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## Development of the WPPSI—III

Diane Coalson, PhD and Jianjun Zhu, PhD

The *Wechsler Preschool and Primary Scale of Intelligence—Revised* (WPPSI—R; Wechsler, 1989) is currently under revision and will be published as the *Wechsler Preschool and Primary Scale of Intelligence—Third Edition* (WPPSI—III). The WPPSI—III is comprised of 15 subtests and is designed to assess the intelligence of children between the ages of 2 years 6 months and 7 years 3 months. In addition to providing updated normative data, the primary goals of this revision are aimed at increasing age-appropriateness and user-friendliness, improving psychometric properties, and enhancing the clinical utility of the scale.

### More Age-Appropriate

The WPPSI—III has undergone substantial revision to increase the age-appropriateness of the scale. This is of particular importance since the age range has been lowered to 2 years 6 months. Because the cognitive abilities of very young children are not yet fully differentiated, children between the ages of 2 years 6 months and 3 years 11 months take fewer subtests that are designed to measure abilities in verbal comprehension and perceptual organization. Children between the ages of 4 years and 7 years 3 months take a greater number of subtests that are designed to measure the child's abilities in verbal comprehension, perceptual organization, and processing speed.

Additional revisions aimed at increasing the age-appropriateness of the scale include simplified instructions to the child, less emphasis on speed performance, and the addition of more play-like tasks to the scale. To enhance young children's understanding of the tasks, instructions to the child have been simplified and made more intuitive in nature. Teaching and practice items have been included for all subtests. In addition, the use of queries and prompts is generally unrestricted in the WPPSI—III.

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## Conventions

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Children and Adults with Attention Deficit/Hyperactivity Disorder (CHADD), Anaheim, CA . . .	10/18 – 20/01
National Academy of Neuropsychology (NAN), San Francisco, CA . . . . .	10/31 – 11/03/01
Learning Disabilities Association of America (LDAA), Denver, CO . . . . .	2/13 – 16/02
International Neuropsychological Society (INS), Toronto, Ontario, Canada . . . . .	2/13 – 16/02
National Association of School Psychologists (NASP), Chicago, IL . . . . .	2/27 – 3/3/02



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## Development of the WPPSI-III, continued from page 1

Due to normal lags in the development of young children's motor skills relative to their cognitive skills, the emphasis on speed and accuracy in the performance subtests has been reduced in the WPPSI-III. For example, children are no longer penalized for some rotation of designs or for gaps and misalignments between blocks on the Block Design subtest. Similar modifications to scoring criteria are incorporated in the Object Assembly subtest. Existing subtests have been modified and new subtests have been developed to include more engaging and play-like tasks in the scale. All art in the stimulus booklet has been redrawn to be more contemporary and colorful. The new Concept Grouping subtest includes a set of brightly colored plastic animals. These modifications should make the WPPSI-III more engaging and game-like for young children.

### More User-Friendly

A number of revisions are designed to increase the user-friendliness of the scale. Instructions to the examiner and scoring procedures have been simplified to enhance ease of administration. Test materials have also been modified to make administration of the scale more user-friendly. For example, the new page layout of the stimulus booklet allows the examiner to turn pages for the child without reaching across the table. Similarly, use of the Object Assembly shield has been eliminated to make the presentation of puzzle pieces less difficult and time-consuming. In addition, the overall testing time required to administer the core subtests has been reduced, especially for children between the ages of 2 years 6 months and 3 years 11 months.

### Improved Psychometric Properties

Other revision goals are aimed at improving the scale's psychometric properties. New items have been developed to ensure that all existing subtests have adequate floors, ceilings, and difficulty-level gradients. Despite the addition of these items, the overall administration time has not increased significantly. Overlapping items between the WPPSI-R and the *Wechsler Intelligence Scale for Children—Third Edition* (WISC-III; Wechsler, 1991) that might have produced significant practice effects have been replaced with new, parallel items. All items in the current version of the WPPSI-III have been reviewed for ethnic, gender, regional, and socio-economic bias by statistical analysis and expert review. Items that have been identified as biased according to these methods have been modified

or dropped from the scale and will be analyzed in a similar manner prior to the scale's publication. A series of three scoring studies have been performed to refine the scoring criteria of all items following these revisions.

