal labeling required by tests that use simplistic geometric figures and common objects.

The CVMT includes 3 tasks for assessing visual memory, (1) the Acquisition Task tests recognition memory; (2) the Delayed Recognition Task measures retrieval from long-term storage after a 30-minute delay; and (3) a Visual Discrimination Task distinguishes visual discrimination deficits from visual memory problems. The clinical sensitivity of the CVMT has been demonstrated in patients with unilateral right hemisphere CVA, individuals with Alzheimer's disease, as well as patients who have suffered severe head trauma.

Delis-Kaplan Executive Function System™ (D-KEFS™)

Dean C. Delis, PhD, Edith Kaplan, PhD, Joel H. Kramer, PsyD

With nine new stand-alone tests, the D-KEFS comprehensively assesses the key components of executive functions believed to be mediated primarily by the frontal lobe. Incorporating principles from cognitive science, the D-KEFS™ evaluates higher-level cognitive functions in both children and adults.

The D-KEFS has multiple uses. It can be used to assess the integrity of the brain; to determine how deficits in abstract, creative thinking may impact daily life; and to help plan coping strategies and rehabilitation programs tailored to each patient's profile of executive function strengths and weaknesses.

Normed on over 1,500 individuals demographically and regionally matched with the U.S. population, the D-KEFS is individually administered. Its game-like format is designed to be interesting and engaging for examinees, encouraging optimal performance without providing "right/wrong" feedback that can create frustration in some children and adults.

The Standard Record Forms include all nine D-KEFS tests (each test is available for individual ordering as well); the Alternate Record Forms include alternate versions of D-KEFS Sorting, Verbal Fluency, and 20 Questions Tests. An alternate set of Sorting Cards also is available.

The D-KEFS is correlated with the Wechsler® Abbreviated Scale of Intelligence™ (WASI™) and the California Verbal Learning Test®, 2nd Ed. (CVLT®-II), providing information concerning the role of intellectual ability and memory on D-KEFS performance. The scoring process is enhanced with the

convenient D-KEFS™ Scoring Assistant® that reduces your scoring time. The scoring software enables you to quickly and easily generate score reports in either a tabular or graphic format.

The scoring process is enhanced with the convenient D-KEFS™ Scoring Assistant™ that reduces your scoring time. The scoring software enables you to quickly and easily generate score reports in either a tabular or graphic format.

Requirements: Windows® 95/98/2000/Me/XP/NT 4.0, 100 MHz processor (166 MHz recommended), 32MB of RAM (64MB recommended), 2MB video card capable of 800x600 resolution (16-bit color), 75MB free hard disk space

Note: The Trail Making Test and the Design Fluency Test require separate response booklets. If you are ordering either of these tests, or are ordering the Standard Record Forms and intend to administer either of these tests, be sure you also order the corresponding response booklets.

Dementia Rating Scale - 2 (DRS - 2)

Steven Mattis, Ph.D.

Research conducted after the publication of the original Dementia Rating Scale (DRS) showed that both age and education contribute significantly to DRS subscale and Total Scores. This finding, along with several other factors, provided the impetus for the development of the DRS-2.

The DRS-2 measures cognitive function at lower ability levels where some other evaluation instruments are limited by floor effects. The DRS-2 also can be used to track changes in cognitive status over time. By design, the DRS-2 measures deficits in a large range of higher cortical functions and differentiates deficits of varying severity levels.

The DRS-2 incorporates the original 36 DRS tasks and 32 stimuli, yielding five subscale scores, and an assessment of the patient's overall level of cognitive functioning. The five DRS-2 subscales provide additional information on specific abilities including Attention (8 items), Initiation/Perseveration (11 items), Construction (6 items), Conceptualization (6 items), and Memory (5 items). Stimulus items consist of material familiar to most individuals.

The DRS-2 tasks are presented in a fixed order. Within each subscale the most difficult tasks are presented first. Generally, if the first one or two tasks in a subscale are performed well, subsequent tasks in the subscale are credited with a correct performance and the examiner proceeds to the next subscale. This procedure significantly shortens the total testing time for individuals with relatively intact cognitive functioning.

The DRS-2 Includes the Following Features:

- A newly designed 12-page DRS-2 Scoring Booklet that facilitates administration and scoring.
- A new Profile Form helps to create a graphical representation for interpretation.
- An expanded age range (55-89 years and older).
- Age-corrected normative tables for all DRS-2 subscales with age- and education-corrected normative data for the DRS-2 Total Score.
- The 32 Stimulus Cards and the 36 tasks of the original DRS.
- Expanded literature review with a discussion of DRS reliability and validity studies.

- Validity studies comparing the DRS with WMS® and WAIS-R® subtests and the MMSE™.

DRS-2 test materials include the Professional Manual, one set of Stimulus Cards, 50 Scoring Booklets, and 50 Profile Forms. The 32 Stimulus Cards are contained in a separate binder for ease of administration. The Scoring Booklet provides prompts for administration of the items and complete instructions for scoring the patient's responses.

Digit Vigilance Test (DVT)

Ronald F. Lewis, Ph.D.

User Qualification: Psychologist
Suitable for: Adults
Time: Timed, 10 minutes

The DVT, included in Robert K. Heaton's expanded HRB normative system, is a simple task designed to measure vigilance during rapid visual tracking and accurate selection of target stimuli. It is sensitive to subtle changes in neuropsychological status, but relatively insensitive to the effects of either repeated administrations or practice. The DVT appears to isolate alertness and vigilance while placing minimal demands on two other components of attention: selectivity and capacity.

Time to complete the task is recorded using a stopwatch. The 4 scoring templates (one for 6s and one for 9s in each of the colors) allow the test administrator to count and record errors of commission and omission.

Interpretation within the context of a comprehensive neuropsychological evaluation requires training in clinical psychology or neuropsychology. Normative data are not provided in the Professional User's Guide, but are presented in Comprehensive Norms for an Expanded Halstead-Reitan Battery.

Dementia Rating Scale-2™: Alternate Form (DRS-2™: Alternate Form)

Kara S. Schmidt, PhD

The DRS-2 is a widely used instrument for the assessment of neurocognitive status. Because it is appropriate for use by professionals across multiple disciplines (e.g., neuropsychology, psychiatry, neurology, gerontology), an equivalent form was needed, and subsequently, the DRS-2: Alternate Form was developed.

The DRS-2: Alternate Form reduces the practice effects that occur with serial administrations of the original DRS-2. This issue is particularly important in the assessment of older adults (ages 55-89 years and older) with neuro-psychiatric illness. Accurate documentation of cognitive changes is crucial to arrive at a precise diagnosis. Often, it is necessary to administer mental status measures multiple times over a relatively brief period. Thus, having two DRS-2 forms available allows for a better characterization of declining cognitive status and an improvement in the evaluation of treatment efficacy.

The DRS-2: Alternate Form test materials include the Professional Manual Supplement, 1 set of Stimulus Cards, Scoring Booklets, and Profile Forms. The Professional Manual Supplement is an

adjunct to the original DRS-2 Professional Manual, which provides all normative tables and data as well as interpretive guidelines for both forms of the DRS-2. The item content in the newly designed DRS-2: Alternate Form Scoring Booklet and the stimuli in the DRS-2: Alternate Form Stimulus Cards are structured to mirror their respective original forms. The DRS-2: IR software also has been updated to include the use of either or both forms.

Reliability and Equivalency Studies
Test-retest reliability of the DRS-2: Alternate Form is strong. In addition, alternate form reliability between the original DRS-2 and the DRS-2: Alternate Form is strong, with a correlation coefficient of .82 for the Total Score, and correlation coefficients ranging from .66 to .80 for the subscales. Several other studies, including a generalizability and equipercentile equating, were utilized to determine the equivalency between the two forms.

The Dean-Woodcock Neuropsychological Battery

The *Dean-Woodcock Neuropsychological Battery* (DW) is a comprehensive assessment of sensory-motor functioning that also includes a structured interview and an emotional status exam. The DW adds standardized procedures and normative information to typically unstandardized measures used in neuropsychology.

Appropriate for ages 4 and up (including the geriatric population), the DW can be administered in just 40 to 45 minutes. It measures simple and complex sensory and motor functioning and both cortical and subcortical functions. First, a structured interview is used to determine an individual's medical and family background. This is followed by an emotional status exam, during which the clinician records psychiatric signs and symptoms--covering most major disorders found in the DSM-IV--as well as clinical impressions. The third part of the battery assesses sensory-motor functioning on the following subtests:

Lateral Preference Scale	Object Identification	Construction Test (Cross and Clock)
Near Point Visual Acuity	Finger Identification	Mime Movements
Visual Confrontation	Simultaneous Localization	Left-Right Movements
Naming Pictures of Objects	Gait and Station	Finger Tapping
Auditory Perception	Romberg Test	Expressive Speech
Palm Writing	Coordination Test	Grip Strength

Scores indicate functional ranges of impairment: Within Normal Limits; Mildly Impaired; Moderately Impaired; or Severely Impaired. Several levels of interpretation are offered, allowing various professionals--from school psychologists to neurologists--to benefit from battery results.

Developmental Test of Visual-Motor Integration (VMI) 5th Edition

by Keith E. Beery, Ph.D. and Norman A. Buktenica, and Natasha A. Beery

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

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

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

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

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

A revised scoring system permits finer discrimination between performances, especially at older age levels. The Manual presents very clear scoring criteria, standard scores, percentiles, and teaching suggestions. It also reports recent medical and neuropsychological applications of the VMI.

Five teaching tools, new to the Fifth Edition, offer activities and exercises that help teachers respond to VMI results. These are described below.

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

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

Developmental Scoring System for the Rey-Osterrieth Complex Figure (DSS-ROCF)

Jane Holmes Berenstein, Ph.D. and Deborah Waber, Ph.D.

User Qualification: Psychologist
Suitable for: Individuals Aged 5 to 14 Years
Time: Untimed, approximately 35 minutes

The DSS-ROCF allows the examiner to objectively evaluate ROCF performance within a developmental context and to determine the age-appropriateness of the child's Copy and Recall productions. The DSS-ROCF measures not only the child's ability to accurately reproduce the figure, but also the child's qualitative, organizational, and stylistic approaches to the figure. Clinical experience has shown that children's responses to the ROCF often predict their responses in comparable situations where novel, complex material is presented.

The DSS-ROCF measures four parameters of ROCF performance: Organization, Style, Accuracy, and Errors. Age-referenced norms for these four parameters provide guidelines for determining the developmental appropriateness of a child's production.

Digit Vigilance Test (DVT)

Ronald F. Lewis, PhD

Sensitive to subtle changes in neuropsychological status, but relatively insensitive to the effect of repeated administrations, the DVT is a simple task designed to measure vigilance during rapid visual tracking and accurate selection of target stimuli. It appears to isolate alertness and vigilance while placing minimal demands on two other components of attention: selectivity and capacity.

- Four color-coordinated Scoring Keys.
- Administration and scoring can be accomplished by individuals with no formal training under the supervision of a qualified psychologist. Interpretation within the context of a comprehensive neuropsychological evaluation requires training in clinical psychology or neuropsychology.
- Respondents are asked to find and cross out either "6s" or "9s," which appear randomly within 59 rows of single digits.
- The 59 rows of digits are printed in red on the first stimulus page and in blue on the second.

The Dot Counting Test (DCT)

Kyle Boone, Ph.D., Po Lu, Psy.D., and David Herzberg, Ph.D.

The *Dot Counting Test* (DCT) is a brief task that assesses test-taking effort in individuals ages 17 and older. This convenient instrument allows you to detect lack of effort on cognitive measures, whether it is intentional (malingering) or unintentional (unconscious). The DCT measures an "overlearned" skill that is preserved in all but the most severe brain injuries. Because of this, a poor performance on the DCT suggests lack of effort. A validity study reported in the manual compared the DCT scores of 85 "suspect effort" patients (previously identified as "under attempters" by rigorous inclusion and exclusion criteria) to those of patients in seven "normal effort" diagnostic groups: Depression, Schizophrenia, Head Injury, Stroke, Learning Disability, Mild Dementia, and Nonclinical. This study verified the ability of the DCT to discriminate among patients based on their effort status. In interpreting DCT results, you can select a cut off score that minimizes false positives while maintaining adequate sensitivity to "suspect effort." Simply compare the patient's performance to that of a similar reference group. The DCT is highly useful in any setting where examinees have external incentives to fabricate or exaggerate cognitive problems—personal injury litigation, disability evaluations, and criminal cases, for example. The test's usefulness, however, reaches far beyond these situations. Routine assessment of effort often reveals unexpected features of other clinical complaints. For instance, patients who fail effort tests are sometimes found to have factitious or somatoform disorders. Even patients who have legitimate brain injuries sometimes exaggerate existing problems or fabricate new symptoms to ensure that their complaints are taken seriously. Administered and scored in less than 10 minutes, the DCT can easily be added to routine assessment practice, rather than limited to forensic and disability cases. Its value in research is also apparent, especially in studies focusing on disorders that can't be independently confirmed through laboratory or imaging tests.

