**Adolescent Anger Rating Scale™ (AARS™)**
DeAnna McKinnie Burney, PhD

**Purpose:** Assess level and type of adolescent response to anger

**Age range:** 11 to 19 years

**Admin:** Individual or group

**Admin time:** 5-10 minutes for individuals; 10-20 minutes for groups

**Scoring time:** 10 minutes

The AARS is a 41-item psychometrically sound instrument that can help to identify adolescents who are at risk for diagnoses of conduct disorder, oppositional defiant disorder, or attention-deficit/hyperactivity disorder.

Evaluates the intensity and frequency of anger expression in adolescents

- Respondents indicate which behaviors they exhibit when angered and how often each behavior typically occurs.

- Scores are reported for Total Anger and for three subscales measuring aspects of the adolescent’s typical anger response pattern: Instrumental Anger, Reactive Anger, and Anger Control.

- Validated with students in two age groups: middle school (Grades 6-8) and high school (Grades 9-12). Five ethnic groups were represented in the normative sample of 4,187 adolescent boys and girls in middle schools and high schools.

- Conversions of raw scores to percentiles and T scores are provided by gender and age group.

- Statistical analyses support the use of the AARS in both clinical and research applications. It is useful for measuring behavior change and selecting an appropriate intervention program.

**Adolescent Drinking Index (ADI)**
Adele V. Harrell, PhD and Philip W. Wirtz, PhD

**Purpose:** Measure the severity of adolescents' drinking problems

**Age range:** 12 to 17 years
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 Psychopathology Scale™ (APS™) and Adolescent Psychopathology Scale™ Short Form (APS™-SF)

William M. Reynolds, PhD

Purpose: Evaluate the presence and severity of symptoms of psychological disorders and distress

Age range: 12 to 19 years

Admin: Individual or group

Admin time: 45-60 minutes
The APS empirically assesses the severity of symptoms associated with specific DSM-IV™ clinical and personality disorders.

Features and benefits

- A multidimensional self-report instrument.
- Also assesses other psychological problems and behaviors that may interfere with an adolescent’s psychological adaptation and personal competence, including substance abuse, suicidal behavior, emotional lability, excessive anger, aggression, alienation, and introversion.
- APS scores represent the severity of disorder-specific symptomatology evaluated across different time periods. This close match between APS item content and DSM-IV criteria enhances clinical utility and facilitates ease of interpretation.

Test structure

- Measures three broad disorder-problem domains: Clinical Disorders (20 scales), Personality Disorders (five scales), and Psychosocial Problem Content areas (11 scales). The Response Style Indicator scales (four scales) include indexes of response consistency and infrequency, response veracity, and unusual endorsement propensities.
- Must be scored using the APS Scoring Program. The software calculates scores for all scales and automatically generates a Clinical Score Report. The report includes a summary of APS scale elevations, a score summary table, a profile, a critical items summary form, and an item response summary table.

Short form also available

The 115-item APS-SF (Qualification Level B) is a multidimensional measure of psychopathology and personality derived from the APS.

- Ideal for use when time and circumstance necessitate a brief measure of psychopathology.
- Addresses issues regarding school safety by assessing excessive anger and propensity for violence toward others.
- Consists of 12 clinical scales and two validity scales. Six of the clinical scales focus on DSM-IV™ symptomatology associated with the following disorders: conduct disorder, oppositional defiant disorder, major depression, generalized anxiety disorder, posttraumatic stress disorder, and substance abuse disorder.
- The remaining six clinical scales are not anchored to specific DSM-IV disorders and symptoms but evaluate the related and important areas of eating disturbance, suicide, academic problems, anger/violence proneness, self-concept, and interpersonal problems.
- Must be scored using the APS-SF Scoring Program. In less than 5 minutes, the program calculates T scores for each scale and generates the APS-SF Clinical Score Report, which includes critical item endorsements.

ADOLESCENT SYMPTOM INVENTORY–4 (ASI-4) (2008)
This checklist screens adolescents for nearly the same disorders addressed by the Child Symptom Inventory–4. While it drops Asperger’s Syndrome, PDD, and Posttraumatic Stress Disorder, the ASI-4 adds seven problems that are more common in adolescents:

- Dysthymia
- Schizoid Personality
- Panic Attack
- Bipolar Disorder
- Anorexia
- Bulimia
- Drug Use

Like the other DSM-IV checklists, the ASI-4 can be used to determine the need for further testing or to inform diagnostic interviews.

**Aggression Questionnaire™ (AQ™)**

By Arnold H. Buss, PhD and W.L. Warren, PhD

**BENEFITS**

Offers a quick, practical way to screen large groups or individuals for aggressive tendencies

**AGES**

9 to 88 years

**ADMIN TIME**

10 minutes

**FORMAT**

Self-report

**NORMS**

Based on an age-stratified sample of 2,138 individuals; separated by sex for Verbal and Physical Aggression Scales
This self-report inventory makes it possible—and practical—to routinely screen children and adults for aggressive tendencies. The Aggression Questionnaire (AQ) measures an individual’s aggressive responses and his or her ability to channel those responses in a safe, constructive manner. Because it takes just 10 minutes to complete, the AQ can be administered quickly to large numbers of people.

The AQ is a full revision of the Buss-Durkee Hostility Inventory, a longtime standard for assessing anger and aggression. It consists of just 34 items, scored on the following scales:

- Physical Aggression
- Verbal Aggression
- Anger
- Hostility
- Indirect Aggression

A Total Score is also provided, along with an Inconsistent Responding Index. Standardization is based on a sample of 2,138 individuals, ages 9 to 88, and norms are presented in three age sets: 9 to 18, 19 to 39, and 40 to 88. In addition, norms for the Verbal Aggression and Physical Aggression scales are separated by sex.

Written at a third-grade reading level, AQ items describe various characteristics related to aggression. The respondent simply rates each item on a 5-point scale ranging from “Not at all like me” to “Completely like me.” Because it is brief and easy to read, the scale can be used with virtually anyone, including respondents who have difficulty with more complex verbal measures. The test can be hand scored in minutes. Or it can be administered and scored using the AQ CD, which also allows you to print out a detailed interpretive report on the spot.

While the 34-item AQ is recommended for clinical purposes, a short form is available for use in research and in those instances when a client fails to complete the full questionnaire. To use the short version, simply administer and score the first 15 items on the AQ AutoScore Form. Because these 15 items include three from each AQ scale, the short version gives you not only a total score but also scale scores, which correlate well with their counterparts from the full AQ.

In clinical settings, the AQ’s five subscale scores provide a level of detail that is particularly useful for treatment planning and outcome measurement. In correctional settings, the simplicity of the AQ makes it an excellent choice for documenting need for service and focusing rehabilitation efforts. In other institutional settings—schools, businesses, military installations, and geriatric or convalescent hospitals—it can be used for both screening and program evaluation. Brief and inexpensive, the AQ makes large-scale screening of aggression a realistic option.
**Bar-On EQ-i® Emotional Quotient-Inventory**  
Reuven Bar-On, Ph.D.

**Description**

The Bar-On Emotional Quotient Inventory (EQ-i®) is the first scientifically validated and most widely used Emotional Intelligence assessment in the world. Based on more than 20 years of research worldwide, the EQ-i examines an individual’s social and emotional strengths and weaknesses.

**Scales & Forms**

- Intrapersonal
- Interpersonal
- Stress Management
- Adaptability
- General Mood
- Positive Impression
- Inconsistency Index

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**Behavioral and Emotional Rating Scale--2nd Ed.**  
(BERS-2)  
Michael H. Epstein, EdD

**Purpose:** Measure child strengths and competencies in ages 5-18 years

**Age range:** 5 to 18 years

**Admin:** Self- and informant report

**Admin time:** 10 minutes
The BERS-2 measures the personal strengths and competencies of children from three perspectives: self, parent, and teacher.

- Examines the child’s interpersonal strengths, functioning in and at school, affective strength, intrapersonal strength, family involvement, and career strength.

- Designed to be used in school settings, mental health clinics, juvenile justice settings, and child welfare agencies, the BERS-2 can be used to identify a child’s strengths and weaknesses for intervention, target goals for IEPs and/or treatment plans, document progress, and help collect data for research purposes.

- Four sets of normative data are provided—two for the teacher report (one for children with emotional and behavioral disorders; one for children without emotional and behavioral disorders), and one set each for the self and parent reports.

- Test-retest reliability was excellent for all three forms; content validity, criterion validity, and construct validity all were examined and provide evidence that the BERS-2 is a valid measure of behavioral and emotional strengths.

Behavior Rating Profile (BRP-2)

Ages: 6-6 through 18-6

Testing Time: 20 minutes

Administration: Individual

The BRP-2 is a unique battery of six norm-referenced instruments that provides different evaluations of a student’s behavior at home, at school, and in interpersonal relationships from the varied perspectives of parents, teachers, peers, and the target students themselves. The responses allow examiners to test different diagnostic hypotheses when confronted with reports of problem behavior. The BRP2 can identify students whose behavior is perceived to be deviant, the settings in which behavior problems are prominent, and the persons whose perceptions of a student's behavior are different from those of other respondents.

The BRP-2 is appropriate for students in Grades 1 through 12. The BRP2 components were all normed individually on large, representative populations. The Student Rating Scales normative group included 2,682 students residing in 26 states. The Parent Rating Scales were completed by 1,948 parents in 19 different states, and the Teacher Rating Scales were normed on a group of 1,452 teachers from 26 states. The internal consistency reliability of the BRP-2 components was established with normal subjects and with groups of students who were learning disabled and emotionally disturbed. Coefficients generally exceed .80 at all ages. Stability reliability coefficients are also reported. Extensive evidence of validity is reported in the manual. Correlations between the BRP2 components and other measures of behavior are reported.
Behavioral Summary™

By David Lachar, PhD

BENEFITS
Gathers information from multiple sources to provide a quick yet complete assessment of student behavior

AGES
Kindergarten through 12th grade

ADMIN TIME
20 minutes or less for each of 3 forms

FORMAT
Parent and Student Reports with true/false items; Teacher Report with items using a 4- to 5-point response scale

NORMS
Based on a sample of more than 7,000 children and teens (2,000+ for each form, reflecting the national population in regard to gender, ethnicity, and parent education)

Quick, focused, and easy to use, this convenient new test draws information from three sources to give you an accurate assessment of student behavior and adjustment problems. It is composed of a Parent Report, a Teacher Report, and a Student Report, which together reveal the specific nature of student difficulties and point toward effective intervention.

The Parent and Teacher Reports can be used to evaluate students from kindergarten through 12th grade. The Student Report should be added when you are assessing children and teens in 4th grade or higher. (All three forms have a 4th-grade reading level.) Although each form is administered separately and can be used independently, it is strongly recommended that both Parent and Teacher Reports be used for younger children and that all three reports be used for students above age 9.
Parent and Student Reports

Completed in less than 15 minutes, the Parent and Student Reports are parallel in content, each composed of 96 true/false items covering 8 Adjustment Scales:

Impulsivity and Distractibility
Defiance
Family Problems
Atypical Behavior
Somatic Concern
Emotional Problems
Social Withdrawal
Social Skill Deficits

In addition, two validity scales—Inconsistency and Exaggeration—alert you to conflicting responses and overstated problems.

Teacher Report

The Teacher Report focuses on behavior that can be observed at school, with 11 scales addressing Academic Resources and Adjustment Problems and 3 measuring Disruptive Behavior:

Academic Resources and Adjustment Problems
Academic Performance
Academic Habits
Social Skills
Parent Participation
Health Concerns
Emotional Distress
Unusual Behavior
Social Problems
Verbal Aggression
Physical Aggression
Behavior Problems

Disruptive Behavior
Attention-Deficit/Hyperactivity
Oppositional Defiant
Conduct Problems
Completed in less than 20 minutes, the Teacher Report includes 102 items rated on a 4- to 5-point response scale. Although this response format minimizes the likelihood of extreme item endorsement, the Teacher Report also includes a validity scale measuring exaggeration.

