Clinical

We offer clinical trials in different spheres:

- Autism
- Executive functions
- Personality
- Psychopathology
- Parental Stress
- Post-traumatic stress
- ADD / ADHD

TESTS

- ADIR
- ADOS
- ASEBA
- BRIEF
- CONNERS
- EXACT
- HIT
- HUDSON SCALES
- LEITER-3
- LSB-50
- MVPT-4
- PAI
- PSI-4
ADI-R - SEMI-STRUCTURED FOR DIAGNOSIS OF AUTISM
M. Rutter, A. Lecouteur et C. Lord.

A semi-structured interview with the parents
The ADI-R is a semi-structured interview conducted with parents, or caretaker of the child, to complete a first diagnosis of autism. The orientation of the maintenance based on pre-defined items which are listed according to the precise description of the desired behavior, intensity and frequency.

The examiner should be able to evaluate, during the interview, if the information available to it is sufficient to listing before continuing by other issues. This interview takes into account the elements of development in early childhood as the current clinical presentation.

Search the first manifestations of the symptoms of autism.
This tool allows you to search the first manifestations of the disorder and their development in early childhood. Different strategies, such as references to important life events, remarkable periods in the year are used to specify the dating of different behaviors. The comparison with other children of the entourage facilitates the description of events and provides information for assessing the intensity of the unrest. The use of the ADI-R requires an experienced interviewer clinically and an informant (a parent or caregiver of the child), familiar with both the history of development and behavior current daily of the child, or the assessed patient. The estimated individual who is absent during the interview can come from any environment and be any age as long as his mental abilities reach a level of development of at least two years.

Price

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<th></th>
<th>Complete material</th>
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<th>10 Care Guide - 10 sheets of algorithms</th>
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Did you know?
The ADI-R complements the ADOS test
The ADI-R complements the observation scale for diagnosing autism spectrum (ADOS) in reference to DSM-IV (APA 1994) and ICD-10 (WHO 1992, 1993) with a threshold for the diagnosis of autism defined by an algorithm.
This revision improves an instrument already viewed as «the gold standard» for observational assessment of autism spectrum disorder (ASD).

With updated protocols, revised algorithms, a new Comparison Score, and a Toddler Module, the ADOS-2 provides a highly accurate picture of current symptoms, unaffected by language. It can be used to evaluate almost anyone suspected of having ASD from one year olds with no speech, to adults who are verbally fluent.

Like its predecessor, the ADOS-2 is a semi-structured, standardised assessment of communication, social interaction, play, and restricted and repetitive behaviours. It presents various activities that elicit behaviours directly related to a diagnosis of ASD. By observing and coding these behaviours, you can obtain information that informs diagnosis, treatment planning, and educational placement. Five Modules

The ADOS-2 includes five modules, each requiring just 40 to 60 minutes to administer. The individual being evaluated is given only one module, selected on the basis of his or her expressive language level and chronological age. Following guidance provided in the manual, you choose the module that's appropriate for the individual you’re evaluating.

Toddler Module: for children between 12 and 30 months of age who do not consistently use phrase speech

Module 1 - for children 31 months and older who do not consistently use phrase speech
Module 2 - for children of any age who use phrase speech but are not verbally fluent
Module 3 - for verbally fluent children and young adolescents
Module 4 - for verbally fluent older adolescents and adults

Standardised Administration, Coding, and Scoring
Each ADOS-2 module has its own Protocol Booklet, which structures the administration and guides you through coding and scoring. As you administer activities, you observe the examinee and take notes. Immediately afterwards, you code the behaviours observed. Then you use the Algorithm Form for scoring.

In Modules 1 to 4, algorithm scores are compared with cutoff scores to yield one of three classifications: Autism, Autism Spectrum, and Non-spectrum. The difference between autism and autism spectrum classifications is one of severity, with the former indicating more pronounced symptoms. In the Toddler Module, algorithms yield «ranges of concern» rather than classification scores.

Improved Protocol Booklets, Revised Algorithms, and a New Comparison Score
Administration and coding procedures for the ADOS-2 are functionally identical to those for the ADOS. Modules 1 to 4 retain the same basic activities and codes, though some codes have been expanded and several new codes have been added. Protocol Booklets for these modules have been significantly improved they now provide clearer, more explicit administration and coding instructions.

NB We also supply protocol booklets for the first version of ADOS please see pricing information at the bottom of the page for more details. In the ADOS-2, algorithms for Modules 1 to 3 have been revised to achieve more accurate and useful results. These updated algorithms provide a more uniform basis for comparing results across the three modules that are used with child-ren and young adolescents.

A new Comparison Score for Modules 1 to 3 allows you to compare a child’s overall level of autism spectrum-related symptoms to that of children diagnosed with ASD who are the same age and have similar language skills.
This score also makes it easier to monitor an individual’s symptoms over time. A continuous metric, the Comparison Score ranges from 1 to 10. However, to facilitate clinical interpretation it can also be expressed as one of four descriptive categories from «no evidence of autism spectrum-related symptoms» to «a high level of autism spectrum-related symptoms.»

The new ADOS-2 scoring program helps you choose the correct algorithm, converts item codes to algorithm scores, adds up the algorithm, calculates the Comparison Score, and quickly arrives at an ADOS-2 classification or «range of concern.»