Ecologically Oriented Neurorehabilitation of Memory (EON-MEM)

by Anthony Y. Stringer, Ph.D.

The EON-MEM is a systematic, structured, and detailed cognitive rehabilitation program designed to help patients overcome memory impairment. Incorporating the author's 20 years of experience in cognitive rehabilitation and best empirical practices, the EON-MEM is ideal for adults with mild to moderate memory impairments caused by neurological conditions, including stroke, traumatic brain injury, and brain tumors.

Incorporating mnemonic strategies and written aids, the EON-MEM introduces a simple, practical way to improve memory. Using the **W**rite-**O**rganize-**P**icture-**R**epeat (WOPR) method, along with an ingenious rhyming technique, EON-MEM helps patients recall information they need to function in their daily lives.

The program includes a Therapist Guide and a Patient Workbook. The Therapist Guide provides step-by-step instructions, making it easy for both novice and experienced clinicians to use. It walks you through the program, explaining what to say and do with the patient in each session. The EON-MEM system is consistent across patients, quickly mastered by clinicians, and useful for outcome evaluation studies of cognitive rehabilitation.

Each patient receives a Patient Workbook, in which he or she practices skills taught by the therapist. Homework assignments save the therapist time, as substantial progress can be made between sessions. Included in the Patient Workbook is *The Memory Strategies and Concerns Questionnaire*, a self-report inventory that allows the therapist to collect information on the kinds of everyday memory problems a patient is experiencing, the subjective severity of those problems, and the strategies that the patient currently uses to compensate for his or her impairment. Administered before and after treatment, this questionnaire allows you to demonstrate and monitor the efficacy of the program,

create individualized treatment plans, monitor change in the patient's subjective experience of his or her everyday memory, and increase the patient's knowledge of memory improvement strategies.

Implemented in 21 sessions of 1 to 2 hours each, the program allows for considerable flexibility and individualization and actively solicits input from the patient in order to address his or her treatment needs. Session topics include learning numbers and appointments, remembering future tasks and locations of objects, and recalling names, faces, and biographical information. The program can be easily shortened to focus on the areas most critical to the individual. With a strong emphasis on oral and written information, the EON-MEM is useful, practical, and designed to improve necessary skills and everyday functioning.

Electronic Tapping Test

Here is an accurate, easy-to-use finger or foot tapping measure for neuropsychological evaluation. This redesigned, compact electronic tapper automatically starts a 10-second timer as soon as the first tap is made. The digital display shows a dash (--) until 10 seconds are up—at which point it shows the number of taps made during that interval. Additional taps, made after the 10-second period has elapsed, are not recorded. Measuring 4½" x 2¾" x 1" high, this pocket-size unit comes in a sturdy but lightweight plastic housing. It operates on a single 9-volt battery (not included) and requires no adapter. Normative data confirm that results obtained using this tapper is comparable to those obtained from mechanical tappers. Norms included with the Electronic Tapping Test are based on a sample of 184 individuals, ages 16 and up. They are provided separately for males and females, for various age groups, and for preferred and non-preferred hands.

Executive Control Battery (ECB)

E. Goldberg, K.Podell, R. Bilder and J. Jaeger

User Qualification: Psychologist

Suitable for: Patients with frontal lesions
Time: Approx 15 mins per subtest (4 subtests)

The Executive Control Battery has been designed to document the presence and the extent of the "executive dyscontrol" or "frontal lobe" syndrome. It was created as a result of the work done by Alexander Luria and Elkhonon Goldberg whilst studying patients with focal prefrontal lesions.

The battery is one of a kind amongst other similar tests in the area showing much greater sensitivity and specificity in measuring deficits resulting from the "frontal lobe" syndrome.

The battery consists of four subtests: (1) the Graphical Dequences Test; (2) the Competing Programs Test; (3) the Manual Postures Test; and (4) the Motor Sequences test each of which can be administered on its own or altogether. Distinct patterns of performance on each subtest indicate various aspects of the executive dyscontrol syndrome.

Extended Complex Figure Test (ECFT)

Philip Fastenau, Ph.D.

The *Extended Complex Figure Test* (ECFT) retains the strengths and overcomes the limitations of the *Rey-Osterrieth Complex Figure Test (*CFT), a standard measure of perceptual organization and visual memory in brain-injured individuals. By adding Recognition and Matching Trials to the CFT's design copying task, the ECFT allows clinicians to distinguish perceptual operations from constructional skills, and encoding processes from retrieval processes. This gives the ECFT greater diagnostic

sensitivity. The ECFT is useful not only in evaluating the effects of head injury, stroke, seizure, various medical conditions, and exposure to neurotoxins, but also in differentiating depression from dementia; distinguishing dementia-related memory deficits from normal, age-related memory lapses; and identifying aspects of memory functioning relevant to rehabilitation.

Facial Recognition

Arthur L. Benton, PhD

A 3-part standardized measure of the ability to match unfamiliar faces. Contains a 27-item short form and a 54-item long form.
This test has demonstrated validity and provides additional substantive data in the evaluation of brain-damaged patients.

Frontal Systems Behaviour Scale™ (FrSBe™)

Janet Grace, PhD, Paul F. Malloy, PhD

The FrSBe, formerly known as the Frontal Lobe Personality Scale (FLoPS), provides a brief, reliable, and valid measure of three frontal systems behavioural syndromes: apathy, disinhibition, and executive dysfunction. It also quantifies behavioural changes over time by including both baseline (retrospective) and current assessments of behaviour.

Research has demonstrated that many individuals with frontal lobe damage are capable of normal performance on traditional neuropsychological measures. However, their behaviour in natural settings is often disordered, resulting in severe impairment in social and occupational functioning. The FrSBe fills a gap in the assessment of frontal systems behavioural syndromes by providing a means to identify and quantify these behavioural problems so that they may be targeted for treatment.

The FrSBe includes a Total Score, as well as scores on three subscales related to the three frontal systems behavioural syndromes: Apathy (14 items), Disinhibition (15 items), and Executive Dysfunction (17 items). This 46-item, paper-and-pencil behaviour rating scale is much easier and less time-consuming to administer than a neuropsychological test battery. Two hand-scorable, carbonless test booklets are available: one for self-rating and one for rating by a family member or caregiver. Each item is rated on a 5-point Likert scale. Items are written at a 6th-grade reading level. Two profile forms (Self and Family) allow comparisons of behaviours pre- and post-injury/illness.

The Professional Manual provides normative data for a community-based sample of 436 men and women for two levels of education (i.e., ≤12 years and >12 years). Data also provided for several clinical groups, including patients with frontotemporal dementia, frontal lesions, nonfrontal stroke, head injury, Alzheimer's disease, Huntington's disease, and Parkinson's disease.

The FrSBe is particularly useful to neuropsychologists, clinical psychologists, rehabilitation psychologists and counselors, behavioural neurologists, neuropsychiatrists, and occupational therapists and speech pathologists who provide cognitive rehabilitation services.

The FrSBe can be administered to individuals or groups (ages 18-95 years) in 10 minutes. Scoring takes 10-15 minutes.

Halstead Russell Neuropsychological Evaluation System, Revised (HRNES-R)

Elbert W. Russell, Ph.D., and Regina I. Starkey
This convenient computer scoring system, available on an unlimited-use disk or CD, makes it easier to tailor your neuropsychological exam to the patient's particular needs.

Hooper Visual Organisation Test (VOT)

H. Elston Hooper, Ph.D.

This brief screening test measures the individual's ability to organise visual stimuli - a task that is particularly sensitive to neurological impairment. It taps both general and specific cognitive functions, including: Arousal, Visual analysis and synthesis, Concept formation, Short and long term memory, Written or oral labelling of familiar objects.

The test consists of 30 line drawings, each showing a common object - such as an apple or a ball - that has been cut into several pieces. The pieces are scattered on the page like parts of a puzzle. The client's task is to identify what the object would be if the pieces were put back together correctly.

The VOT minimizes situational factors, such as low motivation or inattention on the client's part, which can lead to diagnostic error. It is relatively independent of distractibility or verbal ability and doesn't require a motor response. The test is non-threatening and it usually engages even the most reluctant clients. Those who can't come up with the correct answers can still respond to the items in some way. This allows the clinician to successfully test individuals who might refuse to co-operate on an intellectual task where failure is more obvious.

Hopkins Verbal Learning Test-Revised™ (HVLT-R™)

Jason Brandt, PhD, Ralph H. B. Benedict, PhD

THE HVLT-R offers a brief assessment of verbal learning and memory (recognition and recall) for individuals 16 years and older. It is easy to administer and score and is well-tolerated even by significantly impaired individuals. Its use has been validated with brain-disordered populations (e.g., Alzheimer's disease, Huntington's disease, amnestic disorders).

The Professional Manual provides information on administration and scoring, interpretation (including four case examples), development and psychometric characteristics, reliability, and validity of the instrument. Raw score to T-score conversions by age group are provided in the Appendix.

Six distinct forms of the HVLT-R are available, eliminating practice effects on repeated administrations. Each form consists of a list of 12 nouns (targets) with four words drawn from each of three semantic categories. The semantic categories differ across the six forms, but the forms are very similar in their psychometric properties. Each form is printed in a different colour.

The HVLT-R tasks include three learning trials, a delayed recall trial (20-25 minute delay), and a yes/no delayed recognition trial. This latter trial consists of a randomized list that includes the 12 target words and 12 nontarget words, six of which are drawn from the same semantic categories as the targets. Raw scores are derived for Total Recall, Delayed Recall, Retention (% retained), and a Recognition Discrimination Index.

The HVLT-R has high test-retest reliability, and its construct, concurrent, and discriminant validity have been well established. The normative sample included 1,179 community residents (300 men, 879 women), who reported being free of neurological or psychiatric disorders. Their ages ranged from 16-92 years (M = 59 years), and their educational backgrounds ranged from 2-20 years (M = 13.5 years).

The HVLT-R was intentionally designed to be methodologically similar to the Brief Visual Memory Test-Revised (BVMT-R; Benedict, 1997). Both tests share the same administration procedures (three learning trials, delayed recall, and delayed recognition). The HVLT-R assesses verbal learning and memory while the BVMT-R measures visual learning and memory.

HVLT-R/BVMT-R Professional Manual Supplement
The HVLT-R/BVMT-R Professional Manual Supplement provides information on the development, use, and interpretation of several new scores, including Reliable Change scores and Discrepancy scores.

Hopkins Verbal Learning Test-Revised™/Brief Visuospatial Memory Test-Revised™ Software Portfolio (HVLT-R™/BVMT-R™ SP)

Ralph H. B. Benedict, PhD, Jason Brandt, PhD, and PAR Staff

Because of their brief and complementary nature, the HVLT-R and BVMT-R are often administered together. The new HVLT-R/BVMT-R SP provides unlimited scoring and reporting for both instruments after hand entry of an individual's raw scores. Several new scores have been developed, including:

- *T* scores for Trials 1, 2, and 3 of the HVLT-R.
- Reliable Change Scores (evaluates change in scores over time for the HVLT-R and BVMT-R Total Recall and Delayed Recall scores).
- Discrepancy Scores (compares a client's auditory/verbal [HVLT-R] and visual/spatial [BVMT-R] memory test performances; also calculated for Total Recall and Delayed Recall scores).

The software generates up to five reports:

- **HVLT-R Score Report**--provides raw scores, *T* scores, percentiles and profiles; also includes new *T* scores for Trials 1, 2, and 3.
- **HVLT-R Longitudinal Report**--includes the new Reliable Change Score.
- **BVMT-R Score Report**--provides raw scores, *T* scores, percentiles and profiles.
- **BVMT-R Longitudinal Report**--includes the new Reliable Change Score.
- **HVLT-R/BVMT-R Discrepancy Report**--includes the new Discrepancy Score.

HVLT-R/BVMT-R Professional Manual Supplement
The Professional Manual Supplement provides information on the development, use, and interpretation of new scores. In addition, normative data are included for all new scores.

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

Intermediate Booklet Category Test (IBCT)

Paul B. Byrd, Ph.D.

User Qualification: Psychologist
Suitable for: Adolescents Aged 9 to 14 Years
Time: Untimed, approximately 30-60 minutes, 168 items

This booklet version of the Halstead Category Test (CT) can be used to help discriminate normal students from those with learning and behavior disorders. Equivalency studies reported in the manual support using the IBCT as an alternative form of the CT.

The IBCT consists of 168 stimulus items in 6 subtests. Presented in the same format as the Booklet Category Test, the white designs on black backgrounds duplicate the designs used in the original slide version.

Interference Learning Test (ILT)

Michael M. Schmidt, Ph.D., and Frederick L. Coolidge, Ph.D.