**Easy Hand or Computer Scoring**

Convenient AutoScore™ Forms for the Parent, Student, and Teacher Reports include test items, scoring instructions, and profile forms. You can hand score the forms in just 5 minutes and profile results in only a few minutes more, producing an informative visual display of the findings. Easier still, an unlimited-use computer scoring CD gives you quick results and allows you to compare reports from various respondents, or the same respondent at two different times.

T-scores are generated for all scales. In addition, 3 Composite Scores and a Total Score are available for the Parent and Student Forms:

- **Externalizing**
  Acting out, disruptive, or noncompliant behavior
- **Internalizing**
  Internal concerns and emotional problems
- **Social Adjustment**
  Social discomfort and conflict
- **Total Score**
  A general index of behavioral adjustment

These four scores are useful in documenting behavior change across repeated administrations—for example, before and after intervention—and in research applications that require only broad measures of adjustment.

Normative data, based on a sample of more than 7,000 nonreferred children (2,000+ for each form), reflect the U.S. population in regard to gender, ethnicity, and parent education. A clinical sample exceeding 4,000 was used in test development and validation.

**A More Efficient Way to Assess Student Behavior**

Based on decades of research, and supported by ample evidence of validity, the Behavioral Summary is an excellent way to evaluate children and teens for behavior and adjustment problems. Because it gathers information from multiple sources, you can be confident that you are getting a complete picture of the student being assessed. And you can quickly compare reported problems between classroom and home, across classrooms, or between parents.
The Behavioral Summary is easy to use, it covers a wide age range, and it focuses on issues that affect classroom performance. Why struggle with more cumbersome, time-consuming assessments when the Behavioral Summary gives you a comprehensive profile of student behavior?

Bell Relationship Inventory for Adolescents™ (BRIA™)

By Morris D. Bell, PhD

BENEFITS

A quick, convenient way to evaluate psychological disturbance and relationship problems in preteens and teens

AGES

11 to 17 years

ADMIN TIME

10-15 minutes

FORMAT

Self-report

NORMS

Based on a sample of 815 preteens and teens from public schools and clinics, with equal numbers of boys and girls, from various ethnic backgrounds

PUBLISH DATE

2005

With adolescents, the presenting problem may be academic, emotional, or behavioral, but the solution is often interpersonal. If you look at the teenager's interpersonal world, you'll have a better chance of understanding his or her school performance, emotional issues, and behavior.

Evaluate adolescents in context
The Bell Relationship Inventory for Adolescents (BRIA) offers a quick and convenient way to evaluate psychological disturbance and interpersonal relationship problems in preteens and teens. It gives you a glimpse into the interpersonal world of the adolescent, providing a context in which to view data obtained from achievement, neuropsychological, and personality tests.

Assess attachment, social functioning, and emotional bonds

Fifty items, covering five scales, measure the adolescent's ability to maintain a stable sense of identity and appropriate emotional bonds with others:

Alienation
Lack of trust, difficulty with intimacy, feelings of alienation

Insecure Attachment
Sensitivity to rejection, fears of separation and abandonment

Egocentricity
Lack of empathy, self-protectiveness, tendency to control and exploit

Social Incompetence
Social discomfort, shyness, difficulty making friends

Positive Attachment
Satisfaction with current relationships with peers and parents

Test in Just 10 to 15 Minutes

Completed in just 10 to 15 minutes, the BRIA provides standard scores and percentiles for each scale. Norms are based on a sample of 815 children and teens (11 to 17 years of age), 705 from public schools and 110 from clinics and residential treatment centers. The sample includes roughly equal numbers of boys and girls from various ethnic backgrounds.

Identify teens having trouble with interpersonal connections due to trauma, NLD, or PDD

In schools or clinics, the BRIA can be used to identify preteens and teens who are likely to have difficulty with interpersonal relationships. It may be especially helpful in assessing youngsters who have experienced trauma, as well as those with nonverbal learning disability, Asperger's Syndrome, or other conditions in which interpersonal connections are problematic. By revealing deficits in object relations, the BRIA can also help distinguish between conduct disorder, borderline personality disorder, mood disorders, and psychosis. In addition, the Positive Attachment scale can inform treatment planning by uncovering feelings of support that might moderate difficulties indicated by pathological scores on the other scales.
Burks Behavior Rating Scales™, Second Edition

By Harold F. Burks, PhD

BENEFITS

Provides a quick, practical, and proven way to evaluate problem behavior in school children

AGES

Preschool through grade 12

ADMIN TIME

10-15 minutes

FORMAT

Parent or teacher rating scale

PUBLISH DATE

2006

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

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

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

The BBRS-2 produces seven scale scores:

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

BBRS-2 scores can be used to:
• Pinpoint personality areas that require further evaluation or treatment
• Identify behaviors that may interfere with school functioning
• Identify children who will (or will not) benefit from special education
• Provide parents with information that is concrete, specific, and easy to understand

Normative data is based on a nationally representative sample of 2,864 individuals, including separate samplings of teachers (N = 1,481) and parents (N = 1,383). The BBRS-2 was validated on a clinical sample of 860 individuals; demonstrated strong internal consistency, retest reliability, and content validity; and was validated against widely used concurrent measures.

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**Checklist for Child Abuse Evaluation (CCAE)**

**Joseph Petty, PhD**

**Purpose:** Investigate and evaluate possible abuse or neglect

**Age range:** 10 to 16 years

**Admin:** Individual

**Admin time:** Untimed
This valuable information-gathering tool is used for investigating and evaluating children and adolescents who may have been abused or neglected. You may obtain extensive data for preparing clinical reports or standard documents in the clinical file. The checklist is transferable to all pertinent professionals to eliminate repetitive stressful questioning of the child. Using the checklist will also enhance the possibility of providing legally sound conclusions.

Psychologists, social workers, and other professionals involved in child abuse investigations and evaluations will agree that this checklist provides an excellent survey of child abuse symptomatology.

**Description**

The 264-item, 40-page CCAE contains 24 sections, including:

- Child's historical and current status
- Emotional abuse (child and witness reports)
- Sexual abuse (child and witness reports)
- Physical abuse (child and witness reports)
- Neglect (child and witness reports)
- Child's psychological status
- Credibility/competence of the child
- Conclusions
- Case-specific treatment recommendations and issues

When conducting an evaluation, you can use the entire checklist or only those sections applicable to the specific situation.

**Children's Aggression Scale™ (CAS)**
Jeffrey M. Halperin, PhD and Kathleen E. McKay, PhD
Purpose: Evaluate frequency and severity of child and adolescent aggression

Age range: 5 to 18 years

Admin: Informant report; Individual administration

Admin time: Approximately 10-15 minutes

The CAS is a multi-informant rating scale to evaluate the setting-specific frequency and severity of aggressive acts in children through Parent and Teacher Rating Forms.

**Facilitates treatment planning and monitoring in response to acts of aggression**

- Items describe aggressive acts and are weighted differentially depending on the severity of the act.

- Standardized on a community sample of 438 parents and 516 teachers of children ages 5-18 years. Data were also collected on a clinical sample of 247 parents and 252 teachers of children who had been diagnosed with one or more of the following: ADHD, oppositional defiant disorder, conduct disorder, and social maladjustment.

- Validity was examined in terms of intercorrelations among the scales and clusters, convergent validity with existing behavioral measures (i.e., BASC-2, CBCL) and domain-specific assessments (i.e., OAS, CDS, IOWA Conners), and clinical validity among the clinical samples.

**Children’s Depression Inventory 2™ CDI 2**

Maria Kovacs, Ph.D.

**Description**

The CDI 2 is a revision of the Children’s Depression Inventory (CDI™). The CDI 2 can be used in both educational and clinical settings to evaluate depressive symptoms in children and adolescents. Authored by Dr. Maria Kovacs, an internationally recognized researcher of childhood and adolescent depressive disorders, the CDI 2 retains many of the essential features of its predecessor, while introducing a number of important refinements. Such refinements include: new items that focus on the core aspects of childhood depression, revised scales, and new norms that are representative of the U.S. population.

The CDI 2 is a comprehensive multi-rater assessment of depressive symptoms in youth aged 7 to 17 years. When results from the CDI 2 are combined with other sources of verified information, the CDI 2 can aid in the early identification of depressive symptoms, the diagnosis of depression and related disorders, as well as, the monitoring of treatment effectiveness.

The CDI 2 quantifies depressive symptomatology using reports from children/adolescents (full-length and short); teachers, and parents (or alternative caregivers). It can be administered and scored using paper-
and-pencil format with MHS Quikscore™ forms, or online through the MHS Online Assessment Center. The CDI 2 can also be scored using scoring software.

How to Use the Assessment
The CDI 2 is available in paper-and-pencil, online, and software formats.

Paper-and-Pencil Administration and Scoring
All CDI 2 forms can be administered and scored using the MHS QuikScore™ format. The rater writes on the external layers of the form, and the results transfer through to a hidden scoring grid within the internal layers. The assessor then uses the internal layers for tabulating results. Each QuikScore form includes conversion tables, which are used to convert raw scores to T-scores. For individuals who wish to use software or online scoring, CDI 2 items are also available as Response/E-Paper forms that do not include the scoring pages.

Online Administration and Scoring
The CDI 2 can be completed and automatically scored online wherever an internet connection is available. Online administration allows the assessor the flexibility to send a link to each respondent to complete the assessment at a location convenient to the respondent (e.g., child care center, school). It also significantly reduces administration and data entry time. Assessors using online scoring have the option of printing E-Paper forms that can be scored online by entering responses from the paper-and-pencil administration into the online program.

Software Scoring
The CDI 2 can be scored using the scoring software by entering responses from a completed paper-and-pencil administration into the software program.

Scales & Forms

Scales:

- Emotional Problems
- Functional Problems

Subscales:

- Negative Mood
- Negative Self-Esteem
- Ineffectiveness
- Interpersonal Problems

Forms:
**Children's Depression Rating Scale™, Revised (CDRS™-R)**

By Elva O. Poznanski, MD and Hartmut B. Mokros, PhD

**BENEFITS**

Offers an efficient way to diagnose childhood depression and monitor treatment response. Captures slight but notable changes in symptoms.

**AGES**

6 to 12 years

**ADMIN TIME**

15-20 minutes

**FORMAT**

Rating scale based on semistructured interview

**NORMS**

Based on a nonclinical sample of children who were directly interviewed

Modeled after the Hamilton Rating Scale for Depression, the Children’s Depression Rating Scale has long been used to diagnose depression and determine its severity. This version, updated and standardized, with complete interpretive and psychometric data, is more useful than ever. In clinical settings, it can be used to diagnose depression and monitor treatment response. In nonclinical contexts, such as schools and pediatric clinics, it can be used as a quick and economical screener, identifying children who need professional intervention.

The CDRS-R is a brief rating scale based on a semistructured interview with the child (or an adult informant who knows the child well). Designed for 6- to 12-year-olds and successfully used with adolescents, it can be administered in just 15 to 20 minutes and easily scored in a few minutes more. The interviewer rates 17 symptom areas (including those that serve as DSM-IV criteria for a diagnosis of depression):

- Impaired Schoolwork
- Difficulty Having Fun
- Social Withdrawal
- Appetite Disturbance
- Sleep Disturbance
- Excessive Fatigue
• Physical Complaints
• Irritability
• Excessive Guilt
• Low Self-Esteem
• Depressed Feelings
• Morbid Ideation
• Suicidal Ideation
• Excessive Weeping
• Depressed Facial Affect
• Listless Speech
• Hypoactivity

Most of these symptom areas are rated on a 7-point scale—so the CDRS-R can capture slight but notable changes in a child’s symptoms. This makes the scale ideal for monitoring symptoms during illness or remission. Other additions to the scale include suggested interview prompts and guidelines for integrating information from multiple informants.