**Prices**

| Complete kit Hand Scoring | 5010-60500 | 3889,99 |
| Complete Software Kit     | 5010-60501 | 4085,99 |
| Ados-2 Module 1 Protocols  | 5010-60502 | 104,95 |
| Ados-2 Module 2 Protocols  | 5010-60503 | 104,95 |
| Ados-2 Module 3 Protocols  | 5010-60504 | 104,95 |
| Ados-2 Module 4 Protocols  | 5010-60505 | 104,95 |
| Ados-2 Toddler Module Protocols | 5010-60506 | 104,95 |
| Manual                    | 5010-60510 | 199,99 |
| Ados-2 Scoring CD         | 5010-60590 | 459,95 |
| Ados-2 Hand-Scoring Upgrade Kit (Form Ados to Ados-2) | 5010-60600 | 1024,99 |
| Ados-2 Software upgrade Kit (Form Ados Software Kit to Ados-2 Software Kit) | 5010-60699 | 1228,99 |

**The New Toddler Module**

The Toddler Module is designed specifically for children between 12 and 30 months of age who do not consistently use phrase speech. Existing ADOS-2 components have been revised, and new components added, to more accurately identify toddlers at risk for ASD.

The Toddler Module engages the child with loosely structured activities involving highly motivating materials. The goal, again, is to see if the child demonstrates behaviours associated with ASD.

As in Modules 1 to 4, observations are coded immediately following administration, and the codes are converted to algorithm scores. However, Toddler Module algorithms provide «ranges of concern» rather than cutoff scores. These ranges help you form clinical impressions, but they avoid formal classification, which may not be appropriate at such a young age. The Toddler Module quantifies risk for ASD and signals the need for continued monitoring.

The Most Accurate Picture of Current ASD Symptoms

With improved algorithms, the ADOS-2 demonstrates strong predictive validity. It gives you a highly accurate picture of current ASD related symptoms, based on realtime observations. Physicians, clinical psychologists, educational psychologists, speech and language therapist and occupational therapists rely on ADOS-2 results to inform diagnosis, intervention, educational placement and treatment planning.

Because it can be used with a wide range of children and adults, the ADOS-2 is an essential addition to any hospital, clinic or school that serves individuals with developmental disorders.

**Did you know?**

Like its predecessor, the ADOS-2 is a semi-structured, standardized assessment of communication, social interaction, play, and restricted and repetitive behaviours.
ASEBA - Achenbach System of Empirical Based Assessment

Dr. Achenbach

ASEBA Overview
The ASEBA is a comprehensive evidence-based assessment system developed through decades of research and practical experience. The ASEBA assesses competencies, adaptive functioning, and behavioral, emotional, and social problems from age 1½ to over 90 years.

ASEBA instruments clearly document clients' functioning in terms of both quantitative scores and individualized descriptions in respondents' own words. Descriptions include what concerns respondents most about the clients, the best things about clients, and details of competencies and problems that are not captured by quantitative scores alone.

The individualized descriptive data, plus competence, adaptive, and problem scores, facilitate comprehensive, in-depth assessment. Numerous studies demonstrate significant associations between ASEBA scores and both diagnostic and special-education classifications (for references, see the Bibliography of Published Studies using the ASEBA).

The ASEBA is widely used in mental health services; schools; medical settings; child and family services; multicultural assessment; HMOs; public health agencies; child guidance; training; and research.

The ASEBA approach originated in the 1960s with Dr. Achenbach's efforts to develop a more differentiated picture of child and adolescent psychopathology than was provided by the prevailing diagnostic system. At that time, the American Psychiatric Association’s Diagnostic & Statistical Manual (DSM) provided only two categories for childhood disorders. These were Adjustment Reaction of Childhood and Schizophrenic Reaction, Childhood Type.

The Achenbach System of Empirically Based Assessment (ASEBA): Development, Findings, Theory, and Applications by Dr. Achenbach illuminates and integrates four decades of work related to the ASEBA. Starting with the ASEBA's origins in the 1960s, it traces major milestones in the ASEBA's conceptual, methodological, and theoretical development. It also elucidates applications of the ASEBA to practical assessment, training, and research.

The first scientific report of ASEBA findings was presented at the Society for Research in Child Development (Achenbach, 1965), and the first scientific publication was a monograph in the American Psychological Association's Psychological Monographs series (Achenbach, 1966).

The ASEBA approach involves:
Recording the problems reported for large samples of children, adolescents, and adults.
Performing multivariate statistical analyses of correlations among the problems to identify syndromes of problems that tend to co-occur.
Using reports of skills and involvement in activities, social relations, school, and work to assess competencies and adaptive functioning.
Constructing profiles of scales on which to display individuals' scores in relation to norms for their age and gender.
Preschool (Ages 1½-5) Assessments

Also see Observational Assessment of Children (TOF)

The preschool forms and profiles span ages 1½-5 years. The forms obtain parents’, daycare providers’ and teachers’ ratings of 99 problem items plus descriptions of problems, disabilities, what concerns parents or respondent most about the child, and the best things about the child.

The empirically based syndromes scored from the CBCL/1½-5 and C-TRF reflect actual patterns of problems derived from factor analyses that were coordinated between the two instruments. The CBCL/1½-5 also has a Sleep Problems syndrome. Both forms have parallel Internalizing, Externalizing, and Total Problems scales and a Stress Problems scale.

Based on over 27,000 CBCLs and C-TRFs from 24 societies, the ADM Module for Ages 1½-5 with Multicultural Options scores problem scales with norms for societies that have relatively low problem scores (Group 1 societies), intermediate scores (Group 2), or high scores (Group 3). Select societies by name or select Group 1, 2, or 3 norms for profiles of syndrome, DSM-oriented, Internalizing, Externalizing, and Total Problems scales.

Sample Forms
Revision Information

You can also select norms for displaying scale scores in cross-informant bar graphs for up to 8 CBCLs and C-TRFs per child. Scores from each form can even be displayed in relation to more than one set of norms; e.g., display scores from a CBCL completed by an immigrant parent with norms for the parent’s home society and the host society. You can then see whether scores are clinically deviant according to either or both sets of norms.