This multiple-trial verbal learning and memory test offers innovative design and psychometric sophistication. Ongoing interference with the learning process is embedded into the test procedure. This interference taxes source memory, invites intrusion errors, and impedes efforts to organize the material to be learned. In doing so, it frees the ILT from the ceiling effects that limit many other neuropsychological tests—making the ILT ideal for detecting mild and moderate as well as severe impairment. In addition, this ongoing interference establishes learning conditions more similar to those encountered in everyday life. The ILT is composed of two word lists. List 1 includes 20 target words and 24 distracters. List 2 presents 16 targets and no distracters. Each word is printed on a separate card—targets on white cards, distracters on blue. The examinee is instructed to read all the words aloud while trying to learn the targets and ignore the distracters. Four trials are administered for List 1, then two trials for List 2. The examinee is then asked to recall List 1 targets. After a 30-minute interval filled with nonverbal tests, the examinee is again asked to recall List 1 targets. This is followed by a category cued recall trial, a recognition memory trial, and an indirect memory task.

Integrated Visual and Auditory Continuous Performance Test (IVA)

by Joseph A. Sandford, Ph.D. and Ann Turner, M.D.

In just 13 minutes, this unique continuous performance test assesses impulsivity, inattention, and hyperactivity in individuals ages 6 to 96. And the computer does almost all the administration, scoring, and test-retest comparisons.

The IVA is the only continuous performance test to combine visual and auditory stimuli. And it's the first to provide an objective measure of fine motor hyperactivity. The IVA is an excellent way to differentiate ADHD Predominantly Inattentive Type, ADHD Predominantly Hyperactive-Impulsive Type, and ADHD Combined Type.

The client sits at the computer, instructed to click the mouse only when he or she sees or hears a "1" and not to click when he or she sees or hears a "2." Some portions of the test "pull for" errors of commission (impulsivity), while others pull for errors of omission (inattention). Administration and scoring are fully automated, and test instructions are presented both visually and aurally by the computer.

The IVA produces quotient scores for impulsivity and inattention. These identify performances outside the norm. In addition, it gives you a separate scale of fine motor hyperactivity based on impulsive and off-task behavior with the mouse. Twenty-two other scale scores help you pinpoint differences in auditory and visual processing related to impulsivity, attention, focus, stamina, motivation, consistency, speed, and learning problems.

Normative information is based on a sample of more than 1,700 individuals from 6 to 96 years of age, screened to rule out attention, learning, neurological, and psychological problems.

Norms are separated by sex and age.

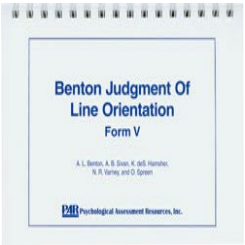
Because the IVA assesses auditory and visual modalities for both inattention and impulsivity, it functions as four CPTs in one. It provides immediate analysis, and stores data for future comparisons. An automated test-retest analysis lets you quickly assess the effects of treatment or medication. IVA has demonstrated 92% sensitivity (i.e., an 8% rate of false negatives) and 90% specificity (i.e., a 10% rate of false positives) in differentiating ADHD and normal children. Also, recent research has shown the test 97% accurate in differentiating individuals with mild traumatic brain injury from normals (with age and education controlled).

IVA now comes with The Investigator, an unlimited-use program that lets you analyze your client's performance. Comparing performance test by test, quintile by quintile, or response by response, you can use The Investigator to titrate medication more accurately, evaluate treatment effectiveness, judge the client's stamina, demonstrate progress to parents or insurance companies, or export data into statistical programs for further study.

Hardware requirements: *Pentium 166 or higher PC compatible processor, DirectX 7 (Included on IVA CD), 100 MB available hard drive program space, 32 MB RAM, Windows ME/2000/XP/Vista, VGA Color Monitor, 4X CD ROM, External Speakers or Headphones, USB Mouse, Sound Card.*

Judgment Of Line Orientation

Arthur L. Benton, PhD



This is a standardized measure of visuospatial judgment in two alternate forms. The spiral-bound booklet contains 35 stimuli, five of which are practice items.

This test has demonstrated validity and provides additional substantive data in the evaluation of brain-damaged patients. This test is designed to be quickly and easily administered, minimizing patient fatigue and maximizing the collection of reliable neuropsychological test data. Normative and validity data are described in the manual, *Contributions to Neuropsychological Assessment*, which must be purchased separately.

Kent Visual Perceptual Test (KVPT)

Lawrence E. Melamed, PhD

The KVPT is an integrated battery of interrelated tests that demonstrate impairment and distinguish skill levels among three visual processes related to the development of basic reading, early mathematics, and written expression. These tests are particularly effective in both individualized

neuropsychological assessment and psychoeducational assessment.

The KVPT-D (Discrimination) requires the individual to select (from a set of alternatives) the item that matches a standard form. Stimuli are presented in a binder for ease of administration.

The KVPT-C (Copy) consists of three increasingly difficult subtests that require the individual to reproduce forms of the same type as the KVPT-D items.

The KVPT-M (Immediate Memory) requires the individual to locate a target form within a set of alternatives immediately following a brief exposure to the form. Stimuli are presented in a binder for ease of administration.

For neuropsychological assessment, the KVPT can be used as the core visual processing battery to characterize visual-perceptual deficits and distinguish them from visual memory or visual motor problems. Use the KVPT to distinguish visual-spatial errors or to distinguish a deficit due to errors in processing the spatial features of forms from errors in reproducing (copying) the forms. The KVPT is sensitive to stroke-related deficits.

In a school setting, the KVPT can help professionals in school psychology and/or special education to predict early achievement and to identify and remediate reading, mathematics, and written expression difficulties due to visual processing (e.g., determining that a child with difficulty identifying appropriate mathematical operations has a visual-spatial processing deficit). The Professional Manual provides a chapter on clinical interpretation that demonstrates the way appropriate academic interventions can be developed based on a child's KVPT profile.

All three tests come from a common pool of two-dimensional items based on form perception literature, assuring both construct validity and comparability in processing difficulty. Although the KVPT was normed with all three tests administered, it is possible to use only one or two of the tests so long as the tests are presented in the following order: KVPT-D, KVPT-C, KVPT-M.

Specific scoring criteria and examples are provided for each test. Standard scores and percentile ranks are provided by gender for all three KVPT tests for children ages 5-11 years. Additional normative data are provided by gender for KVPT-D and KVPT-M scores for adults ages 18-22 years and for all three KVPT tests for older adults ages 55-91 years. Comprehensive norms are provided for both level of performance and error analysis, facilitating both brief and in-depth analysis of deficits in visual processing. Normative data for the KVPT-D and the KVPT-M allow for quantitative evaluation of rotation (spatial) errors, nonrotation (patterns of organization or content) errors, and errors due to the complexity of the item.

Koppitz Developmental Scoring System for the Bender Gestalt Test -- Second Edition (KOPPITZ-2)

by Cecil R. Reynolds, Ph.D.

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

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

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

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

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

Learning and Memory Battery (LAMB)

James P. Schmidt, Ph.D. and Tom N. Tombaugh, Ph.D.

User Qualification: Psychologist
Suitable for: Adults Aged 20 to 80 Years
Time: Untimed, approximately 45-60 minutes

The Learning and Memory Battery (LAMB) assesses both specificity and sensitivity to diverse memory problems. With the use of test administration methods already familiar to practitioners who evaluate memory functioning, LAMB provides a uniform format for unambiguous test interpretations. The LAMB evaluates learning and retention across several dimensions, including initial versus repeated trial learning, immediate versus delayed recall, and free versus cued versus recognition recall. It also evaluates verbal, visual, and numerical learning and retention.

The LAMB consists of the following subtests: (1) Paragraph Learning; (2) Word List Learning; (3) Simple Figures (drawn); (4) Word Pair Learning; (5) Complex Figure; and (6) Digit Span and Supraspan Learning.

Luria-Nebraska Neuropsychological Battery (LNNB)

Charles J. Golden, Ph.D., Arnold D. Purisch, Ph.D., and Thomas A. Hammeke, Ph.D.

Suitable for: ages 15 and above

This widely used battery takes the clinical procedures of neuropsychologist A. R. Luria and adds standardized administration and scoring to produce a comprehensive but convenient measure of neuropsychological functioning. The LNNB is used to diagnose cognitive deficits, including lateralization and localization of focal brain impairments. Unlike other neuropsychological tests, which give only a global measure of cerebral dysfunction, the LNNB also detects very specific problems, as well as mild impairment that might otherwise go unnoticed. Designed for individuals ages 15 and

older, the LNNB has also been used successfully with 13- and 14-year-olds. It assesses a wide range of cognitive functions. In addition, 28 factor scales reflect more specific sensory and cognitive functions. The LNNB can be administered in only 1.5 to 2.5 hours. Depending on the patient's condition, it can be given in a single session or in a series of brief sessions. Completely portable, it can even be given at bedside if necessary. The battery is available in two equivalent forms: Form I (269 items) and Form II (279 items). Although they yield similar information, Form II features improved Stimulus Cards that are much easier to use. They are spiral bound, rather than loose, and are arranged in the proper sequence. Also, Form II includes one additional scale, Intermediate Memory, which permits more detailed memory assessment. In addition, Form II is computer scored only, while Form I can be scored by hand or computer.

Luria-Nebraska Neuropsychological Battery Children's Revision (LNNB-C)

Charles J. Golden, Ph.D

Suitable for: ages 8-12

This Children's Revision of the widely used Luria-Nebraska Neuropsychological Battery (LNNB) offers the same comprehensiveness and flexibility of the adult version, in a form designed for 8- to 12-year-olds. It assesses cognitive deficits. The LNNB-C uses the same stimulus materials as Form I of the adult version, with the addition of three extra cards and an audiotape. Like the adult version, the LNNB-C is comparatively easy to administer and score. Typically, it takes about 2.5 hours to give the complete battery, which can then be hand or computer scored.

MATRICS™ (Measurement and Treatment Research to Improve Cognition in Schizophrenia) Consensus Cognitive Battery (MCCB™)

Keith H. Nuechterlein, PhD and Michael F. Green, PhD

Cognitive deficits, including impairments in such areas as memory, attention, and executive function, are a major determinant and predictor of long-term disability in schizophrenia. Unfortunately, available antipsychotic medications are relatively ineffective for improving cognition. Scientific discoveries during the past decade suggest that there may be opportunities for developing medications that will be effective for improving cognition in schizophrenia. To aid in that process, the MATRICS (Measurement and Treatment Research to Improve Cognition in Schizophrenia) Consensus Cognitive Battery (MCCB) has been developed to help researchers and clinicians measure cognition in individuals diagnosed with schizophrenia and related disorders.

The MCCB is a standardized battery that is intended for use with adults with schizophrenia and related disorders. It consists of 10 individually administered tests to measure cognitive performance in the following seven domains: Speed of processing, Attention/Vigilance, Working memory, Verbal learning, Visual learning, Reasoning and problem solving, and Social cognition.

Special Features of the MATRICS Consensus Cognitive Battery

- The MCCB is the result of a unique broad-based consensus process that included the academic community, the National Institutes of Health (NIH), the U.S. Food and Drug Administration (FDA), and the pharmaceutical industry.
- It assesses the key separable cognitive deficits of schizophrenia, using tests that experts selected as best suited for this purpose.
- Standardized battery with co-norming of 10 component tests, the MCCB exhibits high test-retest reliability and has high utility as a repeated measure.
- The MCCB has a demonstrated relationship to functional outcome and high tolerability by respondents.
- The MCCB provides convenient administration, scoring and conversion to standardized scores, and creation of a computer data file of summary scores.

Materials
The MATRICS Consensus Cognitive Battery (MCCB) Kit includes materials for 25 administrations of the entire battery. The MCCB Retest Packet includes the materials needed for 25 additional administrations. For situations in which practice effects with repeated administration can occur, alternate forms are available as part of the Retest Packet.

The MCCB Manual contains information about the development, reliability and validity, standardization, administration, and scoring of the battery. The MCCB Administrator's Form is to be used by test administrators to record results for one respondent. In some cases (for HVLT-R™ and NAB® Mazes), there is a separate booklet or form to use, which then gets attached to the MCCB Administrator's Form. For three of the tests in the battery, the respondent marks in the MCCB Respondent's Booklet. For one test (CPT-IP), the responses are made via a computer program. For all the other tests, administrators record the responses.

Uses of the MATRICS Consensus Cognitive Battery
This battery is intended to provide a relatively brief evaluation of key cognitive domains that are relevant to schizophrenia and related disorders. It was designed for the following purposes:

- As an outcome measure for clinical trials of cognition-enhancing drugs for schizophrenia,
- As an outcome measure for studies of cognitive remediation,
- As a sensitive measure of cognitive change in other repeated testing applications, and
- As a cognitive reference point for non-intervention studies of schizophrenia and other severe psychiatric disorders.