The CDRS-R gives you a single Summary Score (a T-score), with an interpretation of, and recommendations for, six different score ranges. If applicable, it also compares ratings based on different sources (e.g., parent and child interviews) for each of the 17 symptom areas—and notes clinically significant results. Norms are derived from a nonclinical sample of children who were directly interviewed. The Manual provides interpretive guidelines for CDRS-R scores based on parent interviews.

Unlike self-report inventories, the CDRS-R not only assesses depression, but also takes the first step in the therapeutic process. A direct interview engages children who are isolated and withdrawn (as most depressed children are), bringing them into positive contact and interaction. Using the CDRS-R, treatment begins with evaluation.

**Children's Inventory of Anger™ (ChIA™)**

By W. M. Nelson III, PhD, ABPP, and A. J. Finch, PhD, ABPP

**BENEFITS**

A quick measure of anger provocation and intensity from the child's perspective

**AGES**
Anger Triggers and Anger Intensity

Children’s anger, and their ability to cope with it, are of increasing concern to professionals working in school and clinical settings. This self-report inventory identifies the kinds of situations that provoke anger in particular children—as well as the intensity of their anger response. Yet it contains only 39 items and requires just 10 minutes to complete. Brief, quick, and inexpensive, the ChIA is one of the few instruments available that provides the child’s perspective on his or her own anger. Designed for 6- through 16-year-olds, the ChIA produces a Total Score, an Inconsistent Responding Index, and four subscale scores: Frustration, Physical Aggression, Peer Relationships, Authority Relations. Results are expressed as age-stratified standard scores based on a nationally representative sample of more than 1,600 youngsters between 6 and 16. A Kid-Friendly Test Form Test items are written at a third-grade reading level. (They can be read aloud to young children or those who are poor readers.) Response options are keyed to drawings of four faces, with expressions ranging from happy to furious. The child simply marks the option that shows how angry he or she would be in the circumstances described. This response format seems to help children differentiate degrees of anger. The test can be hand-scored in less than a minute. A CD is available for users who prefer computer scoring. Efficient and cost-effective, the ChIA is ideal any time you need a quick assessment of children’s anger. It is highly useful in youth programs, in clinical interventions aimed at anger control, and in systematic efforts to assess children’s anger. Because it measures the subjective experience of anger, the ChIA is helpful in treatment planning and program evaluation. It has proven especially useful in measuring change following anger management interventions.

Child Sexual Behavior Inventory (CSBI™)
William N. Friedrich, PhD, ABPP

Purpose: Evaluate children who have been or may have been sexually abused
The CSBI is a measure of sexual behavior in children that is completed by the mother or other primary female caregiver.

**Features and benefits**
- For use with children ages 2-12 years who have been or may have been sexually abused.
- Covers nine major content domains: Boundary Issues, Gender Role Behavior, Sexual Interest, Sexual Knowledge, Exhibitionism, Self-Stimulation, Sexual Intrusiveness, Voyeuristic Behavior, and Sexual Anxiety.
- Written at a 5th-grade reading level; the primary female caregiver indicates how often she has observed each of the listed behaviors during the preceding 6 months.
- The CSBI was normed on 1,114 children from a wide range of socioeconomic backgrounds in the general population. CSBI data from 512 children from child abuse centers also are presented.

**Test structure**
- The CSBI Total scale indicates the overall level of sexual behavior the child exhibits.
- The Developmentally Related Sexual Behavior (DRSB) scale indicates sexual behaviors that can be considered normative for the child’s age and gender.
- The Sexual Abuse Specific Items (SASI) scale indicates sexual behaviors that can be viewed as relatively atypical for the child’s age and gender; such behaviors raise the suspicion of possible sexual abuse.

**Clinical Assessment of Depression™ (CAD™)**
Bruce A. Bracken, PhD and Karen Howell, PhD

Purpose: Comprehensively assess depressive symptomatology
Age range: 8 to 79 years

Admin: Self-report; Individual or group

Admin time: 10 minutes

Scoring time: 20 minutes

The CAD is a 50-item self-report instrument that is sensitive to depressive symptomatology throughout the life span. It is closely aligned with the hallmarks of depression in children, adolescents, and adults as well as the additional seven criteria for major depressive episodes listed in the *DSM-IV-TR™*.

A single form is appropriate for individuals ages 8 to 79 years

- The CAD Total Scale, symptom scales (i.e., Depressed Mood, Anxiety/Worry, Diminished Interest, Cognitive and Physical Fatigue), and critical item clusters (i.e., Hopelessness, Self-Devaluation, Sleep/Fatigue, Failure, Worry, Nervous) represent a well-defined and theoretically supported measure of depressive symptomatology.

- Three validity scales—Inconsistency, Negative Impression, and Infrequency—make the assessment more efficient than other well-known depression assessment scales (e.g., BDI®-II, Hamilton Depression Inventory).

- Critical item clusters identify behaviors with known risk factors for potential self-harm.

- An optional scoring program, the CAD-SP, scores and profiles an individual’s performance on the CAD Rating Form after hand-entry of an individual’s demographic information and item responses.

Clinical Assessment of Interpersonal Relationships™ (CAIR™)
Bruce A. Bracken, PhD

Purpose: Assess students' perceptions of their relationships with their mother, father, male peers, female peers, and teachers

Age range: 9 to 19 years

Admin: Individual

Admin time: 15 minutes
The CAIR assists you to measure the perceptions that youths between the ages of 9 to 19 years (i.e., Grades 5 to 12) have regarding the quality of their relationships with the most important individuals in three primary contexts (Social, Family, and Academic) of their lives—mother, father, male and female peers, and teachers.

The CAIR is a psychometrically sound instrument based on Dr. Bracken's multidimensional, context-dependent model of adjustment. It helps with the early identification and remediation of a youth's relationship difficulties and assists with the identification of emotional disturbance (ED) by assessing the quality of the youth's primary relationships.

The CAIR is composed of 35 items, all of which appear on each of five scales (i.e., Mother scale, Father scale, Male Peers scale, Female Peers scale, Teachers scale). All or a select number of scales may be administered. Additionally, the CAIR items reflect the 15 specific aspects of relationships that are commonly reported in the literature, thereby helping you to identify the specific relationship qualities that may be deficient and that may require intervention.

**Standardization, Reliability, and Validity**

The CAIR normative sample was composed of 2,501 children enrolled in Grades 5-12 between the ages of 9-19 years. The CAIR was group administered to children of both genders and from all major racial/ethnic groups.

The instrument demonstrates exceptional technical adequacy, with reliabilities well above .90 for each of the five scales as well as the Total Relationship Index (TRI). For each grade level, the TRI coefficient alpha is .96, and the TRI coefficient for the entire standardization sample is .96. Each scale demonstrates internal consistency estimates that exceed .90, regardless of the child's age or gender. Each CAIR scale and the TRI is sufficiently reliable to contribute to important identification decisions.

**CAIR Materials**

The CAIR materials consist of the Professional Manual, the CAIR Rating Form, and the CAIR Score Summary/Profile Form. The CAIR Rating Form is hand scored to determine raw scores that can then be converted to T scores, percentile ranks, confidence intervals, and qualitative classifications.
The Conduct Disorder Scale (CDS) is an efficient and effective instrument for evaluating students exhibiting severe behavior problems who may have Conduct Disorder. It is the only test of its kind that provides standard scores for use in identifying students with Conduct Disorder. The 40 items on the CDS describe the specific diagnostic behaviors characteristic of persons with Conduct Disorder. These items comprise four subscales representing the core symptom clusters necessary for the diagnosis of Conduct Disorder: Aggressive Conduct, Non-aggressive Conduct, Deceitfulness and Theft, and Rule Violations.

Normed on a representative national sample of more than 600 persons who were diagnosed with Conduct Disorder, these results constitute the most current norms on Conduct Disorder currently available. Exact demographics of the standardization sample are reported in the manual by age, gender, geographic location, race, ethnicity, and socioeconomic status. Studies of internal consistency and test-retest reliability produced high alpha coefficients. Additional studies confirmed the test's content, construct, and criterion-related validity. Concurrent validity was established by correlating the CDS with the Behavior Rating Profile-Second Edition: Teacher Rating Scales and the Differential Test of Conduct and Emotional Problems. The results of these studies attest to the CDS's utility and effectiveness in the evaluation of students with Conduct Disorder. Extensive evidence of the statistical properties of the test is reported in the test manual.

The CDS is for individuals ages 5 though 22 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, etc.). Items on the subscales have strong face validity because they are based on the diagnostic criteria for Conduct Disorder published in the Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition-Text Revision (DSM-IV-TR).

Characteristics of the CDS

- 40 items in a behavioral checklist format are easily rated using objective frequency-based ratings.
- A detailed interview form (derived from DSM-IV-TR diagnostic criteria) is provided to document infrequent but serious behavior problems that are indicative of persons who have Conduct Disorder.
- The test was standardized on 1,040 persons representing the following diagnostic groups: normal, gifted and talented, intellectually disabled, with attention-deficit/hyperactivity disorder, emotionally disturbed, learning disabled, physically handicapped, and persons with Conduct Disorder.
- Norms were developed based on 644 representative individuals with Conduct Disorder.
- The amount of time required for completing a rating on an individual is minimal (approximately 5 to 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 Conduct Disorder and the severity of the disorder.
Coping Responses

Inventory (CRI)

Rudolf H. Moos, PhD

Purpose: Identify and monitor coping strategies

Age range: 12 to 90 years

Admin: Individual or group

Admin time: 10-15 minutes

Scoring time: 5 minutes

A brief self-report inventory, the CRI identifies the cognitive and behavioral responses an individual used to cope with a recent problem or stressful situation.

Forms are customized to your client’s age

- The CRI—Adult is for clients older than 18 years of age; the CRI—Youth is for clients ages 12-18 years. Each has its own manual and set of forms.

- The Actual Form surveys the individual’s actual coping behavior, whereas the Ideal Form surveys preferred coping styles. The Ideal Form may be used to compare actual and preferred coping styles, to set treatment goals, and to monitor progress.

- Both forms are written at a 6th-grade reading level.

Identify strategies and monitor treatment

- Helps you identify and monitor coping strategies in adults and adolescents, develop better clinical case descriptions, and plan and evaluate the outcome of treatment.

- Eight scales cover the areas of 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).

- An excellent resource for clinicians and for researchers involved in teaching, research, and/or grant writing, the manual supplement includes a review of studies that have utilized the CRI to examine coping and well-being in children, adolescents, and adults.
This completely revised and updated test assesses self-esteem in a culturally fair manner. The CFSEI-3 is a set of self-report inventories used to determine the level of self-esteem in students ages 6-0 through 18-11. Three new age-appropriate forms were developed: Primary, Intermediate, and Adolescent. All three forms of the inventory provide a Global Self-Esteem Quotient (GSEQ). The Intermediate and Adolescent Forms provide self-esteem scores in 4 areas: Academic, General, Parental/Home, and Social. The Adolescent Form provides an additional self-esteem score: Personal Self-Esteem. A defensive measure is also provided to assess the extent to which an examinee's responses are guarded.

The CFSEI-3 is easy to administer and score. It can be administered to individuals or groups in 15 to 20 minutes each. Responses (simple yes-or-no answers) can be either written or spoken. New, easy-to-use Profile/Scoring Forms are now included. Conversion tables provide subscale standard scores based on a mean of 10 and a standard deviation of 3 and quotient scores based on a mean of 100 and a standard deviation of 15. The CFSEI-3 was standardized on a sample of 1,727 persons from 17 states. The normative group was stratified on the basis of geographic region, gender, race, rural or urban residence, ethnicity, family income, parent education, and disability. The demographic characteristics match those projected for the school-age population in the year 2000 by the U.S. Bureau of the Census (1999).