The Multicultural Supplement to the Manual for the ASEBA Preschool Forms and Profiles fully documents construction of the multicultural norms for the CBCL/1½-5 and C-TRF. The Supplement illustrates multicultural scoring, cross-informant comparisons, and practical applications in school, mental health, medical, and forensic contexts. The Supplement also reports multicultural findings for confirmatory factor analyses, internal consistencies, cross-informant correlations, and distributions of scale scores. Updates are provided for the Language Development Survey (LDS) of the CBCL/1½-5. Research guidelines and extensive reviews of research on the instruments are also provided, plus a bibliography of over 300 publications reporting their use with young children.

Language Development Survey (LDS)

An especially valuable feature of the CBCL/1½-5 is the LDS, which uses parents’ reports to assess children’s expressive vocabularies and word combinations, as well as risk factors for language delays. Developed by Dr. Leslie Rescorla, the LDS has been used in numerous studies of language problems. (For references, see the Bibliography of Published Studies Using the ASEBA) Based on our national normative sample, the LDS indicates whether a child’s vocabulary and word combinations are delayed relative to norms for ages 18-35 months. The LDS can be completed for language-delayed older children for comparison with norms up to 35 months.

Preschool CBCL 1½-5-LDS and C-TRF Scales

Syndrome Scales: Emotionally Reactive; Anxious/Depressed; Somatic Complaints; Withdrawn; Sleep Problems (CBCL only); Attention Problems; Aggressive Behavior

The profile of DSM (Diagnostic and Statistical Manual)-oriented scales, which comprise CBCL/1½-5-LDS and C-TRF items that experienced psychiatrists and psychologists from many cultures rated as being very consistent with DSM-5 diagnostic categories.

DSM-Oriented Scales: Depressive Problems; Anxiety Problems; Pervasive Developmental Problems; Attention Deficit/Hyperactivity Problems; Oppositional Defiant Problems.

Revisions of Forms:

In 2000, we revised the Child Behavior Checklist/2-3 (CBCL/2-3) and Caregiver-Teacher Report Form (C-TRF) to span ages 1½-5. Two items in the CBCL/2-3 that were un-scored or rare were replaced on the CBCL/1½-5/LDS with items that sharpen assessment of important syndromes: 51. Overweight was replaced by 51. Shows panic for no good reason and 79. Stores up things was replaced by 79. Rapid shifts between sadness and excitement.
School-Age (Ages 6-18) Assessments
Also see Observational Assessment of Children (TOF & DOF) and Semistructured Clinical Interview (SCICA)

The school-age assessment forms are the CBCL/6-18, completed by parents or surrogates; the TRF/6-18, completed by teachers and other school staff; and the YSR/11-18 completed by youths.

The ADM Module for Ages 6-18 with Multicultural Options displays problem-scale profiles and cross-informant bar graphs in relation to multicultural (including U.S.) norms. The Multicultural Supplement fully documents the multicultural norms and scales added in 2007.

Different norms can be selected for a child’s CBCL, TRF, and YSR scores. If the norms are unavailable for a society, you can elect default norms or other norms deemed appropriate for the child. The same scale scores can also be displayed with different norms.

School-Age (CBCL/6-18, TRF & YSR) Scales
The Module includes the 2007 Obsessive-Compulsive Problems, Posttraumatic Stress Problems, Sluggish Cognitive Tempo (not on YSR), and Positive Qualities (YSR only) scales.

Empirically Based Syndromes Scales scored from the CBCL/6-18, TRF, and YSR are based on factor analyses coordinated across the forms.

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<thead>
<tr>
<th>Anxious/Depressed</th>
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<tr>
<td>Withdrawn/Depressed</td>
<td>Attention Problems</td>
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<tr>
<td>Somatic Complaints</td>
<td>Rule-Breaking Behavior</td>
</tr>
<tr>
<td>Social Problem</td>
<td>Aggressive Behavior</td>
</tr>
</tbody>
</table>

DSM-oriented scales comprise items identified by experts from many cultures as very consistent with DSM-5 categories. The six DSM-oriented scales are:

- Affective Problems
- Anxiety Problems
- Somatic Problems
- Attention Problems
- Oppositional Defiant Problems
- Conduct Problem

The DSM-oriented scales are scored from all three forms. Inattention and Hyperactivity-Impulsivity subscales are also scored from the TRF Attention Deficit/Hyperactivity Problems scale.

Response to Intervention (RTI)
ASEBA provides optimal evidence-based, normed tools for identifying intervention needs, monitoring progress, and evaluating responses to interventions for behavioral, emotional, and social problems.

Revisions of Forms:
We revised the school-age forms in 2001 by replacing problem items that were unscored or rare with items that sharpen assessment of important syndromes. Factor analyses showed that the new items concerning alcohol and tobacco use and breaking rules load on the syndrome designated as Rule-Breaking Behavior, which is a revision of the Delinquent Behavior syndrome. The new items concerning failure to finish tasks and being easily distracted load on the revised Attention Problems syndrome. The new item concerning lack of enjoyment loads on the Withdrawn/Depressed syndrome, which is a revision of the Withdrawn syndrome.

ASEBA Software and Applications
The ASEBA recognizes that our clients operate in different environments and offers desktop and web applications to choose what best suits your organization. See our comparison chart and security information (in PDF format) to determine which of our applications is best for you.

The Assessment Data Manager (ADM) makes it easy to manage data obtained with ASEBA forms. ADM runs on Windows® 2000 and 2007, XP, Vista (32-bit), and Macintosh with computer virtualization software such as Parallels, BootCamp, and VMware.

Web-Link is a premier Internet solution that is carefully designed to meet a wide variety of needs. It is a convenient, secure Internet solution that enables completion of ASEBA forms online, printing of ASEBA forms, scoring of ASEBA profiles, and transmission of data to your ADM. (Web-Link cannot be used with the DOF, TOF, or SCICA.)