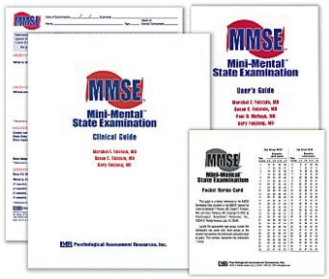
Administration and Scoring
Each of the 10 tests should be individually administered. Testing can usually be completed in one session lasting approximately 1 to 1.5 hours. A template is provided in the Kit to use in scoring the BACS Symbol-Coding test. Results for MSCEIT Managing Emotions and CPT-IP are computer-generated. The front of the Administrator's Form has places to record the raw scores.

Normative data for the battery allow age and gender correction; age, gender, and education correction; or no demographic correction. Both *T* scores and percentiles are available. The MCCB Computer Scoring Program allows entry of the primary raw scores on a PC and then provides the corresponding *T* scores and percentiles and a graphic profile of the *T* scores for each of the seven

cognitive domains. This Scoring Program also produces a data file for entry of data into statistical programs for group analyses.

Mini-Mental State Examination (MMSE)

by Marshal F. Folstein, M.D., Susan E. Folstein, M.D., and Paul R. McHugh, M.D



The MMSE is a brief, quantitative measure of cognitive status in adults. It can be used to screen for cognitive impairment, estimate the severity of cognitive impairment at a given time, monitor cognitive change over time, and document response to treatment.

Individually administered in just 5 to 10 minutes, the MMSE involves brief tasks or questions assessing orientation to time, orientation to place, registration, attention and calculation, recall, naming, repetition, comprehension, reading, writing, and drawing. A convenient new "all-in-one" test form includes a detachable sheet with stimuli for the comprehension, reading, writing, and drawing tasks.

Every package of test forms contains a new pocket-sized User's Guide with detailed administration and scoring instructions plus recommended cutoff scores for classifying the severity of cognitive impairment. This handy User's Guide also provides population-based normative data (by age and years of education). These norms allow you to compare an individual's MMSE Score with the appropriate reference group, and they make it easier to interpret the scores of individuals who are illiterate, older than 80, or lacking more than 9 years of formal education.

A new Clinical Guide to the MMSE describes the development, validation, administration, and interpretation of the exam. It provides in-depth information about using the MMSE in diagnosis and treatment. In addition, a convenient laminated Pocket Norms Card gives you raw score to T-score conversions for 14 age and education groups--making it ideal for use in clinical settings.

Motor-Free Visual Perception Test--Vertical (MVPT-V)

by Louisette Mercier, OT, M.A., Jean Hebert, Ph.D., Ronald P. Colarusso, Ed.D., and Donald D. Hammill, Ed.D.

Adapted from the widely used MVPT-3 for use with adults, this version of the test presents all stimuli vertically, at visual midline, rather than horizon- tally across the page. This modification reduces the effect of hemifield visual neglect (HVN), a common result of brain injury. HVN

interferes with the patient's ability to attend to a portion of the horizontal visual field, even though his or her vision, per se, may be normal. Patients with HVN may score low on tests with horizontally presented stimuli not because of visual perception problems but because of visual attentional difficulties.

The MVPT-V lessens the effect of HVN by presenting all stimuli at visual midline. This is helpful not only in planning rehabilitation for brain-injured adults but also in assessing individuals with learning disabilities, who often have similar visual attentional deficits.

The test provides separate norms for adults with and without head injury. Because visual perception is considered mature by age 10, the MVPT-V can be used with anyone over that age.

Memory Assessment Scales™ (MAS®)

J. Michael Williams, PhD

The MAS is a comprehensive battery that assesses short-term, verbal, and visual (nonverbal) memory functioning in individuals ages 18-90 years. Verbal and visual tasks use both recall and recognition formats and assess memory immediately after stimulus presentation as well as after a delay period.

The MAS has been designed for use by clinical and consulting psychologists, as well as researchers. Its self-contained easel format increases ease of use and greatly simplifies administration.

The MAS consists of 12 subtests based on the following seven memory tasks: Verbal Span, List Learning, Prose Memory, Visual Span, Visual Recognition, Visual Reproduction, and Names-Faces.

The 16-page record form contains instructions for the clinician to use during administration of the seven memory tasks. Three of the tasks are administered entirely from the record form. The Visual Span, Visual Recognition, Visual Reproduction, and Names-Faces tasks require the accompanying stimulus card set for administration.

MAS administration requires only the stimulus card set (contained in an easel format) and the record form.

The MAS can be scored in 10-15 minutes. The resulting Global Memory and Summary Scale scores provide measures of overall memory performance, short-term memory, verbal memory, and visual memory. All measures have a mean of 100 and a standard deviation of 15.

Subtest scale scores have been derived to have a mean of 10 and a standard deviation of three. They can be profiled by functional memory area to facilitate scale comparison. Process scores from subtests using the List Learning task can be calculated to examine cognitive learning strategies and problems involving encoding and retrieval.

The MAS normative sample is based on data collected from 843 adults. Normative tables facilitate interpretation for a variety of clinical questions: norms based on 843 adults by age decade, norms based on 843 adults by age and education levels, and norms based on 467 adults selected to match the U.S. census on the basis of age, education, and gender.

Reliability/Validity

Generalizability coefficients (reliability estimates), calculated for all three sets of norms, ranged from .70-.95 for MAS subtests, .86-.92 for the Summary Scales, and .94-.95 for the Global Memory Scale. Validity data demonstrate that MAS scores distinguish normal from neurologically impaired subjects and produce expected profiles for criterion groups of patients with neurological disorders, such as dementia, closed head injury, left-hemisphere lesions, and right-hemisphere lesions.

Multilingual Aphasia Examination, 3rd Edition (MAE)

Arthur L. Benton, PhD, Kerry deS. Hamsher, PhD, Abigail B. Sivan, PhD. MAE Spanish Version by Gustavo J. Rey, PhD, Abigail B. Sivan, PhD, Arthur L. Benton, PhD

The MAE is a relatively brief test battery designed to evaluate the presence, severity, and qualitative aspects of aphasic disorder. Three tests assess different aspects of oral expression--naming, sentence repetition, and verbal associative capacity; three tests assess oral verbal understanding; one test assesses reading comprehension; and three tests assess oral, written and block spelling. Speech articulation and the fluency-nonfluency dimension of expressive speech are rated, but not systematically sampled. Writing is evaluated from performance on the test of written spelling.
As a comprehensive aphasia battery, the MAE complements the use of other tests of neuropsychological function developed at the Benton Laboratory of Neuropsychology. The Manual includes new normative standards for elderly individuals, data on the discriminative value of each test, and recent clinical research results.
Most of the tests were standardized on a sample of 360 subjects, ranging in age from 16-69 years, whose native language was English, and who showed no evidence or history of hemispheric brain disease. The MAE was also standardized on 229 children, ages 6-12 years, who were within the normal range of intelligence.
MAE Tests Include:
Visual Naming
Oral Spelling
MAE Token Test
Reading Comprehension of Words and Phrases
Sentence Repetition
Written Spelling
Aural Comprehension of Words and Phrases
Controlled Word Association
Block Spelling
Rating of Articulation
Rating of Praxic Features of Writing

Neuropsychological Assessment Battery® (NAB®)

Robert A. Stern, PhD, Travis White, PhD

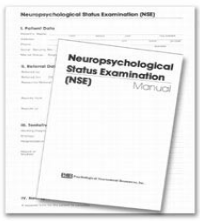
The NAB is a comprehensive, integrated, modular battery of 33 new neuropsychological tests developed to assess a wide array of neuropsychological skills and functions in adults (ages 18-97 years) who have known or suspected disorders of the central nervous system. The individual tests are grouped into six modules: Attention, Language, Memory, Spatial, Executive Functions, and Screening (which allows the clinician to determine which of the other five domain-specific modules are appropriate to administer to an individual patient).

The NAB has excellent psychometric properties, includes extensive normative and validation data, provides clinical information that meets the needs of a broad range of modern referral sources, and offers two equivalent forms that reduce practice effects and facilitate reevaluation. The examiner can administer the entire NAB for a comprehensive evaluation of neuropsychological functioning in less than 4 hours.

The NAB was created and developed over a 7-year period and was funded, in part, through grants from the National Institute of Mental Health. Decisions pertaining to the content and format of the NAB were guided by the results of the publisher's national survey of neuropsychological assessment practices and needs, as well as by the feedback and guidance of members of the NAB Advisory Council (a group of experts recognized nationally in the field of clinical neuropsychology) and numerous other consultants and contributors.

Neuropsychological Status Examination (NSE)

John A. Schinka, PhD



The NSE provides the format for comprehensive data collection as well as a detailed outline for generation of a complete clinical report. Designed to ensure ease of use and rapid accumulation of a comprehensive data base, the neuropsychological activities range from screening procedures to extensive workups and preparation for expert witness testimony. The Neuropsychological Symptom Checklist (NSC) is a 2-page screening instrument, which can be completed by the clinician, the patient, or a significant other in the event that the patient is not capable.

Neitz Test of Colour Vision

Jay Neitz, Ph.D., Phyllis Summerfelt, and Maureen Neitz, Ph.D.

The *Neitz Test of Colour Vision* is a revolutionary new approach to testing for colour blindness. Developed at the Eye Institute of the Medical College of Wisconsin, the *Neitz Test* is accurate, quick, and inexpensive. It identifies the type and severity of colour vision deficiency in just a few minutes. It can be used with people of any age, including very young children. And it can be administered in fluorescent light, daylight, or a combination of the two—making it much more convenient than competing instruments.

Neuropsychological Impairment Scale (NIS)

William E. O'Donnell, Ph.D., M.P.H., Clinton B. DeSoto, Ph.D., Janet L. DeSoto, Ed.D., and Don McQ. Reynolds, Ph.D.

Suitable for: age 17 and up

Here is a quick and convenient way to screen adults for neuropsychological symptoms. This brief self-report questionnaire addresses both global impairment and specific symptom areas, eliciting diagnostically relevant information that might otherwise go unreported. The NIS brings up symptoms that patients often fail to mention in an informal clinical interview. A useful addition to any general psychological evaluation, it is an efficient way to screen for organic problems. Serving as an "early warning system," the NIS can identify areas for inquiry, focus treatment efforts and help determine whether the patient will benefit from therapy. It has proven particularly useful in assessing age- and AIDS-related dementia. Composed of 95 items, the NIS provides three very helpful summary scores, plus subscale scores and validity checks. Written at a fifth-grade reading level, the scale can be completed in just 15 to 20 minutes by anyone over the age of 17. Nonclinical norms, based on a sample of 1,000 adults (18 to 88 years old), are stratified by age (young adult, adult, middle-aged, and elderly). Clinical norms, drawn from a sample of 534 neuropsychiatric patients, are separated by diagnostic group (neurological, psychiatric, alcohol/drug, learning disability, and physical trauma). A second form of the NIS—the Observer Report—presents items in the third person. This nonstandardized form, which can be completed by a relative or close friend of the patient, provides a different perspective on the patient's symptoms. Comparisons of Self and Observer Reports can help the patient understand the impact of his or her deficits and help family members adopt realistic expectations. A third form of the test—the Senior Interview—is useful with older patients who can't complete the NIS Self-Report due to poor vision, strength, or manual dexterity. The Senior Interview consists of 40 questions that are read to the patient by the examiner. The patient indicates his or her response on a large-print visual cue card. This form provides a Global Measure of Impairment and scores for Defensiveness, Affective Disturbance, and Inconsistency. A Subjective Distortion Index can also be calculated if WAIS-R Digit Span and Similarities scores are available.

Philadelphia Head Injury Questionnaire

Lucille M. Curry, Ph.D., Richard G. Ivins, Ph.D., and Thomas L. Gowen, J.D.

This convenient questionnaire answers the need for a detailed history-gathering instrument designed specifically for individuals who have sustained head injuries. It can be used by all professionals—neuropsychologies, psychologists, neurologists, attorneys, and others—who are involved with head trauma patients. Although it is not a diagnostic tool, this questionnaire is an extremely efficient way to gather and organize information about head trauma. Attorneys will find it useful in screening potential head injury cases, referring clients for diagnosis and treatment, and documenting the injury for purposes of litigation. Medical and mental health professionals will find it equally helpful because it provides an organized record of symptoms.

Portable Tactual Performance Test (P-TPT)

PAR Staff

This portable version of the Tactual Performance Test offers a convenient alternative to the original for use with the Halstead-Reitan Neuropsychological Test Battery. Its unique design, as an attractive wooden carrying case with a handle that doubles as a portable testing easel, facilitates easy storage, handling, and set-up for test administration. The P-TPT Kit includes both 6-hole and 10-hole boards. Appropriate for ages 5 years to adult.

Note: The P-TPT Kit does not include norms. However, norms are available in *A Compendium of Neuropsychological Tests: Administration, Norms, and Commentary, 3rd Ed.* for ages 5-85 years and in the *Revised Comprehensive Norms for an Expanded Halstead-Reitan Battery: Demographically Adjusted Neuropsychological Norms for African American and Caucasian Adults (HRB)* for ages 20 years and older.

