PsychPress

Talent Management Psychologists

Health Psychology 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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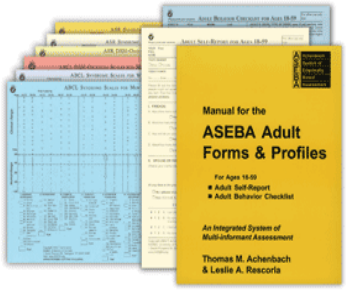
Alcadd Test, Revised (AT)
by Morse P. Manson, Ph.D

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

ASEBA Adult Self-Report/18-59 and the ASEBA Adult Behaviour Checklist/18-59 (ASR, ABCL)
Thomas M. Achenbach, PhD, Leslie A. Rescorla, PhD



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

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

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 The eight syndromes are: Anxious/Depressed, Withdrawn, Somatic Complaints, Thought Problems, Attention Problems, Aggressive Behavior, Rule-Breaking Behavior, and Intrusive.

Six scales were constructed to have characteristics consistent with *DSM-IV*™ categories (Depressive Problems, Anxiety Problems, Somatic Problems, Avoidant Personality Problems, Attention Deficit/Hyperactivity Problems, and Antisocial Personality Problems).

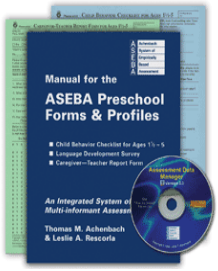
Assessment Data Manager (ADM)
With the ADM software, you can quickly enter, score, compare, and save data from parent-, teacher-, and self-reports. ADM's cross-informant comparisons help you efficiently integrate multi-source data for evaluations, interventions, and measurement of outcomes. ADM displays cross-informant comparisons of up to eight forms per client, including side-by-side item scores and scale scores from each completed form, correlations between informants, and reports on whether agreement between informants is below average, average, or above average.

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

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

ASEBA Child Behaviour Checklist for Ages 1.5-5, and ASEBA Caregiver-Teacher Report Form for Ages 1.5-5 (CBCL 1.5-5, C-TRF)

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



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

The CBCL 1.5-5

- Consists of 99 items rated by parents concerning issues, disabilities, descriptions of problems about the child being rated, and the best things about the child being rated.
- CBCL 1.5-5 scales are based on ratings of 1,728 children; normed on a new national sample of 700 children.

The C-TRF

- Obtains caregiver's/teacher's ratings on 99 items, plus descriptions of problems, disabilities, issues that concern the respondent most about the child, and things that respondent views to be best about the child.
- C-TRF scales are based on ratings of 1,113 children; normed on 1,192 children.

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

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

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

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

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

- Affective Problems

- Pervasive Developmental Problems

- Anxiety Problems

- Oppositional Defiant Problems

- Attention Deficit/Hyperactivity Problems

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

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

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

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

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

The CBCL 6-18

- Consists of 118 items rated by parents that describe specific behavioural and emotional problems, plus two open-ended items used to report additional problems.
- Parent ratings based on how true each item is now or has been within the past 6 months on a 3-point scale.
- CBCL 6-18 scales are based on new factor analyses from parent ratings of 4,994 clinically referred children; normed on 1,753 children ages 6-18 years.

The TRF 6-18

- Designed to obtain teachers' reports of the child's academic performance, adaptive functioning, and behavioural/emotional problems.
- Teachers rate academic performance, adaptive functioning and appropriateness of the child behaviour, how much the child is learning, how hard the child works, and how happy he/she is.
- Consists of 118 problem items, of which 93 have counterparts on the CBCL 6-18; remaining items concern school behaviors.
- TRF syndromes based on new factor analyses of 4,437 referred students; normed on 2,319 nonreferred students.

The YSR 11-18

- Completed by youths having 5th-grade reading skills, or can be administered orally.
- Youth rate themselves for how true each item is now or has been during the past 6 months, using the same 3-point scale as the CBCL 6-18 and the TRF. YSR also has 14 socially desirable items that most youths endorse about themselves.
- YSR scales based on 2,581 high-scoring youths; normed on 1,057 nonreferred youths. New national norms were used for the problem, competence, and adaptive scales. The revised school-age profiles feature *DSM*™-oriented scales in addition to empirically based scales. The following cross-informant syndromes were derived from factor analyses of the three forms: Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Social Problems, Thought Problems, Attention Problems, Rule-Breaking Behaviour, and Aggressive Behaviour. All forms are parallel regarding the three primary scales (Internalizing, Externalizing, Total Problems).

***DSM*-Oriented Scales**

Six scales were identified and constructed to have characteristics consistent with *DSM* categories:

- Affective Problems
- Attention Deficit/Hyperactivity Problems
- Anxiety Problems
- Oppositional Defiant Problems
- Somatic Problems

- Conduct Problems

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With the ADM software, you can quickly enter, score, compare, and save data from parent-, teacher- and self-reports. ADM's cross-informant comparisons help you efficiently integrate multi-source data for evaluations, interventions, and measurement of outcomes. ADM displays cross-informant comparisons of up to eight forms per client, including side-by-side item scores and scale scores from each completed form, correlations between informants, and reports on whether agreement between informants is below average, average, or above average.

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New! Module for Ages 6-18 with Multicultural Options

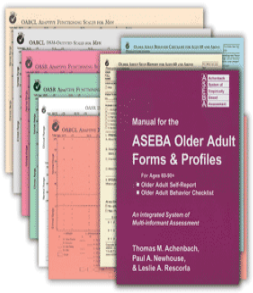
Replacing the 2001-2006 ages 6-18 modules, this new module displays problem-scale profiles and cross-informant bar graphs in relation to multicultural (including U.S.) norms. If the user selects a society for which norms are available, the Module displays the child's scale scores with norms for that society. If the norms are unavailable, the user can elect default norms of other norms deemed appropriate for the child. Different norms can be selected for a child's CBCL, TRF, and YSR forms. The same scale scores also can be displayed with different norms. The new Module scores the same scales as the previous edition, plus Obsessive-Compulsive Problems, Posttraumatic Stress Problems, Sluggish Cognitive Tempo (only on CBCL and TRF), and Positive Qualities (only on YSR) scales. All forms have parallel Internalizing, Externalizing, and Total Problems scales.

The new *Multicultural Supplement to the Manual for ASEBA School-Age Forms and Profiles* documents the basis for the multicultural norms and illustrates applications.

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

ASEBA Older Adult Self-Report and the ASEBA Older Adult Behaviour Checklist (OASR, OABCL)

Thomas M. Achenbach, PhD, Paul A. Newhouse, MD, Leslie A. Rescorla,PhD



The OASR is a self-administered instrument appropriate for ages 60-90 years and older that examines diverse aspects of adaptive functioning and problems. The OABCL is a parallel form used to obtain information about the individual being assessed from others who know that individual well, such as a spouse or partner, a family member or friend, a caregiver or healthcare provider.

The OASR and the OABCL are scored on profiles that make it easy to see similarities and differences between the self-report(s) and the report(s) given by the observer(s). The profile displays scale scores in relation to

gender- and age-specific norms. Responses from both forms can be hand-scored, taking between 5-10 minutes. The Manual (i.e., ASEBA Adult Manual [Achenbach System of Empirically Based Assessment]) provides full documentation for the scales, reliability, and validity, and illustrates numerous clinical and research applications for the instruments.

The OASR and the OABCL can aid assessment in a variety of settings. To measure changes in functioning, the forms can be completed at specified intervals in order to determine whether functioning is stable, improving, or worsening.

The forms for scoring the OASR and the OABCL include normed scales for adaptive functioning, empirically-based syndromes, *DSM*-oriented scales, critical items, and total problems. The Manual provides full documentation for the scales, reliability, and validity, and illustrates numerous clinical and research applications for the instruments.

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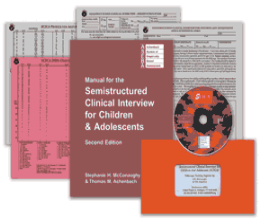
Requirements: Windows® 95/98/NT/XP/2000; 128 MB RAM; 75 MB free hard disk space; 166 MHz Pentium processor.

ASEBA Semistructured Clinical Interview for Children & Adolescents (SCICA/6-18)
Thomas Achenbach, PhD



The SCICA is a standardized clinical interview for children ages 6-18 years. It was designed to be part of the Achenbach System of Empirically Based Assessment (ASEBA®), an integrated set of rating forms for assessing competencies, adaptive functioning, and problems in an easy and cost-effective manner.

The SCICA maximizes the value of interviews with a flexible user-friendly protocol, along with a self-report and observational items rated by the interviewer. The SCICA scoring profile includes eight syndrome scales: Aggressive/Rule-Breaking Behavior, Anxious, Anxious/Depressed, Attention Problems, Somatic Complaints (ages 12-18 only), and Withdrawn/Depressed, as well as Internalizing, Externalizing, and separate Total Problems for Observation and Self-Report items. Some of the syndromes have counterparts on the CBCL/6-18, TRF/6-18, and YSR.

- Items are scored on empirically based syndromes, *DSM*-oriented scales, Internalizing, Externalizing, and separate scales for total observed and self-reported problems.

- The SCICA includes a *DSM*-oriented ADH Problems scale with Inattention and Hyperactivity-Impulsivity subscales.

- The following topics are addressed in the SCICA: activities, school, job; friends; family relations; fantasies; self-perceptions, feelings; parent-/teacher-reported problems; and achievement tests (optional).

- The SCICA also screens for fine and gross motor abnormalities (optional for ages 6-11 years); somatic complaints; alcohol; drugs; and trouble with the law (for ages 12-18 years).

- Both hand-scored and computer-scored profiles are available.

The SCICA has demonstrated reliability and validity. Weighted combinations of the SCICA syndromes yielded 66.7% sensitivity and 80.8% specificity for ages 6-11 years and 67.5% sensitivity and 92.5% specificity for ages 12-18 years.

SCICA materials include the Manual, Protocol Form for the interviewer, Observation and Self-Report Forms, and Profiles for Ages 6-18 (hand-scored or computer-scored). The Profile Forms for hand-scoring accommodate both genders so no templates are required. The SCICA can be used in a variety of settings such as mental health outpatient clinics, community mental health centers, educational settings, and forensic settings for custody evaluations and placement decisions.

Requirements: Windows® 95/98/NT/XP/2000; 128MB RAM; 75MB free hard disk space; 166 MHz Pentium processor; CD-ROM drive, DVD player

Adolescent Drinking Index (ADI)

Adele V. Harrell, PhD, Philip W. Wirtz, PhD

The ADI quickly assesses alcohol abuse in adolescents with psychological, emotional, or behavioral problems; identifies referred adolescents who need further alcohol abuse evaluation or treatment; and defines the type of drinking problem the adolescent is experiencing. The ADI can also help in developing treatment plans and recommendations.

Description

This 24-item rating scale measures the severity of drinking problems, differentiating between alcohol use considered to be normal in adolescent development and alcohol use that is not considered to be normal. ADI items focus on the problems that arise from alcohol use, not on the amount or the frequency of consumption. ADI items were selected to represent the four domains of problem drinking indicators: loss of control of drinking; social indicators; psychological indicators; and physical indicators.

Administration/Scoring

The ADI can be administered to individuals or groups by counselors, teachers, or others who work with adolescents. Adolescents with 5th-grade reading skills can complete the ADI, and scoring is quick and easy.

Reliability/Validity

The ADI is normed on three groups ages 12-17 years: adolescents in school, adolescents under evaluation for psychological problems, and adolescents in substance abuse programs. Internal consistency coefficients across adolescent samples are uniformly high, exceeding .90. The cutoff score has an 82% accuracy rate, and the ADI correlates .60 to .63 with the Michigan Alcoholism Screening Test (MAST).

Adolescent SASSI-A2 (SASSI-A2)

The SASSI Institute

The SASSI-A2 replaces the SASSI Adolescent Kit and components. It takes only 15 minutes to administer and score and requires only a 3rd-grade reading level. The SASSI-A2 is proven to be effective even with individuals who are unable or unwilling to acknowledge relevant behaviors (ages 12-18 years).

New Features

- **Improved Accuracy:** Empirically validated as a screening instrument for Substance Use Disorders (for both substance dependence and substance abuse):

  - 94% overall accuracy rate for substance use disorders.
  - 96% accuracy rate for substance dependence.
  - 90% accuracy rate for substance abuse.

