Neurological Test

Brief Cognitive Status Exam (BCSE)

Assess cognitive abilities quickly and reliably.

The Brief Cognitive Status Exam helps evaluate global cognitive functioning in patients with dementia, mild MR, TBI, or suspected Alzheimer’s disease. This brief, reliable test is a stand-alone version of the optional Brief Cognitive Status Exam found in the WMS®-IV (Wechsler Memory Scale®, Fourth Edition).

Users & Applications

The Brief Cognitive Status Exam is used by clinical psychologists, medical professionals, and other mental health professionals in hospitals, mental health facilities, and assisted living facilities.

Features & Benefits

- Covers seven cognitive domains: Orientation, Time, Mental Control, Planning and Visual-Perceptual Processing, Incidental Recall, Inhibitory Control, and Verbal Productivity
- Designed to yield a performance classification focused on impaired rather than normal or superior performance (Average, Low Average, Borderline, Low, Very Low)
- Provides classifications stratified by age and years of education

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

Ralph H. B. Benedict, PhD, ABCN

Purpose: Measure visuospatial memory

Age range: 18 to 79 years

Admin: Individual

Admin time: 45 minutes timed (includes 25-minute delay)

Scoring time: 25 minutes
A measure of visuospatial memory, the BVMT-R can be used as part of a large neuropsychological battery, as a screening measure, and as a repeat measure to document changes over time.

**Features and benefits**
- Designed for easy administration in clinical settings or at the bedside
- Six equivalent, alternate stimulus forms consist of six geometric figures printed in a 2 x 3 array on separate pages.

**Test structure**
- In three Learning Trials, the respondent views the stimulus page for 10 seconds and is asked to draw as many of the figures as possible in their correct location on a page in the response booklet. A Delayed Recall Trial is administered after a 25-minute delay. Last, a Recognition Trial, in which the respondent is asked to identify which of 12 figures were included among the original geometric figures, is administered.
- An optional Copy Trial may be administered to screen for severe visuoconstructive deficits and to help in scoring recall responses.

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

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**Brief Neuropsychological Cognitive Examination (BNCE)**
by Joseph M. Tonkonogy, M.D., Ph.D.

**Purpose:** Assesses major cognitive functions in one short session, yielding a general cognitive profile

**Ages / Grade:** 18 years and up

**Administration Time** Less than 30 minutes

**Format:** 10 subtests composed of easily administered tasks, none
Scores

Total score indicating overall severity of impairment, subtest scores, and two aggregate scores for the simple and complex subtests

This convenient test assesses the cognitive functions targeted in a typical neuropsychological exam. In less than 30 minutes, it gives you a general cognitive profile that can be used for screening, diagnosis, or follow-up. More efficient than a neuropsychological battery and more thorough than a screener, BNCE is an ideal way to evaluate the cognitive status of patients with psychiatric disorders or psychiatric manifestations of neurological diseases.

Measure processing skills needed for everyday functioning

Appropriate for individuals 18 years of age and older, the BNCE assesses

- Working memory
- Gnosis
- Praxis
- Language
- Orientation
- Attention
- Executive functions

It is composed of 10 subtests, none requiring more than minimal reading skills. Five of these subtests measure the ability to process conventional, frequently used information, while the remaining five measure the ability to process novel or incomplete information. The test focuses on processing skills needed for everyday functioning, and is sensitive to mild impairment often missed by other brief cognitive screeners.

Find out how the patient processes novel versus conventional information

The BNCE gives you subtest scores, a total score indicating overall severity, and two aggregate scores for the simple and complex subtests--so that you can look at the patient's ability to process conventional versus novel information. Results can help you differentiate problems caused by subcortical lesions from those caused by cortical lesions and those caused by primary psychiatric disorders. The BNCE Manual is unique in that it provides extensive guidance in interpreting test results.

Quickly uncover cognitive abnormalities

The BNCE is an excellent way to start a process-oriented neuropsychological exam--It quickly reveals specific cognitive abnormalities that may warrant more detailed evaluation. And it can be used to monitor the course of both psychiatric and neurological disease. It has been found especially useful in evaluating
patients with sequelae of head injury, stroke, encephalitis, and primary degenerative disorders such as Alzheimer’s, Huntington's, Parkinson's and Pick's diseases and those suffering from seizure disorders, schizophrenia, mood disorders, and alcohol and drug abuse.