Quick Neurological Screening Test II (QNST-II)
Second Revised Edition

by Margaret Mutti, M.A., Harold M. Sterling, M.D., N. Martin, and Norma V. Spalding, Ed.D

Here is a rapid and reliable way to identify possible neurological interference in learning. Individually administered to children in grades K--12, the QNST-II assesses 15 areas of neurological integration in approximately 20 minutes. This revision includes the latest research findings concerning the soft neurological signs that may accompany learning disabilities. The test alerts special education professionals to physical problems (in dexterity, visual tracking, spatial orientation, tactile perceptual abilities, and motor skills) that often co-occur with learning disabilities.

The QNST-II requires the examinee to perform a series of motor tasks adapted from neurological pediatric examinations and from neuropsychological and developmental scales. These nonthreatening tasks sample maturity of motor development, skill in controlling large and small muscles, motor planning and sequencing, sense of rate and rhythm, spatial organization, visual and auditory perceptual skills, balance and cerebellar-vestibular function, and disorders of attention. This revision features clearer instructions, simplified scoring, and a protocol sheet with a handy summary of all subtest scores and classifications as well as the overall score and functional category determination.

Normative data on more than 1,200 regular classroom students and 1,000 learning-disabled subjects are presented in the Manual. Scores are easily recorded as the test is administered. The QNST-II is an excellent way to screen students for suspected learning disabilities.

Recognition Memory Test (RMT)

Elizabeth K. Warrington

This measure of visual and verbal memory allows clinicians to quickly distinguish between right- and left- hemisphere brain damage—and to make judgments about localization. Sensitive enough to detect minor degrees of memory deficit, the *Recognition Memory Test* (RMT) does not tap, and is therefore not diluted by, cognitive skills as is the *Wechsler Memory Scale*. The test consists of two simple subtests, Recognition Memory for Words and Recognition Memory for Faces. It takes less than 15 minutes to administer and is easily scored. Standardization is based on more than 300 individuals, including normal and patients suspected of having neurological disease, brain damage, or head injury. Norms are provided for ages 18–70 years. The RMT is easy-to-use and it provides clinically relevant information for those treating organic neurological disease or dysfunction.

Rey Auditory Verbal Learning Test: A Handbook

Michael Schmidt, Ph.D., ABPP, ABPN

Here is a comprehensive manual for the *Rey Auditory Verbal Learning Test* (RAVLT). This handbook brings together everything the clinician needs to know about this widely used neuropsychological test. Originally developed in the 1940s, the RAVLT has evolved over the years, and several variations of the test have emerged. The standard RAVLT format starts with a list of 15 words, which an examiner reads aloud at the rate of one per second. The patient's task is to repeat all the words he or she can remember, in any order. This procedure is carried out a total of five times. Then the examiner presents a second list of 15 words, allowing the patient only one attempt at recall. Immediately following this, the patient is asked to remember as many words as possible from the first list. The RAVLT has proven useful in evaluating verbal learning and memory, including proactive inhibition, retroactive inhibition, retention, encoding versus retrieval, and subjective organization. Because the test is brief, straightforward, easy to understand, and appropriate for both children and adults (ages 7 through 89), it has gained widespread acceptance. However, until now, data about the RAVLT-norms, validity studies, different administration and scoring procedures-have been scattered in various sources. What this handbook provides is a definitive guide to the RAVLT-in a single volume. It describes the test, its development, and its use.

Repeatable Battery for the Assessment of Neuropsychological Status (RBANS™)

Christopher Randolph

The RBANS is a brief, individually administered test that helps determine the neuropsychological status of adults ages 20-89 years who have neurological injury or disease such as dementia, head injury, or stroke. You can get a quick sampling of important cognitive areas using content and a format familiar to clinicians who use the Wechsler™ Scales. The overall battery length is less than 30 minutes, in order to maximize patient cooperation and to minimize the effect of fatigue on performance. In addition, the RBANS has two parallel forms, ideal for measuring change in the client's neuropsychological status over time.

The RBANS Can Be Used in a Variety of Ways

- As a stand-alone 'core' battery for the detection and characterization of dementia in the elderly.
- As a neuropsychological 'screening battery' when lengthier standardized assessments are either impractical or inappropriate.
- For repeat evaluations when an alternate form is needed to control for content practice effects.

The RBANS Is Useful in a Variety of Settings

Because the RBANS is a brief, portable, and hand scorable instrument, it is appropriate for use in a variety of settings. You can administer the RBANS for screening for deficits in acute-care settings, for tracking recovery during rehabilitation, for tracking progression in degenerative diseases, or as a neuropsychological screening for non-neuropsychologists who must make referrals to neuropsychologists. Although the RBANS was originally developed with a primary focus on assessment of dementia, it has potential utility for screening neurocognitive status in younger patients.

The RBANS enables you to examine areas of cognitive functioning and profile impairment across domains with 12 subtests, including: List Learning, Story Memory, Figure Copy, Line Orientation, Digit Span, Coding, Picture Naming, Semantic Fluency, List Recall, List Recognition, Story Recall, and Figure Recall.

Reynolds Intellectual Assessment Scales™ (RIAS™)

Cecil R. Reynolds, PhD, Randy W. Kamphaus, PhD

PsychPress
Talent Management Psychologists

Suitable for: Individuals Aged 6 to 89 Years
Time: Untimed, approximately 45 minutes, 3 items
The RCFT standardizes the materials and procedures for administering the Rey complex figure. The newly developed Recognition trial measures recognition memory for the elements of the Rey complex figure and assesses the respondent's ability to use cues to retrieve information.

The 8 1/2" x 11" Stimulus Card contains a computer-rendered replica of the original Rey complex figure. Prior to this publication, Rey's original figure has not been available commercially.

The Test Booklet provides all forms necessary to administer and score the RCFT. Pages for the 3 freehand drawing trials (Copy, Immediate Recall, and Delayed Recall) and the new Recognition trial are perforated for easy detachment.

Ruff 2&7 Selective Attention Test (RUFF)

Ronald M. Ruff, Ph.D. and Christopher Allen, Ph.D.

User Qualification: Psychologist
Suitable for: Individuals Aged 16 to 70 Years
Time: Timed, 5 minutes, 20 trials

The Ruff 2 & 7 Test was developed to measure two aspects of visual attention: sustained attention (ability to maintain consistent performance level over time) and selective attention (ability to select relevant stimuli while ignoring distractors). The test consists of a visual search and cancellation task. The respondent detects and marks through all occurrences of the two target digits, "2" and "7." In the 10 Automatic Detection trials, the target digits are embedded among alphabetical letters that serve as distractors. In the 10 Controlled Search trials, the target digits are embedded among other numbers that serve as distractors. Correct hits and errors are counted for each trial and serve as the basis for scoring the test. Speed scores reflect the total number of correctly identified targets (hits). Accuracy scores evaluate the number of targets identified in relation to the number of possible targets. A stopwatch is required for administration.

Rivermead Behavioural Memory Test, Third Edition (RBMT-3) Including the Implicit Memory Test (IMT)

by Barbara A. Wilson, Eve Greenfield, Linda Clare, Alan Baddeley, Janet Cockburn, Peter Watson, Robyn Tate, Sara Sopena, and Rory Nannery

(Note: Product will be available for purchase December 2008)

Over the past two decades, the *Rivermead Behavioural Memory Test* has become a preferred measure for assessing everyday memory problems in people with acquired, non-progressive brain injury. This updated edition expands and refines the test's coverage, making it even more clinically useful.

Replacing both the RBMT-II and the RBMT-E, this version covers the full range of memory impairment, from mild to severe. In addition, it adds a separate measure of implicit memory and a new subtest, the Novel Task, which assesses the ability to learn new skills. The other RBMT-3 subtests measure immediate and delayed recall and recognition, plus orientation. All are listed below:

- First and Second Names
- Belongings
- Appointments
- Picture Recognition
- Story
- Face Recognition
- Route
- Messages
- Orientation and Date
- Novel Task

In addition to these subtests, the RBMT-3 provides a completely new measure, the *Implicit Memory Test* (IMT). The first standardized test of implicit memory, the IMT assesses the ability to learn something without necessarily being aware of what has been learned. For example, implicit memory is at work when people acquire certain motor skills, conditioned responses, or habits. The IMT includes two subtests, Fractionated Pictures and Stem Completion, both of which provide information that is useful in planning individualized rehabilitation.

Norms for the RBMT-3 are based on a sample much larger than those used for previous editions of the test. Because the RBMT-3 and IMT were normed together, results from the two tests can be compared.

With expanded coverage and increased sensitivity, the RBMT-3 is an excellent way to measure memory stability, improvement, or deterioration.

Screening Test for the Luria-Nebraska Neuropsychological Battery (ST-LNNB): Adult and Children's Forms

Charles J. Golden, Ph.D.

This convenient screener requires less than 20 minutes, yet accurately predicts overall performance on the *Luria-Nebraska Neuropsychological Battery* (LNNB)—in many cases eliminating the need to administer the full 2.5-hour battery. Like the LNNB, the Screening Test includes both an Adult Form, for individuals 13 years of age or older, and a Children's Form for 8- to 12-year-olds. Each form is composed of 15 items that can be administered and scored by a technician or paraprofessional with minimal training in neuropsychology. Because testing can be discontinued as soon as the client reaches the critical score, administration time often amounts to no more than a few minutes. Items on the Screening Test were selected from the LNNB on the basis of research with more than 500 adults and 350 children. Original screening cut points were independently cross-validated on a second sample of the same size. The test is designed to accurately predict overall LNNB scores and should be used only for that purpose. It should not be used as a separate measure of neuropsychological impairment, but should instead be administered only as a means of identifying those who need further evaluation with the LNNB. Test materials include an Administration and Scoring Booklet and a set of sturdy, spiral bound Stimulus Cards with a convenient built-in stand. These materials can be easily carried or slipped into a briefcase.

Shipley Institute of Living Scale

Walter C. Shipley, Ph.D

This popular measure of intellectual ability and impairment has been used with millions of individuals 14 years of age and older. The Scale is composed of two brief subtests: (1) a 40-item Vocabulary Test that requires the respondent to choose which of four listed words "means the same or nearly the same" as a specified target word; and (2) a 20-item Abstract Thinking Test, which requires the respondent to fill in numbers or letters that logically complete a given sequence. The Manual provides standard scores, updated norms (ages 16 and up), a new impairment index with empirically derived

corrections for age and education, age-adjusted norms for estimating WAIS and WAIS-R IQs, and a complete review of the Shipley literature.

Short Category Test, Booklet Format

Linda Wetzel, Ph.D. and Thomas J. Boll, Ph.D.

The *Short Category Test, Booklet Format* (SCT) reduces the length and complexity of the Halstead-Reitan Category Test, one of the most sensitive indicators of brain damage. The SCT includes five subtests, each in a 5" x 7" booklet of 20 Stimulus Cards. As in the original Category Test, the cards show various geometric shapes, lines, colours, and figures. All the cards within each booklet are organized around a single principle.

Symbol Digit Modalities Test (SDMT)

Aaron Smith, Ph.D.

User Qualification: Psychologist
Suitable for: Individuals Aged 8 Years to Adult
Time: Timed, 90 seconds

The SDMT has demonstrated remarkable sensitivity in detecting not only the presence of brain damage, but also changes in cognitive functioning over time and in response to treatment.

The SDMT involves a simple substitution task that normal children and adults can easily perform. Using a reference key, the examinee has 90 seconds to pair specific numbers with given geometric figures. Individuals with cerebral dysfunction perform poorly on the SDMT, in spite of normal or above average intelligence.

Studies documented in the SDMT Manual have shown the test effective in a wide range of clinical applications, including: differentiation of brain damaged from psychotic patients, differentiation of organics from depressives, early detection of senile dementia and Huntington's disease, differential diagnosis of children with learning disorders, early identification of children likely to have reading problems,
assessment of change in cognitive functioning over time and/or with therapy in individuals with traumatic, vascular, neoplastic and other brain insultsm and assessment of recovery from closed-head injury.

Shipley Institute of Living Scale (SILS)

Walter C. Shipley, Ph.D.

User Qualification: Psychologist
Suitable for: Adolescents Aged 14 Years to Adult
Time: Timed, 10 minutes for each of two subtests; Vocabulary Test 40 items, Abstract Thinking Test 20 items

The SILS is a popular measure of intellectual ability and impairment which has been used with millions of individuals 14 years of age and older. The Scale is a quick yet accurate measure of general intellectual functioning and is composed of two brief subtests: 40-item Vocabulary Test that requires the respondent to choose which of four listed words means “the same or nearly the same” as a specified target word and a 20-item Abstract Thinking Test, which requires the respondent to fill in numbers or letters that logically complete a given sequence.

The SILS is based on clinical and research findings suggesting that intellectual impairment differentially affects various cognitive abilities - vocabulary has proven relatively resistant to change, whereas abstract thinking has been shown to be more susceptible to cognitive deterioration associated with brain dysfunction, mental disorders or normal aging.