- **User's Guide:** Easy-to-understand instructions for administration, scoring, and interpretation.
- **Manual:** Comprehensive information on development, reliability, and validity.

Five New Scales

- **Family & Friends Risk Scale (*FRISK*)** -- Measures the extent to which the adolescent is part of a family/social system that is likely to enable substance misuse.
- **Attitudes Toward Substance Use (*ATT*)** -- Measures the adolescent's attitudes and beliefs regarding substance use.
- **Symptoms of Substance Misuse (*SYM*)** -- Measures the consequences of substance misuse and loss-of-control in usage.
- **Validity Check (*VAL*)** -- Identifies some individuals for whom further evaluation may be valuable even though the Adolescent SASSI-A2 indicates they have a low probability of having a substance use disorder--abuse or dependence.

- **Secondary Classification Scale (*SCS*)** -- Helps distinguish between substance abuse and dependence; and, like high *VAL* scores, serves as an indication that further assessment may be of value for some individuals with negative test results.

Cigarette Use Questionnaire (CUQ)

by Ken C. Winters, Ph.D.

Quickly determine what factors contribute to a smoker's addiction

Cigarette smoking is one of the most persistent addictions. Only 6% of smokers who try to quit succeed for more than a month. These odds can be improved, however, if health professionals identify and address the personal and environmental factors that sustain addiction.

The *Cigarette Use Questionnaire* (CUQ) helps clinicians evaluate, refer, and treat people who wish to quit smoking or must do so for health reasons. It is intended to measure factors related to cigarette use for the purpose of discussing, planning, and evaluating effective smoking cessation treatment and for research about cigarette use. This straightforward self-report questionnaire can be administered to individuals or groups in only 10 minutes. With 44 items written at a fifth-grade reading level, the CUQ generates the following scores:

- Nicotine Addiction
- Environmental Cues
- Negative Emotional Relief
- Readiness for Change

In addition, two validity scores alert clinicians to defensiveness and inconsistent responding on the client's part.

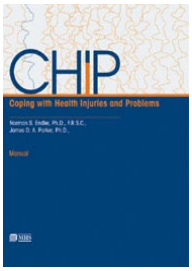
CUQ scores correlate with frequency, intensity, and duration of cigarette smoking, and with participation in smoking cessation treatment. Norms are based on a nationally representative sample of 609 adults, aged 18 to 83.

Increase the likelihood of success

Research shows that therapy is more effective when it's individualized. This is why the CUQ is such a powerful smoking cessation tool. For each smoker, the test identifies personal and situational factors related to cigarette use, making it easier for clinicians to understand the particular addiction and plan effective treatment. The personalized assessment provided by the CUQ increases the odds of success in any smoking cessation program -- particularly those that employ a cognitive-behavioral approach.

Coping With Health Injuries and Problems (CHIP)

Norman S. Endler, Ph.D. & James D. A. Parker, Ph.D.



Current conceptions relating psychological variables to health recognize the key role of coping processes as mediating variables between stress and illness, yet few reliable and valid instruments exist for the assessment of coping with physical health problems. With the CHIP inventory you can identify a patient's typical coping strategies and suggest coping strategies that will best help the patient cope with and overcome his or her health problem.

The CHIP inventory examines four basic coping dimensions for responding to health problems: distraction, palliative, instrumental, and emotional preoccupation. It can be administered over the course of a specific health problem to help determine the coping strategies used at different times in the development and/or treatment of the problem. It has also been used effectively with chronic pain, cancer, asthma, and diabetes patients, as well as with other health problems such as sports injuries.

The CHIP was normed on 2,358 subjects—1,312 American and Canadian adults, 476 university students, and 391 adults seeking medical treatment.

Chronic Pain Coping Inventory™ (CPCI™)

Mark P. Jensen, PhD, Judith A. Turner, PhD, Joan M. Romano, PhD, and Warren R. Nielson, PhD

Designed to assess the use of coping strategies that are typically targeted for change in multidisciplinary pain treatment programs, the CPCI addresses several shortcomings of existing measures, including the lack of behavioral-strategy assessment. It is a 70-item self-report instrument on which the individual is asked to indicate the number of days during the past week he/she used the listed coping strategy to deal with his/her pain. This newly standardized version of the CPCI was normed using a sample of 527 patients with chronic pain. The CPCI was designed to assist numerous health care providers, including psychologists, physicians, psychiatrists, clinical social workers, occupational therapists, and physical therapists, as well as other mental health and health care providers working with adults ages 21-80 years.

The CPCI assesses pain coping strategies that have been identified as contributors to the adjustments a patient makes to chronic pain. The CPCI can be used in a variety of testing situations, including:

- pretreatment screening to determine treatment necessity;
- pretreatment and posttreatment to determine treatment effectiveness; and
- periodic reevaluations to document treatment progress.

The CPCI consists of nine scales that are divided into two domains--the Illness-Focused Coping Domain and the Wellness-Focused Coping Domain.

Illness-Focused Coping Domain

- **Guarding Scale**--Assesses the extent to which a patient reports restricting the use/movement of a body part as a way of coping with pain.
- **Resting Scale**--Assesses the extent to which a patient uses pain-contingent rest (e.g., lying down) as a way to cope with pain.
- **Asking for Assistance Scale**--Assesses the frequency with which a patient asks someone (e.g., a family member) for help with a chore when he/she is in pain.

Wellness-Focused Coping Domain

- **Exercise/Stretch Scale**--Assesses how many days per week a patient stretches various muscle groups, engages in various muscle strengthening exercises, and engages in aerobic exercise for at least 15 minutes.
- **Relaxation Scale**--Assesses the frequency with which a patient uses strategies (e.g., imagery, listening to music, meditation, self-hypnosis) to experience relaxation.
- **Task Persistence Scale**--Assesses the extent to which a patient continues normal activity despite his/her pain.
- **Coping Self-Statements Scale**--Assesses the frequency with which a patient purposefully uses adaptive cognitions when he/she experiences pain.
- **Pacing Scale**--Assesses the extent to which a patient is able to conduct activities in a paced, steady manner that is not contingent on pain.
- **Seeking Social Support Scale**--Assesses the frequency with which a patient seeks out a friend/loved one for companionship and support when in pain.

Features of the CPCI

- Standardized on a sample of 527 chronic pain patients.
- *T* scores and percentiles are included for calculating scores.
- Reliable Change scores are included to assist in determining if there are differences between scores obtained on two different testing occasions (e.g., pretreatment vs. posttreatment).

- Interpretive guidelines and case examples are included.
- Profile Form includes a skyline for clinically elevated scores and treatment goals.

Reliability and Validity

- Median internal consistency for the nine CPCI scales ranges from .70 to .94 for the four subsamples of chronic pain patients that compose the standardization sample.
- Corrected correlations for the test-retest stability of the CPCI scales range from .55 to .84.
- The validity of the CPCI is discussed in terms of evidence based on intercorrelations among the CPCI scales, factor analysis of the CPCI, correlational analyses examining the relationships between the CPCI scores and scores on related measures (i.e., coping, mental health/psychological functioning, physical dysfunction/disability, stages of change, pain attitudes/beliefs), and the use of the CPCI as a measure of treatment outcome.

Clinical Assessment of Attention Deficit--Adult™ (CAT-A™)

Bruce A. Bracken, PhD and Barbara S. Boatwright, PhD

The CAT-A is a 108-item self-report instrument that is comprehensive, highly reliable, and sensitive to the symptomatology of attentional deficits both with and without hyperactivity for adults. Closely aligned with current diagnostic criteria, the CAT-A includes scales, clusters, and items that are sensitive to symptom presentation in differing contexts and as expressed as either internal sensations or overt behaviors.

The CAT-A consists of two parts: Part 1 (Childhood Memories) assesses the individual's memories of his/her behaviors and sensations as a child; and Part 2 (Current Symptoms) assesses parallel issues in adulthood. The CAT-A provides Clinical Index scores for the Childhood Memories section, the Current Symptoms section, as well as the summation of these two sections. In addition, three validity scales are embedded within the instrument--Negative Impression, Infrequency, and Positive Impression.

The CAT-A closely resembles the child version of the CAT (CAT-C™). All item content, Clinical scales, Context clusters, and Locus clusters are similar and parallel between both forms. Together, the CAT-C and the CAT-A assess a continuum of behaviors and sensations across an individual's life span.

The CAT-A assessment materials consist of the CAT-A/CAT-C Professional Manual, the carbonless CAT-A Rating Form, and the CAT-A Score Summary/Profile Form. The Rating Form can be hand-scored, or item responses can be hand-entered into the CAT Software Portfolio™ (CAT-SP™).

Standardization and Validity

The CAT-A was standardized on a sample of 800 adults ages 19-79 years. The sample was well-matched to the U.S. population for gender, race/ethnicity, and education level. Concurrent validity for the CAT-A was assessed

via comparison with the Conners' Rating Scales, the Brown Attention-Deficit Disorder Scales®, and the Clinical Assessment of Depression™, revealing correlations for both the nonclinical and combined clinical samples that are in the moderate-to-high range.

Special Features of the CAT-A

- Consists of a self-report form that is appropriate for individuals ages 19-79 years.
- Represents a well-defined, theoretically and empirically supported measure of behaviors, characteristics, and diagnostic criteria associated with ADD/ADHD.
- Thorough and complete score reporting system that includes standard scores (*T* scores), percentile ranks, confidence intervals, qualitative classifications, and graphical profile displays.
- Linkage to the *DSM-IV*™ diagnostic criteria with comprehensive content coverage both within and across scales/clusters, assisting in rendering a differential diagnoses.
- Context clusters that indicate contexts in which ADD/ADHD symptoms are most problematic and Locus clusters that indicate the extent to which ADD/ADHD symptoms are experienced internally as sensations versus symptoms that are acted out upon as overt behaviors.

Clinical Assessment of Attention Deficit--Child™ (CAT-C™)

Bruce A. Bracken, PhD and Barbara S. Boatwright, PhD

The CAT-C is a 42-item assessment instrument with three parallel forms: a Self-Rating Form completed by the child/adolescent; a Parent Rating Form completed by one or both parents; and a Teacher Rating Form completed by the child's/adolescent's teacher(s). All three CAT-C Rating Forms are comprehensive, highly reliable, and sensitive to the symptomatology of attentional deficits both with and without hyperactivity for children and adolescents.

Closely aligned with current diagnostic criteria, the CAT-C includes scales, clusters, and items that are sensitive to symptom presentation in differing contexts and as expressed as either internal sensations or overt behaviors. The CAT-C presents a balanced framework of clinical diagnostic content dispersed across important life contexts. In addition, three validity scales are embedded within the instrument--Negative Impression, Infrequency, and Positive Impression.

In keeping with the goal of instrument development, the CAT-C closely resembles the adult version of the CAT (CAT-A™). All item content, Clinical scales, Context clusters, and Locus clusters are similar and parallel between both forms. Together, the CAT-C and the CAT-A assess a continuum of behaviors and sensations across an individual's life span.

The CAT-C assessment materials consist of the CAT-A/CAT-C Professional Manual, three carbonless CAT-C Rating Form (one each for the Self-Rating, Parent Rating, Teacher Rating Forms), and the three CAT-C Score Summary Profile Forms, each corresponding to one of the Rating Forms. The three Rating Forms can be hand-scored or the item responses can be hand-entered into the CAT Software Portfolio (CAT-SP™).

Standardization and Validity

The CAT-C was standardized on a sample of 800 children/adolescents ages 8-18 years, 800 matched parents of the children/adolescents, and 500 teachers of these same children. The sample was well-matched to the U.S. population for gender, race/ethnicity, and education level.

Concurrent validity for the CAT-C was assessed via comparison with the Conners' Rating Scales, the Attention-Deficit/Hyperactivity Disorder Test, the Clinical Assessment of Behavior™, and the Clinical Assessment of Depression™, revealing correlations for both the nonclinical and the combined clinical samples that are in the moderate-to-high range across all three Rating Forms.