Bell Object Relations and Reality Testing Inventory (BORRTI)

by Morris D. Bell, Ph.D.

**Purpose:** Quickly identifies adults with character disorders and psychoses and tells you which treatment methods are likely to be most effective

**Ages / Grade:** 18 and over

**Administration Time:** 15 to 20 minutes

**Format:** Self-report

**Norms** Based on a nonclinical sample of 1,000 adults

This exciting self-report inventory gives clinicians a quick, convenient, and reliable way to evaluate adults with character disorders and psychoses. Administered in just 15 to 20 minutes, the BORRTI identifies clients with Borderline Personality Disorder and tells you which treatment methods are likely to be most effective. It is especially helpful when character pathology co-occurs with other problems, such as substance abuse or PTSD. It lets you know immediately whether the individual's problems are complicated by characterological deficits that could drastically alter the course of treatment.

Composed of 90 items, the inventory measures object relations and reality testing on seven scales:

**Object Relations**
- Alienation
- Insecure Attachment
- Egocentricity
- Social Incompetence

**Reality Testing**
- Reality Distortion
• Uncertainty of Perception
• Hallucinations and Delusions

If you are interested only in the items measuring Object Relations, you can use Form O, which includes just those items.

You can administer the BORRTI as part of an initial evaluation of the client. This gives you useful clinical information at the outset--and it instantly engages the individual in the therapeutic process. Clients seem to like the test, viewing it as evidence that you understand and are interested in their problems.

Scores from the full scale indicate the respondent's ability to sustain essential relationships and to accurately identify internal and external reality. Norms are based on a nonclinical sample of approximately 1,000 adults.

The test can be hand scored, using either the Full Form or Form O AutoScore Answer Form. It can also be computer scored, using WPS TEST REPORT prepaid Mail-In Answer Sheets, CD, or FAX Service. Each of these computer options gives you a full interpretive report. A Research CD, which offers scoring only, is also available.

The BORRTI test report profiles scores, describes client characteristics, makes diagnostic suggestions, and provides explicit, individualized treatment recommendations. It also alerts you to potential threats to the therapeutic relationship, and lists Specific Clinical Themes that apply to the client in question.

Quicker, more reliable, and easier to use than individually administered projective tests, the BORRTI simplifies what is often a difficult task--evaluating and treating clients with personality and thought disorders.

Cognitive Distortion Scales™ (CDS™)
John Briere, PhD

Purpose: Assess negative thinking patterns that interfere with optimal functioning

Age range: 18 to 91 years
Admin: Individual or group
Admin time: 10-15 minutes to administer; 5 minutes to score

The CDS is a 40-item, self-assessment of cognitive distortions for adults ages 18 years and older. The CDS scales reflect five types of cognitive distortion:
• Self-Criticism (SC)—Low self-esteem and self-devaluation as expressed in the tendency to criticize or devalue oneself.

• Self-Blame (SB)—Extent to which the respondent blames himself or herself for negative, unwanted events in his or her life, including events outside the respondent's control.

• Helplessness (HLP)—Perception of being unable to control important aspects of one's life.

• Hopelessness (HOP)—Extent to which the respondent believes that the future is bleak and that he or she is destined to fail

• Preoccupation With Danger (PWD)—Tendency to view the world, especially the interpersonal domain, as a dangerous place.

CDS materials include the professional manual, the test booklet, and the profile form. The professional manual provides information on administration, scoring, interpretation, psychometric characteristics, normative data on the standardization sample, as well as data from subsamples of psychotherapy outpatients.

The carbonless test booklet can be administered in 10-15 minutes to individuals or groups. Respondents use a 5-point scale to rate the frequency of occurrence of each item during the previous month. The CDS requires only minimal (5th grade) reading level. Hand-scoring takes only 5 minutes.

The CDS profile form allows conversion of raw scale scores to T scores based on the gender of the respondent. The normative sample included 611 individuals from the general population. A profile graph can be drawn to portray the respondent's scores relative to the scores of the general population.