This standardized version of the Stroop consists of 2 parts. In the Color Task, the individual reads aloud a list of 112 color names in which no name is printed in its matching color. In the Color-Word Task, the individual names the color of ink in which the color names are printed.

The SNST may be administered and scored by individuals with limited training. Interpretation of the resulting Color and Color-Word scores requires professional training in psychology, psychiatry, or educational testing. A stopwatch is required to administer each 2-minute test.

Serial Digit Learning

Arthur L. Benton, PhD

This test consists of the presentation of either eight or nine randomly selected single digits for a varying number of trials up to a maximum of 12. Three alternate versions are provided for each form. Administration requires 5-10 minutes.

This test has demonstrated validity and provides additional substantive data in the evaluation of brain-damaged patients. This test is designed to be quickly and easily administered, minimizing patient fatigue and maximizing the collection of reliable neuropsychological test data. Normative and validity data are described in the manual, *Contributions to Neuropsychological Assessment*, which may be purchased separately.

Severe Cognitive Impairment Profile™ (SCIP™)

Guerry M. Peavy, PhD

The SCIP is a reliable and valid measure of overall dementia severity, as well as a patient's relative strengths and weaknesses in all the basic areas of cognitive functioning. This assessment tool is designed for patients previously diagnosed with dementia (ages 42-90 years and older) and can provide important information about

the degree to which the individual's symptoms are consistent with those of patients with a progressive dementia at various levels of severity. In addition, information about relative strengths and weaknesses in cognitive functioning can lead to ideas concerning the individual patient's care, management, and treatment planning.

One important advantage of this measure over many other neuropsychological tests is that the SCIP items span a wide range of difficulty relevant to severely impaired adults, thus avoiding both floor and ceiling effects in this population. The SCIP is an excellent companion instrument to the Dementia Rating Scale-2™ (DRS-2™)--it picks up where the DRS-2 leaves off. Because of the growing number of severely demented individuals, the increasing survival time for Alzheimer's disease patients in the late stages of dementia, and the challenges these individuals present to caregivers and health professionals, an accurate assessment of cognitive functioning has become increasingly important.

- Provides detailed information about a wide variety of cognitive areas.
- Eight subtests include measures of Comportment, Attention, Language, Memory, Motor Functioning, Conceptual Reasoning, Arithmetic, and Visuospatial Abilities.
- Scores can be used to identify relative strengths and weaknesses in specific cognitive areas - a key to developing successful strategies for enhancing communication and interactions in clinical and institutional settings.
- Scaled scores facilitate within-subject comparisons of performance across different subtests.
- Total or subtest scores can serve as outcome measures for efficacy studies.
- Total scores yield four levels of impairment: Moderately Severe, Severe, Very Severe, and Profound.

Test results can be used to inform caregivers about the patient's individual needs and to adjust the type and level of care provided throughout the course of the illness. The SCIP also facilitates empirically based estimates of both the capacity for activities required in daily living (ADLs) and the likelihood of psychiatric and/or behavioural difficulties.

Research has shown that the SCIP is reliable with respect to both interrater scoring and temporal stability across a brief retest interval. Highly significant correlations with traditional measures of dementia severity provide strong evidence of construct validity. The SCIP was standardized on a group of 92 well-characterized severely impaired AD patients, and SCIP standardized scores reflect an individual patient's performance relative to this sample. Patients with very severe dementia who scored at or near the floor on standard mental status examinations (e.g., Mini-Mental™ State Examination) obtained meaningful scores on the SCIP.

The Professional Manual provides detailed information about the test materials and procedures for administration and scoring, standardization and descriptive information, psychometric and technical information (including development, reliability, and validity), scoring criteria, scoring examples, and three case illustrations.

Smell Identification Test™ (SIT™)

Richard L. Doty, PhD

The SIT, also known as the University of Pennsylvania Smell Identification Test (UPSIT), consists of four self-administered test booklets, each containing ten stimuli for smell. Respondents (ages 4-99 years) pick from one of four multiple choices. By incorporating microencapsulation technology and sound psychometric principles into a simple test format, the SIT provides a rapid, easy means of quantifying smell functioning.

Sensitive to smell deficits caused by a wide range of medical, neurological, and psychiatric disorders, the SIT is useful in a variety of clinical, laboratory, and industrial settings. It has been used in occupational settings to screen persons working in hazardous manufacturing areas for their ability to smell; to evaluate the effect of occupational exposure to airborne chemicals on the ability to smell; to select members for sensory panels within the food and beverage industries; and to screen firemen, municipal gas works employees, plumbers, and others who are in potential danger from smoke or leaking natural gas. In addition, the SIT has been shown to be an excellent measure of frontal lobe dysfunction and has gained interest in the area of Schizophrenia, as it is one of a few neuropsychological measures that tracks the progression of the disease.

The SIT focuses on the comparative abilities of individuals to identify a number of odorants at the suprathreshold level. Test stimuli include a number of odorous components mimicking the types of stimuli usually experienced by individuals in the general population. An individual's test scores are compared to scores from normal persons of equivalent age and gender using tables provided in the manual. The resulting percentile score provides a measure of the individual's performance that is easy to interpret. The test-retest reliability of the SIT exceeds .90 and correlates well with other olfactory tests, including detection threshold tests.

One of the strengths of this unique test is its normative data base of nearly 4,000 individuals of all ages. Another strength is its means for detecting malingerers.

Stroop Color and Word Test: Children's Version

Charles J. Golden, PhD, Shawna M. Freshwater, Zarabeth Golden

The children's version of the Stroop Color and Word Test was developed in response to the demand for a Stroop test that is similar to the adult version, but is specifically normed and interpreted for children. The Stroop Color and Word Test: Children's Version Manual details specific administration, scoring, and interpretive strategies for use with children ages 5-14 years.

The interpretation of a child's score is affected by developmental trends, possible learning disabilities, attentional problems, emotional problems, and overall maturity--therefore, it is more difficult to interpret a child's score than it is to interpret an adult's score. The children's version of the Stroop has been designed to avoid measurement issues that exist in attempting to apply the scoring approach of the adult Stroop to children's data. Interpretive strategies also differ between younger children (ages 5-10) and older children (ages 11-14). Therefore, interpretive strategies for each age group are presented separately in the Manual.

Each Stroop Test Booklet consists of three basic sections:

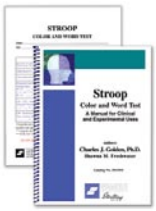
- Word Page-names of colors are printed in black ink;
- Color Page-semantically meaningless symbols are printed in various colors of ink; and
- Color-Word Page-composed of words from the first page (i.e., Word Page) printed in the colors from the second page (i.e., Color Page).

The task consists of moving down five columns on each page as quickly as possible, and reading words or naming colors. The test yields three scores (i.e., Raw Word score, Raw Color score, and Raw Color-Word score), based on the number of items completed. Raw scores are then converted to *T* scores by age using the

Appendixes in the Manual. In addition, an Interference score is derived from the difference between the Color-Word *T* score and the Color *T* score.

Stroop Color and Word Test

Charles Golden, PhD



The Stroop Color and Word Test has long been a standard measure in neuropsychological assessment. It measures cognitive processing and provides valuable diagnostic information on brain dysfunction, cognition, and psychopathology. The 2002 Examiner's Manual provides updated scoring, norms, and interpretations for ages 15-90 years.

The Stroop Color and Word Test is based on the observation that individuals can read words much faster than they can identify and name colours. The cognitive dimension tapped by the Stroop is associated with cognitive flexibility, resistance to interference from outside stimuli, creativity, and psychopathology--all of which influence the individual's ability to cope with cognitive stress and process complex input. Whether the test is used as a screener or as part of a general battery, its quick and easy administration, validity, and reliability make it a highly useful instrument.

The Stroop Color and Word Test consists of a Word Page with colour words printed in black ink, a Color Page with 'Xs' printed in colour, and a Color-Word Page with words from the first page printed in colours from the second page (the colour and the word do not match). The test-taker looks at each sheet and moves down the columns, reading words or naming the ink colours as quickly as possible within a time limit. The test yields three scores based on the number of items completed on each of the three stimulus sheets. In addition, an Interference score, which is useful in determining the individual's cognitive flexibility, creativity, and reaction to cognitive pressures also can be calculated. A **stopwatch** is required to administer each test.

Stroop Neuropsychological Screening Test (SNST)

Max R. Trenerry, PhD, Bruce Crosson, PhD, James DeBoe, PhD, William R. Leber, PhD

This standardized version of the Stroop consists of two parts. In the Color Task, the individual reads aloud a list of 112 color names in which no name is printed in its matching color. In the Color-Word Task, the individual names the color of ink in which the color names are printed.

The SNST may be administered and scored by individuals with limited training. Interpretation of the resulting Color and Color-Word scores requires professional training in psychology, psychiatry, or educational testing. A stopwatch is required to administer each 2-minute test.

Reliability/Validity

The SNST was standardized on 156 adults ages 18-79 years. Norms are provided for two age groups, 18-49 years and 50 years and older. The test correctly differentiates 79%-92% of brain-damaged from normal adults. Test-retest reliability is .90.

Short Category Test, Booklet Format

by Linda Wetzel, Ph.D. and Thomas J. Boll, Ph.D.

The *Short Category Test, Booklet Format* (SCT) reduces the length and complexity of the Halstead-Reitan Category Test, one of the most sensitive indicators of brain damage.

Brief, portable, and easy to administer, the SCT uses less than half the items on the original test and presents them in convenient, spiralbound booklets. It eliminates entirely the expensive and cumbersome equipment required by the Category Test. Yet this practical new format retains the diagnostic power of the original test, effectively assessing cognitive deterioration in adults age 20 and older.

Compact, Convenient Test Materials

The SCT includes five subtests, each in a 5" x 7" booklet of 20 Stimulus Cards. As in the original Category Test, the cards show various geometric shapes, lines, colours, and figures. All the cards within each booklet are organized around a single principle.

The client is shown the cards, one at a time. In order to respond correctly, he or she must discern the principle underlying each series of cards. This requires specific mental abilities: abstract concept formation, learning capacity, adaptive skill, and cognitive flexibility. By testing these abilities, the SCT uncovers the important, but often subtle, deficits that are frequently present in brain-damaged individuals.

Although the SCT measures a complex set of abilities, it is quite easy to administer and score. Under appropriate supervision, a paraprofessional can administer all five subtests in just 15 to 30 minutes. The only materials required are the SCT Answer Sheet and the five subtest booklets.

The test can be given to anyone who can see clearly and is alert enough to give a simple one-word response. (Individuals who are language impaired can respond by pointing to numbers on a special card provided with each subtest booklet.) And because the test materials are compact and portable, the SCT is easy to administer at bedside.

Scoring the test requires only a few minutes. Errors are totaled to produce raw scores, which are then converted to T-scores and percentile equivalents.

Diagnostic Power of the Category Test

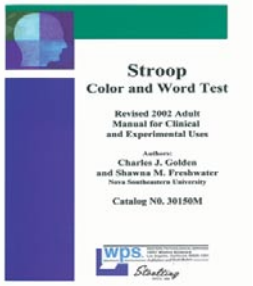
The SCT functions in a manner very similar to the Category Test--in terms of psychometric properties, discriminative ability, and correlation with other neuropsychological tests. It serves as a sensitive screening device in a variety of medical and mental health settings. Typically, the test is used to:

- Detect the subtle effects of closed-head injuries
- Isolate the organic components of psychiatric illness
- Identify the early stages of dementia related to Alzheimer's disease, multiple infarcts, drug and alcohol abuse, or drug toxicity
- Assess the effects of chronic conditions, such as renal failure and diabetes
- Measure cognitive status following neurosurgery or rehabilitation
- Confirm suspected deficits in abstract concept formation

The SCT gives you the diagnostic power of the Category Test--without its practical limitations.

Stroop Color and Word Test

by Charles J. Golden, Ph.D. and Shawna M. Freshwater



Here is a standardized version of the *Stroop Color and Word Test*, which maximizes the benefits of this popular measure of cognitive processing.

The Stroop is based on the observation that individuals can read words much faster than they can identify and name colors. The cognitive dimension tapped by the *Stroop* is associated with cognitive flexibility, resistance to interference from outside stimuli, creativity, and psychopathology--all of which influence the individual's ability to cope with cognitive stress and process complex input. Whether the test is used as a screener or as part of a general battery, its quick and easy administration, validity, and reliability make it an especially attractive instrument.

The test features a three-page test booklet. On the first page, the words "RED," "GREEN," and "BLUE," are printed in black ink and repeated randomly in columns. On the second page, the item "XXXX" appears repeatedly in columns, printed in red, green, or blue ink. On the third page (referred to as the interference page), the words "RED, "GREEN," and "BLUE" are printed in red, green, or blue ink--but in no case do the words and the colors in which they are printed match. For example, the word "BLUE" appears in either red or green ink.