WebForms Direct is especially easy to use, as it is designed for users whose strengths lie in areas other than computer savvy.

We also have the following utilities:

A2S 3.1 Utility is an SPSS® command file that formats item ratings and scale scores exported from RTS and ADM (all ASEBA forms except DOF). Ratings to Scores Utility (RTS) computes raw sums, T scores, and percentiles for current and legacy scales of ASEBA forms (except SCICA, DOF, TOF, 2007 scales, new 2010 Preschool Stress Problems scale, and multicultural norms).
Adult (Ages 18-59) Assessments

The Adult Self-Report (ASR) and Adult Behavior Checklist (ABCL) incorporate many items of the 1997 editions of the Young Adult Forms (YASR & YABCL), plus new items and new national norms that span ages 18-59.

The profiles for scoring the ASR and ABCL include normed scales for adaptive functioning, Personal Strengths, empirically based syndromes, substance use, Internalizing, Externalizing, and Total Problems. In addition, the ABCL profiles feature DSM-oriented scales consisting of items that experts from many cultures identified as being very consistent with DSM-5 categories. The profiles also include a Critical Items scale consisting of items of particular concern to clinicians. The profiles display scale scores in relation to norms for each gender at ages 18-35 and 36-59, based on national probability samples.

Adults complete the ASR to report their own adaptive functioning, problems, and substance use. People who know the adult complete the parallel ABCL.

Both forms are valuable for assessing adults in mental health, family therapy, forensic, counseling, medical, substance abuse, and other settings. The ASR and ABCL are especially valuable for assessing parents of children seen for mental health and family therapy services. By having parents complete ASRs to describe themselves and ABCLs to describe their partner, you obtain profiles that highlight crucial agreements and disagreements between parents’ self-descriptions and other people’s descriptions of their functioning. You can also compare parents’ ASR and ABCL profiles with their children’s ASEBA profiles.

**Adult (ASR/18-59 & ABCL/18-59) Scales**

Adaptive Functioning Scales: Friends; Spouse/Partner; Family; Job; Education, Personal Strengths

Syndrome Scales: Anxious/Depressed; Withdrawn; Somatic Complaints; Thought Problems; Attention Problems; Aggressive Behavior; Rule-breaking Behavior, and Intrusive

DSM-oriented Scales: Depressive Problems; Anxiety Problems; Somatic Problems; Avoidant Personality Problems; Attention Deficit/Hyperactivity Problems (Inattention and Hyperactivity/Impulsivity subscales); and Antisocial Personality Problems

Substance Use Scales: Tobacco; Alcohol; Drugs

Older Adult (Ages 60-90+) Assessments

The Older Adult forms (OABCL and OASR) can greatly improve assessment in a variety of contexts, including psychiatric and psychological evaluations; medical care; assessments following significant life changes, such as loss of a loved one or a move to an assisted living environment; and evaluations before and after planned changes and interventions.

The OASR obtains older adults’ self-reports of diverse aspects of adaptive functioning and problems. The OABCL is a parallel form for obtaining reports from people who know the adult well.

Cross-informant comparisons make it easy to see similarities and differences between self-reports and reports by other people.

Greatly improve assessment in contexts such as: psychiatric and psychological evaluations; medical care, including routine care and evaluation of functioning following events such as strokes, falls, and illnesses; following significant life changes, such as loss of a loved one, moves to retirement communities, assisted living, and nursing homes; and evaluations before and after planned changes and interventions.

Especially helpful is to have forms completed at regular intervals, such as 2 months, to determine if functioning is improving, worsening, or stable.

**Older Adult (OASR/60-90+ & OABCL/60-90+) Scales**

Adaptive Functioning Scales: Friends; Spouse/Partner; Personal Strengths

Syndrome Scales: Anxious/Depressed; Worries; Somatic Complaints; Functional Impairment; Memory/Cognition Problems; Thought Problems; and Irritable/Disinhibited

DSM-oriented Scales: Depressive Problems; Anxiety Problems; Somatic Problems; Dementia Problems; Psychotic Problems; and Antisocial Personality Problems
### Clinical

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Assess executive function behaviors in the school and home environments with the BRIEF, a questionnaire developed for parents and teachers of school-age children. Designed to assess the abilities of a broad range of children and adolescents, the BRIEF is useful when working with children who have learning disabilities and attention disorders, traumatic brain injuries, lead exposure, pervasive developmental disorders, depression, and other developmental, neurological, psychiatric, and medical conditions.

Features and benefits
Provides multiple perspectives. The Parent and Teacher Forms of the BRIEF each contain 86 items that measure different aspects of executive function.
Specific normative data based on age and gender. Separate normative tables for parent and teacher forms provide T scores, percentiles, and 90% confidence intervals for four developmental age groups by gender of the child.
Nonoverlapping scales. Theoretically and statistically derived scales measure different aspects of a child or adolescent’s behavior, such as his or her ability to control impulses, move freely from one situation to the next, modulate responses, anticipate future events, and keep track of the effect of his or her behavior on others.

Test structure
Eight clinical scales (Inhibit, Shift, Emotional Control, Initiate, Working Memory, Plan/Organize, Organization of Materials, Monitor) and two validity scales (Inconsistency and Negativity) give the clinician a well-rounded picture of the behavior of the child or adolescent being rated.
The clinical scales form two broader Indexes (Behavioral Regulation and Metacognition) and an overall score, the Global Executive Composite. The Working Memory and Inhibit scales differentiate among ADHD subtypes.