The CDS has demonstrated construct, convergent, and discriminant validity in both the general population and in clinical samples. Studies suggest that individuals with a history of child abuse or later personal trauma are especially likely to score in the clinical range on the CDS scales. Data presented in the CDS Professional Manual support use of this instrument in clinical and nonclinical contexts with adults who have no significant trauma history and those who have been traumatized.

**Comprehensive Trail-Making Test (CTMT)**

by Cecil R. Reynolds, Ph.D.

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

The CTMT is for individuals ages 8 through 74. Administration is timed and takes from 5 to 12 minutes. Scoring typically requires just a few minutes more. Normative scores, derived from a nationwide sample of 1,664 people, are provided as percentile ranks and T-scores with a mean of 50 and a standard deviation of 10.

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

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

Constructive Thinking Inventory™ (CTI)
Seymour Epstein, PhD

Purpose: Measure beliefs and thinking patterns that underlie emotional intelligence, coping ability, physical and emotional well-being

Age range: 18 to 80 years

Admin: Individual or group

Admin time: 15-30 minutes

The CTI is a 108-item self-report inventory that assesses constructive and destructive beliefs and thinking patterns. The CTI is based on Dr. Epstein's Cognitive-Experiential Self-Theory. According to this theory, people have two fundamental adaptive systems: an "experiential system" that automatically learns from lived experience, and a "rational/intellectual system" that operates by conscious reasoning. The CTI measures the efficacy of the experiential system; intelligence tests measure the efficacy of the rational/intellectual system. Note that the CTI cannot be hand-scored. The individual's responses are entered into the software, and the program scores the protocol and automatically generates a score report with raw scores and gender-based T scores with a profile of the results.

The CTI predicts a variety of desirable abilities/states, that are either unrelated or only very weakly related to intellectual intelligence, including work performance, social skills, and emotional and physical well-being. It has also been found that CTI scores significantly
supplement intellectual intelligence in the prediction of academic performance as measured by grade point average.

- 5-point rating scale.
- Appropriate for ages 18-80 years.
- Normative sample of 908 U.S. census-matched adults.
- Gender-based raw score to T-score conversions provided for all scales/subscales and for the Global Constructive Thinking Scale.
- Computer scoring program that generates a score report and a profile of the results.

CTI Scales

The CTI scales provide information about beliefs and thinking processes at three levels of generality. A global scale (Global Constructive Thinking), composed of items from several other scales, is the most general score. At the next level are six main scales (Emotional Coping, Behavioral Coping, Personal Superstitious Thinking, Categorical Thinking, Esoteric Thinking, and Naive Optimism) that measure basic ways in which people think (constructively or destructively). Almost all main scales have subscales, which identify the specific thoughts and ways of thinking that make up the main scales. This information is useful for elucidating the scores on the main scales, for providing refined diagnoses, and, most important, for counseling and psychotherapy geared toward correcting maladaptive beliefs and ways of thinking. The CTI also includes Validity and Defensiveness scales. Scores are provided for the Global Constructive Thinking Scale, 6 scales, and 15 subscales.

The CTI Has Many Uses

The CTI is widely applicable. In clinical and counseling settings, it can be used to obtain diagnostic information about beliefs and ways of thinking that can be directly applied in psychotherapy and counseling. In this respect, the CTI has been particularly useful in treatment centers for drug abuse that emphasize the development of coping skills. In business settings, the CTI can be used for personnel selection and for training and counseling at all administrative levels. In educational settings, it can assist in the selection of students for college admissions and in the counseling of high school and college students.

DTVP-A: Developmental Test of Visual Perception–Adolescent and Adult
Ages: 11-0 through 74-11
Testing Time: 25 minutes
Administration: Individual

The DTVP-A is a battery of six subtests that measure different but interrelated visual-perceptual and visual-motor abilities. The battery, which is designed for use with individuals ages 11-0 through 74-11, has empirically established reliability and validity. The normative sample consists of 1,664 adolescents and adults residing in 19 states; demographic characteristics approximate the current census data.

The DTVP-A is the latest test based on the work of Marianne Frostig; work which has been carried forward in the Developmental Test of Visual Perception-Second Edition (DTVP-2), which is frequently used to evaluate perceptual-motor skills in children ages 4 through 10. The DTVP-A is an extension and redevelopment of this classic work, designed for use with adolescents and adults. The DTVP-A can be administered by psychologists, neuropsychologists, occupational therapists, physical therapists, regular and special educators, and diagnosticians who are interested in examining the visual-perceptual status and visual-motor integration skills of adolescents and adults. Administration is individual and takes approximately 25 minutes.