Special Features of the CAT-C

- Consists of three forms--a self-report form, a parent report form, and a teacher report form.
- Thorough and complete score reporting system that includes standard scores (*T* scores), percentile ranks, confidence intervals, qualitative classifications, and graphical profile displays.
- Linkage to the *DSM-IV*™ diagnostic criteria with comprehensive content coverage both within and across scales/clusters, assisting in rendering a differential diagnoses.
- Context clusters that indicate contexts in which ADD/ADHD symptoms are most problematic and Locus clusters that indicate the extent to which ADD/ADHD symptoms are experienced internally as sensations versus symptoms that are acted out upon as overt behaviors.

Clinical Assessment of Attention Deficit--Software Portfolio™ (CAT-SP™)

Bruce A. Bracken, PhD, Barbara S. Boatwright, PhD, and PAR Staff

The CAT-SP scores and profiles an individual's performance on either the CAT-A™ or any of the three CAT-C™ Rating Forms. After demographic and item response information is hand-entered from an individual's completed Rating Form, the CAT-SP generates a Score Report.

The CAT-A Score Report includes: demographic information; CAT-A Validity Scales Table; CAT-A Childhood Memories Scales/Clusters/Index Table; CAT-A Current Symptoms Scales/Clusters/Index Table; CAT-A *T*-Score Profile; CAT-A Percentile Profile; and Item Responses Table.

The CAT-C Score Reports include: demographic information; CAT-C Validity Scales Table; CAT-C Scales/Clusters Index Table; CAT-C *T*-Score Profile; CAT-C Percentile Profile; and Item Responses Table.

The CAT-SP provides unlimited scoring and report generation after hand-entry of an individual's CAT responses. The program generates profile graphs with the ability to overlay profiles from prior administrations for the same client; for the CAT-C, it allows for overlays of different raters' responses (e.g., parent's profile overlaid with child's profile). The software includes built-in, easy-to-use report editing features. Client data can be exported to many spreadsheet and database programs, and client reports can be exported to common word processing programs.

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

Clinical Assessment of Behaviour™ (CAB™)

Bruce A. Bracken, PhD, Lori K. Keith, PhD

The CAB is an objective, comprehensive, and highly reliable behavior rating scale that is closely aligned with current diagnostic criteria found in the *DSM-IV-TR*™ and IDEA. Standardized on a large representative national sample, the CAB assists in the identification of children and adolescents across a wide age range who are in need of behavioral, educational, or psychiatric treatment or intervention. It enables professionals to identify behaviors associated with educationally relevant exceptionalities.

The CAB offers a balanced theoretical framework of both competence-based qualities and problem-based concerns for the CAB scales and clusters, making it useful for evaluating adaptive strengths and clinical risks in children and adolescents. The CAB assesses behaviors that reflect current societal concerns and issues about youth and their behavior (e.g., bullying, aggression, executive function, gifted and talented). It includes both Parent and Teacher Rating Forms, thus providing a multisource, multicontext assessment of children's and adolescents' behaviors.

Features of the CAB

- Provides three separate Rating Forms: the Parent Extended Rating Form (CAB-PX), with a total of 170 items, and the Parent Rating Form (CAB-P) and the Teacher Rating Form (CAB-T), each with a total of 70 items.
- Provides Parent (ages 2-18 years) and Teacher (ages 5-18 years) Rating Forms with corresponding items, thus allowing both parents and teachers to contribute equally to the evaluation of target behaviors.
- Requires only an 8th-grade reading level for completion.
- Rating Forms are quick to administer and can be efficiently scored by the CAB Scoring Program (CAB-SP).
- Normative data includes 2,114 parent ratings and 1,689 teacher ratings.

Based on scale and cluster internal consistency (alpha) coefficients in the .88 and higher range across the three CAB Rating Forms, examiners can expect to use the CAB-PX, CAB-P, and CAB-T Rating Forms with confidence

to assist in making important diagnostic or intervention decisions for individual children and adolescents. Scale and cluster reliabilities also were consistently high across age level, gender, and race/ethnicity. Test-retest reliability coefficients across the three CAB forms ranged from .77-.95 with a mean test-retest interval of 17.6-19.3 days. Interrater reliabilities indicate a high level of agreement between parents and teachers (.44-.56) and even higher agreement between pairs of parent raters (.70-.90). Finally, the CAB-PX, CAB-P, and CAB-T scales and clusters demonstrate good evidence of validity based on test content, factor analytic studies, convergent and discriminant evidence, and concurrent validity studies across various clinical groups, including conduct/disruptive behavioral disorders, cognitive dysfunction, and ADD/ADHD.

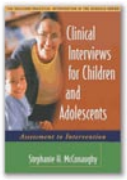
New! CAB™ Scales Can Now Distinguish Emotional Disturbance From Social Maladjustment

Scales for Differentiating Emotional Disturbance From Social Maladjustment
The Individuals With Disabilities Education Act (IDEA; 1997) requires treatment for students with emotional disturbance because it is viewed as an educationally related disorder. The Act further requires that emotional disturbance be differentiated from social maladjustment, which is not considered to be an educationally related disorder and, therefore, requires no mandated services under the law. In response to the difficulties faced by many clinicians in distinguishing emotional disturbance from social maladjustment, the CAB can now be used to help differentiate these conditions for students between the ages of 2 and 18 years (i.e., Grades Pre-K through 12).

These new scales appear in Appendix H of the CAB Professional Manual. They also are available free by contacting one of our Customer Support Specialists (**1.800.331.8378**). The new scales, Emotional Disturbance (*ED*) and Social Maladjustment (*SM*), are discussed in terms of item assignments for each of the CAB Forms (CAB-PX, CAB-P, and CAB-T) and norms development based on the same *T*-score metric as the other CAB scales. A case example is included and interpretation is discussed. Discrepancy score tables are included for each of the CAB Forms that further differentiate Emotional Disturbance and Social Maladjustment. The CAB Scoring Program (CAB-SP) also has been updated to provide *T* scores for both scales by age and gender, and each scale can be considered in light of its respective qualitative classifications.

Free CAB Scoring Program (CAB™-SP) Is Included!
The CAB-SP calculates raw and *T* scores and percentiles for all scales and clusters. After paper-and-pencil administration, the parents' and/or teachers' responses are entered manually using the CAB-SP. The software offers easy and rapid data entry for CAB items, calculation of all scores, and generation of a complete Score Report and profile for each of the three CAB Rating Forms.

Clinical Interviews for Children and Adolescents
Stephanie H. McConaughy, PhD



This easy-to-read and well-organized text offers guidelines for interviewing children and their parents and teachers. The author provides an empirically based approach to clinical interviewing and shows how to use assessment data in planning early interventions. The reproducible worksheets, interview guidelines, illustrative case examples, and chapters on assessing risk for suicide and violence are helpful additions.

Conduct Disorder Scale (CDS)

James E. Gilliam, EdD

The CDS is appropriate for individuals ages 5-22 years who present unique behavioral problems. It is designed to help in the diagnosis of Conduct Disorder and can be administered by anyone who has had direct, sustained contact with the referred individual (e.g., teachers, parents, siblings). Items on the subscales have strong face validity because they are based on the diagnostic criteria for Conduct Disorder published in the *DSM-IV-TR*.

- The CDS consists of 40 items in a behavioural checklist format that is easily rated using objective frequency-based ratings.
- A detailed interview form is provided to document infrequent but serious behavioural problems that are indicative of individuals who have Conduct Disorder.
- The test was standardized on 1,040 persons representing the following diagnostic groups: normal, gifted and talented, mentally retarded, attention-deficit/hyperactivity disorder, emotionally disturbed, learning disabled, physically handicapped, and persons with Conduct Disorder.
- Norms were developed based on 644 representative individuals with a Conduct Disorder.
- The amount of time required to complete an individual rating is minimal (approximately 5-10 minutes in most cases).
- Standard scores and percentiles are provided. A Conduct Disorder Quotient is derived based on information from all four subscales.
- *The Conduct Disorder Quotient* is an interpretation guide provided for determining the likelihood that a participant has a Conduct Disorder and for assessing the severity of the disorder.

Coping Responses Inventory (CRI)

Rudolf H. Moos, PhD

Use the CRI in counseling, stress management education, and other settings to identify and monitor coping strategies in adults and adolescents, to develop better clinical case descriptions, and to plan and evaluate the outcome of treatment.

This brief self-report inventory identifies cognitive and behavioral responses the individual used to cope with a recent problem or stressful situation. The 8 scales include Approach Coping Styles (Logical Analysis, Positive Reappraisal, Seeking Guidance and Support, and Problem Solving) and Avoidant Coping Styles (Cognitive

Avoidance, Acceptance or Resignation, Seeking Alternative Rewards, and Emotional Discharge). Information about reliability and validity is presented in the professional manual for each version.

Two separate versions of the CRI have been developed, the CRI-Adult (over 18 years of age) and the CRI-Youth (ages 12-18 years). Each version has its own manual, with information about reliability and validity, and an Ideal and an Actual form. The Ideal form may be used to compare actual and preferred coping styles, to set treatment goals, and to monitor progress. The Actual form surveys the individual's actual coping behavior, while the Ideal form surveys preferred coping styles. Both forms are written at a 6th-grade reading level.

Individuals complete the self-report inventory, marking answers on the answer sheet. The carbonless bottom sheet contains a scoring grid for quick and easy calculation of raw scores.

The back page of the answer sheet contains a profile for determining and plotting *T* scores and examining patterns of coping. Scoring and profiling take about 5 minutes.

Coping Responses Inventory: An Update on Research Applications and Validity (Manual Supplement)

Rudolf H. Moos, PhD

The CRI assesses an individual's approach and avoidance coping skills in response to stressful life circumstances and other challenges. The CRI also allows clinicians to develop more complete case descriptions and to evaluate treatment outcomes.

This Manual Supplement to the original manuals for both versions of the Coping Responses Inventory (i.e., CRI-Adult, CRI-Youth) includes a review of studies that have utilized the CRI to examine coping and well-being in children, adolescents, and adults. This Manual Supplement also presents new normative and psychometric data for the CRI appraisal items and new data on the long-term stability of the subscales for both men and women. Topics covered include, but are not limited to, the following:

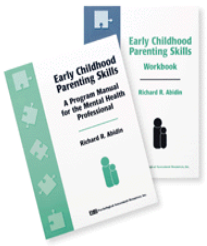
- Family-related stressors (e.g., bereavement, divorce, caregiving for impaired family members).
- Work-related stressors (e.g., service-related professions, exposure to traumatic situations).
- Health-related stressors (e.g., life-threatening illness such as stroke, HIV/AIDS, and cancer; chronic disorders such as diabetes, hypertension, cardiac disease, and weight gain).
- School-related stressors (e.g., transition from elementary to junior high school, transition to college).
- Physical and sexual abuse.
- Economic distress and poverty (e.g., homelessness, lack of income).
- War-related and natural disasters (e.g., flood, tornado).
- Combat stress and internment (e.g., combat exposure and subsequent PTSD, depression).
- Alcohol and substance use.
- Psychiatric disorders (e.g., depression, anxiety, PTSD, and dual diagnoses).

An invaluable companion for researchers and clinicians who use the CRI, this Manual Supplement provides a broad range of information about recent applications of the CRI-Adult and CRI-Youth versions and summarizes

validity information based on more than 180 studies and dissertations published over the past decade. With its extensive reference list, the Manual Supplement is an excellent resource for clinicians and for researchers involved in teaching, research, and/or grant writing.

Early Childhood Parenting Skills (ECPS)

Richard R. Abidin, EdD



This modular program is designed to teach parents the skills that are recognized as key to successful parenting: developing a positive relationship, communication, discipline, managing emotions, and developing appropriate structure.

Program Manual for the Mental Health Professional

The manual organizes current knowledge about children and their development into a systematic program for basic parenting skills training. Section I provides information that will be useful to the professional before the training begins. Section II contains a scripted narrative and notes to the professional for each of the 19 sessions that form the substantive core of the program. These sessions are drawn from four general areas: self-concept, relationships, behavioral principles, and cognitive psychology. Professionals are free to use this modular program in a flexible manner, selecting appropriate sessions and/or modules to meet specific needs. Section III provides five different lecture/workshops designed as single-session presentations. Section IV provides an extensive annotated bibliography, which is also included in the Parenting Skills Workbook.

Workbook for Parents

The workbook contains home practice exercises designed to help parents master the ideas and skills presented in each of the 19 core program sessions. The homework exercise for each session includes a review of the main ideas, practical examples, practice exercises, and a main homework assignment. Through this structured program, the professional continuously interacts with the parents in ways that foster a positive parenting self-concept. In turn, parents learn the importance of interacting with their children in ways that help develop a positive self-concept in each child.