Reliability of the CFSEI-3 was investigated using estimates of content sampling and time sampling. For GSEQ scores, average internal consistency coefficients range from .81 to .93; time sampling coefficients range from .72 to .98.

Validity of the CFSEI-3 was investigated using content, criterion-prediction, and construct-identification validity. The CFSEI-3 correlates strongly with other measures of self-esteem and self-concept. Many new studies demonstrating the cultural fairness of the CFSEI-3 have been added, including Differential Item Functioning analyses and separate reliability and validity information for seven subgroups (male, female, European American, African American, Hispanic American, gifted and talented, and learning disabled). In addition, a full chapter in the Examiner's Manual is devoted to the test's bias.
**Devereux Scales of Mental Disorders (DSMD™)**

Jack A. Naglieri, PhD, Paul A. LeBuffe, Steven I. Pfeiffer, PhD, ABPP

Overview: Identify behavioral or emotional problems in children and adolescents

Age Range: 5:0 - 18:0

Administration: 15 minutes

Forms: Two: Child (5-12 years) and Adolescent (13-18 years)

Norms: More than 3,000 cases, separate by sex for both parent and teacher raters

Publication Date: 1994

Indicate whether a child or adolescent is experiencing, or is at risk, for an emotional or behavioral disorder. The Devereux Scales of Mental Disorders (DSMD™) are especially designed for treatment planning and outcome evaluation. The 111-item child form and the 110-item adolescent form cover a full range of psychopathology and are based on DSM-IV categories.

Versatile Assessment

The DSMD helps professionals evaluate behavior in a variety of settings, compare results to a large national sample, and analyze information for treatment planning and evaluation of treatment effectiveness.

Any adult who has known the child for four weeks may serve as a rater. The same form is used for parent and teacher raters, with separate norms provided for each.

Special features of the DSMD include:

- Items reflecting the full range of psychopathology including Externalizing disorders (Conduct and Attention/Delinquency scales), Internalizing disorders (Anxiety and Depression scales), and Critical Pathology disorders (Autism and Acute Problems scales)
- Consistently excellent composite scale reliabilities
- Content validity based on DSM–IV and mapping of specific items to corresponding DSM–IV criteria
- Factorially and logically derived scales reflecting major dimensions of psychopathology
- Validity studies utilizing inpatient and outpatient clinical groups
Differential Scales of Social Maladjustment and Emotional Disturbance DSSMED:

Ages: 6-0 to 17-11
Testing Time: 5-10 minutes
Administration: Individual

The Differential Scales of Social Maladjustment and Emotional Disturbance (DSSMED) is a 46-item, norm-referenced teachers’ rating scale that can be used to identify students with socio-emotional disturbance. The DSSMED is used primarily to differentiate between students with social maladjustment and those with emotional disturbance. The DSSMED is normed on a national sample of 1,337 students and has proven reliability and validity.

Teachers, school psychologists, or other knowledgeable professionals rate the items on a 5-point Likert-like scale. Ideally, the examiner should be someone who has had regular, daily contact with the student in a school setting for at least four weeks. It takes approximately 10 minutes to rate a student’s observed emotional behavior. Results of the DSSMED can be used as part of a pre-referral/referral tool to identify “at risk” students and to assist with education programming decisions.

Dimensions Of Self-Concept (DOSC)

Quick Facts

Forms: Form E, S and H
Range: Fourth grade through college
Length: Form E - 70 items, Form S - 70 items, or Form H - 80 items
Norms: Form E - 4th-6th grade (elementary), Form S - 7th-9th grade (secondary), Form S - 10th-12th grade (secondary), Form H - college (higher education)
Administration Time: 20-40 minutes of response time for elementary school students; 15-35 minutes of response time for secondary and college examinees. Total administration time should not exceed 55 minutes.
Scoring Options: Hand-scoring using directions in the Manual

Self-Concept Diagnostic for Students

- Assess students' self-esteem
- Promote self-awareness
- Help individuals improve academic performance
The Dimensions Of Self-Concept (DOSC) is a self-report instrument for measuring non-cognitive factors that are associated with self-esteem or self-concept in the school setting.

The DOSC scales:
1. Level of Aspiration
2. Anxiety
3. Academic Interest & Satisfaction
4. Leadership and Initiative
5. Identification vs. Alienation

The Dimensions Of Self-Concept (DOSC) Scales

Level of Aspiration
Reflects behavior patterns that portray the degree to which achievement levels and academic activities are consistent with students' perceptions of their scholastic potentialities.

Anxiety
Reflects behavior patterns and perceptions associated with emotional instability, lack of objectivity and heightened or exaggerated concern about tests and preserving self-esteem in relation to academic performance.

Academic Interest and Satisfaction
Portrays the degree of intrinsic motivation, involving love of learning for its own sake gained by students in doing academic work and in studying new subject matter.

Leadership and Initiative
Represents those behavior patterns and perceptions that are associated with star-like qualities, as when a student demonstrates mastery of knowledge and willingness and ability to help and give guidance to others, and takes pride without display of conceit in the capability of doing a job quickly and well.

Identification vs. Alienation
Represents the extent to which a student feels accepted by the academic community and respected by teachers and peers for his or her own personal worth and integrity as opposed to feeling isolated or rejected by the academic environment.
Eating Disorder Inventory™–3 (EDI™-3)
David M. Garner, PhD

Purpose: Provides a standardized clinical evaluation of symptomatology associated with eating disorders

Age range: 13 to 53 years

Admin: Individual or group

Admin time: 20 minutes

Scoring time: 20 minutes

A revision of one of the most widely used self-report measures of constructs shown to be clinically relevant in individuals with eating disorders, the EDI-3 includes enhancements that make the instrument more consistent with the psychological domains identified by modern theories to be most relevant.

Consistent with prior editions, yet significantly updated

- The EDI-3 consists of 91 items organized into 12 primary scales: Drive for Thinness, Bulimia, Body Dissatisfaction, Low Self-Esteem, Personal Alienation, Interpersonal Insecurity, Interpersonal Alienation, Interoceptive Deficits, Emotional Dysregulation, Perfectionism, Asceticism, and Maturity Fears.

- Yields six composites: one that is eating-disorder specific (i.e., Eating Disorder Risk) and five that are general integrative psychological constructs (i.e., Ineffectiveness, Interpersonal Problems, Affective Problems, Overcontrol, General Psychological Maladjustment).
• The item set from the original EDI, as well as items from the 1991 revision (EDI-2), has been carefully preserved so that clinicians and researchers can compare data collected previously with data from the EDI-3.

• The EDI-3 has clinical norms for adolescents in addition to U.S. and international adult clinical norms. It also provides multisite nonclinical comparison samples.

• The easy-to-use Percentile/T-Score Profile Forms include critical item sets that allow for the development of a more meaningful clinical picture.

**EDI-3 Symptom Checklist aids in diagnosis**

An independent and structured self-report form, the EDI-3 SC is easy to complete and provides data regarding frequency of symptoms (i.e., binge eating; self-induced vomiting; exercise patterns; use of laxatives, diet pills, and diuretics) necessary for determining whether patients meet *DSM-IV-TR™* diagnostic criteria.

**EDI-3 Referral Form is designed for allied health professionals**

• An abbreviated form of the EDI-3, the EDI-3 RF can be administered in 5-10 minutes (and scored in 15 minutes) and includes behavioral symptom questions to help identify individuals with potential eating disorders or pathology, including the three scales that compose the Eating Disorder Risk Composite (i.e., Drive for Thinness, Bulimia, Body Dissatisfaction).

• Referral indexes are used to identify individuals who have or are at risk for eating disorders. These indexes are based on the individual’s body mass index (BMI) only; on BMI plus responses to EDI-3 questions about excessive eating concerns; and on responses to behavioral questions pertaining to eating disorder pathology.

**Feelings, Attitudes, and Behaviors Scale for Children FAB-C™**

Joseph H. Beitchman, M.D.

**Description**

The FAB–C provides insight into a young child's feelings and attitudes that may be contributing to certain behaviors. It is used as a screening tool in schools, outpatient clinics, residential treatment centers, and
child protective services. Complementing parent and teacher ratings of the Conners 3™, the Conners CBRS™, and other assessments, children under 12 can complete the FAB–C self-report for multiperspective assessment of child's social and emotional state.

**How to Use the Assessment**
The FAB–C is available as a handscored QuikScore™ form and in online format. The items are statements, such as "Kids pick on me." The child is asked to respond to the statements by checking Yes or No. A score is provided for each scale, along with a total score. With the online format, you can instantly generate Profile Reports.

**Scales and Forms**
- Conduct Problems
- Self-Image
- Worry
- Negative Peer Relations
- Antisocial
- Lie (validity)
- Problem Index

**Firestone Assessment of Violent Thoughts**
**Adolescent (FAVT-A)**
Robert W. Firestone, PhD and Lisa A. Firestone, PhD

Purpose: Assess the underlying thoughts that predispose violent behavior

Age range: 18 to 75 years
Admin: Individual
Admin time: 15 minutes

Designed on the basic hypothesis that an individual’s thought process strongly influences his or her behavior, the FAVT measures different types of thoughts that have been found to predispose an individual to violent behavior.
Determine if violent individuals need to be separated from prospective targets

- Derived directly from clinical material gathered from violent individuals, FAVT items represent thoughts experienced prior to committing violent acts.

- FAVT items are organized into five levels (i.e., Paranoid/Suspicious, Persecuted Misfit, Self-Depreciating/Pseudo-Independent, Overtly Aggressive, Self-Aggrandizing) and two theoretical subscales (i.e., Instrumental/Proactive Violence, Hostile/Reactive Violence), allowing you to better understand the client and thus offer more targeted treatment.

- Data on two reference groups (i.e., Incarcerated, Anger Management) provide you with valuable information for making level-of-care/restriction decisions and for identifying the appropriate intervention intensity.

- Change score tables are provided across four different levels of significance for four normative groups and two reference groups so that you can judge the significance of a change over two administrations.

- 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) for monitoring an individual’s level of change or progress at regular intervals or at key points in the treatment process.

Adolescent version also available

Derived directly from clinical material gathered from violent individuals, FAVT-A items represent thoughts experienced prior to committing violent acts.

- Items are organized into four levels (i.e., Paranoid/Suspicious, Persecuted Misfit, Self-Depreciating/Pseudo-Independent, Overtly Aggressive) and two theoretical subscales (i.e., Instrumental/Proactive Violence, Hostile/Reactive Violence).

- Data on two reference groups (i.e., Incarcerated, Probation) are included.

- Change score tables are provided across four different levels of significance for the four normative groups and for the two reference groups so that you can easily find out if a significant change has occurred over two administrations.

Hare Psychopathy Checklist

A. Forth, PhD, D. Kosson, PhD, et al.
BENEFITS
Assesses, screens for, or identifies facets of psychopathic (antisocial) personality disorder. Identifies antisocial behavior in teens, permitting targeted intervention.

AGES
18 years and older for PCL-R:2 and PCL:SV; 12 to 18 years for PCL-YV; 13 years and older for P-SCAN RV.

ADMIN TIME
Up to 1 hour 30 minutes for PCL-R:2; Up to 120 minutes for PCL-YV; Up to 45 minutes for PCL:SV; 10—15 minutes for P-SCAN RV.

FORMAT
Individual Structured Interview and Collateral Review for PCL-R:2 and PCL:SV; Semi-structured interview and rating checklist for PCL-YV Semi-structured interview and rating checklist.

SCORES
T-scores for PCL-R:2; Cutoff scores indicating the need for the full assessment for PCL:SV.

The second edition of the Hare Psychopathy Checklist—Revised: 2nd Edition (PCL–R: 2nd Edition) supplants its predecessor as the accepted standard for conducting forensic assessments of psychopathy. Revisions are based on the large numbers of articles, reports, presentations and dissertations that have appeared since the original instrument was published in 1991.