Technical information
Normative data are based on child ratings from 1,419 parents and 720 teachers from rural, suburban, and urban areas.
The clinical sample included children with developmental disorders or acquired neurological disorders (e.g., reading disorder, ADHD subtypes, traumatic brain injury, Tourette’s disorder, mental retardation, localized brain lesions, high functioning autism).
High internal consistency (alphas = .80-.98) and test-retest reliability (rs = .82 for parents, .88 for teachers) were found.
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Conners-3
Keith C. Conners, Ph.D

WARNING!! : NOTE THAT THE AGE OF DEPARTURE IS Conners-3 6 YEARS

The scale of assessment Conners, Third Edition, is the result of five years of intensive research and
development. The Conners-3 proves a reliable tool to assist the professional in the diagnostic pro-
cess. Based on sound findings and several key elements of the revised Conners rating scale. (CRS-
R), the Conners-3 provides a comprehensive assessment of attention deficit hyperactivity disorder.
The Conners-3 also assesses often associated disorders such as oppositional defiant disorder and
conduct disorder. The questionnaires for parents, teachers and self-assessment are available in the
long version or short version.

FORMS AND LADDERS
multiple sources
The Conners-3 provides a professional multi-source inventory (parent, teacher and self-evaluation)
which strengthens the diagnostic process.
The questionnaires for parents and self-assessment are available in English, French and Spanish.

Conners-3 LONG FORM
The long form can be used as part of the diagnostic process and is directly connected to the DSM-IV-
Tr. The parent version consists of 110 items, Teacher of the 115 items in the questionnaire and self-
assessment of 99 items . These long forms are used to identify specific needs and areas that require
more attention.

Conners-3 SHORT FORM
The Conners-3 also provides a short form to clinicians. This form includes 43 items for the question-
aire of parents, 39 teachers and self-assessment. It is ideal to decide who in a group may need
further evaluation. It can also be useful when evaluation should be given to repetition or when there
is little time to administer the Conners-3. The short form can also assess the success of intervention
programs.

Conners-3: INDEX OF ATTENTION DEFICIT / HYPERACTIVITY
The Conners-3 provides a revised index of attention deficit / hyperactivity disorder (Conners 3AI). This
questionnaire of 10 items taken from the long version of the Conners-3 is ideal in situations where
time is limited. It also proves useful when the clinician needs to identify children or adolescents who
require further assessment in a class for example. This form of the Conners can be used to measure
the effectiveness of intervention programs for patients who suffer from attention deficit / hyperactivity
disorder.
## Price

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<td>104,95$</td>
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### Did you know?

**GLOBAL INDEX**

The overall index of the Conners-3 (Conners-3 GI) is an effective and rapid measurement of general psychopathology. This index uses 10 items that proved the best preachers of psychopathology in the revised Conners. The selected items are the same as for the revised version. A new standard has yet been made.
Standardized cognitive assessments in the context of Cranio-cerebral trauma

An overall score and five sub-ratings, 22 subtests (total = 100)

1. Language: Outrights, repeating sentences, reading regular and irregular words, reading comprehension
2. Instrumental functions: Automation calculation praxis gestural, visual gnosis
3. Attention and working memory: Alertness, selective auditory attention, short-term memory, working memory and attentional control
4. Orientation and anterograde memory: Spatial and temporal orientation (with and without indexes.) Free recall, cued recall and image recognition
5. Control the behavior and executive functions: Reasoning, inhibition, flexibility, abstraction and mental activation

Characteristics:
1. Briefly assesses all cognitive functions, especially attentional functions, memory and executive
2. Sensitive to the different phases of recovery following TBI (items to quantify alertness, behavior and speaking)
3. CBT allows discrimination of different degrees of severity
4. Can be administered at the bedside
5. Quantifies each process of episodic memory

Prices

<table>
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<td>Professional Manual</td>
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<td>Response Sheet (25)</td>
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Construct
Standardized cognitive assessments in the context of trauma Traumatic Brain and in cases of concussion (mild TCC)

Population
12 to 89 years old

Administration
Individual

Time
15 to 45 minutes
This widely used questionnaire can be used independently or to enhance the EQUIP training program. It measures four categories of self-serving cognitive distortions (thinking errors), Self-Centered, Blaming Others, Minimizing/Mislabeling, and Assuming the Worst. The questionnaire is a 54 item measure that can be administered in groups or with individuals.

It is typically completed in 5 to 15 minutes and requires only a fourth-grade reading level. The questionnaire, which includes scoring and computation instructions and forms, is useful in assessment, treatment planning, tracking therapeutic progress, and individual or program-level outcome evaluation.

The How I Think (HIT) Questionnaire contains 54 items divided into four cognitive distortion subscales:

- Self-Centered
- Blaming Others
- Minimizing/Mislabeling
- Assuming the Worst

The items are also applied to four behavioral referent subscales:

- Opposition-Defiance
- Physical Aggression
- Lying
- Stealing

The How I Think (HIT) Questionnaire is sold in sets of 20 and is accompanied by a 44 page manual.
Hudson Scales

Walter W. Hudson

**Scale of self-esteem (ISE)**
This measurement scale contain 25 items, the degree of self-esteem of the individual. One must make a distinction in the interpretation of scores on the difference between self-esteem and self-concept. An individual may have a very high score on his self-esteem and have a depressive potential. It is recommended that the scale of overall satisfaction together with the scale of self-esteem.

**General Satisfaction Scale (GCS)**
The general satisfaction scale is a measure of nonpsychotic depression of the individual or of a suicidal crisis. It allows to follow up with a patient who experienced a psychotic episode or who have experienced a crisis. Clinical experiments show that a patient with a level of 70 should have immediately followed on his suicidal potential.

**Scale Parent Relations - Children**
There are three scales to measure the extent, severity and magnitude of the problems in the parent-child relationship.

**Scale parenting attitudes (IPA)**
The scale is completed by parents in respect of a child. This scale measures the magnitude of the problems of relationship he has with his child, regardless of age. The scale covers all ages of children, from 1 year to 20 years.