Although this ECPS program is structured to provide a curriculum for group instruction, the concepts and skills are equally applicable to one-on-one consultations with parents of young children in a variety of settings.

Emotional Disturbance Decision Tree™ (EDDT™)

Bryan L. Euler, PhD

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

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

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

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

Standardization, Reliability, and Validity

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

- Internal consistency was high (*r* = .94) for the EDDT TOTAL Score, ranging from .75-.88 for the other EDDT scales.
- Test-retest stability was high (*r* = .92) for the EDDT TOTAL Score, ranging from .81-.94 (interval of 1-44 days, mean = 18 days).
- Interrater reliability was good (*r* = .84) for the EDDT TOTAL Score (mean *T*-score change = 1.04).
- Convergent validity was examined for the normative sample using the Clinical Assessment of Behaviour™ (CAB™) Teacher Form and the Behaviour Assessment System for Children, Second Edition (BASC-2) Teacher Form. These same forms were used to examine convergent validity for a subgroup of the ED

sample, along with the CAB Parent Form and the Teacher Report Form of the Achenbach Child Behaviour Checklist (CBCL).

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

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

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

Eyberg Child Behaviour Inventory™ (ECBI™) & Sutter-Eyberg Student Behaviour Inventory- Revised™ (SESBI-R™) (ECBI SESBI-R)

Sheila Eyberg, PhD

The ECBI and the SESBI-R are comprehensive, behaviorally specific rating scales that assess the current frequency and severity of disruptive behaviors in the home and school settings, as well as the extent to which parents and/or teachers find the behavior troublesome. Both instruments consist of items that represent common behaviors in all children. The variety and frequency of these behaviors distinguishes normal behavior problems from conduct-disordered behavior in children and adolescents. The non-age-specific nature of the items also makes them widely generalizable. On both the 36-item ECBI and the 38-item SESBI-R, the parent or teacher indicates how often each behavior currently occurs (7-point Intensity scale) and whether or not the behavior is a problem (Yes/No Problem scale). ECBI and SESBI-R scores can be quickly and easily computed by hand in about 5 minutes each.

Test Materials

Test materials include the Professional Manual and the individual ECBI and SESBI-R Test Sheets. Completion of each rating sheet requires a 6th-grade reading level. Both instruments are also suitable for group administration or for administration via telephone.

The Professional Manual provides normative data and information on the psychometric strength of both instruments. The ECBI and the SESBI-R are reliable and valid instruments for efficient screening and tracking of disruptive behaviors in children and adolescents. The ECBI Intensity and Problem scales demonstrated high internal consistency, significant test-retest reliability, and significant interrater reliability, as well as convergent and discriminant validity. The newly developed SESBI-R Intensity and Problem scales demonstrated high internal consistency and significant test-retest reliability, as well as convergent, discriminant, and predictive validity. Both measures are sensitive to changes that can occur during treatment.

The section on interpretation includes case studies, as well as information about appropriate uses of the instruments for treatment screening and assessment of treatment outcome. Raw score-to-*T*-score conversions for the ECBI and SESBI-R Intensity and Problem scales for the total normative sample are provided in the appendix tables. A separate appendix lists various studies using the two instruments.

Using the ECBI and the SESBI-R

Used together, the ECBI and SESBI-R provide useful information for identifying and treating disruptive behavior in children and adolescents, ages 2 through 16 years. Each instrument provides a single set of non-age-specific items with a constant cutoff score across the ages from 2 to 16 years that facilitates longitudinal measurement of treatment progress and evaluation of the long-term effects of treatment. Because they measure both the frequency of each problem behavior and the parent's (or teacher's) reaction to the child's behavior, they may provide additional insights into areas of the adult-child interaction that should be addressed.

Family Assessment Measure, Version III (FAM-III)

Harvey A. Skinner, PhD, Paul D. Steinhauer, MD, Jack Santa-Barbara, PhD

The FAM-III is a self-report measure that assesses the strengths and weaknesses within a family. It can be completed by pre-adolescents, adolescents, and adult family members (ages 10 years to adult).

The FAM-III consists of three types of forms: a 50-item General Scale that examines overall family health; a 42-item Dyadic Relationship Scale that examines how a family member views his or her relationship with other family members; and a 42-item Self-Rating Scale that allows each person to rate his or her own functioning within the family. By comparing these scales, you can obtain a comprehensive picture of how family members view levels of family interaction.

Two types of profiles are available for the FAM-III. The FAM-III Colorplot® of Family Perceptions is color-coded and can be used to present results to clients in an easy-to-understand manner. The Progress Colorplot is specifically designed for displaying changes in family functioning over time.

FAM Brief Version

Ideally suited for preliminary screening, the Brief FAM provides an overview of family functioning in 5-10 minutes. The Brief FAM QuikScore® Forms are self-contained, allowing for administration, scoring, and comparison to norms. Information regarding the use and interpretation of the Brief FAM is provided in the FAM-III Manual.

Firestone Assessment of Violent Thoughts™ (FAVT™)

Robert W. Firestone, PhD and Lisa A. Firestone, PhD

The FAVT is designed to be a brief, efficient indicator of an individual's violence potential. Designed on the basic hypothesis that an individual's thought process strongly influences his or her behavior, this self-report assessment tool measures the different types of thoughts that have been found to predispose an individual to violent behavior. It is valuable for helping clinicians to make decisions regarding safety and for separating violent individuals from prospective targets.

- FAVT items are organized into five Levels (i.e., Paranoid/Suspicious, Persecuted Misfit, Self-Depreciating/Pseudo-Independent, Self-Aggrandizing, Overtly Aggressive) and two Theoretical Subscales (i.e., Instrumental/Proactive Violence, Hostile/Reactive Violence), which allow a better understanding of the individual in order to offer more targeted treatment.
- The FAVT was standardized on a sample of 639 individuals that was well-matched to the U.S. population in terms of age, gender, race/ethnicity, educational attainment, and geographic region.
- In addition, demographic and FAVT data on two reference groups (i.e., Incarcerated, Anger Management) also were collected as part of the standardization process. These data provide the evaluator with valuable information for making level-of-care/restriction decisions and for identifying the appropriate intervention intensity.
- Two validity scales (i.e., Inconsistency Scale, Negativity Scale) are included to assist the examiner in determining whether or not the administration is accurate.
- Change score tables are provided across four different levels of significance for the four normative groups and for the two reference groups so that clinicians can easily find out if a significant change has occurred in an individual's FAVT score over two administrations.
- Test items were taken directly from thoughts experienced by violent individuals prior to engaging in violent behaviour. Because violent individuals who are administered the FAVT are able to recognize the exact content of their thoughts in the items, the FAVT taps directly into the cognitions of violent individuals.

The FAVT is ideal for use (a) as a screening device of violence potential within normal, clinical, and forensic settings; (b) as a threat assessment measure; (c) in the identification of violent thoughts and subsequent clinical intervention; and (d) in tracking changes in behavior over time and in response to intervention (RTI). The FAVT is directly tied to treatment because the thoughts endorsed are those that need to be addressed in treatment. In

whatever modality the clinician is working, he or she has an opportunity to deal directly with the thoughts that are driving the client's violent behavior

Gilliam Asperger's Disorder Scale (GADS)

James E. Gilliam, EdD

The GADS is a norm referenced test designed to evaluate individuals with unique behavioral problems who may have Asperger's Disorder. Based on the most current and relevant definitions and diagnostic criteria of Asperger's Disorder, the GADS is useful for contributing valuable information toward the identification of individuals who have this disorder. Easily completed by a parent and professional who knows the individual, the GADS provides documentation about the essential behavior characteristics of Asperger's Disorder necessary for diagnosis. It can be used in the assessment process to document behavioral progress, to target goals for IEPs, and for research purposes. The validity of the GADS was demonstrated by confirming that (a) the items of the test are directly related to the definitions of Asperger's Disorder, (b) the subscales are strongly related to each other and the overall diagnosis of Asperger's Disorder, and (c) the GADS scores discriminate persons with Asperger's Disorder from persons with autism and other behavioral disorders.

The GADS has the following characteristics:

- Thirty-two clearly stated items divided into four subscales describe specific, observable, and measurable behaviors.
- Eight additional items are included for parents to contribute data about their child's development during the first 3 years of life.
- Items are based on the most current definitions of Asperger's Disorder.
- The test was normed on 371 representative individuals with Asperger's Disorder (ages 3-22 years) from 27 states, the District of Columbia, Canada, and Australia.
- Behaviors are rated using objective, frequency-based ratings.
- Standard scores and percentiles are provided.
- A table is provided for determining the likelihood that an individual has Asperger's Disorder.
- A list of books, journals, media, Internet sites, and organizations concerned about Asperger's Disorder are provided to give teachers, parents, and others information about Asperger's Disorder.

Health Dynamics Inventory (HDI)

Stephen Saunders, Ph.D. & James Wojcik, Ph.D.

The HDI identifies psychological or psychiatric symptoms in order to highlight areas the areas that require further attention. It is often administered prior to or at the first meeting with an individual. During treatment, the HDI can be readminisitered to monitor symptom change and document progress. At termination, it can be used to document outcomes.

How To Use The Assessment
The HDI consists of a self-report form (HDI–Self), a parent form (HDI–Parent), and a Background Information Questionnaire. The Background Information questionnaire systematically collects important demographic information and medical/mental health history. All components are available in handscored and software format. With the software format, you can instantly generate Interpretive Reports or Medical Summary Reports.

HDI–Self (HDI–S)
The HDI–Self gathers information from the individual being assessed and provides scores for all the scales and subscales. It is use with individuals 14 years of age and older.

HDI–Parent (HDI–P)
The HDI–Parent gathers information from parents when the individual being assessed in between the ages of 4 and 19.

Normative Data
The normative sample for the HDI included 2,161 patients and 1,574 nonpatients.

Reports
Interpretive Reports provide scores graphically and numerically, as well as a narrative text to aid mental health professionals in the interpretation process.

Medical Summary Reports are a subset of the Interpretive Report. They are ideal for rapid analysis and treatment decisions in health care settings where the full Interpretive Report may be unnecessary.

Illness Effects Questionnaire -Multi-Perspective (IEQ-MP)
Glen D. Greenberg, Ph.D. & Rolf A. Peterson, Ph.D.

With the IEQ–MP, you can accurately assess the effects that an illness and treatment are having on a patient's life. The tool's strength lies in its ability to improve communication among patients, families, and healthcare providers using four separate questionnaires to assess a patient's medical experience from multiple perspectives.

Using the IEQ–Self-Report (IEQ–S), the patient communicates his or her perception of the impact an illness is having on his or her life. The IEQ–Professional (IEQ–Pro) allows medical professionals to describe their perception of the effects the illness is having on the patient. The IEQ–Observer (IEQ–O) lets someone close to the patient report the impact of the illness on the patient's life. Rounding out the assessment of the medical

experience, the IEQ–Treatment Effects (IEQ–Tx) is a self-report form to measure the patient's biological, psychological, and social effects resulting from the treatment he or she is receiving. Finally, a Comparative and Integrated Profile (IEQ–CIP) facilitates the monitoring of illness effects over time from all perspectives.

Index of Teaching Stress™ (ITS™)

Richard R. Abidin, EdD, Ross W. Greene, PhD, Timothy R. Konold, PhD

The ITS is a 90 item self report measure normed on 1488 teachers. It is designed to be used as either a part of individual case consultations. or as a screening measure to identify situations where excessive levels of stress are being experienced by the teacher in relation to teaching a specific student.

The ITS evaluates a teacher's level of stress in three domains (Attention-Deficit/Hyperactivity Disorder, Student Characteristics and Teacher Characteristics). The domain and sub scales alert the clinician to specific needs or perceptions that impinge on or may be disrupting the teaching process, and the teacher-student relationship. The subscales of the ITS assess teaching stressors related to the following student characteristics: emotional lability, learning limitations, aggressiveness, anxiety, ADHD type behaviors. The ITS also assesses teaching stressors related to the teacher's perceptions of loss of satisfaction from their teaching role, sense of competence, lack of support, disruption of the teaching process, and frustration working with the student's parents.