The PCL–R: 2nd Edition is a 20-item symptom construct rating scale designed to assess psychopathic (antisocial) personality disorders in forensic populations. The PCL–R: 2nd Edition Rating Booklet facilitates rating the 20-item scale; the QuickScore form is used to record the ratings, obtain the scores, and profile the results. Ratings are based on responses to the semi-structured interview and on a review of collateral information.

As in the original version, the PCL–R: 2nd Edition provides a total score that is important for the overall assessment of psychopathy. The total score can be interpreted dimensionally in terms of degree of match to the prototypical psychopath, or it can be used categorically to help identify or diagnose psychopaths.

This new edition retains the two major factors of psychopathy:

- Factor 1: Callous, selfish, remorseless use of others
- Factor 2: Chronically unstable and antisocial lifestyle

The interpretive power of the PCL–R: 2nd Edition has increased through the evolution of four subfactors. Factor 1 and Factor 2 have been divided into two empirically derived and validated subfactors:

- Factor 1a: Interpersonal (4 items)
- Factor 1b: Affective (4 items)
- Factor 2a: Impulsive Lifestyle (5 items)
• Factor 2b: Antisocial Behavior (5 items)

The PCL–R: 2nd Edition is highly reliable and is supported by impressive concurrent, predictive, and construct validity. Ratings are made using a semistructured interview and a review of collateral information. Scoring is based on the degree to which a person’s personality and behavior match the Rating Booklet items.

The Manual provides item descriptions, scoring procedures, extensive reliability and validity information, and normative data. New large-sample descriptive and validation data are provided for use of the PCL–R: 2nd Edition with both male and female offenders, substance abusers, sex offenders, African American offenders, and forensic psychiatric clients.

HARE PSYCHOPATHY CHECKLIST: YOUTH VERSION (PCL:YV™)
BY A. FORTH, PHD, D. KOSSON, PHD, AND R. D. HARE, PHD

The PCL:YV identifies potential patterns of cheating, fighting, bullying, and similar acts in adolescents. It sheds light on factors that lead to antisocial behavior and psychopathy in adults.

The checklist includes four scales:
• Interpersonal
• Affective
• Behavioral
• Antisocial

The clinician conducts a semi-structured interview, eliciting information needed to rate the adolescent in question. He or she then completes the checklist, using a 3-point scale (yes, no, or maybe) to answer each item. Responses can be quickly transferred to a scoring grid, where problematic behavior patterns can be easily spotted and targeted for intervention.

HARE PSYCHOPATHY CHECKLIST: SCREENING VERSION (PCL: SV™)
BY STEPHEN HART, PHD, DAVID N. COX, PHD, AND ROBERT D. HARE, PHD

The 12-item Hare Psychopathy Checklist: Screening Version (PCL:SV) is an abbreviated and highly correlated version of the PCL–R: 2nd Edition that takes approximately half the time to administer. It’s an efficient and cost-effective tool that screens for the possible presence of psychopathy in both forensic and nonforensic populations. Cutoff scores indicate when to follow up with the more comprehensive instrument.

Scales:
• Interpersonal/Affective
• Social Deviance
• Impulsive Lifestyle
• Antisocial Behavior
**Interpersonal Behavior Survey™ (IBS™)**

By Paul A. Mauger, PhD, David R. Adkinson, MA, et al.

**BENEFITS**
Distinguishes between assertive and aggressive behaviors, identifying excesses and deficits in each

**AGES**
Adolescents and adults

**ADMIN TIME**
45 minutes for Full Form; 30 minutes for Short Form; 10 minutes for Screening Form (composed of first 38 items on Short Form)

**FORMAT**
Self-report

**NORMS**
Sex-specific for a general sample of 800, with separate for adolescents, college students, and African Americans

**PUBLISH DATE**
1980

The IBS identifies interaction styles that may lead to conflict at home, on the job, or in school. Used in individual and group therapy, assertiveness training, marriage and family counseling, and career guidance, the IBS measures various dimensions of assertive and aggressive behavior on the following scales:

- General Aggressiveness
- Conflict Avoidance
- Frankness
- Hostile Stance
- Dependency
- Praise (Giving/Receiving)
- Expression of Anger
- Shyness
- Requesting Help
- Disregard for Rights
- General Assertiveness
- Refusing Demands
- Verbal Aggressiveness
- Self-Confidence
- Denial
- Physical Aggressiveness
- Initiating Assertiveness
- Infrequency
- Passive Aggressiveness
- Defending Assertiveness
- Impression Management

Written at a sixth-grade reading level, the IBS is commonly used in marriage and family counseling to identify interaction styles that lead to conflict. In individual or group therapy, it is used to help people distinguish assertive from aggressive behavior. It is an excellent pre- and post treatment measure because the items, written in the present tense, are highly sensitive to change.
Learning Styles Inventory™ (LSI™)

By Albert A. Canfield, PhD

BENEFITS
Provides a quick measure of learning preferences

AGES
Junior High School and up

ADMIN TIME
15-20 minutes

FORMAT
Self-report

NORMS
Standardized on more than 2,500 individuals, the LSI provides college, high school, and junior high

PUBLISH DATE
1980

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

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

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

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

- Mode of Learning
  Does the student prefer to obtain new information through listening, reading, interpreting illustrations or graphs, or hands-on experience?
• Expectation for Course Grade
  How well does the student expect to perform in the class?

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

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

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

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

Life Stressors and Social Resources Inventory Youth (LISRES-Y)
Rudolf H. Moos, PhD

Purpose: Monitor ongoing life stressors and social resources in individuals ages 12-18 years (LISRES-Y)

Admin: Individual or group

Admin time: 30-60 minutes

Scoring time: 20 minutes

A structured interview, the LISRES provides a unified framework to measure ongoing life stressors and social resources and their changes over time. It can be used to describe a person’s life context, to monitor stability and changes, to compare individuals and groups, and to examine how life events affect an individual’s situation and functioning.

• The LISRES-Y is for youths ages 12-18 years; it may be used with healthy teenagers, those with conduct disorders, or adolescent medical and psychiatric patients. Eight major areas of life experiences are addressed: physical health, school, home and money, parents, siblings, extended family, boyfriend/girlfriend, and friends and social activities.
• Ideal for use with clients whose reading and comprehension skills are below a 6th-grade level.
• Can be administered and scored by those with no formal training in clinical or counseling psychology.
• LISRES-A norms are based on a sample of 1,884 adults. Internal consistency reliabilities range from .77 to .93 for the Stressor scales and from .50 to .92 for the Social Resources scales.
• LISRES-Y norms are based on a sample of 400 youth. Internal consistency reliabilities range from .66 to .92 for Stressor scales and from .78 to .93 for Social Resources scales.

Mental Status Checklist™–
Adolescent (MSC)
Edward H. Dougherty, PhD, John A. Schinka, PhD, and PAR Staff

Purpose: Helpful in assessing mental status in adolescents

Age range: 13 to 17 years

Admin: Individual

Admin time: Varies

Scoring time: 5 minutes

Designed for use with adolescents ages 13-17 years. Assesses adolescent mental status.
**Mental Status Checklist™–**
**Children (MSC)**
Edward H. Dougherty, PhD and John A. Schinka, PhD

**Purpose:** Helpful in assessing mental status of children

**Age range:** 5 to 12 years

**Admin:** Individual; child, parents, and caregivers

**Admin time:** Varies

**Scoring time:** 5 minutes

Designed for use with children ages 5-12 years. Allows you to gather information from the child and his or her parents and caregivers.

**Multidimensional Self Concept Scale (MSCS)**

**Ages:** 9 through 19 years

**Testing Time:** 20 minutes

**Administration:** Individual or Group

The Multidimensional Self Concept Scale (MSCS) is a thoroughly researched and standardized clinical instrument. It assesses global self-concept and six context-dependent self-concept domains that are functionally and theoretically important in the social-emotional adjustment of youth and adolescents. The six domains assessed by the MSCS include the six most important areas of psycho-social functioning for youth and adolescents: Social, Competence, Affect, Academic, Family, and Physical. Each MSCS subscale evidences very high reliability (coefficient alpha > .90), and the Total Scale Score reliability exceeds .97 for the total sample. The MSCS correlates very strongly with other measures of self-concept and self-esteem and has been shown empirically to identify clients previously identified as being low in self-concept. Several concurrent validity studies were conducted during the MSCS development and are presented in the manual.
The MSCS can be administered either to individuals or to groups in approximately 20 minutes. The scale is simple to score and interpretation allows for both norm-referenced and interchild comparisons across each of the six scales. Scores are reported as standard scores (M = 100, SD = 15) or as T scores (M = 50, SD = 10) and can be graphically displayed for ease of interpretation.

**NEO™ Inventories: NEO™ Five-Factor Inventory-3 (NEO™-FFI-3)**
Paul T. Costa, Jr., PhD and Robert R. McCrae, PhD

**Purpose:** Obtain a quick assessment of general personality in adolescents and adults

**Age range:** 12 to 99 years

**Admin:** Individual or group

**Admin time:** 10-15 minutes

**Scoring time:** 5 minutes

The NEO-FFI-3 is a 60-item version of the NEO-PI-3 that provides a quick, reliable, and accurate measure of the five domains of personality (Neuroticism, Extraversion, Openness, Agreeableness, and Conscientiousness). All updates made in the NEO-PI-3 are reflected in this instrument.

**Understand an individual’s basic emotional, interpersonal, experiential, attitudinal, and motivational styles**

- Fifteen of the 60 NEO-FFI items have been replaced to improve readability and psychometric properties.
- Self-report (Form S) and observer rating (Form R) forms are available.
- Separate adolescent and adult norms are available.
- The NEO Style Graph Booklet and Your NEO Summary feedback sheets provide an innovative way to give feedback to respondents based on their NEO profiles.
**Personal Problems Checklist™– Adolescent (PPC)**
John A. Schinka, PhD

**Purpose:** Screen for personal problems in adolescents

**Age range:** 13 to 17 years

**Admin:** Individual

**Admin time:** Varies

**Scoring time:** 5 minutes

Designed for adolescents ages 13-17 years. Covers such areas as social, job, home, school, money, religion, emotions, appearance, family, dating, health, attitude, and crises.


**Personality Assessment Inventory™– Adolescent (PAI®-A)**
Leslie C. Morey, PhD

**Purpose:** Assess adolescent personality

**Age range:** 12 to 18 years

**Admin:** Self-report; Individual or group

**Admin time:** 30-45 minutes to complete; 15-20 minutes to score

**Scoring time:** 20 minutes
Designed to complement its parent instrument, the Personality Assessment Inventory (PAI), the PAI-A is an objective personality assessment for use with adolescents.

**Features and benefits**
- The PAI-A closely parallels the adult version of the instrument, but contains fewer items. Items are written at a 4th-grade reading level.
- Clinical constructs, which were selected on the basis of their importance within the nosology of mental disorder and their significance in contemporary diagnostic practice, assess experiences (e.g., suicidal ideation, depression, anxiety) that are expressed with reasonable consistency across the life span.
- PAI-A scores are presented in the form of linear T scores, which were calculated with reference to a U.S. Census-matched community sample.

**Test structure**
- Twenty-two non-overlapping scales—four Validity scales, 11 Clinical scales, five Treatment Consideration scales, and two Interpersonal scales—comprise 264 items. Ten of these scales contain conceptually driven subscales designed to facilitate interpretation and coverage of the full breadth of complex clinical constructs.
- PAI-A Profile Form–Adolescent contains a clinical “skyline” indicating the distribution of scores from a large sample of clinical cases, enabling you to compare your client’s scores with those in the clinical sample.
- PAI-A Critical Items Form–Adolescent lists 17 items whose responses may alert the clinician to the existence of behavior or psychopathology that requires immediate attention.