**Clinical attitude toward the mother (CAM)**
The scale measures the severity and amplitude of the problematic relationship the child has with his mother. The questionnaire is completed by each child assessed. It allows to provide a measure of the problems as perceived by the child.

**Clinical attitude toward the father (CAF)**
The scale measures the severity and amplitude of the problematic relationship the child has with his father. The questionnaire is completed by each child assessed. It allows to provide a measure of the problems as perceived by the child.

**Scale family relationships (IFR)**
This scale measures the severity and magnitude of problematic relationships that the person perceives his relationship with his family and can be designed as a measure of intra-family stress. This scale can be used in a context of family therapy.

**Scale peer relationships (IPR)**
This scale measures the severity and magnitude of problematic relationships that the person perceives his relationship with peers (friends or relations). It can be used in a context of difficult or problematic relationships with a reference group.

**Price**

| Online Passation | 3,00$ |
Leiter-3

Gale H. Roid, Ph. D., Lucy J. Miller, Ph. D., Mark Pomplun, Ph. D. and Chris Koch, Ph. D.

The Leiter-3 evaluates nonverbal cognitive, attentional and neuropsychological abilities, and targets «typical» as well as «atypical» children, adolescents, and now adults. Its engaging, nonverbal format makes it ideal for use with individuals with Autism and Speech/Language Disorders, as well as those who do not speak English. It provides an IQ score, as well as percentile and age-equivalent scores for each subtest.

The Leiter-3 has retained the best of the widely-used Leiter-R subtests, and includes a number of new measures. It now uses a refined block-and-frame format, plus foam manipulatives, for easier manipulation by all subjects. Completely nonverbal, the Leiter-3 maintains an easy, game-like administration throughout the test, which holds interest for a wide range of ages and clinical groups.

Overall efficiency and utility of the Leiter-3 has been increased by combining Leiter-R subtests, and removing items with similar difficulty levels, based on Leiter-R data. Through this process, the number of subtests has been reduced from 20 to 10. The streamlined Leiter-3 provides improved assessment of Fluid Reasoning and Attention/Memory.

Enhanced Data on Difficult-to-Assess Clinical Groups
Attention Deficit/Hyperactivity Disorder
Autism
Cognitive Delay (severe)
English as a second language (ESL)
Gifted/Talented
Hearing Impairment (severe)
Learning Disability
Motor Delay (severe)
Speech/Language Impairment (severe)
What’s New with Leiter-3!
Block and Frame format for more accurate assessment of Autistic individuals
Decreased number of subtests, increasing overall efficiency and utility of the instrument
A neuropsychological subtest (Nonverbal Stroop Test) has been added
All new Attention-Divided subtest, with greater reliability, and ease of use
New Manipulatives

Designed with Safety in Mind
The Leiter-3 was redesigned to accommodate individuals with a wide range of cognitive and physical disabilities. Blocks are lightweight, colorful, non-toxic, and choke-safe, with rounded corners, to prevent harm to either the subject or examiner. The Frame is lightweight, yet durable, without sharp corners. Foam Pieces are durable and brightly-colored. Easel and Stimulus Books are laminated for durability and easy clean-up.

No Cultural or Language Bias
Psychometric studies show the Leiter-3 to have exceptional fairness for all cultural and ethnic backgrounds. The test is very useful for nonverbal, non-English speaking individuals, as well as those with ADHD, Autism and other Communication Disorders.

Leiter-3 Subtests
Cognitive Scales (Fluid Intelligence)
Unlike other IQ tests, the Leiter-3 emphasizes fluid intelligence, the truest measure of an individual’s innate cognitive abilities. This makes the Leiter-3 more accurate and fair, since IQ is not significantly influenced by the individual’s educational, social and family experience.
Sequential Order (SO)
Form Completion (FC)
Classification and Analogies (CA)
Figure Ground (FG)
Matching/Repeated Patterns (M/RP)- optional

Attention and Memory Scales
Attention and Memory subtests enhance interpretation of the global IQ score, by providing valuable diagnostic indicators regarding the score on the Cognitive portion of the Leiter-3. They also distinguish individuals with ADHD, LD or neuropsychological impairments, from typically-functioning individuals.
Forward Memory (FM)
Attention Sustained (AS)
Reverse Memory (RM)
Nonverbal Stroop (NS)
Attention Divided (AD)
**Examining Rating Scale**
The Social-Emotional Examiner Rating Scale gathers information about the individual's:
- Attention
- Organization Skills
- Impulse Control
- Activity Level
- Anxiety
- Energy and Feelings
- Mood Regulation
- Sociability
- Sensory Reactivity
- Scoring

**The Leiter-3 provides individual subtests, and numerous composite scores, that measure intelligence and discrete ability areas.**
These scores identify strengths and weaknesses in individual skills, as well as skill sets. Percentile and age-equivalent scores are provided.

Growth Scores are provided for all domains, enabling professionals to measure small, but important, cognitive shifts within a skill set, particularly important for children with cognitive disabilities. Tracking these shifts allows professionals, educators, and parents to see the improvement (growth) across time, irrespective of age-based standard scores.

**Normative Data**
Normative data includes more than 1600 individuals, representative of the most current general population, in terms of ethnicity/race, gender and age. The normative sample is also diverse in terms of parent/self education level and geographical region.

**The Leiter-3 Kit includes all Manipulatives** (Frame, Blocks, Foam Shapes, Stimulus Cards, Attention Divided Bowls), an Easel Book, a Stimulus Book, Scoring Keys, Administration Gestures Laminate, Record Forms, Response Booklets, a Manual, a Timer and a Purple Marker, all in a convenient Rolling Backpack.