The ITS's validity data indicates that teachers who are highly stressed in relation to a specific student may alter their teaching behaviors in negative ways toward both that student and other students in their class; that they are actively considering leaving the profession; and that their physical health is being affected. The ITS allows the clinician to be aware of the teacher's need for specific forms of support, which is critical if any teacher-based-intervention is being considered for the targeted student.

When used as a screening measure, the ITS helps teachers to self-identify particularly distressing teaching situations, and helps the clinician to prioritize cases. The ITS recognizes that teachers create the learning environment that facilitates student success.

The ITS includes a Professional Manual, a reusable Item Booklet, a hand-scorable carbonless Answer Sheet, and a two-sided Profile Form. Based on the purpose of the evaluation, the ITS Profile Form provides the clinician with a choice of comparison samples (i.e., Randomly Selected Student Normative Sample, Behavior Problem Student Normative Sample), for use in the interpretation of examinee responses.

Interpersonal Adjective Scales (IAS)

Jerry S. Wiggins, PhD

The IAS is a self-report instrument that yields a reliable, valid, efficient, and theoretically sound assessment of the two primary dimensions of interpersonal transactions: Dominance and Nurturance. It provides important information about how an individual typically behaves in different interpersonal situations. The structural model underlying this instrument has been applied widely within the area of clinical psychology and personality assessment over the last 35 years.

The IAS was normed on 4,000 college students and adults, and separate norms are available for each group. Administration and scoring can be performed by individuals who have no formal training in psychology or related fields. IAS interpretation requires professional training in clinical or counseling psychology.

The test materials consist of the IAS Professional Manual, a 4-page Test Booklet, a 1-page glossary of terms, and a 4-page Scoring Booklet. The IAS Professional Manual includes information concerning the usefulness of this instrument in a clinical context and provides normative information as well as case illustrations. The test booklet lists 64 adjectives that describe interpersonal interactions. Respondents use an 8-point Likert scale (ranging from *Extremely Inaccurate* to *Extremely Accurate*) to rate how accurately each adjective describes them as individuals. The glossary clarifies the meaning of the 64 adjectives and is an important part of the test. The IAS requires 10th-grade reading ability.

The scoring booklet provides instructions for summing and scoring the respondent's answers and plotting these scores on the interpersonal circumplex. Responses to the 64 adjectives yield scores on eight interpersonal interactions (Assured-Dominant, Arrogant-Calculating, Cold-Hearted, Aloof-Introverted, Unassured-Submissive, Unassuming-Ingenuous, Warm-Agreeable, and Gregarious-Extraverted). These interpersonal types are distributed continuously around a circle whose primary axes are Dominance and Nurturance.

The IAS measures the respondent's interpersonal type and the intensity of that type and utilizes a framework within which all interpersonal behaviors may be represented as "blends" of the two primary axes. The IAS may be conveniently converted to an observer rating form by changing the instructions from rating self to rating a specified other person.

In most clinical situations, the IAS should be supplemented by instruments that measure additional dimensions of personality, particularly the remaining dimensions of the 5-factor model. In screening and research contexts, the efficiency of the IAS may justify its use as the single instrument of choice.

Jesness Inventory--Revised (JI-R)

Carl F. Jesness, PhD

The JI-R is a restandardized version of the Jesness Inventory (JI) with new norms based on large and diverse samples of approximately 3,500 general population individuals and 1,000 offenders/delinquents (ages 8 years to adult). An easy-to-understand, 160-item true/false questionnaire, the JI-R provides valuable information about functioning across a variety of different areas. It has 11 personality subtype scales that measure key traits and attitudes, including Social Maladjustment, Manifest Aggression, Value Orientation, Withdrawal-Depression, Immaturity, Social Anxiety, Autism, Repression, Alienation, Denial, and Asocial Index.

The JI-R also provides subtype evaluation with nine distinct subtype areas. The subtype system not only helps you understand the individuals being assessed, but also leads to specific suggestions about treatment and risk. The nine subtypes are Undersocialized/Active, Undersocialized/Passive, Conformist, Group-Oriented, Pragmatist, Autonomy-Oriented, Introspective, Inhibited, and Adaptive.

This revision to the JI includes two new scales: the Conduct Disorder and Oppositional Defiant Disorder scales. These new scales are fully normed and add to the clinical diagnostic utility of the Jesness scale. The JI-R also contains validity scales to assess potentially invalid response patterns. There is a Lie scale, as well as a Random Response scale that can be easily scored and interpreted when using the inventory.

The JI-R Technical Manual describes the development of the scales, new norms and validation, and provides information on administration, use, and interpretation. Scoring time is greatly reduced using the JI-R Scoring Templates.

Job Stress Survey™ (JSS™)

Charles D. Spielberger, PhD, Peter R. Vagg, PhD

Occupational stress affects productivity, absenteeism, accidents, worker turnover, and stress-related health problems. Identifying major sources of stress in a workplace can help to identify changes in the work environment and other interventions that will reduce stress and increase productivity. The JSS was developed to assess generic sources of work-related stress experienced by men and women ages 18 years and older in a wide variety of business, industrial, and educational settings.

The JSS focuses on common work situations that often result in psychological strain. Each of the 30 items describes a job-related stressor event and assesses both the perceived severity and the frequency of occurrence of that event. In addition to providing information about stressors that adversely affect individual employees, the

JSS can also help to identify sources of occupational stress for groups of workers and allow comparison of stress levels among employees in different departments or divisions within the same organization.

Consists of Three Scales Based on all 30 Items and Six 10-Item Subscales

- The JSS Severity and Frequency scales provide information on the average level of perceived severity and frequency of occurrence of the 30 JSS stressor events.
- The Stress Index assesses the overall level of stress based on the combined severity and frequency ratings of all 30 stressor events.
- The 10-item JSS subscales measure components of occupational stress associated with the job itself (Job Pressure) and with lack of support from supervisors, coworkers, or the policies and procedures of the organization (Lack of Organizational Support).

In addition to the scales and subscales, individual JSS items provide valuable information about the specific aspects of a particular job or a work environment that may be good targets for job redesign, organizational change, or other interventions.

Test materials include the JSS Professional Manual and the hand-scorable JSS Test Booklet. An optional computerized Scoring Program is also available. A special OCR-scannable test form (Form SP) has been developed for use with the scoring software (responses must be entered into the software) or for large group administrations or research projects.

Administration, Scoring, and Interpretation

A 6th-grade reading ability is generally sufficient to understand and respond to the JSS items. First, the individual rates the perceived severity of each of the 30 stressor events on a 9-point scale. Then the individual indicates (on a scale of 0 to 9+ days) how often each event has occurred during the preceding 6 months. Scores are then calculated for the three JSS scales and 6 subscales. To compare an individual's scores with those of other workers in a particular normative group, percentile ranks and *T* scores can be obtained from the appendix tables in the Professional Manual.

Comparison of item scores with appropriate norms provides important information about how the stress experienced by an individual or group of employees compares with that of others engaged in similar activities. Scores may be plotted on the JSS Profile Form. Scoring Program users key the individual's responses into the software, and the program rapidly calculates the raw scores, percentiles, and *T* scores.

The Professional Manual provides information on administration, scoring, and interpretation of the JSS, as well as the development and standardization of the instrument. Normative data were obtained from 2,173 adults employed in business and industry, university, and military settings. Normative groups include managers, professionals, clerical employees, skilled-trades or maintenance employees, and military personnel. Gender-specific and combined-gender norms are provided.

Computerized scoring program (JSS-SP) also is available!

- Users key the individual's responses into the software.
- The program rapidly calculates the raw scores, percentiles, and *T* scores.
- A special test form (Form SP) has been developed for use with the scoring software (responses must be entered into the software), or for large group administrations or research projects.

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

Life Stressors and Social Resources Inventory (LISRES-A and LISRES-Y) (LISRES)

Rudolf H. Moos, PhD

The LISRES provides a unified framework to measure ongoing life stressors and social resources and their changes over time. Integrating these 2 domains in 1 assessment tool provides a comprehensive picture of an individual's overall life context. This inventory identifies the level of current stressors and their sources as well as the available social resources.

Two separate versions of the LISRES are available, the LISRES-A (for adults 18 years and older) and the LISRES-Y (for youth ages 12-18 years). Each version has its own Manual, coauthored by Bernice S. Moos, that describes the development of the instrument and provides normative data, as well as complete instructions for administration, scoring, and interpretation. The Manuals also discuss validity and research applications.

The LISRES-A may be used with healthy adults, psychiatric, substance abuse, or medical patients. It covers eight major areas of life experience: Physical Health, Spouse/Partner, Finances, Work, Home/Neighborhood, Children, Friends & Social Activities, and Extended Family.

The LISRES-Y may be used with healthy teenagers, those with conduct disorders, or adolescent medical and psychiatric patients. It covers eight major areas of life experiences: Physical Health, School, Home & Money, Parents, Siblings, Extended Family, Boyfriend/Girlfriend, and Friends & Social Activities.

The LISRES can be used as a structured interview with individuals whose reading and comprehension skills are below a 6th-grade level. The LISRES can be administered and scored by those with no formal training in clinical or counseling psychology.

The respondent answers the 200 (LISRES-A) or 208 (LISRES-Y) items contained in the 8-page reusable Item Booklet. Responses are marked on the 2-part carbonless Answer/Profile Form.

Reliability/Validity

The LISRES-A was normed on 1,884 adults (1,181 men and 703 women). Internal consistency reliabilities range from .77-.93 for the Stressor scales and from .50-.92 for the Social Resources scales.

The LISRES-Y was normed on 400 youth (179 boys and 221 girls). Internal consistency reliabilities range from .66-.92 for Stressor scales and from .78-.93 for Social Resources scales.

Marital Satisfaction Inventory, Revised (MSI-R)

Douglas K. Snyder, PhD

The revised edition of the Marital Satisfaction Inventory (MSI) assesses the nature and extent of conflict within a marriage or relationship. It is an excellent tool to use at the beginning of marital therapy to guide subsequent treatment, because it helps couples communicate hard-to-express feelings, thereby providing an easy, economical way to gather information about a broad range of issues. The MSI-R also helps you identify relationship issues that may be contributing to individual or family problems: depression, substance abuse, and trouble with children or adolescents.

- 150 True-False items (129 items if the couple has no children).
- Scores for both partners can be plotted on a single profile (AutoScore™ Answer Form).
- Two additional scales indicate inconsistency and a tendency to respond in an unrealistically positive manner, giving you a quick, graphic comparison of the two sets of scores.
- The profile highlights the primary concerns of each partner, clearly indicating differences in their perceptions of the relationship.
- Normative data collected from 2,040 people (1,020 intact couples).
- Standardization sample approximated the U.S. population in regard to geographic region, education, and ethnicity; gender-specific norms provided.
- Hand-scorable computerized scoring and interpretation program also available (20 uses; ordered separately).

Maryland Addictions Questionnaire (MAQ)

by William E. O'Donnell, Ph.D., MPH, Clinton B. DeSoto, Ph.D., and Janet L. DeSoto, Ed.D.

Brief, economical, and easy to administer and score, the MAQ is one of the best treatment planning tools you'll find. Administered at intake, it quickly tells you how severe the addiction is, how motivated the patient is, which treatment approach is most likely to work, what the risk of relapse is, and whether treatment may be complicated by cognitive difficulties, anxiety, or depression.

Find out if the patient will benefit from treatment.

The MAQ can be used with anyone aged 17 or older who can read at a fifth-grade level. It is a self-report inventory composed of 111 items on the following scales:

Substance Abuse Scales
- Alcoholism Severity
- Drug Abuse Severity
- Craving
- Control
- Resentment

Summary Scores
- Emotional Distress
- Resistance to Treatment
- Admission of Problems

Treatment Scales
- Motivation for Treatment
- Social Anxiety
- Antisocial Behaviour
- Cognitive Impairment
- Affective Disturbance

Validity Scales
- Inconsistent Responding
- Defensiveness

The test gives you standard scores and percentiles for each of these scales. Based on the relative elevation of the Summary Scores, it also assigns the patient one of six Summary Codes, indicating his or her ability to benefit from treatment.

Determine treatment readiness, treatment approach, and relapse risk.