The DTVP-A is especially useful in the evaluation of the neuropsychological integrity of TBI and stroke patients where right-hemisphere function may be at issue. Normed through age 75, the DTVP-A has sufficient floor or easy items to allow accurate assessment of even individuals with severe TBI and other neurologically impaired individuals. The reliability of the various subtests and index scores indicates that the DTVP-A will be sensitive to improvement over the course of treatment. The subtests and indexes also will suggest areas of emphasis in cognitive and fine motor rehabilitation. The DTVP-A is particularly useful in distinguishing true visual-perceptual deficits from problems solely with complex eye-hand or perceptual-motor actions. The DTVP-A may also assist in differential diagnosis of various of the dementias in elderly patients, providing a baseline for normal aging changes in perception and perceptual-motor skills against which the referred patient may be referenced.

Subtests

Subtest 1-Copying: Individuals are shown a simple figure and asked to draw it on a piece of paper. The figure serves as a model for the drawing.

Subtest 2-Figure-Ground: Individuals are shown stimulus figures and asked to find as many of the figures as they can on a page where the figures are hidden in a complex, confusing background.

Subtest 3-Visual-Motor Search: The individual is shown a page covered in numbered circles, randomly arranged on the page. The individual connects the circles with a line, in numerical sequence, as quickly as possible.

Subtest 4-Visual Closure: Individuals are shown a stimulus figure and asked to select the exact figure from a series of figures that have been incompletely drawn.

Subtest 5-Visual-Motor Speed: Individuals are shown (a) four different geometric designs, two of which have special marks in them, and (b) a page filled completely with the four designs, none of which have marks in them.

Subtest 6-Form Constancy: Individuals are shown a stimulus figure and asked to find it in a series of figures. In the series, the targeted figure will have a different size, position, and/or shade, and it may be hidden in a distracting background.
Composite Scores or Indexes The most reliable scores for the DTVP-A are the indexes. These scores are found by adding the standard scores of the subtests that comprise a composite and converting the sum to an index.

General Visual-Perceptual Index: The GVPI is the best measure of what the majority of people mean when they say "visual perception." Data from six subtests, each of which measures a different type of visual perception in a different manner, contribute to the GVPI. When GVPIs are below 90, examiners need to pay more attention to the clinically important indexes- the Motor-Reduced Visual Perceptual Index (MRPI) and the Visual-Motor Integration Index (VMII). Examination of these indexes may help explain the causes for low GVPIs.

Motor-Reduced Visual Perception Index: Of all of the DTVP-A indexes, the MRPI is the "purest" and most direct measure of visual perception in that only minimal motor skills (e.g., pointing) are required to show perceptual competence. This index is formed by combining the standard scores from the Figure-Ground, Visual Closure, and Form Constancy Subtests.

Visual-Motor Integration Index: To do well on this composite, individuals must perform complex eye-hand coordination tasks. Low scores do not necessarily indicate poor visual perception; they may mean that the individuals have awkward hand movements or that they have difficulty coordinating hand-to-eye movements. This index is formed by combining the standard scores of the Copying, Visual-Motor Search, and Visual-Motor Speed Subtests.

Special Features of the DTVP-A

Subtests were developed to be appropriate for adolescents and adults.

The normative sample reflects the current population characteristics of the United States relative to race, ethnicity, gender, geographic region, parent education, and income.

Internal consistency, stability, and interscorer reliability for all indexes are high.

Validity evidence shows that all DTVP-A subtests and indexes are useful for measuring visual-perceptual and visual-motor integration skills.

Evidence is provided to show that the test is unbiased with respect to gender and race.

Developmental Test of Visual Perception: Second Edition (DTVP-2)

by Donald D. Hammill, Nils A. Pearson, and Judith K. Voress

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

The Second Edition can be used with 4- through 9-year-olds. Individually administered in just 35 minutes, it is composed of eight subtests:
The DTVP-2 provides scores for both pure visual perception (with no motor response) and visual-motor integration abilities. These scores are reliable (.8 or .9 levels) for all age groups. Norms are based on a large sample, representative of 1990 U.S. census data, and studies have shown that the test is unbiased in regard to race and gender.