---

**Prices**

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<td>Leiter-3 Scoring software</td>
<td>5017-34150</td>
<td>494.99$</td>
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The abstract of symptoms Inventory LSB 50 is a short version of a list of symptoms, allowing you to quickly assess the psychological symptoms of an individual. This is a scale based on self-assessment and for supporting psychologists, psychiatrists, nurses and other health professionals in their clinical decision-making on admission of new patients and when treatment variety of settings.

Designed for patients 13 and older, the evaluation tool is versatile 50 LSB. The LSB-50 assesses a wide range of psychological problems and psychopathological symptoms in a variety of settings. This classic assessment is also useful for measuring a patient’s progress and treatment outcomes.

It can be used for:
- Provide a first clinical evaluation
- Support, objectively, decisions related to care management
- The evaluation of patient progress during and after treatment in order to track changes

Advantages
- Brief assessment; can be completed in only 6-10 minutes
- Open for repeated administrations over time, in order to assess the progress of patients
- Evaluates 8 primary symptoms dimensions
- Designed in order to provide an overview of a patient’s symptoms, and the intensity thereof at a specific time.
- Includes validity scales and an overall index of severity of symptoms.

SCALES
Validity Scale:
Amplification of symptoms, symptoms Minimization

general indices:
- Global severity index
- Number of symptoms present
- Index of intensity of symptoms present

clinical Scale
- Psycho-reactivity, hypersensitivity, Obsession - compulsion, Anger - Hostility, anxiety, somatization, depression, sleep disorder.

Overall index of psychopathological risk.
A report with T scores and percentile for normal population and a clinical population.

Price

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<tr>
<th>Online passation</th>
<th>5,00$</th>
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<tr>
<td>Manual</td>
<td>50,00$</td>
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The MVPT-4 is the most recent revision of the only non-motor visual perceptual assessment that can be used throughout the lifespan. The MVPT-4 provides a quick, reliable, and valid measure of overall visual perceptual ability in children and adults. The MVPT-4 includes 45 items from the MVPT-3 which have been reorganized and grouped for easier administration.

Stimuli are comprised of black-and-white line drawings and designs, with answer choices presented in an easy to record multiple-choice format. No motor involvement is needed to make a response, making the test particularly useful with those who may have motor disabilities. The MVPT is one of the most widely used visual perceptual assessments used by occupational therapists and driver rehabilitation specialists.

The MVPT-4 is designed to be used for screening and research purposes by psychologists, occupational therapists, educational specialists, optometrists, and others who may need to determine a person’s overall ability to discern and understand visual stimuli.

Visual Perceptual Abilities Assessed

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<th>Population</th>
<th>Administration</th>
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<td>Visual Discrimination - the ability to discriminate dominant features of different objects, including the ability to discriminate position, shapes, and forms.</td>
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<td>Individual</td>
<td>20-25 minutes</td>
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<td>Spatial Relationships - the ability to perceive the positions of objects in relation to oneself and to other objects. Items assess the perception of pictures, figures, or patterns that are disoriented in relation to each other, such as figure reversals and rotations</td>
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<td>Visual Memory – the ability to recognize a previously presented stimulus item after a brief interval</td>
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<td>Figure-Ground – the ability to distinguish an object from background or surrounding objects</td>
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<td>Visual Closure – the ability to perceive a whole figure when only fragments are presented</td>
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The MVPT-4 includes new norms for ages 4-0 through 80-0+ years. Data was collected from 2012-2014 on a national, stratified sample of more than 2700 individuals. Results of reliability and validity studies are provided, as well as performance comparisons with clinical populations.

Administration and Scoring

The MVPT-4 takes approximately 20-25 minutes to administer. Test plates are contained in one easy-to use book with an easel back. Test administration cues are provided in the test plates to facilitate administration. Scoring is extremely easy; no basals or ceilings are needed. The raw score is quickly converted to ONE overall standard score and percentile rank.

Price

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<td>Complete kit</td>
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<td>Manual</td>
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<td>Test plates</td>
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<td>Record Forms</td>
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This objective inventory of adult personality assesses psychopathological syndromes and provides information relevant for clinical diagnosis, treatment planning and screening for psychopathology.

Features and benefits
Unique, efficient scale structure. All 22 scales are nonoverlapping, promoting high discriminant validity.
Scale development was content-driven.
Fast, cost-effective administration. Clients generally complete the 344 items in less than an hour. Can be used with low-reading level populations. The PAI requires only a 4th-grade reading level; an audio administration CD is also available.
No scoring keys needed. A two-part carbonless Answer Sheet provides scores for all 344 items.
Hand-scoring is fast and easy. Scales and subscales can be hand scored in only 15-20 minutes.
Provides strategies for interpretation. The Professional Manual includes an expanded discussion of administration considerations and a variety of strategies for the interpretation of clinical data.
Portable materials. The handy PAI Administration Folio provides a hard surface for both the Item Booklet and Answer Sheet for situations in which no desk or tabletop is available.

Test structure
The 344 PAI items constitute 22 nonoverlapping scales covering the constructs most relevant to a broad-based assessment of mental disorders: four validity scales, 11 clinical scales, five treatment scales and two interpersonal scales. To facilitate interpretation and to cover the full range of complex clinical constructs, 10 scales contain conceptually derived subscales.

Clinical scales provide critical diagnostic features of 11 important clinical constructs. These 11 scales may be divided into three broad classes of disorders: those within the neurotic spectrum, those within the psychotic spectrum and those associated with behavior disorder or impulse control problems.

Treatment scales indicate potential complications in treatment. These five scales include two indicators of potential for harm to self or others, two measures of the respondent’s environmental circumstances and one indicator of the respondent’s motivation for treatment.