The MAQ can be completed in just 15 to 20 minutes. (A 30-item Short Form, which includes the scales Alcoholism Severity, Drug Abuse Severity, Craving, Control, and Affective Disturbance, can be completed in only 5 minutes.) While the AutoScore™ Answer Sheet makes hand scoring quick and easy, the test can also be computer scored using WPS TEST REPORT Mail-In Answer Sheets, CD, or FAX Service. All of these computer options give you an interpretive report full of concrete, specific information about the most productive treatment

approach, the patient's treatment readiness, relapse risk, and related problems.

Norms are based on a large sample of people receiving substance abuse treatment at outpatient clinics, residential facilities, or halfway house programs.

The MAQ is brief yet multidimensional, the items are easy to complete, the scales are easy to interpret, and the results facilitate treatment planning. All of this makes it the ideal intake measure for patients entering an addiction treatment program.

Mind Body Wellness Geriatric Rehabilitation and Restorative Assessment System™ (GRRAS™)

P. Andrew Clifford, PhD, Kristi D. Roper, PhD, and Daisha J. Cipher, PhD

The GRRAS is designed to assess emotional and behavioral dysfunction that is associated with medical and psychiatric comorbidities of geriatric individuals who reside in long-term care (LTC) settings. It is intended to be used by psychologists, psychiatrists, psychiatric nurse practitioners, clinical social workers, and geriatric psychotherapists for the evaluation of LTC (i.e., nursing home, assisted living facility, rehabilitation setting) residents who display emotional and behavioral dysfunction associated with chronic medical conditions and psychiatric syndromes. Because the GRRAS documents the frequency, duration, and intensity of symptoms of psychiatric conditions and medical-psychiatric comorbidities, it plays an important role in establishing the medical necessity for mental health services for this population.

The GRRAS is composed of three clinician rating forms. These three forms can be used jointly as part of a comprehensive rehabilitation and restorative assessment evaluation and/or they can be used in treatment planning, in establishing medical necessity, and for monitoring response to intervention. The Psychosocial Resistance to Activities of Daily Living Index (PRADLI) Rating Form is an 8-item measure that assesses the level of LTC residents' resistance to and cooperation with staff in performing ADLs (on a 7-point scale) that, when resisted, commonly triggers a psychiatric or psychological referral. The Geriatric Multidimensional Pain/Illness Inventory (GMPI) Rating Form is a 14-item measure that assesses (on a 10-point scale) the perceptual, functional, and emotional concomitants of pain and illness as they have affected the resident's abilities to perform activities within the past 7 days. The Geriatric Level of Dysfunction Scale (GLDS) Rating Form assesses the intensity, frequency, and duration (each on a 7-point scale) of 20 behaviors that can potentially interfere with care provided in the LTC setting, such as agitation, wandering, unsafe/impulsive behaviors, and low activity levels.

For each of the three GRRAS measures, percentile ranks and predetermined clinical raw score ranges were established based on a criterion-referenced approach. A raw score of a specific magnitude on the GRRAS reflects a particular level of pain severity, behavioral disturbance, or activity impairment. Item and scale analyses enable ease of tracking progress over time and monitoring of response to intervention. Using the GRRAS Profile Form, visual profiles of single or repeated administrations enable the easy identification of trends in an individual's rehabilitation process.

Reliability and Validity

- Internal consistency for the PRADLI and the GMPI ranges from .71 to .93; for the GLDS, the range is from .68 to .80.
- Interrater reliability for all GRRAS Total and Cluster scores range from .87-.97.
- Validity of the GRRAS measures was examined in terms of concurrent validity, content validity, construct validity, convergent and divergent validity, clinical group contrasts, and treatment utility.

Mind Body Wellness Geriatric Rehabilitation and Restorative Assessment System™ Software Portfolio (GRRAS™-SP)

P. Andrew Clifford, PhD, Kristi D. Roper, PhD, Daisha J. Cipher, PhD, and PAR Staff

The GRRAS-SP is used to score and generate reports for the Mind Body Wellness Geriatric Rehabilitation and Restorative Assessment System™. After the examiner enters the client's demographic information and GRRAS scores, the program generates up to three useful and informative reports:

- The **GRRAS Score Report** includes a description of the GRRAS measures and components, a Score Summary Table, Scale and Cluster Score Profiles, an Item Summary Table, Brief Scale and Cluster Score Interpretations, Item Score Profiles, and a Critical Elevation Care Plan. The Critical Elevation Care Plan provides basic recommendations for critical items and elevated scales.
- The **GRRAS Progress Monitoring Report** includes a Longitudinal Assessment Summary Table, Scale and Cluster Score Profiles, Longitudinal Item Summary Tables, and Item Score Profiles. Up to three protocols can be selected from the client's prior history to compare to the current protocol.
- The **GRRAS Quick Note Report** includes a Score Summary Table and a Critical Item Summary Table and is designed for easy placement in a resident's clinical chart.

To obtain comparisons between the client's scores and those of others, the examiner can choose a comparison group (i.e., General Unaffected, General Affected, Dementia, Pain) for each report. The easy-to-use software enables the examiner to edit reports, organize protocols into individual client files, and compare a client's prior administrations. The system is user-friendly, allowing for simple program navigation and file handling as well as easy viewing of the On-Screen Software Manual.

Requirements: Windows® 2000/XP/Vista™; NTFS file system; CD-ROM drive for

installation; Internet connection or telephone for software activation

Multidimensional Health Profile™ (MHP™)

Linda S. Ruehlman, PhD, Richard I. Lanyon, PhD, Paul Karoly, PhD

The MHP is a comprehensive screening instrument designed for general use in health-related settings. Evidence over the past 30 years indicates that early identification of adjustment disorders, dysfunctional attitudes, and health-compromising habits can facilitate cost-effective prevention programs and overall improvement of health care quality. This is the first instrument to provide comprehensive information about psychosocial and health functioning. National representative norms based on a sample of 2,411 participants are available by gender for three age groups (18-32 years, 33-50 years, and 51-90 years).

- Detects areas of clinical concern and targets areas for follow-up evaluation.
- Developed and standardized for use with individuals ages 18 years and older.
- Consists of two 4-page carbonless, hand-scorable Test Booklets for use together or separately.

The MHP materials consist of a Professional Manual and two test booklets written at a fourth-grade reading level. The MHP-Psychosocial Functioning (MHP-P) booklet contains 58 items that cover four major areas of concern: life stress, coping skills, social resources, and mental health. The MHP-Health Functioning (MHP-H) booklet consists of 69 items that provide information in five major areas of concern: response to illness, health habits, adult health history, health care utilization, and health beliefs and attitudes.

Once the respondent has completed the booklet, the health professional peels back the top page to reveal the scoring page. Scale scores are plotted on the profile grid provided in the booklet. *T* scores are used to interpret the respondent's level of psychosocial and health functioning.

The MHP Professional Manual provides information on the development of the instrument; guidelines for administration, scoring, and interpretation; normative data; and data bearing on the reliability and validity of the scales.

Occupational Stress Inventory-Revised™ (OSI-R™)

Samuel H. Osipow, PhD

The OSI-R is a concise measure of three domains of occupational adjustment: occupational stress, psychological strain, and coping resources. The original research edition of the OSI was designed to (a) develop an integrated theoretical model to link these three important dimensions, and (b) develop generic occupational stress measures that would apply across different occupational levels and environments. This revision, appropriate for ages 18 years and older, provides normative data for both gender and specific occupational categories (i.e., executive, professional, technical, administrative support, public service/safety, and agricultural/production/laborer). It also includes modifications to several original OSI items and generates new items for each of the three domains. A number of correlational and multivariate studies using the OSI provide evidence of the relationship among stress, strain, and coping.

OSI-R Scales Assess Three Dimensions of Occupational Adjustment

- Occupational stress is measured by a set of six scales that comprise the **Occupational Roles Questionnaire (ORQ)**. The ORQ scales measure the following stress-inducing work roles: Role Overload, Role Insufficiency, Role Ambiguity, Role Boundary, Responsibility, and Physical Environment.
- Psychological strain is measured by a set of four scales that comprise the **Personal Strain Questionnaire (PSQ)**. The PSQ scales reflect affective responses in four major categories: Vocational Strain, Psychological Strain, Interpersonal Strain, and Physical Strain.
- Coping resources are measured by four scales that comprise the **Personal Resources Questionnaire (PRQ)**: Recreation, Self-Care, Social Support, and Rational/Cognitive Coping.

The OSI-R test materials include an Item Booklet, a Hand-scorable Answer Sheet, and two types of Profile Forms. The Gender-Specific profile form has a male profile grid on one side and a female profile grid on the other. The generic profile form can be used with *T* scores from the total normative sample (*N* = 983) or from one of the specific occupational groups. The Professional Manual provides information on test development and validation; test administration, scoring, and interpretation; and research studies using both the original and the revised OSI. Three composite case studies illustrate appropriate uses of the instrument to assess occupational stress, personal strain, and/or current coping resources.

The OSI-R is suitable for a number of important mental health applications:

- Individual screening can provide information about the work roles that are producing the individual's stress in order to help him or her develop coping strategies.
- Organizational/occupational assessment can help to identify the sources of stress and the symptoms of strain prevalent in a specific occupational unit or group.
- Programs for employee assistance and counseling can utilize the results of the OSI-R to help the individual understand the sources of his or her occupational stress.
- Career counseling may help an employee to either adjust to the present situation or change to a more appropriate position.
- The OSI-R can serve as a reliable and consistent outcome measure to establish the effectiveness of individual or organizational interventions.

Overeating Questionnaire (OQ)

by William E. O'Donnell, Ph.D., MPH and W. L. Warren, Ph.D.

Get a relevant psychological profile and personalized plan of action in just 20 minutes

Recent surveys indicate that nearly half of all American children are overweight. While most instruments related to eating behavior focus on bulimia and anorexia, the Overeating Questionnaire (OQ) measures key habits, thoughts, and attitudes related to obesity. Appropriate for individuals as young as 9 years of age, it can be extremely helpful in designing effective individualized weight-reduction programs.

The OQ is an 80-item self-report questionnaire that can be group or individually administered in about 20 minutes. (Items are written at a fourth-grade reading level.) It yields the following scores:

Overeating	Health Habits
Undereating	Body Image
Craving	Social Isolation
Expectations About Eating	Affective Disturbance
Rationalizations	Motivation to Lose Weight

The first six scores relate to eating habits and attitudes, while the last four help identify problems that may need to be addressed concurrently with obesity. Two additional scores -- Inconsistent Responding and Defensiveness -- assess response bias. Norms are based on a nationally representative sample of 1,788 individuals aged 9 through 98.

Clients trust a treatment plan based on scientifically valid and defensible evidence

OQ scores correlate with other measures of eating-related characteristics, body mass index, health habits, mood disturbance, social functioning, and successful engagement in weight-loss activities. Information generated by the OQ is invaluable in planning effective individualized weight-loss programs. And because the test can be administered and scored by any trained and supervised technician, it is a practical and cost-effective addition to any treatment effort focused on weight loss and related psychological problems.

OQ Case Study: Michael

Michael seems to passively accept his weight gain. What's behind his apparent apathy?

Michael is a 138-pound, 11-year-old boy whose weight problem has escalated alarmingly over the past 2 years. He believes that obesity "runs in the family." His mother has observed that he has been "moodier than usual" lately.

Michael's pediatrician referred him to a weight-loss program for preteens. There he took the *Overeating Questionnaire* as part of a routine intake procedure.

Michael's high scores on the "Rationalization" and "Affective Disturbance" scales suggest that he attributes his weight to factors other than his own behavior and that mood disturbances divert his attention and energy away from his weight-loss efforts. His high score on the "Motivation to Lose Weight" scale indicates that

apathy is not to blame.

The most important insight Michael's counselor took away from the OQ profile is that Michael's eating habits are closely tied to his moods. Michael eats to alleviate stress and loneliness. This knowledge allowed his counselor to design a plan that addresses Michael's emotional issues, encourages him to find diversions that will help him control his emotional overeating, and teaches him to assume responsibility for whatever successes or failures he may encounter in his effort to shed pounds.

Parenting Alliance Measure™ (PAM™)

Richard R. Abidin, EdD, Timothy R. Konold, PhD

The PAM is a useful screening and diagnostic instrument for family counseling, joint custody evaluations, identification of dysfunctional parenting skills, and assessing the impact of intervention. The PAM was standardized on 1,224 parents of children from the general population and a clinical sample of 272 parents of children diagnosed with ADHD, CD, ODD, or other problems.