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

Inventory of Altered Self-Capacities™ (IASC™)
John Briere, PhD

Purpose: Assess difficulties in relatedness, identity, and affect control in ages 18 years and older

Age range: 18 to 91 years

Admin: Individual or group

Admin time: 10-15 minutes to complete; 10-15 minutes to score and profile

Scoring time: 15 minutes

The IASC is a self-report measure of an individual’s psychological functioning capacity in the areas of forming and maintaining meaningful relationships, creating a stable sense of personal identity and self-awareness, and the ability to modulate and tolerate negative affect. This instrument is particularly useful with adults who have experienced significant childhood abuse or trauma.

Facilitates assessment of individuals with personality difficulties
• Helps to identify targets for treatment, such as identity disturbance and affect regulation problems; predicts potential problems that may arise during psychotherapy; and provides clinical
data to corroborate diagnoses, especially those involving dysfunctional personality traits or disorders.

- Seven 9-item scales ask respondents to rate the frequency of occurrence over the past 6 months of each symptom on a 5-point scale.
- Normed on 620 individuals from the general population, making it an ideal component of a comprehensive assessment of adult psychopathology.

KOPPITZ-2: Koppitz Developmental Scoring System for the Bender® Gestalt Test, 2nd Ed. (KOPPITZ-2)

Cecil R. Reynolds, PhD

Purpose: Measure visual-motor integration skills

Age range: 5 to 85 years

Admin: Individual administration

Admin time: 5-10 minutes

The KOPPITZ-2 is a highly reliable, valid measure of visual-motor integration skills that applies the developmental approach to scoring made so popular by its originator, Dr. Elizabeth Munsterberg Koppitz.

True to original conceptualization but updated to meet current psychometric standards

- Requires the examinee to draw increasingly complex figures from a model (the Bender designs, derived from theories of Gestalt psychology) on a plain sheet of white paper and to organize the task independently, effectively assessing the ability to relate visual stimuli accurately to motor responses.
- Uses a less structured task than other tests of visual-motor integration, thereby providing a more ecologically sound approach to this type of assessment.
- Extended age range allows for the evaluation of special education students through age 21 years and the evaluation of the visual-motor integration deficits of the growing population of seniors.
- For older children and adults, both 2- and 3-dimensional drawings are now required that reveal subtle deficits in visual-motor integration processes.
Maintains a developmental view of visual-motor integration

- Provides separate scoring systems for young children (ages 5-7 years) as well as older children and adults (ages 8-85 years and older).

- Normative sample of 3,600 persons is matched to U.S. Census statistics on socioeconomic factors, ethnicity, geographic region, community size, and other critical variables to ensure representativeness of the total population.

- Completely nonverbal and useful with individuals from widely varied cultural and ethnic backgrounds.

- A special chapter of the Examiner’s Manual is devoted to the Koppitz Emotional Indicators (EIs) and their proper use; a specialized scoring form is also provided.

Highly reliable across age, gender, and ethnicity

- Reliability coefficients are reported for multiple subgroups, including individuals with various disorders.

- Internal consistency (alpha) reliabilities for all but one age are greater than .80; the average of reliabilities across ages is .88. The test correlates highly with the WISC®-III Performance Scale and Perceptual Organization Index.

- Detailed scoring guides and a clear scoring template ensure high levels of interscorer reliability.

Mental Status Checklist™—Adult (MSC)

John A. Schinka, PhD

Purpose: Helpful in assessing mental status of adults

Age range: 18 to 60 years

Admin: Individual

Admin time: Varies

Scoring time: 5 minutes

Consists of 120 items typically included in a comprehensive mental status exam of adults.
Motor-Free Visual Perception Test (MVPT-3)