**Technical information**
- The standardization of the PAI-A utilized information from (a) a Census-matched sample of 707 community-based students ages 12-18 years in junior and senior high school and college and (b) a clinical sample composed of 1,160 adolescents, most of whom were tested in an outpatient mental health setting.
- Average internal consistency for the substantive scales was .79 and .80 for the community standardization sample and the clinical sample, respectively.
- An average test-retest stability coefficient of .78 was found for the substantive scales ($M = 18$ days; $SD = 5.77$).
- The PAI-A was validated against several popular measures of personality and psychopathology, including the MMPI-A™, the APS™, the NEO-FFI™, and the BDI®.

**Personality Inventory for Children™, Second Edition (PIC™-2)**

By David Lachar, PhD and Christian P. Gruber, PhD
BENEFITS

Provides a complete picture of a child's emotional, behavioral, social, and cognitive adjustment

AGES

5 through 19 years

ADMIN TIME

Full scale, 40 minutes; Behavioral Summary, 15 minutes

FORMAT

Parent rating

NORMS

Based on ratings from more than 2,000 parents of children in grades K-12. Additional data were collected from more than 1,500 parents of children referred for intervention.

PUBLISH DATE

2002

This highly regarded test is widely used by clinical and school psychologists to evaluate the emotional, behavioral, cognitive, and interpersonal adjustment of children and teens. The PIC-2 is one of three coordinated instruments:

- PIC-2: provides the parents’ description of the child
- SBS (page 96): provides a teacher rating
- PIY (page 97): provides the child’s self-report

While each of these instruments has been validated to function independently, together they provide an integrated picture of the child’s adjustment at home, at school, and in the community.

Broad Content Coverage

Appropriate for evaluating 5- through 19-year-olds, the PIC-2 includes 275 true/false items on the following scales:

Response Validity Scales

- Inconsistency
- Dissimulation
• Defensiveness

Adjustment Scales and Subscales

• Cognitive Impairment
  o Inadequate Abilities
  o Poor Achievement
  o Developmental Delay

• Impulsivity and Distractibility
  o Disruptive Behavior
  o Fearlessness

• Delinquency
  o Antisocial Behavior
  o Dyscontrol
  o Noncompliance

• Family Dysfunction
  o Conflict Among Members
  o Parent Maladjustment

• Reality Distortion
  o Developmental Deviation
  o Hallucinations and Delusions

• Somatic Concern
  o Psychosomatic Preoccupation
  o Muscular Tension and Anxiety

• Psychological Discomfort
  o Fear and Worry
  o Depression
  o Sleep Disturbance/Preoccupation With Death

• Social Withdrawal
  o Social Introversion
  o Isolation
• Social Skill Deficits
  o Limited Peer Status
  o Conflict With Peers

Flexible, Time-Saving Administration

The full scale can be completed by a parent or parent surrogate in about 40 minutes.

When you need a shorter administration, the PIC-2 offers a Behavioral Summary, which is comprised of the first 96 items on the test. Requiring just 15 minutes to administer, this version can be used for screening, research, or monitoring behavior change. It includes eight of the Adjustment Scales (all except Cognitive Impairment), each shortened to just 12 items. The Behavioral Summary Profile provides scores for the eight scales, plus a Total Score and three Composites: Externalization, Internalization, and Social Adjustment. Because the items on this short form are all in the present tense and all focused on conditions and behaviors that are responsive to relatively brief intervention, the Behavioral Summary is especially helpful in designing and evaluating individual treatment plans. It can be used on its own or scored as part of the full test.

By providing two administration formats, the PIC-2 gives you a great deal of flexibility. The standard, 275-item profile assesses the full range of developmental, cognitive, adjustment, and interpersonal issues, with subscales that supply useful clinical detail and an optional critical items list divided into nine content categories. The 96-item Behavioral Summary offers brevity, strong correlation with the full scale, a focus on current behavior that is likely to respond to treatment, and broad summary measures useful in evaluating change.

The PIC-2 was standardized on ratings from 2,306 parents of boys and girls in kindergarten through 12th grade. Protocols were collected from 23 urban, rural, and suburban schools in 12 states. Participating parents represented all socioeconomic levels and all major ethnic groups. In addition, data were collected from a sample of 1,551 parents whose children had been referred for educational or clinical intervention.

**Personality Inventory for Youth™ (PIY™)**

By David Lachar, PhD, and Christian P. Gruber, PhD

**BENEFITS**

Provides a multidimensional, psychometrically sound measure of emotional and behavioral adjustment, family interaction, and academic functioning
AGES
9 through 19 years

ADMIN TIME
Full scale, 45 minutes; Screener composed of first 80 items, 15 minutes

FORMAT
Self-report

NORMS
Based on a sample of more than 2,300 students in grades 4-12; also, clinical sample of more than 1,100

PUBLISH DATE
1995

The PIY is a multidimensional, psychometrically sound self-report instrument designed specifically for young people. It is composed of 270 items covering 9 nonoverlapping clinical scales and 24 nonoverlapping subscales:

Cognitive Impairment
- Poor Achievement and Memory
- Inadequate Abilities
- Learning Problems

Impulsivity/Distractibility
- Brashness
- Distractibility and Overactivity
- Impulsivity

Delinquency
- Antisocial Behavior
- Dyscontrol
- Noncompliance

Family Dysfunction
- Parent-Child Conflict
- Parent Maladjustment
- Marital Discord
Reality Distortion

- Feelings of Alienation
- Hallucinations and Delusions

Somatic Concern

- Psychosomatic Syndrome
- Muscular Tension and Anxiety
- Preoccupation With Disease

Psychological Discomfort

- Fear and Worry
- Depression
- Sleep Disturbance

Social Withdrawal

- Social Introversion
- Isolation

Social Skill Deficits

- Limited Peer Status
- Conflict With Peers

The 24 subscales reveal more specific clinical content, making the PIY an excellent diagnostic tool. In addition, four validity scales tell you whether the respondent is exaggerating, malingering, or responding defensively, carelessly, or without adequate comprehension. The first 80 items of the test can be used as a screener to quickly identify students who would show problems on the full inventory.

Items are written at a third-grade reading level. An audio CD is available for poor readers, and a Spanish Administration Booklet is available for those who read Spanish only.

The PIY gives you a reliable and valid measure of child and adolescent psychopathology, based on the respondent’s own perceptions.
**Piers-Harris Children's Self-Concept Scale, 2nd Edition (PHCSCS-2)**

Ellen V. Piers, PhD, Dale B. Harris, PhD, and David S. Herzberg, PhD

**Purpose:** Measure self-concept in children and adolescents

**Age range:** 7 to 18 years

**Admin:** Self-report; Individual or group

**Admin time:** 10-15 minutes

The PHCSCS-2 assesses self-concept and quickly identifies individuals who need further testing or treatment.

**A quantitative self-report measure of children’s and adolescents’ conscious self-perceptions**

- Ratings are based on the individual’s own perceptions rather than the observations of parents or teachers.

- Test items are simple descriptive statements, written at a 3rd-grade reading level.

- A total score reflects overall self-concept; subscale scores (Behavioral Adjustment, Freedom from Anxiety, Happiness and Satisfaction, Intellectual and School Status, Physical Appearance and Attributes, and Popularity) permit more detailed interpretation.

- Psychometrically equivalent to the original scales, so results from the PHCSCS-2 can be compared, for research or clinical purposes, to those obtained using the original test.

- Useful for routine classroom screening as well as in clinical settings to determine specific areas of conflict, typical coping and defense mechanisms, and appropriate intervention techniques.

- Standardized on a sample of 1,387 students throughout the U.S.

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**Pre-School Behavior Checklist (PBCL)**

By Jacqueline McGuire, PhD, and Naomi Richman, MSc, FRC Psych
BENEFITS
Offers a systematic, objective way to screen preschoolers for emotional and behavioral problems

AGES
2 to 5 years

ADMIN TIME
5-10 minutes

FORMAT
22-item observation checklist with 3- to 4-point response format, completed by teacher or other professional

SCORES
Item scores for frequency and severity, and a total score that's compared to cutoff points for behavioral or emotional problems

PUBLISH DATE
1988

This quick, 22-item checklist helps professionals screen 2- to 5-year-old children for behavioral and emotional difficulties. It is ideal for use in preschools, nursery schools, and group day-care centers. If a child appears to be troubled, school staff can complete the Pre-School Behavior Checklist (PBCL), check the accuracy of their impressions, and determine whether further evaluation or intervention is warranted.

The checklist covers emotions (fears, worries, mood), conduct, temper, activity level, concentration, social relations, speech, language, habits, wetting, and soiling. Each item lists three or four degrees of a particular behavior. The examiner simply marks the degree that best describes the child in question. Items are scored for frequency and severity. By comparing Total Scores to cutoff points provided in the Manual, the examiner can quickly determine whether the child has an emotional or behavioral problem. And to give parents feedback, the PBCL includes a Developmental Activities Checklist. Using this, school personnel can recommend home activities designed to benefit the child.

The PBCL provides a systematic, objective way to screen preschool children for emotional and behavioral problems. Quick, cost-effective, and designed for group settings, it encourages early identification of children at risk.
The Preschool and Kindergarten Behavior Scales-Second Edition (PKBS-2) is a behavior rating scale designed for use with children ages 3 through 6 years. This unique behavior rating scale is easy to use, very practical, and based on a solid foundation of research. With 76 items on two separate scales, it provides an integrated and functional appraisal of the social skills and problem behaviors of young children. The scales can be completed by a variety of behavioral informants, such as parents, teachers, and other caregivers.

Separate score conversion tables are available for home-based and school-based raters. Completion of the rating form takes about 12 minutes. The Social Skills scale includes 34 items on 3 subscales: Social Cooperation, Social Interaction, and Social Independence. The Problem Behavior scale includes 42 items on 2 subscales: Externalizing Problems and Internalizing Problems. In addition, 5 supplementary problem behavior subscales are available for optional use.

The PKBS-2 was standardized with a nationwide sample of ratings of 3,317 children ages 3 through 6. Ethnicity, socioeconomic status, and special education classification of the standardization sample are very similar to those characteristics of the U.S. population, based on the 2000 census. Internal consistency reliability ranges from .96 to .97 for the two scale totals and from .81 to .95 for the subscales. A wide variety of reliability and validity evidence in support of the PKBS-2 is included in the Examiner's Manual.

Problem Behavior Inventory Symptom Screening Form

By Leigh Silverton, PhD

BENEFITS
Helps structure and focus diagnostic interviews, listing more than 100 DSM-IV-related symptoms
This convenient checklist helps clinicians structure and focus the diagnostic interview. Requiring just 10 to 15 minutes to complete, it lists more than 100 DSM-IV-related symptoms in clear, easy-to-understand language. The adolescent simply checks those symptoms that he or she has experienced. The symptoms listed relate to the following areas: cognitive disorders, substance abuse, psychosis, mood and anxiety disorders, cluster A personality disorders, oppositional behavior, attention-deficit hyperactivity, conduct problems, eating disturbance, sexual deviance, somatoform and dissociative disturbances, sleep difficulties, communication disorders, and V-code problems such as bereavement, academic troubles, parent-child conflict, phase-of-life issues, and identity problems.

Using a WPS AutoScore Form, the adolescent checks problems on the top sheet, and these marks are automatically transferred to a bottom sheet, where they are aligned with corresponding clinical symptoms and associated diagnoses. When the form is separated, this bottom sheet serves as the clinician's worksheet. It guides the initial interview, provides material for the intake report, and identifies areas where personality testing might be helpful—saving the clinician considerable time. This convenient checklist helps structure and focus the diagnostic interview. Requiring just 10 to 15 minutes to complete, it lists more than 100 DSM-IV related symptoms in clear, easy-to-understand language. The client simply checks those symptoms that he or she has experienced.