Interpersonal scales provide valuable information regarding the client’s relationships and interactions. Interpersonal style is assessed along two dimensions: a warmly affiliative versus a cold rejecting style and a dominating/controlling versus a meekly submissive style.

Two scales assess pathology. The Borderline Features scale is the only PAI scale that has four subscales, reflecting the factorial complexity of the construct. The Antisocial Features scale includes three subscales: one assessing antisocial behaviors and the other two assessing antisocial traits.

Critical Items form alerts you to issues that require immediate attention. This form lists 27 items (distributed across nine content areas) that suggest behavior or psychopathology that may demand immediate attention. They are identified as critical based on two criteria: indications of a potential crisis situation and a very low endorsement rate in normal individuals.
**Technical information**

Reliability and validity are based on data from a U.S. Census-matched normative sample of 1,000 community dwelling adults, a sample of 1,265 patients from 69 clinical sites, and a college sample of 1,051 students.

Because the PAI was normed on adults in a variety of clinical and community settings, profiles can be compared with both normal and clinical populations. Reliability studies indicate that the PAI has a high degree of internal consistency across samples results are stable over periods of 2-4 weeks (median alpha and test-retest correlations exceed .80 for the 22 scales). Validity studies demonstrate convergent and discriminant validity with more than 50 other measures of psychopathology.

**Supplemental components make PAI use even easier**

A separate screener, the Personality Assessment Screener® (PAS®), saves you time and money by quickly identifying individuals who may be free from acute pathology and provides rapid, efficient screening for 10 distinct clinical problem domains.

The PAI Software Portfolio (PAI-SP) provides unlimited comprehensive, useful and accurate 10- to 15-page PAI Clinical Interpretive Reports or 2 to 4 pages PAS Score Reports.

The PAI Audio Administration CD-ROM can be used with individuals who have limited reading skills or who might otherwise benefit from an audio presentation of the PAI. The CD includes a 7 seconds delay for each item to allow the client to mark his or her response on the PAI Hand-Scorable Answer Sheet.

**Price**

| Comprehensive kit (professional manual, 2 hardcover reusable item booklets, 2 administration folios, 25 hand scorable answer sheets, 25 adult profiles and 25 critical item forms) | 5073-59650 | 589.99$ |
| Professional manual | 5073-59660 | 139.99$ |
| Reusable softcover item booklet | 5073-20410 | 78.99$ |
| Reusable hardcover item booklet | 5073-18740 | 65.99$ |
| Handscorable answer sheets | 5073-18750 | 103.99$ |
| Profils adults | 5073-59670 | 72.99$ |
| Profils college | 5073-18770 | 65.99$ |
| Critical items forms | 5073-59680 | 62.99$ |
| administration folio | 5073-18790 | 65.99$ |
PSI-4 Parenting stress index

Richard R. Abidin, EdD

**Summary**

**Construct**
Identify parent-child problem areas

**Population**
0 to 12 years

**Administration**
Individual; Self-report

**Time**
20 minutes

**Designed to evaluate the magnitude of stress in the parent-child system**, the fourth edition of the popular PSI is a 120 item inventory that focuses on three major domains of stress: child characteristics, parent characteristics, and situational/demographic life stress.

**The PSI-4 is commonly used as a screening and triage measure for evaluating the parenting system and identifying issues that may lead to problems in the child’s or parent’s behavior.** This information may be used for designing a treatment plan, for setting priorities for intervention, and/or for follow-up evaluation. Other common settings for administration of the PSI-4 include medical centers where children are receiving medical care, outpatient therapy settings, pediatric practices, and treatment outcome monitoring.

**Features and benefits**
Revised to improve the psychometric characteristics of subscales and domains and to update item wording to more clearly tap into the target construct or behavioral pattern or to be more understandable. The original structure has been retained.

Validation studies conducted within a variety of foreign populations, including Chinese, Portuguese, French Canadian, Finnish, and Dutch, suggest that the PSI is a robust measure that maintains its validity with diverse non-English speaking cultures.

Expanded norms are organized by each year of child age.

Percentiles; the primary interpretive framework for the PSI-4 and T scores are provided.

One validity scale; Defensive Responding indicates whether the parent is responding in a defensive manner.

**Test structure**
Two domains, Child and Parent, combine to form the Total Stress scale. The Life Stress scale provides information about the amount of parent stress caused by factors outside the parent-child relationship.

Within the Child Domain, six subscales (Distractibility/Hyperactivity, Adaptability, Reinforces Parent, Demandingness, Mood, and Acceptability) evaluate sources of stress as gathered from the parent’s report of child characteristics.

Within the Parent Domain, seven subscales (Competence, Isolation, Attachment, Health, Role Restriction, Depression, and Spouse/Parenting Partner Relationship) measure sources of stress related to parent characteristics.

**Technical information**
All new normative data were collected from a sample of 534 mothers and 522 fathers stratified to match the demographic composition of the 2007 U.S. Census.

Coefficient alpha reliability coefficients based on the responses of individuals in the normative sample ranged from .78 to .88 for Child Domain subscales and from .75 to .87 for Parent Domain subscales. Reliability coefficients for the two domains and the Total Stress scale were .96 or greater, indicating a high degree of internal consistency for these measures.

Test-retest reliability coefficients, obtained through several studies, ranged from .55 to .82 for the Child Domain, from .69 to .91 for the Parent Domain, and from .65 to .96 for the Total Stress score.

Validity has been investigated in studies that focused on at-risk children, attachment, ADHD, child abuse, forensic contexts, medical treatment adherence, substance abuse, parental depression, and more.

**Price**

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<tr>
<th>Item</th>
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<td>PSI-4 ANSWER SHEETS</td>
<td>5073-10269</td>
<td>143,99$</td>
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<td>PSI-4 INTRODUCTORY KIT</td>
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