Ages: 4 through 85 years
Testing Time: 20 minutes
Administration: Individual
The third edition of the Motor-Free Visual Perception Test (MVPT-3) is appropriate for children and adults ages 4 through 85 years. Designed to assess visual perception without reliance on an individual's motor skills, the MVPT-3 is particularly useful with those who may have learning, cognitive, motor, or physical disabilities. The MVPT-3 can be used for screening as well as diagnostic and research purposes by teachers, psychologists, educational specialists, rehabilitation therapists, and others who need a quick, highly reliable, and valid measure of overall visual-perceptual processing ability in children and adults. The MVPT-3 measures skills without copying tasks. It contains many new, more difficult items at the upper end for older children and adults. Tasks include matching, figure-ground, closure, visual memory, and form discrimination. Stimuli are line drawings. Answers are presented in multiple-choice format. Responses may be given verbally or by pointing. Standard scores and percentiles are provided. Item response times may be interpreted in terms of functional behavioral categories. Clinical population comparisons are also provided. The test takes about 20 minutes and is individually administered.

Neuropsychological Impairment Scale (NIS)

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

Purpose: Provides a quick, accurate picture of neuropsychological symptoms, eliciting relevant diagnostic information that might otherwise go unreported

Ages / Grade: 18 to 88 years
Administration Time: 15 to 20 minutes
Format: Self-report, observer report, and senior interview
Here is a quick and convenient way to screen adults for neuropsychological symptoms. This brief self-report questionnaire addresses both global impairment and specific symptom areas, eliciting diagnostically relevant information that might otherwise go unreported. The NIS brings up symptoms that patients often fail to mention in an informal clinical interview. A useful addition to any general psychological evaluation, it is an efficient way to screen for organic problems.

Serving as an "early warning system," the NIS can identify areas for inquiry, focus treatment efforts and help determine whether the patient will benefit from therapy. It has proven particularly useful in assessing age- and AIDS-related dementia.

Composed of 95 items, the NIS provides three very helpful summary scores, plus subscale scores and validity checks:

- **Global Measure of Impairment**--serves as a general index of neuropsychological functioning.
- **Total Items Circled**--distinguishes patients who report many low-intensity symptoms from those who report a few high-intensity symptoms.
- **Symptom Intensity Measure**--alerts you to individuals with organic personality disorder, diminished affective experience, limited awareness of their impairments, or high levels of frustration or psychological distress.

### Subscale Scores
- Cognitive Efficiency
- Attention
- Memory
- Frustration Tolerance
- Learning-Verbal
- Academic Skills

### Validity Checks
- Defensiveness
- Affective Disturbance
- Response Inconsistency
- Subjective Distortion

The Subjective Distortion Check is particularly helpful because it tells you whether the client is under- or over-reporting symptoms.

Written at a fifth-grade reading level, the scale can be completed in just 15 to 20 minutes by anyone over the age of 17. Nonclinical norms, based on a sample of 1,000 adults (18 to 88 years old), are...
stratified by age (young adult, adult, middle-aged, and elderly). Clinical norms, drawn from a sample of 534 neuropsychiatric patients, are separated by diagnostic group (neurological, psychiatric, alcohol/drug, learning disability, and physical trauma).

A second form of the NIS--the Observer Report--presents items in the third person. This nonstandardized form, which can be completed by a relative or close friend of the patient, provides a different perspective on the patient's symptoms. Comparisons of Self and Observer Reports can help the patient understand the impact of his or her deficits and help family members adopt realistic expectations.

A third form of the test--the Senior Interview--is useful with older patients who can't complete the NIS Self-Report due to poor vision, strength, or manual dexterity. The Senior Interview consists of 40 questions that are read to the patient by the examiner. The patient indicates his or her response on a large-print visual cue card. This form provides a Global Measure of Impairment and scores for Defensiveness, Affective Disturbance, and Inconsistency. A Subjective Distortion Index can also be calculated if WAIS-R Digit Span and Similarities scores are available.

Efficient, comprehensive, and systematic, the NIS offers many advantages over an informal clinical interview. It uncovers diagnostically important symptoms that people might otherwise omit or disregard.

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Psychopathic Personality Inventory™–Revised (PPI™-R)
Scott O. Lilienfeld, PhD
Professional Manual by Scott O. Lilienfeld, PhD and Michelle R. Widows, PhD
Software by Scott O. Lilienfeld, PhD, Michelle R. Widows, PhD, and PAR Staff

Purpose: Assess psychopathic personality traits
Age range: 18 to 86 years
Admin: Individual or group
Admin time: 15-25 minutes
Scoring time: 20 minutes

The PPI-R is a 154-item self-report measure of both global psychopathy and the component traits of psychopathy.