The subject's task is to look at each page and move down the columns, reading words or naming the ink colors as quickly as possible, within a given time limit. The test yields three scores, based on the number of items completed on each of the three stimulus sheets. In addition, you can calculate an interference score, which is useful in determining the individual's cognitive flexibility, creativity, and reaction to cognitive stress.

Administration time is just 5 minutes.

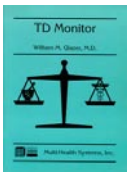
While the adult version of the test is appropriate for individuals 15 years of age and up, a new children's version can be used with 5- to 14-year-olds. Specifically designed for, normed on, and interpreted for children, this version generates *T*-scores, by age, based on means and standard deviation. (Adult *T*-scores are based on multiple regression equations, using age and education.)

Stroop results can be used in the diagnosis of brain dysfunction and in the evaluation of

stress, personality, cognition, ADHD, and psychopathology. Because it is brief, requires very little education, and is not culturally biased, this unique test is an ideal way to screen for neuropsychological deficits.

Tardive Dyskinesia Monitor (TD Monitor)

William M. Glazer, M.D.



User Qualification: None Required
Suitable for: Adults
Time: Untimed

The TD Monitor assists you in systematically monitoring patients receiving chronic neuroleptic maintenance and in developing your approach towards the Risk Benefit Ratio of Neuroleptic Exposure. It centers around the use of the modified Abnormal Involuntary Movement Scale (AIMS) and assists in generating a diagnosis and classifying the course of the movement disorder once it has appeared. The TD Monitor measures the presence and severity of the tardive dyskinesia movements either at first neuroleptic exposure or when the clinician first decides to monitor TD.

The TD Monitor includes the Modified Webster and the Modified Aims. You are provided with descriptive case examples that will provide further explanations of key points and prove beneficial as a point of reference.

The b Test

Kyle Boone, Ph.D., Po Lu, Psy.D., and David Herzberg, Ph.D.

Like the *Dot Counting Test* (DCT), *The b Test* assesses test-taking effort in individuals ages 17 and older. Unlike the DCT, *The b Test* offers entirely new and unfamiliar stimuli, making it ideal for forensic use.

Because *The b Test* assesses "overlearned" skills, individuals with cerebral dysfunction who try hard on the task will not be mistakenly classified as non-cooperative. Similarly, examinees who are feigning symptoms may be tempted to display their "impairment," in which case the test will flag their effort as suspect.

The b Test performance of 91 "suspect effort" patients (previously identified as "under attemptors" by rigorous inclusion and exclusion criteria) was compared to that of patients in 6 "normal effort" diagnostic groups: Depression, Schizophrenia, Head Injury, Stroke, and Learning Disability. Results verified the ability of *The b Test* to discriminate among patients based on their effort status.

In interpreting test scores, you can select a cutoff that minimizes false positives while maintaining adequate sensitivity to "suspect effort." Simply compare the patient's performance to that of a similar reference group.

Like the DCT, *The b Test* is useful in any setting where examinees have external incentives to fabricate or exaggerate cognitive problems--personal injury litigation, disability evaluations, and criminal cases, for example. However, it need not be limited to these applications. There is increasing consensus among psychologists that effort tests should be a standard component of assessment practice.

Administered in less than 15 minutes, *The b Test* is a quick, cost-effective way to routinely

assess test-taking effort.

Test of Everyday Attention (TEA)

by Ian H. Robertson, Tony Ward, Valerie Ridge

Here is a norm-referenced, broad-based measure of the most important clinical aspects of attention. The TEA assesses selective attention, sustained attention, attentional switching, and divided attention, using everyday materials that are relevant to the daily problems that patients encounter following brain damage.

The TEA includes eight subtests:

Map Search, which requires the patient to search for symbols on a large, color map of the Philadelphia area

Elevator Counting, which asks the patient to count a series of tones, presented on audio CD, that represent floors reached on an elevator

Elevator Counting With Distraction, which asks the patient to count the low tones in the imagined elevator while ignoring the high tones

Visual Elevator, in which the patient must count up and down as he or she follows a series of visually presented "floors" in the elevator

Elevator Counting With Reversal, which is the same as the previous subtest except that it is presented at a fixed speed on audio CD

Telephone Search, in which patients must look for key symbols in a simulated telephone directory

Telephone Search While Counting, which requires the patient to search the telephone directory while simultaneously counting tones presented on audio CD

Lottery, in which patients must listen for their "winning number" on an audio CD and write down the two letters preceding all numbers ending in given digits

The entire battery can be administered in just 45 to 60 minutes. (Some of the subtests are timed.) Available in three parallel versions, it yields nine percentile scores that are useful in predicting recovery of function and likelihood of everyday attention problems following brain damage. The normative sample, composed of 154 normal individuals ranging from 18 to 80 years of age, is stratified by age and education.

The TEA can be used with a wide range of people, from normal young adults to patients in the early stages of Alzheimer's disease. Broad-based and relevant to everyday functioning, it is an ideal way to identify patterns of attentional deterioration.

Test of Memory and Learning: Second Edition (TOMAL-2)

by Cecil R. Reynolds and Judith K. Voress

The second edition of the *Test of Memory and Learning* features an expanded age range, shorter administration time, and easier scoring. The TOMAL-2 provides the most comprehensive coverage of memory assessment in children and adults currently available in a standardized battery.

The TOMAL-2 includes 8 core subtests, 6 supplementary subtests, and 2 delayed recall tasks that provide highly interpretable and relevant scores, scaled to a familiar metric. Individually administered, the core battery that provides 3 Core Index scores can be completed in just 30 minutes, or you can administer both core and supplementary tests in 60 minutes. The subtests give information on specific and general aspects of memory and are used to derive the following indexes:

Core Indexes

- Verbal Memory
- Nonverbal Memory
- Composite Memory

Supplementary Indexes

- Verbal Delayed Recall
- Learning
- Attention and Concentration
- Sequential Memory
- Free Recall
- Associate Recall

Standardized on a nationally representative sample of more than 1,900 children, adolescents, and adults aged 5-0 through 59-11, and evaluated at the item and subtest levels for gender and ethnic bias, the TOMAL-2 can be administered with confidence to both males and females, across U.S. ethnic populations.

Test of Memory Malingering (TOMM)

by Tom N. Tombaugh, Ph.D.

Based on research in both neuropsychology and cognitive psychology, the TOMM offers a systematic way to discriminate between malingered and real memory impairments in adults.

Completed in 15 to 20 minutes, the TOMM is particularly effective in detecting malingering for several reasons. First, it looks like a memory test, not a malingering test--patients do not

suspect that they are being evaluated for malingering. Second, the test appears more difficult than it is, which leads malingerers to intentionally perform poorly while non-malingerers exert their full effort and do well. Third, though the TOMM is sensitive to malingering, it is insensitive to neurological impairments. The TOMM offers a norm-based criterion to detect malingering, which supplements the more traditional procedure of using below-chance performance as the criterion for malingering.

Norms are provided for individuals aged 16 to 84. In addition, extensive data has been collected from cognitively intact normals and clinical samples with cognitive impairment, aphasia, traumatic brain injury, dementia, and no impairment at all.

The TOMM provides a reliable, economical first step in judging whether a patient is malingering.

Test of Variables of Attention (T.O.V.A.)

by Lawrence Greenberg, M.D., Robert A. Leark, Ph.D., Tammy R. Dupuy, M.S., Clifford L. Corman, M.D., Carol L. Kindschi, R.N., M.S.N., and Michael Cenedela

This set of computerized continuous performance tests was designed specifically for screening, diagnosis, and treatment of children and adults with attention disorders, both congenital and acquired. It includes both visual and auditory tests, and it is provided in two formats. The Screening Version, intended for use by schools and learning centers, provides a user-friendly report that includes referral recommendations when appropriate. The Clinical Version, for physicians and clinical psychologists, generates a report that refers to DSM-IV diagnostic categories and includes medication suggestions. The two versions use identical test items and make identical calculations--they differ only in the language used to explain results.

Normed on over 4,100 children and adults (ages 4 to 80), these highly reliable, cost-effective, and easily administered tests provide relevant information about attention and impulsivity that is not otherwise available. In addition, the tests are very sensitive to the effects of treatment, including medication. They are commonly used to determine optimal dosage and monitor the course of treatment.

These tests are not language-based and have no practice effects. The visual test uses two simple geometric stimuli, while the auditory test uses two audible tones. With simple stimuli and considerable test length, practice effects are insignificant. The T.O.V.A. tests are intentionally long, easy, and boring in order to assess attentional variables. A nonsequential "go/no-go" response paradigm avoids confounding variables such as complex information processing and memory. A specially designed, highly accurate electronic microswitch eliminates inherent variability of keyboard and mouse responses.

The software automatically records the individual's responses, non-responses, and reaction times, and then calculates raw scores and percentages. Results are reported as standardized scores and standard deviations, presented in quarters, halves, and totals for the full 22 minutes of the test. The program instantly displays test results, including an ADHD score, in narrative and graphic formats. The ADHD score compares the examinee's performance to that of an identified ADHD sample.

Hardware requirements: PC with Windows 95, 98, 98SE, ME, 2000, or XP (also compatible: PC with MS-DOS 6.22, FreeDOS 0.9, or later), 5 MB free RAM, DOS-compatible parallel port (this does not include USB parallel port adapters), VGA or better graphics card, parallel (printer) port.

Test of Verbal Conceptualization and Fluency (TVCF)

by Cecil R. Reynolds, Ph.D., and Arthur MacNeill Horton, Jr., Ph.D.

The new TVCF eliminates the shortcomings associated with other measures of executive functioning:

- It is well-standardized, appropriately normed, and objectively scored.
- It measures multiple, rather than limited, aspects of executive functioning.
- It involves both verbal and nonverbal assessment.

These features, along with quick administration and a wide age range (8 to 89 years), make the TVCF highly useful in both clinical and educational settings. It can help you detect brain injury and track rehabilitation progress, assess language functions, determine disability under IDEA, and evaluate academic difficulties in regular classrooms.

Because executive functioning involves planning and purposeful action in response to external demands, the TVCF requires the individual to perform a range of tasks. It is composed of four subtests:

- **Categorical Fluency**
  Ability to retrieve words within a category (e.g., animals, foods) and fluency of ideation
- **Classification**
  A verbal measure of set shifting and rule induction (a language-based analog to the *Wisconsin Card Sorting Test*)
- **Letter Naming**
  Word retrieval by initial sound and fluency of ideation
- **Trails C**
  Sequencing, visual search, ability to coordinate high attentional demands, and ability to shift rapidly between numerals and words representing numbers (a variation of other "trail-making" tasks, renormed with the TVCF subtests above)

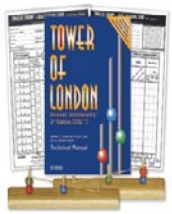
These subtests are easy to administer. Several are timed, and most people can complete all four in just 20 to 30 minutes.

For each subtest, the TVCF generates raw scores, normalized *T*-scores, and percentile ranks. Quotient scores, *z*-scores, and stanines are also provided for the convenience of researchers and others with specialized assessment needs. Norms are based on a sample of 1,788 individuals, aged 8 to 89, approximating the U.S. population in terms of geographic region, gender, ethnicity, education, and disability.

The TVCF is a quick, cost-effective way to identify people who may have executive functioning deficits. In educational settings, such deficits are associated with academic difficulties due to weak study skills, test-taking problems, and poor time management. Because these problems exist in both regular and special education classrooms, the TVCF is useful for pre-referral evaluation as well as assessment of students with identified learning disabilities or ADHD. In clinical settings, the test offers an efficient way to detect brain injury or evaluate executive functioning in people with CNS disease, drug addiction, aphasia, or dementia. Because it is brief, the TVCF is also ideal for monitoring treatment progress.

Tower of LondonDX 2nd Edition (TOLDX 2nd Edition)

William C. Culbertson, PsyD, Eric A. Zillmer, PsyD



The TOL^{DX} 2nd Edition measures higher order problem-solving ability. The information it provides is not only useful when assessing frontal lobe damage but also when evaluating attention disorders and executive functioning difficulties. This new edition includes a Stimulus-bound score that is particularly useful when assessing older adults. The score is rarely produced by healthy older adults, but, when apparent, suggests significant cognitive impairment consistent with dementia or seriously compromised frontally mediated executive control. New normative data for older adults also is included in this new edition, along with recent research findings.

The 2nd Edition eliminates repeated trials for failed problems, thereby maintaining task novelty; introduces 6- and 7-move test problem configurations, increasing sensitivity to executive functioning across age levels; and presents an empirical selection of test problem configurations, which allows assessment of the range of executive planning abilities that characterize child and adult populations.

The TOL^{DX} 2nd Edition is an easily transportable test with minimal set-up time. Scoring can be completed within 5-10 minutes. The Examiner's Manual is appropriate for use with children and adults. The Child Record Forms are suitable for children ages 7-15 years; the Adult Record Forms are suitable for individuals ages 16-80 years and older.