- The only measure that assesses the parenting aspects of a couple's relationship.
- Provides you with the parents' perspective of how cooperative, communicative, and mutually respectful they are with regard to caring for their child(ren).
- Quick and easy for parents to complete (10 minutes).
- Easy to score (5 minutes).
- Appropriate for a variety of parenting partners (married, divorced, unmarried, etc.).
- Appropriate for parents of children ages 1-19 years.

Reliability/Validity

The PAM is highly reliable, with an internal consistency of .97. The test-retest reliability after a 4- to 6-week period was .80. Validity studies show the PAM to be correlated in the expected directions with measures of parenting stress, family and marital functioning, children's social skills and psychosocial adjustment, and other parent characteristics.

Administration/Scoring

The PAM materials consist of the Professional Manual and a self-scoring 20-item PAM test form written at a 3rd-grade reading level. Once the parent has completed the test form, the administrator peels back the top page to reveal the scoring page. Both *T* scores and percentile scores can be used to determine the strength of the parenting alliance. Separate norms are available for fathers and mothers.

The PAM Professional Manual provides information on the PAM materials, administration, scoring, interpretation, development, and psychometric characteristics. It includes summaries of the content, convergent, and discriminant validity studies. The Appendixes include the raw score to percentile and raw score to *T*-score conversion tables.

Parenting Stress Index Software Portfolio (PSI-SP)

Richard R. Abidin, EdD, PAR Staff

The PSI-SP allows you to administer either the 120-item PSI or the 36-item PSI Short Form on-screen or to enter item responses from the PSI or the PSI Short Form. The software automatically scores the item responses and generates a report. All reports can be edited on-screen. The software program contains modifications to the interpretive statements, empirically based cutoff scores, and reference lists of PSI research that are searchable by topic.

The PSI Report Includes the Following:

- 7-9 page report designed to assist you in clinical interpretation of PSI results.
- PSI profile; score summary.
- Information on validity.
- Clinical description of the respondent's perception of his/her personal stress.
- Recommendations on diagnosis, treatment planning, and management.

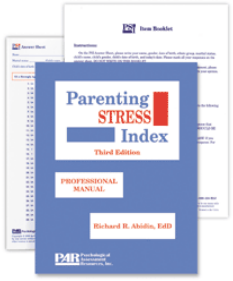
The PSI Short Form Report Includes the Following:

- 2-3 page report.
- PSI Short Form profile; score summary.
- No per-report fees.

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

Parenting Stress Index, 3rd Ed. (PSI)

Richard R. Abidin, EdD



The PSI addresses the early identification and assessment needs recognized by the *Report of the Surgeon General's Conference on Children's Mental Health* (January 2001). It is well-suited for use in primary health care and pediatric practices, as well as in other settings and programs that serve at-risk children and families, or which provide early childhood educational and developmental experiences. The PSI is designed for the early identification of parenting and family characteristics that fail to promote normal development and functioning in children, children with behavioral and emotional problems, and parents who are at-risk for dysfunctional parenting. It can be used with parents of children as young as one month.

The PSI was developed on the theory that the total stress a parent experiences is a function of certain salient child characteristics, parent characteristics, and situations that are directly related to the role of being a parent. The PSI identifies dysfunctional parenting and predicts the potential for parental behavior problems and child adjustment difficulties within the family system. Although its primary focus is on the preschool child, the PSI can be used with parents whose children are 12 years of age or younger.

The PSI consists of 120 items and takes less than 30 minutes for the parent to complete. It yields a Total Stress Score, plus scale scores for both Child and Parent Characteristics, which pinpoint sources of stress within the family.

The child characteristics are measured in six subscales: Distractibility/Hyperactivity, Adaptability, Reinforces Parent, Demandingness, Mood, and Acceptability. The parent personality and situational variables component consists of seven subscales: Competence, Isolation, Attachment, Health, Role Restriction, Depression, and Spouse. The PSI is particularly helpful in:

- Early identification of dysfunctional parent-child systems.
- Prevention programs aimed at reducing stress.
- Intervention and treatment planning in high stress areas.
- Family functioning and parenting skills.
- Assessment of child-abuse risk.
- Forensic evaluation for child custody.

Validated With Diverse Populations

The PSI has been empirically validated to predict observed parenting behavior, and children's current and future behavioral and emotional adjustment, not only in a variety of U.S. populations but in a variety of international populations. The transcultural research has involved populations as diverse as Chinese, Portuguese, French Canadian, Italian, Korean, etc. These studies demonstrated comparable statistical characteristics to those reported in the PSI Manual, suggesting that the PSI is a robust diagnostic measure that maintains its validity with diverse non-English-speaking cultures. This ability to effectively survive translation and demonstrate its usefulness as a diagnostic tool with non-English-speaking populations suggests that it is likely to maintain its validity with a variety of different U.S. populations.

Description

The Manual has 118 pages of information, including reference group profiles and case illustrations, Hispanic norms, and expanded norms by age. A 5th-grade reading level is required.

The PSI consists of a 120-item test booklet with an optional 19-item Life Stress scale; and an all-in-one self-scoring answer sheet/profile form. It yields 17 scores, including seven Child Domain scores, eight Parent Domain scores, and a Total Stress score, plus the optional Life Stress score.

The PSI Short Form is a direct derivative of the full-length test and consists of a 36-item self-scoring questionnaire/ profile. It yields a Total Stress score from three scales: Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child.

Personal Experience Inventory (PEI)
A Measure of Substance Abuse in Adolescents

by Ken C. Winters, Ph.D. and George A. Henly, Ph.D.

The PEI helps you identify, refer, and treat teenagers with drug and alcohol problems. It is particularly useful because it covers all forms of substance abuse, assesses both chemical involvement and related psychosocial problems, and documents the need for treatment.

This convenient self-report inventory, used with more than 100,000 adolescents in facilities throughout the country, documents chemical involvement in 12- to 18-year-olds and identifies personal risk factors that may precipitate or sustain substance abuse.

Problem Severity Scales

- Personal Involvement With Chemicals
- Effects From Drug Use
- Social Benefits of Drug Use
- Personal Consequences of Drug Use
- Polydrug Use
- Transitutional Drug Use
- Psychological Benefits of Drug Use
- Social-Recreational Drug Use
- Preoccupation With Drugs
- Loss of Control

Psychosocial Scales

- Negative Self-Image
- Psychological Disturbance
- Social Isolation
- Uncontrolled
- Rejecting Convention

Drug Use, Frequency, Duration, and Age of Onset

- Alcohol
- Amphetamines
- Marijuana or Hashish
- Quaaludes
- Barbiturates
- LSD
- Other Psychedelics
- Tranquilizers
- Cocaine/Crack
- Inhalants
- Heroin
- Other Opiates

Problem Screens

- Family Chemical Dependency
- Sexual Abuse
- Physical Abuse

Deviant Behaviour
Absence of Goals
Spiritual Isolation
Peer Chemical Involvement
Sibling Chemical Use
Sibling Chemical Use
Family Pathology
Family Estrangement
Eating Disorder
Suicide Potential
Psychiatric Referral

In addition, five validity scales alert you to response distortion, including defensiveness, "faking bad," and inattentive responding. Norms, based on nearly 2,000 adolescents, are provided by age and sex for both drug clinic populations and regular high school samples. So you can see where the teenager stands in relation not only to the most extreme cases but also to average adolescents.

The PEI is routinely used in substance abuse treatment programs, student assistance programs, juvenile rehabilitation centers, and private practice. Reinforcing the trend toward earlier intervention, the PEI makes it easier to evaluate the many adolescents who are entering the health care system at younger ages, with more poorly defined problems. It permits more specialized treatment. And it documents the need for treatment--for insurance companies, the juvenile justice system, and parents.

Psychosocial Evaluation & Threat Risk Assessment™ (PETRA™)

Jay Schneller, PhD

The PETRA is a 60-item, self-report psychosocial assessment instrument for use with adolescents ages 11-18 years who exhibit threatening behavior. Following a threat of violence, the PETRA allows for an analysis of the context of psychosocial, social, and ecological factors to assist in the identification, assessment, and management of adolescents who pose a risk for targeted violence through intervention before the violent act occurs. Critical Items identify known threat risk factors.

The PETRA provides four domain scores (i.e., Psychosocial, Resiliency Problems, Ecological, Total), eight cluster scores (i.e., Depressed Mood, Alienation, Egocentricism, Aggression, Family/Home, School, Stress, Coping Problems), two Response Style Indicators (i.e., Inconsistency, Social Desirability), and eight Critical Items. Also included is the PETRA Threat Assessment Matrix, which is used to classify the content of a threat as low, medium, or high risk based on the information gleaned from the threat itself.

Conversion tables for the domains, clusters, and Response Style Indicators are grouped by age and gender in the appendix tables of the Professional Manual to assist the clinician in obtaining *T* scores, percentiles, and 90% confidence intervals from an individual's raw scores. Interpretation of the PETRA is straightforward using a five step process that is systematic with thorough methodology for gathering, guiding, and interpreting multisource data. These interpretive steps take into consideration the results in light of other data, including background information, information from other informants, and information gleaned from follow-up interviews. These steps also emphasize the simultaneous and dynamic interpretation necessary to fully understand the content and context of a threat of violence.

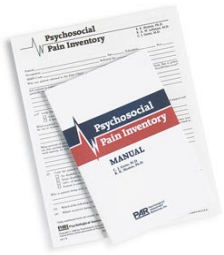
Reliability and Validity

- Internal consistency for the PETRA domains ranged from .66-.90.
- Test-retest stability coefficients (corrected) ranged from .63 for the Coping Problems cluster to .88 for the Aggression cluster.
- Validity studies comparing the PETRA with the Adolescent & Child Urgent Threat Evaluation™ (ACUTE™), Behaviour Assessment System for Children Self-Report of Personality (BASC-SRP); the Achenbach System of Empirically Based Assessment, Child Behaviour Checklist (CBCL); the Clinical Assessment of Depression™ (CAD™); the Children's Depression Inventory (CDI); and the Suicidal Ideation Questionnaire (SIQ) are presented in the Professional Manual.
- PETRA domains and clusters demonstrated moderate to high correlations for both males and females, with the correlations of highest magnitude for each cluster falling onto its assigned domain.

The PETRA materials consist of the Professional Manual, the carbonless Rating Form/Scoring Sheet, and the Score Summary/Profile Form. Written at a 3rd-grade reading level, the PETRA was normed, standardized, and validated with males and females ages 11-18 years that were representative of a wide range of racial/ethnic backgrounds, and urban, suburban, and rural communities (*N* = 1,770).

Psychosocial Pain Inventory (PSPI)

Robert K. Heaton, PhD, Ralph A. W. Lehman, MD, Carl J. Getto, MD

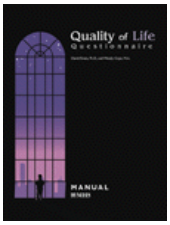


Use the PSPI to evaluate psychosocial factors important in maintaining and exacerbating chronic pain problems. It evaluates several forms of secondary gain, the effects of pain behavior on interpersonal relationships, stressful life events that may contribute to subjective distress or promote avoidance learning, and components of past learning that familiarize the patient with the chronic invalid role and its personal and social consequences.

Based on a large sample of chronic pain patients, PSPI scores form a normal distribution and provide for high interrater reliability. The PSPI and the Personality Assessement Inventory™ (PAI®) provide complementary information for evaluating patients. In addition, high scores on the PSPI have been found to predict poor response to medical treatment for pain.

Quality of Life Questionnaire (QLQ)

David Evans, Ph.D. & Wendy Cope, M.A.



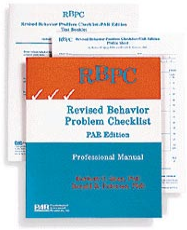
The Quality of Life Questionnaire (QLQ) measures the relationship between a client's quality of life and other behaviors or afflictions, such as physical health, psychological health, and alcohol or other substance use. Results highlight areas of the client's life that may require change to alleviate specific symptoms. Its efficient design makes the QLQ an ideal screening tool for employee assistance, wellness, stress, weight control, or any other program in which people desire change.