- Can detect response styles such as positive or negative impression management and random or careless responding.
Rather than focusing exclusively on antisocial or criminal behaviors, the PPI-R measures the continuum of psychopathic personality traits.

Standardized and validated for use with men and women in a community/college sample that reflects 2002 U.S. Census data for race/ethnicity, educational background, and geographic area. Also includes normative data for a male offender sample.

Useful in a variety of settings, particularly correctional facilities, forensic practice, substance abuse treatment centers, and research.


**Author(s):** by M. Rhonda Folio and Rebecca R. Fewell

Combine in-depth assessment with training or remediation of gross and fine motor skills

This early childhood motor development program contains six subtests that assess the motor skills of children from birth through 5 years. The new illustrated guide to administering and scoring provides detailed descriptions of each item. The subtests are—Reflexes, Stationary, Locomotion, Object Manipulation, Grasping, and Visual-Motor Integration.

Composite scores available include Gross Motor Quotient, Fine Motor Quotient, and Total Motor Quotient. The test contains new normative data representative of the current U.S. population.

The Peabody Motor Activities Program (P–MAP), included in the complete kit, is the instruction/treatment program of the PDMS–2. After a child's motor skills have been assessed and the profile/summary form has been completed, select units from the P–MAP to facilitate the child's development in specific skill areas.

**Quick Neurological Screening Test, 3rd Edition (QNST-3)**

Margaret Mutti, MA, Nancy A. Martin, PhD, Harold Sterling, MD, and Norma Spalding, EdD

**Purpose:** Document the presence of neurological soft signs

**Age range:** 4 to 80 years

**Admin:** Individual

**Admin time:** 20-30 minutes
An assessment of motor skills, the QNST-3 documents the presence of neurological soft signs (NSSs), which can indicate impaired motor coordination and sensory integration and are often harbingers of learning difficulties in individuals without a history of trauma.

- Empirically based, the QNST-3 provides an easy and reliable way to quantify, over time, the presence and extent of behaviors that may be of clinical importance.
- QNST-3 tasks are commonly used in traditional neurologic exams and require no special equipment.
- Expanded norms now cover not only children but also adults, including the geriatric population.
- The manual’s updated literature review includes information about NSSs seen in individuals with sports-related concussions (child and adult), blast injuries (e.g., returning war veterans), learning disabilities, and neurodegenerative diseases (e.g., Alzheimer’s and Parkinson’s diseases).
- Hand-scoring is quick and easy; raw scores (one from each task and an overall total) are interpreted in terms of functional categories (based on the frequencies of NSSs seen in the normative sample).

Risk-Sophistication-Treatment Inventory™ (RSTI™)
Randall T. Salekin, PhD

Purpose: Assess risk of dangerousness, sophistication-maturity, and treatment amenability

Age range: 9 to 18 years

Admin: Individual

Admin time: Interview: 50-65 minutes; Completion of rating form: 15-20 minutes

Scoring time: 20 minutes

The RSTI is an interview and rating scale designed to help you plan treatment for juvenile offenders.

- Each area (risk for dangerousness, sophistication-maturity, and treatment amenability) is measured by a scale composed of 15 items, and each scale contains three clusters.
- Interview questions are designed to obtain background, clinical, and historical information, as well as a sample of the juvenile’s behavioral and psychological functioning.
- You can score items by reviewing and synthesizing information from the entire interview as well as from other sources.
- Each item is rated on a 3-point scale, reflecting the extent to which the individual demonstrates the specific characteristic.
Shipley-2

Walter C. Shipley, PhD, Christian P. Gruber, PhD, Thomas A. Martin, PhD, and Amber M. Klein, PhD.

**Purpose:** Quickly measure intellectual functioning and cognitive impairment

**Age range:** 7 to 89 years

**Admin:** Individual or group administration

**Admin time:** 20-25 minutes to administer, 5 minutes to score

**Scoring time:** 5 minutes

Revised and restandardized, this enduring test offers a brief yet robust measure of intelligence and includes updated norms, an expanded age range, and a nonverbal Block Patterns scale.