Telephone Interview for Cognitive Status™ (TICS™)

Jason Brandt, PhD, Marshal F. Folstein, MD

The TICS is a brief, standardized test of cognitive functioning that was developed for use in situations where in-person cognitive screening is impractical or inefficient (e.g., large-scale population screening, epid emiological surveys, or with patients who are unable to appear in person for clinical follow-up).

Although the TICS is designed to be administered via the telephone, it also may be administered face-to-face. Because it does not require vision, the TICS is particularly useful for examining visually impaired individuals and individuals who are unable to read or write. The test was standardized and validated for use with English-speaking adults, ages 60-98 years.

Research has demonstrated that psychological data obtained over the telephone are as reliable and valid as those obtained through face-to-face interaction. The TICS correlates highly with the Mini-Mental™ State Examination (MMSE™). It has high test-retest reliability and excellent sensitivity and specificity for the detection of cognitive impairment. Among elderly populations, TICS scores approximate a normal distribution and are not subject to the ceiling effects that limit the usefulness of many mental status examinations.

Before administering the telephone interview, the examiner must speak with someone at the same location (e.g., family member, caregiver) who will serve as a proctor to ensure that the environment is appropriate for testing and that the examinee is able to hear spoken language at a conversational volume.

The test materials consist of the Professional Manual and the Record Form. To assist in test administration, the Record Form provides specific instructions for administration, the exact instructions for both the examinee and the proctor, and the scoring criteria for each TICS item.

The 11 test items usually take less than 10 minutes to administer and score. All examinee responses are recorded verbatim. The individual item scores are summed to obtain the TICS Total score. The TICS Total score provides a measure of global cognitive functioning and can be used to monitor changes in cognitive functioning over time.

The impairment ranges have been shown to adequately distinguish between normal participants and patients with cognitive impairment. The appropriate normative reference group for interpretation will depend on the reason for the evaluation, and the examinee's age and level of education.

TICS results are reported using a qualitative impairment range and *T* scores.

Qualitative Impairment Range

> The TICS Total score can be interpreted by means of four qualitative impairment ranges: Unimpaired, Ambiguous, Mildly Impaired, and Moderately to Severely Impaired (based on the results from six nondemented and six cognitively impaired elderly groups representing diverse race/ethnicity).

***T* Scores**

> For individuals ages 60-89 years with at least 12 years of education, TICS *T* scores are provided based on the results from a normative sample of 6,338 participants.
> For individuals ages 65 years or less with less than 12 years of education (based on the results from a sample of 388 participants), *T* scores may be obtained through a process of equating TICS and MMSE Total scores.

The TICS is designed to provide a brief overall assessment of cognitive status; it should not be used alone to diagnose any specific neurological or psychiatric disorder. Specifying the precise nature and cause of cognitive impairment requires a comprehensive assessment that includes diagnostic testing and a complete medical and neuropsychiatric history. In addition to measuring an individual's overall cognitive functioning with the TICS Total score, clinicians also may wish to examine an individual's performance on specific items.

The Professional Manual provides information about the development, reliability, and validity of the instrument, as well as data based on both normative and clinical groups. Two case studies are presented to illustrate appropriate uses of the instrument.

Note: The Mini-Mental™ State Examination (MMSE™) is a brief and valid measure for assessing cognitive function in adults, making it a useful companion to the TICS.

Visual Search and Attention Test (VSAT)

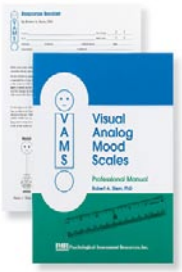
Max R. Trennerry, Ph.D., Bruce Crosson, Ph.D., James DeBoe, Ph.D. and William R. Leber, Ph.D.

User Qualification: Psychologist
Suitable for: Adults
Time: Timed, 6 minutes, 4 tasks

This norm-referenced test quickly measures attentional processes commonly disrupted in acute and chronic brain damage or disease. The VSAT consists of 4 visual cancellation tasks that require the respondent to cross out letters and symbols that are identical to a target. It yields an overall attention score and provides separate scores for left- and right-side performance to assess visual field defects, unilateral spatial neglect, or syndromes that affect the perception of portions of the visual space.

Visual Analog Mood Scales™ (VAMS™)

Robert A. Stern, PhD



The VAMS are reliable and valid measures of eight specific mood states: Afraid, Confused, Sad, Angry, Energetic, Tired, Happy, and Tense. These simple, brief scales place minimal cognitive or linguistic demands on the respondent and are appropriate for neurologically impaired individuals or those who are unable to complete more verbally or cognitively demanding instruments (ages 18-94 years). The scales have a "Neutral" schematic face (and accompanying word) at the top of a 100 mm vertical line and a specific "mood" face (and word) at the bottom of the line.

Because of their standardized approach and the existing normative data from 425 healthy adults as well as from 290 psychiatric inpatients and outpatients, the VAMS can be used for a variety of applications including repeated assessment of mood states to monitor treatment efficacy, screening for mood disorder in primary care settings, and screening for mood disorder in patients with neurologic illness.

Test materials include the Professional Manual, the VAMS Response Booklet, and a metric ruler. A pen or pencil is also required for administration. Respondents indicate the point along the vertical line that best describes how they are currently feeling. The score for each mood ranges from 0-100, with 100 representing a maximal level of that mood and zero representing a minimal level (or absence) of that mood. The Response Booklet includes instructions to the respondent, the eight mood scales, and a profile for plotting the *T* scores for each of the eight scales.

The Professional Manual provides information about the development, administration, and scoring of the VAMS; guidelines for interpretation; normative data; summaries of reliability and validity studies; and *T* score conversion tables by age and gender.

Visual Motor Assessment (ViMo)

by Gerald B. Fuller, Ph.D.

Formerly known as the Minnesota Percepto-Diagnostic Test, the ViMo identifies visual-motor problems in both children and adults -- in just 5 to 10 minutes. It assesses visual input, integration, and execution in order to differentiate individuals with normal perception from those with impaired perception due to brain damage, schizophrenia, emotional disturbance, or personality disorder. Because it is completely nonverbal, the ViMo is ideal for use with people from all socioeconomic, cultural, and educational backgrounds.

The test consists of two sets of six Gestalt designs that the examinee is asked to reproduce. His or her drawings are scored for rotation and configuration errors, and scores are adjusted for age and IQ -- a feature that distinguishes the ViMo from other visual-motor tests and ensures accurate results. If scores indicate that the examinee's perception is not normal, he or she is given an opportunity to recognize and correct earlier errors. This process further refines test results.

Based on 35 years of diagnostic data and research on visual-motor performance, the ViMo features updated norms based on a national sample of more than 12,000 children and adults. Included in this sample are several distinct clinical groups: children with special education needs, emotional disturbance, schizophrenia, or brain damage; and adults with personality disorders, brain damage, schizophrenia, alcoholism, or medical problems.

ViMo scores indicate the presence and type of visual-motor impairment and the likelihood of a learning or behavioral problem, emotional or personality disturbance, brain damage, or schizophrenia. Following a clear, four-step interpretive process, you can compare the examinee's rotation and configuration scores (including separations and distortions) to those obtained from various diagnostic groups. This process clarifies the nature of the examinee's impairment and helps you determine what kind of additional testing may be needed.

Simple, brief, and effective, the ViMo is a reliable and cost-effective way to screen for visual-motor problems.

Wide Range Assessment of Memory and Learning, Second Edition (WRAML2)

by David Sheslow, Ph.D. and Wayne Adams, Ph.D.

Revised in 2003, this test makes it easier to assess memory functions in children, adolescents, and--with this edition--adults as well. The WRAML2 gives clinicians a single, integrated collection of relevant memory tests that can be used across the life span.

Appropriate for individuals from 5 through 90 years of age, the WRAML core battery produces a General Memory Index, plus three more specific index scores and six subtest scores:

Verbal Memory Index

- Verbal Learning Subtest
- Story Memory Subtest

Visual Memory Index
- Design Memory Subtest
- Picture Memory Subtest

Attention and Concentration Index
- Number/Letter Subtest
- Finger/Windows Subtest

Several subtests from the original WRAML are now optional (e.g., Sentence Memory) or limited to a specific age group (e.g., Sound-Symbol for 5- through 8-year-olds).

The WRAML2 also adds supplementary subtests and indexes that reflect current interests in working memory and rapid memory decline:

Working Memory Index
- Verbal Working Memory Subtest
- Symbolic Working Memory Subtest

Delayed Memory Measures
- Recall
- Story Memory Delayed Recall
- Verbal Learning Delayed Recall

Recognition
- Story Memory Recognition
- Picture Memory Delayed Recognition
- Verbal Learning Recognition
- Design Memory Recognition

The delayed recall tasks can provide critical information about rapid decay of memory, an important indicator of possible dementia.

All of the subtest and index scores can be converted to standard scores and percentiles for age-based performance comparisons. The core battery can be individually administered in well under an hour, and a Memory Screening Form, composed of four subtests, requires just 10 to 15 minutes, yet correlates highly with the full test.

Given the important part that memory plays in academic success, WRAML2 is highly useful in evaluating learning and school-related problems. It can clarify the role of memory deficits in learning disabilities and attention disorders. WRAML2 is also an excellent tool for assessing memory impairment following head injury

Wisconsin Card Sorting Test (WCST)

David A. Grant, Ph.D. and Esta A. Berg, Ph.D.

User Qualification: Psychologist
Suitable for: Individuals Aged 6.5 to 89 Years
Time: Untimed, approximately 20-30 minutes

The WCST is used primarily to assess perseveration and abstract thinking and has gained increasing popularity as a neuropsychological instrument. Unlike other measures of abstraction, it provides objective measures of overall success and identifies particular sources of difficulty on the task.

The WCST is sensitive to frontal lobe dysfunction. When used with more comprehensive ability testing, the WCST is helpful in discriminating frontal from nonfrontal lesions.

This untimed test uses stimulus cards and response cards containing various forms in different numbers and colors. Respondents are required to sort the cards according to different principles (color, form, or number) and to alter their approach as unannounced shifts in the sorting principle occur during the test administration. The revised and expanded manual provides demographically corrected normative data for ages 6.5-89 years. Compare scores to the cutoff to assess degree of perseveration.

Wisconsin Card Sorting Test--64 Card Version (WCST-64)

by Susan K. Kongs, Laetitia L. Thompson, Ph.D., Grant L. Iverson, Ph.D., and Robert K. Heaton, Ph.D

This shortened version of the WCST was developed in response to concerns for patient comfort, managed care restrictions, and tighter research budgets. It uses only the first 64 WCST cards, thereby reducing administration time while retaining the task requirements of the standard version. The WCST-64 also eliminates variability in the number of cards administered, allowing the user to easily compare test-retest stability and individual test results with normative and validity data.

In developing the shortened version, WCST protocols were re-scored for the first 64 cards administered. The normative sample includes both adults (18 to 89 years of age) and children (6 to 17 years of age).

Administered in just 10 to 15 minutes, the WCST is an excellent option for clinicians and researchers working within budgetary or time constraints.

Wisconsin Card Sorting Test®Computer Version 4 Research Edition (WCST:CV4™)

Robert K. Heaton, PhD, PAR Staff

This unlimited-use software is designed to assist you in administering and scoring the Wisconsin Card Sorting Test® (WCST). The reports are more visually attractive and easier to read than those reports generated by earlier versions of the software.

- Clinicians have the option of administering the test on-screen (clients enter their responses via either the keyboard or the mouse), or by entering the client's item responses from a previous WCST administration.

- The client record feature allows the clinician to save basic demographic information and to store test response data for each test associated with a particular client. This helps the clinician track the client's progress and monitor changes over time.

Entry of Item Responses

- If the clinician chooses to enter the client's item responses from the Record Form of a previous WCST administration, the data-entry screen presents only the possible valid responses for each card; this prevents certain errors in data entry.

- The clinician can either select all the valid dimensions, or simply click on one of the valid dimensions to which the client was matching; the software will automatically record any other dimension matches.

On-Screen Administration

The software automatically tells the respondent (by both an audible response in English and an on-screen message in one of 10 user-definable languages) whether the choice was correct or incorrect.

- For on-screen administration, keyboard response entry utilizes four predefined alphanumeric keys.

- A set of colored keytops representing the four WCST Stimulus Cards can be attached to these keys.

WCST: CV4 Report

The software program automatically scores the responses according to Dr. Heaton's scoring system and then generates a report which includes the following information and features:

- Demographic information and test performance variables.

- WCST raw scores and corresponding age- and education-corrected standard scores, *T* scores, and percentile scores for major WCST variables for clients ages 6.5-89 years.

- Scores for individuals ages 20-89 years also are compared to normative scores derived from an adult sample matched by age to 1995 U.S. Census data.

- Reports may be printed or saved in Rich Text Format (which is compatible with most word processing programs).

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

How to order

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			$	$
			$	$
			$	$
			$	$
			$	$
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		TOTAL	**$**	**$**

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