The QLQ consists of five major domains, 15 content scales, and a social desirability scale. The five major domains are: General Well-Being, Interpersonal Relations, Organizational Activity, Occupational Activity, and Leisure and Recreational Activity. The QLQ was normed on 437 subjects.

Profile Reports graphically and numerically provide scores for each scale to summarize a QLQ administration.

Revised Behaviour Problem Checklist-PAR Edition (RBPC)

Herbert C. Quay, PhD, Donald R. Peterson, PhD



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

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

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

Overview of the RBPC Scales

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

- **Psychotic Behaviour (PB/6)**--Items tap psychotic symptoms, including speech disturbance, bizarre ideation, delusions, and impaired reality testing.
- **Motor Tension-Excess (ME/5)**--Items focus on motoric symptoms of overactivity, including restlessness, tension, and "jumpiness."

Administration and Scoring

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

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

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

School Motivation and Learning Strategies Inventory (SMALSI)

Kathy Stroud, PhD and Cecil Reynolds, PhD

Poor study skills, ineffective learning strategies, test anxiety--all these things impede academic success. With the new SMALSI you can now measure the skills related to academic success early in a student's school career, enabling you to proactively address weaknesses.

Unlike many other learning measures, the SMALSI does not assess learning styles, preferences, or other process dimensions. Instead, it assesses the actual strategies students use in learning and test-taking--strategies shown through research to be related to academic success.

Designed for both special and general education students, this self-report inventory assesses 10 primary constructs associated with academic motivation, learning strategies, and studies--7 focusing on student strengths and 3 focusing on student liabilities.

Social Behaviour Assessment Inventory (SBAI)

Thomas M. Stephens, DEd, Kevin D. Arnold, PhD

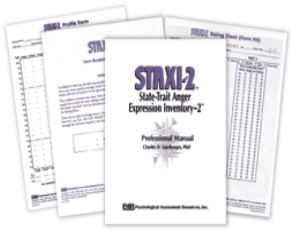
The SBAI measures the level of social behaviors exhibited by children and adolescents in classroom settings (grades K-9). It is appropriate for special education classes or any classroom where behavior problems may exist.

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

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

State-Trait Anger Expression Inventory-2™ (STAXI-2™)

Charles D. Spielberger, PhD, ABPP



The STAXI-2™ provides easily administered and objectively scored measures of the experience, expression, and control of anger for adults and adolescents, ages 16 years and older. The STAXI-2 was developed to assess components of anger and anger expression for a detailed evaluations of normal and abnormal personality and to measure the way these components of anger contribute to medical conditions such as hypertension and coronary heart disease. Recent studies on the nature of anger and its effects on mental and physical health guided the development of the STAXI-2. To investigate the effects of anger on mental and physical disorders, the *experience* of anger must be clearly distinguished from anger *expression* and *control.*

The 57-item STAXI-2 consists of six scales, five subscales, and an Anger Expression Index that provides an overall measure of total anger expression. The STAXI-2 scales and subscales are listed below:

STAXI-2 Scales and Subscales:

State Anger
Feeling Angry
Feel Like Expressing Anger Verbally
Feel Like Expressing Anger Physically

Trait Anger
Angry Temperament
Angry Reaction

Anger Expression-Out
Anger Expression-In
Anger Control-Out
Anger Control-In
Anger Expression Index

The STAXI-2 State Anger scale assesses the intensity of anger as an emotional state at a particular time. The Trait Anger scale measures how often angry feelings are experienced over time. The Anger Expression and Anger Control scales assess four relatively independent anger-related traits: (a) expression of anger toward other persons or objects in the environment (Anger Expression-Out); (b) holding in or suppressing angry feelings (Anger Expression-In); (c) controlling angry feelings by preventing the expression of anger toward other persons or objects in the environment (Anger Control-Out); and (d) controlling suppressed angry feelings by calming down or cooling off (Anger Control-In).

A 6th-grade reading ability is generally required to complete the STAXI-2. Individuals rate themselves on 4-point scales that assess both the intensity of their anger at a particular time and the frequency that anger is experienced, expressed, and controlled. The normative sample for the STAXI-2 included more than 1,900 individuals (1,644 normal adults, 276 hospitalized psychiatric patients). Normative tables provide raw score-to-percentile and raw score-to-*T*-score conversions for STAXI-2 scale and subscale scores for the total normative sample, as well as by gender for three age groups: 16-19 years, 20-29 years, and 30 years and older. The STAXI-2 can be administered and scored by individuals with limited training. Interpretation requires professional training in psychology, psychiatry, or educational testing.

The STAXI-2 materials include the professional manual, reusable item booklets, carbonless self-rating sheets, and profile forms. The manual provides directions for administration and scoring, information on the construction and development of the STAXI/STAXI-2, guidelines for interpretation, validation studies, a summary of current research, and an extensive Bibliography. A profile form for graphing percentiles or *T* scores facilitates the interpretation of individual patterns in scale and subscale scores.

Stress Index for Parents of Adolescents™ (SIPA™)

Peter L. Sheras, PhD, Richard R. Abidin, EdD. Professional Manual by Peter L. Sheras, PhD, Richard R. Abidin, EdD, Timothy R. Konold, PhD

The SIPA is a screening and diagnostic instrument that identifies areas of stress in parent-adolescent interactions and is appropriate for parents of adolescents ages 11-19 years. This upward extension of the popular Parenting Stress Index (PSI) for parents of children ages 1 month to 12 years allows a clinician or researcher to examine the relationship of parenting stress to adolescent characteristics, parent characteristics, the quality of the adolescent-parent interactions, and stressful life circumstances.

Four subscales measure adolescent characteristics:

- Moodiness/Emotional Lability
- Social Isolation/Withdrawal
- Delinquency/Antisocial
- Failure to Achieve or Persevere

Four subscales measure parent characteristics:

- Life Restrictions
- Relationship with Spouse/Partner
- Social Alienation
- Incompetence/Guilt

The SIPA is useful for family counseling, forensic evaluations for adolescent custody, identification of dysfunctional parent-adolescent systems, prevention programs designed to reduce parental stress, and intervention and treatment planning in high stress areas. The SIPA was developed from a normative sample consisting of 778 parents of adolescents from the general population and a clinical sample of 159 parents of adolescents who had received a *DSM-IV*™ diagnosis, usually in the cluster of disruptive behavior disorders.

Reliability/Validity

The SIPA is highly reliable. Internal consistency for the SIPA subscales exceeds .80 with the majority equal to the high .80s-.90. The alpha coefficients for the three SIPA domains (adolescent, parent, adolescent-parent relationship), and the Index of Total Parenting Stress exceed .90. The 4-week test-retest reliability coefficients for the subscales range from .74-.91, suggesting that responses to SIPA responses remain stable over a period of time. Confidence intervals are provided in the SIPA Professional Manual.

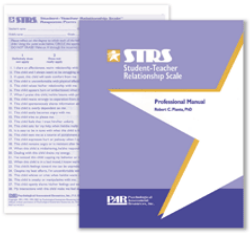
Administration/Scoring

The 112 SIPA items are contained in a reusable item booklet. Parents record their responses on a separate, carbonless, hand-scorable answer sheet/profile form. Completion of the SIPA requires approximately 20 minutes and a 5th-grade reading level. Scoring the responses is easy: SIPA scores are plotted on the profile form (included as part of the answer sheet) and then converted to percentiles to compare the parent's scores to general population scores.

The SIPA Professional Manual provides information on materials, administration, scoring, interpretation, normative data, and psychometric characteristics. It contains information supporting the factor structure of the SIPA, as well as summaries of the reliability and the content, convergent, and discriminant validity studies. The Appendix tables provide the raw score to percentile and raw score to *T*-score conversions.

Student-Teacher Relationship Scale™ (STRS™)

Robert C. Pianta, PhD



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

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

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

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

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

- During the STARS Assessment stage, the consultant incorporates information from both quantitative Student-Teacher Relationship Scale™ (STRS™) and qualitative (student interview, teacher interviews, and classroom observations) assessments to identify problem areas and available resources.
- In the STARS Teacher Support Assessment stage, the consultant helps the teacher to change his/her perception of the student-teacher relationship.
- In the STARS Banking Time stage, the teacher uses a set of specific techniques to create positive interactions with a student and to establish a supportive relationship pattern.
- Appropriate for teachers of preschool to 5th-grade students.

Substance Abuse Relapse Assessment (SARA)

Lawrence Schonfeld, PhD, Roger Peters, PhD, Addis Dolente, PsyD

The SARA is a structured interview designed as a treatment planning instrument for psychologists, psychiatrists, counselors, social workers, nurses, and other professionals who work with substance abusers. It is especially helpful in developing relapse prevention goals for clients who tend to use multiple substances and in monitoring the achievement of these goals during treatment. Based on a model of the substance abuse behavior chain (antecedents, behaviors, and consequences), the SARA helps the individual to identify the events that typically precede his/her substance use, as well as the consequences that may reinforce that use. The behavior chain is then used to develop an individualized treatment plan with specific strategies for coping with high risk situations, slips, and relapses.

The SARA is designed for use with adolescents and adults who have a history of drug and/or alcohol abuse or whose ability to avoid relapse is in question. The 12-page Interview Record Form is administered orally. It focuses on the individual pattern of substance use, positive and negative consequences of substance use, current coping skills, and level of self-confidence. The three Relapse Prevention Planning Forms allow the professional to summarize the interview responses, help to identify the individual's substance behavior chain (Form 1), survey current coping skills (Form 2), and develop treatment plan goals (Form 3).

Survey of Pain Attitudes™ (SOPA™)

Mark P. Jensen, PhD and Paul Karoly, PhD

Research conducted over the past decade indicates that patients' attitudes and beliefs about pain play a key role in their adjustment and treatment outcome. The SOPA was designed to assist clinicians in the understanding of seven key pain-related beliefs of patients who have chronic pain with the assumption that these beliefs reflect and influence patient functioning. It is a self-report instrument on which individuals are asked to indicate their level of agreement with 57 statements using a 5-point Likert scale. This newly standardized version of the SOPA was normed using a sample of 415 patients with chronic pain. The SOPA was designed to assist numerous health care providers working with adults ages 21-80 years.

The SOPA can be used in a variety of testing situations, including pretreatment screening to determine treatment necessity, pretreatment and posttreatment to determine treatment effectiveness, and periodic reevaluations to document treatment progress.

The SOPA consists of seven scales that are divided into two domains--the Adaptive Beliefs Domain and the Maladaptive Beliefs Domain.

Adaptive Beliefs Domain

- **Control Scale**--Assesses the extent to which a patient sees himself/herself as having control over his/her pain.
- **Emotion Scale**--Assesses the patient's belief that emotions have an impact on pain.

Maladaptive Beliefs Domain

- **Disability Scale**--Assesses the extent to which a patient believes that he/she is disabled by pain.
- **Harm Scale**--Assesses a patient's beliefs that pain is a signal/sign of physical damage and that in the presence of pain, exercise/activity should be avoided.
- **Medication Scale**--Assesses a patient's belief that medications are an appropriate treatment for his/her pain problem.
- **Solicitude Scale**--Assesses the extent to which a patient believes that others (e.g., family) should be helpful/solicitous in response to his/her pain (e.g., taking over chores).
- **Medical Cure Scale**--Assesses the extent to which a patient believes that a cure will be found for his/her pain and that the primary responsibility for the management of his/her pain rests with the physician.

Features of the SOPA

- *T* scores and percentiles are included for calculating scores; a validity scale (i.e., Inconsistency Score) is included to measure inconsistency of responses.
- Reliable Change scores are included to assist in determining if there are differences between scores obtained on two different testing occasions (e.g., pre-treatment vs. posttreatment).
- Interpretive guidelines and case examples are included.
- Profile Form includes a skyline for clinically elevated scores and treatment goals.

Reliability and Validity

- Internal consistency for the seven SOPA scales ranges from .65 to .82 for the standardization sample.
- Test-retest stability for the SOPA scales is moderate to good, ranging from .67 to .79 (n = 130).
- The validity of the SOPA is discussed in terms of evidence based on intercorrelations among the SOPA scales, correlational analyses examining the relationships between the SOPA scores and scores on related measures (i.e., mental health/psychological functioning, physical dysfunction/disability, medical utilization), and the use of the SOPA as a measure of treatment outcome.

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