**Get a straightforward and brief measure of intellect**

- Like the original, the Shipley-2 measures two aspects of cognition: crystallized knowledge, which is gained through education and experience, and fluid reasoning, the capacity to use logic to learn and acquire new information or solve problems.

- Ideal when you need to obtain quick ability estimates, screen for cognitive dysfunction, or qualify participants for research studies. It also functions well as a component of more complex assessments in neuropsychological, clinical, and forensic settings.

- Use for intake screening, assessing brain injuries, determining eligibility for disability benefits, measuring the effects of toxic exposure, guiding treatment and rehabilitation, informing educational or job placement decisions, identifying cognitive problems, and monitoring cognitive decline.

**Retains simplicity but expands utility**

- The new Block Patterns scale, which assesses fluid ability, is composed of 12 multiple-choice items based on the Kohs cube designs and offers a good alternative to the Abstraction scale.

- Norms are stratified by age for children (ages 7-19 years) and adults (ages 17-89 years) and based on a sample of 2,826 individuals representative of the U.S. population in terms of ethnicity, gender, and educational level.
Optional unlimited-use computer software enables you to administer the Shipley-2 on-screen and rapidly score responses from paper-and-pencil and/or on-screen administrations.

Provides standard scores, percentiles, age equivalents, and confidence intervals as well as a Composite score, which is reflective of overall cognitive ability, and the Impairment Index, which represents the discrepancy between vocabulary and abstract thinking and is calculated only for adults.

Stroop Color and Word Test
by Charles J. Golden, Ph.D. and Shawna M. Freshwater

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

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

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

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

Administration time is just 5 minutes.

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

Stroop results can be used in the diagnosis of brain dysfunction and in the evaluation of stress, personality, cognition, ADHD, and psychopathology. Because it is brief, requires very little education, and is not culturally biased, this unique test is an ideal way to screen for neuropsychological deficits.

Stroop Neuropsychological Screening Test (SNST)
Max R. Trenerry, PhD, Bruce Crosson, PhD, James DeBoe, PhD, and William R. Leber, PhD

Purpose: Screen for brain damage

Age range: 18 to 79 years

Admin: Individual

Admin time: 4 minutes (timed)

Scoring time: 5 minutes

In just 5 minutes, the SNST briefly assesses cognitive processing and provides valuable information on brain dysfunction, cognition, and psychopathology—all of which affect an individual’s ability to cope with cognitive stress and process complex input. Results may highlight the need for more specific testing.

- In the Color Task, the individual reads aloud a list of color names in which no name is printed in its matching color. In the Color-Word Task, the individual names the ink color in which the color names are printed.
- Norms are provided for two age groups, 18-49 years and 50 years and older.
- The test correctly differentiates over 79% of brain-damaged adults from normal adults. Test-retest reliability is .90.

Wide Range Assessment of Visual Motor Ability (WRAVMA)

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

Benefit: Allows you to assess and compare visual-spatial, fine motor, and integrated visual-motor skills using norms from a single sample

Ages / Grade: 3 through 17 years

Administration Time: 4 to 10 minutes for each of 3 subtests

Format: Design copying, visual-spatial
matching, and pegboard tasks

Norms: Based on a nationally representative sample of 2,600+ children

You no longer have to piece together different tests, standardized on different populations, in order to get a comprehensive evaluation of a child's visual-motor skills. The WRA VMA lets you assess and compare visual-spatial, fine motor, and integrated visual-motor skills using norms gathered from the same sample.

Designed for 3- through 17-year-olds, WRA VMA includes three subtests, which can be used individually or in combination:

- The Drawing Test measures visual-motor integration by asking the child to copy designs that are arranged in order of increasing difficulty.
- The Matching Test assesses visual-spatial skills by asking the child to look at a visual "standard" and select the option that "goes best" with it. Again, items are arranged in order of increasing difficulty.
- The Pegboard Test evaluates fine motor skills by asking the child to insert as many pegs as possible, within 90 seconds, into a waffled pegboard. Norms are provided for both dominant and nondominant hands.

Each test requires just 4 to 10 minutes, and each provides a scaled score, standard score, age equivalent, and percentile score. Norms are based on a nationally representative sample of more than 2,600 children.

Offering attractive materials, easy administration, and sound psychometric properties, the WRA VMA is an excellent choice for assessing visual-motor ability.