The symptoms listed relate to the following areas: cognitive difficulties, psychoactive substance use disorder, psychoses, mood disorders, phobias, obsessive-compulsive behavior, post-traumatic stress, somatoform and dissociative disturbances, sexual deviance, other sexual problems, impulse control difficulties, eating disturbance, and V-code problems involving partner relationships, occupational functioning, grief reactions, and parent-child interaction. The client checks problems on the top sheet of the form, and these marks are automatically transferred to the bottom sheet, where they are aligned with corresponding clinical symptoms and associated diagnoses. When the form is separated, the bottom page serves as the clinician's worksheet. It guides the initial interview, provides material for the intake report, and identifies areas where personality testing might be helpful.
**Problem Experiences Checklist™**

By Leigh Silverton, PhD

**BENEFITS**

Gives you a quick picture of the client's life situation, indicating what kind of difficulties he or she is experiencing.

**AGES**

Adolescents or Adults

**ADMIN TIME**

10-15 minutes

**FORMAT**

Self-report checklist

**PUBLISH DATE**

1991

**Adolescent Version**

This time-saving checklist quickly tells you what kind of difficulties adolescents are experiencing. Completed at the initial intake interview, it helps pinpoint problems and identifies areas for subsequent discussion. More than 250 problems and troubling life events are listed under the following headings: School, Opposite Sex Concerns, Peers, Family, Goals, Crises, Emotions, Recreation, Habits, Neighborhood, Life Phase Transition, Beliefs and Attitudes, and Occupational and Financial Circumstances. The adolescent simply checks the problems that he or she is experiencing.
The Reading Observation Scale (ROS) is a 25-item, norm-referenced teachers’ rating scale that can be used to assess students’ daily classroom reading behaviors. The ROS is normed on a sample of 1,338 persons in 15 states and has proven reliability and validity (including evidence of sensitivity and specificity). Its items relate to specific reading behaviors readily seen in instructional settings (e.g., “enjoys reading,” “retells read material correctly”).

Teachers or other knowledgeable professionals rate the items on a 5-point scale. Usually, only 5 to 10 minutes are required to rate a student’s observed reading behaviors. The scores from the ROS can be used to (a) support a referral, (b) expand the scope of a comprehensive reading evaluation, (c) compare teachers’ ratings with test results, (d) help plan interventions, and (e) monitor the effectiveness of interventions. Results are particularly useful when used as part of a comprehensive reading evaluation or as a pre-referral/referral tool.
Revised Children's Manifest Anxiety Scale™, Second Edition (RCMAS™-2)

By Cecil R. Reynolds, PhD, and Bert O. Richmond, EdD

**BENEFITS**

Measures the level and nature of anxiety, as experienced by children today, using a simple yes-or-no response format

**AGES**

6 to 19 years

**ADMIN TIME**

10-15 minutes; less than 5 minutes for Short Form

**FORMAT**

Self-report

**NORMS**

Age-stratified norms based on a nationally representative sample of more than 2,300 children and teens

**PUBLISH DATE**

2008

One child in nine experiences an anxiety disorder. But because anxious children tend to be quiet, compliant, and eager to please, their problems sometimes go unnoticed. The new RCMAS-2 quickly brings into focus the often invisible worry, stress, and fear that can lead to academic difficulties, social withdrawal, substance abuse, and other problems.

**An Updated Second Edition**

Widely used by school psychologists, clinicians, and researchers, the Revised Children’s Manifest Anxiety Scale is now available in an updated second edition. The new RCMAS-2 retains all the features that made previous versions of the test so popular—brevity, a simple yes/no response format, an elementary reading level, and content-based item clusters that help pinpoint children’s problems and focus intervention. At the same time, it adds a convenient Short Form, updated and ethnically diverse norms, and new items that reflect changes in the way children now experience anxiety.

**A New Look at Performance and Social Anxiety**

Like its predecessor, the RCMAS-2 is a brief self-report inventory measuring the level and nature of anxiety in 6- to 19-year-olds. The test is now composed of 49 items covering the following scales:
The Social Anxiety scale replaces the RCMAS Social Concerns/Concentration scale, and a new cluster of 10 items assesses performance anxiety. These changes address the increased pressure that today’s children feel to achieve, academically and socially. They allow teachers and school psychologists to monitor the stress that children may experience and help them cope with it.

The Defensiveness scale replaces and improves upon the RCMAS Lie scale, while the Inconsistent Responding index is a new addition.

A Convenient Short Form and Audio Administration Option

Test administration remains quick and easy. The RCMAS-2 can be completed in just 10 to 15 minutes, and a new Short Form, composed of the first 10 items, requires less than 5 minutes. Items are written at a second-grade reading level. An Audio CD is provided for younger children and those with reading or attention problems.

The test generates a Total Anxiety score plus scale scores. Norms are based on an ethnically diverse sample of more than 2,300 individuals between the ages of 6 and 19, with almost equal numbers of males and females. Norms are presented separately for three age groups: 6 to 8 years, 9 to 14 years, and 15 to 19 years.

Because RCMAS-2 scales correlate highly with RCMAS scales, scores from the former may be considered equivalent to corresponding scores from the latter. Consequently, research using the RCMAS extends to the RCMAS-2.

Ideal for Routine Screening, Even in Young Students

Research suggests that it’s a good idea to watch for symptoms of anxiety in children between ages 6 and 8. Studies note that excessive worry in children this young puts them at risk for developing anxiety disorders later on. With its brevity, simple response format, and audio administration option, the RCMAS-2 is well suited to this age group. It’s ideal for routine screening and periodic monitoring all the way through elementary and high school.

Insight Into a Range of Academic and Social Problems

The RCMAS-2 sheds light on many problems, including stress, test anxiety, school avoidance, peer and family conflicts, and drug use. Administered regularly, the scale allows you to identify anxiety in individual children, assess levels of anxiety in the classroom as a whole, and help students handle anxiety-producing situations, both academic and social.

With updated structure and content, the RCMAS-2 not only identifies the problem but also points toward the solution.
Reynolds Adolescent Adjustment Screening Inventory™ (RAASI™)
William M. Reynolds, PhD

Purpose: Screen for adolescent adjustment problems

Age range: 12 to 19 years

Admin: Individual or group

Admin time: 5 minutes

Scoring time: 10 minutes

The RAASI is a self-report measure that provides indications of the clinical severity of the most meaningful domains of psychological adjustment problems.

Assesses the frequency of signs and symptoms of adjustment problems

- Its 32 items are derived from the item pool of the Adolescent Psychopathology Scale™ (APS™).

- The RAASI renders an Adjustment Total and four factorially derived scales (Antisocial Behavior, Anger Control, Emotional Distress, and Positive Self) whose scores provide greater specificity into the nature of an adolescent’s psychological adjustment problems.

- Using a 3-point response format, items require respondents to endorse the response that best describes how they have been feeling over the past 6 months.
Purpose: Identify depressive symptoms in adolescents

Age range: 11 to 20 years

Admin: Individual or group

Admin time: 5-10 minutes

Scoring time: 10 minutes

This 30-item self-report measures the four basic dimensions of depression: Dysphoric Mood, Anhedonia/Negative Affect, Negative Self-Evaluation, and Somatic Complaints. The RADS-2 standard scores and associated clinical cutoff score provide an indication of the clinical severity of the individual’s depressive symptoms.

Features and benefits

• A Depression Total score represents the overall severity of depressive symptomatology.

• An empirically derived clinical cutoff score helps to identify adolescents who may be at risk for a depressive disorder or a related disorder. Data demonstrate the ability of this cutoff score to discriminate between adolescents with major depressive disorder and an age- and gender-matched control group.

Test structure

• The six RADS-2 critical items are those that have been identified as being most predictive of a depressive disorder diagnosis.

• Scores are plotted on a Summary/Profile Form, allowing comparison of elevations across subscales.

Technical information

• Standardized with a school-based sample of 3,300 adolescents that was stratified to reflect 2000 U.S. Census data for gender and ethnicity.

• Reliability and validity studies included a school-based sample of more than 9,000 adolescents and a clinical sample of adolescents with DSM-III-R™ or DSM-IV™ diagnoses who were evaluated in both school and clinical settings.
**Short form also available**

The RADS-2:SF serves as a very brief screening measure of depression in adolescents. Symptom content is consistent with a wide range of sources, including the *DSM-IV™* and ICD-10.

- Assesses the frequency of symptoms that are positive psychopathological signs of a depressive disorder.
- One critical item helps to alert you that your client may require immediate clinical attention.
- A total score and clinical cutoff quickly determine those in need of further treatment.

**Reynolds Bully Victimization Scales For Schools™**
( RBVS )
William Reynolds

Overview: Evaluate and monitor bullying behavior and bully-victimization experiences

Age Range: BVS: Grades 3 through 12; BVDS: Grades 3 through 12; SVAS: Grades 5 through 12

Completion Time: 5-10 minutes each

Publication Date: 2003

Bully Victimization Scale (BVS), Bully-Victimization Distress Scale (BVDS), and School Violence Anxiety Scale (SVAS)

**Complete behavior management tool to evaluate and monitor, individuals or groups**

These three self-report, standardized instruments for school aged children will each take 5 to 10 minutes to complete. As a combined battery they will form a comprehensive picture of a child's experience of peer-related threat, level of distress and anxiety related to school safety. Results can provide benchmarks for identifying a child for intervention, or for identifying what students perceive as a threatening or unsafe school environment.
Bully Victimization Scale (BVS)

The Bully Victimization Scale (BVS) is designed to assess bullying behavior and bully-victimization experiences in children and adolescents. The BVS consists of two sub-scales, the Bully Scale and the Victimization Scale. The BVS is designed for use with students grades 3 through 12 and takes 5 to 10 minutes to complete. The BVS provides for the identification of youngsters who are being bullied and students who engage in bullying behavior. The BVS may be used individually and as a school-based screening measure for the identification of bullies and bully-victims. The use of the BVS as a screening measure assists in the creation of safe schools by identifying youngsters who bully as well as their victims who often feel distressed, disenfranchised, and alienated from school.

Bully-Victimization Distress Scale (BVDS)

The Bully-Victimization Distress Scale (BVDS) is designed to evaluate victimization distress in children and adolescents in grades 3 through 12. The BVDS is conceptualized as measuring components of Externalizing Distress and Internalizing Distress. A student's response to being bullied may be characterized as internalizing (symptoms of depression, anxiety/fearfulness, somatic, etc.) and/or externalizing (symptoms of anger, aggression, acting out, oppositional/defiant, etc.). The test provides scores on Externalizing Distress and Internalizing Distress subscales and a Total Distress scale. A moderate correlation between the two sub-scales is expected given that some students will show both internalizing and externalizing responses to bully-victimization. The BVDS is a measure of students' psychological response to bullying and determines the internalizing and externalizing nature of this distress. The BVDS will allow school psychologists, counselors, and clinical psychologists to evaluate students' victimization distress, an important activity given the extent to which bullying is a problem in our nation's schools. The BVDS can be used individually or for school-based screening, and provides a means to identify students experiencing significant levels of distress due to bully-victimization.

School Violence Anxiety Scale (SVAS)

The School Violence Anxiety Scale (SVAS) is a measure of anxiety designed for use with students in grades 5 through 12, to assess students' perception of school violence and safety. The SVAS evaluates students' level of anxiety about the school as a safe environment, including anxiety specific to physical harm at school, harassment at school, and the potential for violence occurring at school. SVAS items evaluate physiological, cognitive, and emotional components of anxiety.

Features and Benefits

- The scales will lend themselves to screening for children who engage in bullying as well as those who are the victims of bullying.
- All three instruments may be used in both school and clinical settings.
- The BVS and BVDS are written at the third grade reading level, while the SVAS is written at the fifth grade reading level.
• When administered with other instruments, such as the Beck Youth Inventories-Second Edition™, individual clinical profiles can be developed to understand and treat the psychological underpinnings of bullying and victimization.

• All scales can be used to monitor environmental changes associated with new safe school initiatives.

Reynolds Child Depression Scale™

William M. Reynolds, PhD

Purpose: Measure depressive symptoms in children

Age range: 7 to 13 years

Admin: Individual or group

Admin time: RCDS-2: 10-15 minutes; RCDS-2:SF: 2-3 minutes

Scoring time: 10 minutes

Designed to screen for depression in children, the RCDS-2 retains the 30 items used in the original measure but presents updated normative data. Children are asked to answer questions
about how they have been feeling during the past 2 weeks. All items are worded in the present tense to elicit current symptoms status.

Updated normative metrics and an expanded age range improve utility
- Now appropriate for children ages 7-13 years.
- No scoring key is needed—the RCDS-2 form is presented in a convenient carbonless form. All scoring and administration information is presented in the brightly-colored Test Booklet.
- A new standardization sample of students drawn from 11 states is stratified to closely match U.S. Census data for gender and ethnic background. $T$ scores and percentile ranges are provided for the total standardization sample, by gender, by grade, and by gender for each grade.
- Maps on to the symptoms of depressive disorders outlined in the $DSM-IV^\text{TM}$.
- Critical items are clearly marked on the scoring sheet, alerting you that your client may need immediate attention.
- All items are presented in a 4- or 5-point rating scale format, making them easy for children to answer.
- A clinical cutoff score helps you to determine whether a child should be referred for further assistance.

Short form is ideal when time is limited or for group screening
- The RCDS-2:SF includes 11 of the 30 RCDS-2 items but features many of the critical items from the full version.
- The short form can be administered in just 2 to 3 minutes and can help you determine whether your client should be administered the full RCDS-2.

School Motivation and Learning Strategies Inventory (SMALSI)
Kathy Stroud, PhD and Cecil Reynolds, PhD

Purpose: Measure skills related to academic success in individuals ages 8-12 years (Child Form), ages 13-18 years (Teen Form), and ages 14-61 years (College Form)

Age range: 8 to 61 years

Admin: Individual or group
Designed for both special and general education students, this self-report inventory assesses 10 primary constructs associated with academic motivation, learning strategies, and studies—strategies shown through research to be related to academic success.

- Seven constructs focus on student strengths and three focus on student liabilities.
- Scores help you identify problems that interfere with academic development. An Inconsistent Responding Index is also included.
- The Child Form is appropriate for students ages 8-12 years; the Teen Form is appropriate for students ages 13-18 years. Both forms are written at a 3rd-grade reading level.
- New! The SMALSI College Form allows you to evaluate learning strategies specifically in college students.
- Scored by hand or computer.
- Standardized on a sample of 2,921 students that reflected U.S. population demographics.

Self-Esteem Index (SEI)

The Self-Esteem Index (SEI) is a multidimensional, norm-referenced measure of the way that individuals ages 7-0 through 18-11 years perceive and value themselves.

The SEI can be administered to individuals or groups in approximately 30 minutes. The self-report format requires subjects to read the SEI items and then to classify each item on a Likert-type scale as always true, usually true, usually false, or always false.

There are four scales on the SEI: Academic Competence, Family Acceptance, Peer Popularity, and Personal Security. Overall self-esteem is measured by the Self-Esteem Quotient. In addition, the four SEI scales each yield a standard score, and percentile ranks are provided.
Evidence of the reliability of the SEI is provided in the form of coefficients alpha computed at each 1-year age interval, all of which approach or exceed accepted standards.

**State-Trait Anxiety Inventory for Children STAIC™**
Charles Spielberger, Ph.D. in collaboration with
C.D. Edwards
R. Lushene
J. Montuori
Denna Platzek

*Description*

The STAIC consists of two 20-item scales that measure state and trait anxiety in children between the ages of 8 and 14. The A-State scale examines the shorter-term state anxiety that is commonly specific to situations. It prompts the child to rate 20 statements from hardly ever true to often true. The A-Trait scale measures longer-term trait anxiety, which addresses how the child generally feels. A separate score is produced for the State scale and the Trait scale to determine which type of anxiety is dominant and which type of treatment is the most appropriate.

Scales & Forms
- State Anxiety
- Trait Anxiety

**Student Adaptation to College Questionnaire™ (SACQ™)**

By Robert W. Baker, PhD and Bohdan Siryk, MA

**BENEFITS**

Assesses overall adjustment to college, detecting problems, guiding intervention, and promoting retention

**AGES**

College students
This quick, convenient instrument helps determine how well a student is handling the demands of college. The SACQ assesses overall adjustment to college, as well as adjustment in four specific areas:

- Academic Adjustment
- Personal–Emotional Adjustment
- Social Adjustment
- Attachment (to the institution)

Used by many universities for routine freshman screening, the SACQ is a cost-effective way to detect problems early in the student’s college career. And because it indicates the nature of those problems, the SACQ provides clear guidelines for subsequent intervention. It is particularly useful in identifying potential dropouts.

This 67-item, self-report questionnaire can be administered to individuals or groups in just 15 to 20 minutes. It can even be mailed to students, self-administered at home, and then returned for scoring. The convenient AutoScore Test Form simplifies scoring and profiling results.

Norms are based on a sample of more than 1,300 male and female college freshmen and stratified by semester of attendance (first and second semesters in college). The SACQ Manual includes an extensive list of studies using the test.

The questionnaire helps overcome the reluctance of many students to seek help—90 percent of those with low SACQ scores accept offers of a posttest interview. The questionnaire gives you reason for follow-up, as well as specific topics for discussion and a clear path toward effective intervention.

By detecting adjustment problems early, the SACQ can help colleges retain students who might otherwise drop out.
**Student Behavior Survey (SBS)**

By David Lachar, PhD, Sabine A. Wingenfeld, PhD, et al.

**BENEFITS**

Provides teacher's perspective on student's emotional and behavioral adjustment, academic resources, and social functioning

**AGES**

Grades K-12

**ADMIN TIME**

15 minutes

**FORMAT**

Teacher rating

**NORMS**

Based on teacher ratings of more than 2,500 diverse students

**PUBLISH DATE**

2000

Teachers offer a unique perspective on children. While clinicians and parents can provide useful insights, teachers are in the best position to evaluate children’s functioning in relation to peers and within the school environment. And this perspective is essential in diagnosing disruptive behavior syndromes, student adjustment, and academic achievement.

The Student Behavior Survey (SBS), from the author of the Personality Inventory for Children, Second Edition (PIC-2) and the Personality Inventory for Youth (PIY), joins these other highly regarded
instruments to give you a comprehensive evaluation of student adjustment from the teacher’s point of view.

Appropriate for evaluating students from kindergarten through grade 12 (5 through 18 years of age), the SBS assesses achievement, academic and social skills, parent cooperation, and emotional and behavioral adjustment.

Completed in just 15 minutes, the SBS asks the teacher to rate the child on 102 items covering the following scales:

Academic Resources
- Academic Performance
- Academic Habits
- Social Skills
- Parent Participation

Adjustment Problems
- Health Concerns
- Emotional Distress
- Unusual Behavior
- Social Problems
- Verbal Aggression
- Physical Aggression
- Behavior Problems

Disruptive Behavior
- Attention-Deficit/Hyperactivity
- Oppositional Defiant
- Conduct Problems

The SBS documents the presence and severity of specific classroom behaviors required to establish disruptive behavior diagnoses.

The SBS manual provides extensive interpretive guidance, including discussion of clinically relevant score elevations and associated behaviors. Case examples are also included, some using the SBS alone to measure student adjustment, and some using the SBS in conjunction with other instruments such as the PIC and PIY. These case examples illustrate the test’s value in educational, clinical, neuropsychological, and forensic applications.

In the course of test development, the SBS was used to rate more than 4,000 students. Over half of these ratings involved concurrent administration of other instruments—providing significant independent
evidence supporting use of the SBS. Standardization was based on teacher ratings of more than 2,500 students (K–12, evenly distributed by grade and gender) from 22 school districts in 12 states spanning the U.S. This sample closely reflects census figures in regard to ethnicity and socioeconomic status. In addition, SBS ratings were collected on more than 1,300 students referred for behavioral or academic problems in special education, clinical, and juvenile justice settings.

The SBS provides a comprehensive description of the student, reflecting academic achievement, adjustment problems, and behavioral assets needed for classroom success. By offering an efficient way to quantify classroom observations, the SBS facilitates communication between school and clinician. In addition, it is an excellent way to measure behavior change over time.

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**Suicidal Ideation Questionnaire (SIQ)**
William M. Reynolds, PhD

**Purpose:** Screen for suicidal ideation in adolescents

**Age range:** 12 to 18 years

**Admin:** Individual or group

**Admin time:** 10 minutes or less

**Scoring time:** 10 minutes

The SIQ assesses the frequency of suicidal ideation and serves as a valuable component in a comprehensive assessment of adolescent mental health.

**Serves as a starting point for gathering information about your client’s suicide potential**

- The SIQ consists of 30 items and is appropriate for students in Grades 10-12.
- The SIQ-JR consists of 15 items and is designed for students in Grades 7-9.
- Reliability coefficients are .97 for the SIQ and .93-.94 for the SIQ-JR.
For many adolescents, the SIQ and the SIQ-JR provide a mechanism for informing adults/professionals of their level of distress and suicidal intent, serving as a “cry for help” that doesn’t involve self-injurious behavior. Adolescents who are thinking about suicide may respond to these measures with the expectation that, in telling others of their suicidal thoughts, people will take notice of their distress and act to assist them. It is therefore vital that professionals act quickly once critical SIQ or SIQ-JR scores are obtained.

**Tennessee Self-Concept Scale, 2nd Edition (TSCS:2)**

William H. Fitts, PhD and W. L. Warren, PhD

- **Purpose:** Measure self-concept
- **Age range:** 7 to 90 years
- **Admin:** Individual or group
- **Admin time:** 10-20 minutes

The TSCS:2, one of the most popular measures of self-concept in adolescents and adults, can be used with children, too. Restandardized on a nationwide sample of more than 3,000 people ages 7-90 years, the TSCS:2 is available for both adults and children. This downward extension allows you to use the test to evaluate self-concept across the life span. Each form can be group or individually administered in 10-20 minutes. The Adult Form, written at a 3rd-grade reading level, is designed for individuals 13 years of age and older; the Child Form, written at a 2nd-grade reading level, can be used with individuals 7-14 years of age.

An additional scale, simplified scoring procedures for hand (AutoScore™) or computer scoring, and more guidance in interpreting scores and designing therapeutic interventions have been included in this edition. The first 20 items on either version serve as a short form, which is convenient when you need only a quick summary of self-concept.

**Trauma Symptom Checklist for Children™ (TSCC™)**

John Briere, PhD

- **Purpose:** Evaluate acute and chronic posttraumatic
The TSCC allows you to measure posttraumatic stress and related psychological symptomatology in children ages 8-16 years who have experienced traumatic events, such as physical or sexual abuse, major loss, or natural disasters, or who have been a witness to violence.

**Features and benefits**

- **Suitable for individual or group administration.** This 54-item self-report measure can be administered in just 15-20 minutes.
- **Easy hand-scoring.** Item responses are entered on the top page of a carbonless test booklet, automatically transferring to the scoring page underneath.

**Test structure**

- The 54-item TSCC includes two validity scales (Underresponse and Hyperresponse), six clinical scales (Anxiety, Depression, Anger, Posttraumatic Stress, Dissociation, and Sexual Concerns), and eight critical items. Profile Forms allow for conversion of raw scores to age- and sex-appropriate T scores and enable you to graph the results.
- The TSCC-A, an alternate 44-item version of the measure, makes no reference to sexual issues.

**Technical information**

The TSCC scales are internally consistent (alpha coefficients for clinical scales range from .77 to .89 in the standardization sample) and exhibit reasonable convergent, discriminant, and predictive validity in normative and clinical samples.