Eight new subtests have been developed to reflect current advances in the assessment of children's intelligence. The new subtests have been designed to measure such abilities as verbal and non-verbal fluid reasoning, receptive versus expressive vocabulary ability, and processing speed. For example, in the Word Context subtest, the child is presented with an increasingly specific series of one to three clues and identifies the common object or concept being described. The Matrix Reasoning subtest has been adapted for young children, and includes several types of non-verbal reasoning tasks, including analogy reasoning, classification, pattern completion, and serial completion. The addition of a Receptive

*“The WPPSI-III will provide a reliable and valid measure that is user-friendly and age appropriate for the child, while providing more clinically useful information to the practitioner.”*

Vocabulary subtest allows the practitioner to examine differences between a child's receptive and expressive vocabulary ability. Symbol Search and Coding have been adapted for use with younger children to provide a relatively pure measure of processing speed. The Symbol Search subtest has symbols that are simpler and larger than those found on the WISC-III. The appearance of the Coding subtest is identical to that of Coding A on the WISC-III, but instructions to the child have been dramatically simplified and made more intuitive in nature. Results from preliminary phases of test development have been encouraging, and indicate that estimates of both reliability and validity are improved in the WPPSI-III.

### Enhanced Clinical Utility

The inclusion of additional validity and clinical studies and optional scores is designed to enhance the clinical utility of the WPPSI-III. During the standardization phase of development, validity data will be obtained using such measures as the *Adaptive Behavior Assessment System* (ABAS; Harrison & Oakland, 2000), the *Wechsler Individual Achievement Test—Second Edition* (WIAT-II; Wechsler, 2001), and the *Differential Ability Scales* (DAS; Elliott, 1990). The addition of these and other validity studies is designed to reflect changes in federal legislation and the use of multiple criteria for identification of children for special services. In addition, data will be obtained from a number of clinical groups, including mental retardation (mild and moderate severity), developmental delay, Attention-Deficit/Hyperactivity Disorder, cognitively gifted, and limited English proficiency. Data from these and other clinical groups will allow the practitioner to better examine the relative performance of clinical and non-clinical groups on the WPPSI-III and to describe the performance of an individual child relative to his or her appropriate reference group.

### Summary

The WPPSI-III represents a major revision in light of advances in the areas of intelligence theory, cognitive developmental research, and the assessment of intelligence in children. The WPPSI-III will provide a reliable and valid measure of intelligence in young children that is user-friendly and age-appropriate for the child, while providing more clinically useful information to the practitioner for diagnosis, treatment, and intervention.

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# Protecting the Brains of Student Athletes: The Importance of Concussion Assessment

**Rosemarie Scolaro Moser, PhD, ABPN**

More than ever, children are playing both recreational and school-supervised sports, often beginning as early as age five. Participation in sports is highly valued for both genders, especially in high school where students prepare for the competition of college admission. Sports participation is seen as a way of rounding out the academic record of prospective applicants, as well as a possible source of scholarship funds.

However, little attention has been paid to the cognitive risk of youth contact sports. In a survey of 235 schools, Powell and Barber-Foss (1999) documented that 5.5% of the reported sports injuries were mild traumatic brain injuries. The greatest percentage of injuries occurred in football, girls' and boys' soccer, and wrestling.

## Identifying Concussions

In a preliminary study by Moser and Schatz (in press), 34 of 35 healthy high school student athletes reported a history of some form of concussion. Although this seems high, these students were interviewed based on the guidelines for the classification of concussion set forth by the Quality Standards Subcommittee of the American Academy of Neurology (1997). In this classification system, any symptom that lasts under 15 minutes is considered a Grade One concussion. So when Johnny takes a hit on the football field and feels momentarily dazed, that qualifies as a Grade One concussion. A Grade Two concussion occurs when any symptom lasts longer than 15 minutes. For example, after a hard check or hit while playing ice hockey, it is not uncommon for an athlete to go home with a headache that lasts a few hours. That would be considered a Grade Two concussion. A Grade Three concussion occurs when there is any loss of consciousness, whether brief or prolonged. Guidelines have also been recommended regarding how long an athlete should refrain from play based on the grade and number of concussions sustained.

Mild head trauma or concussions probably occur more commonly than we realize. But brain injuries are not visible, as are physical injuries, and are frequently unidentified. Yet once an individual sustains a concussion, he or she is four to six times more likely than another individual to sustain an additional concussion. Most parents and coaches are unaware of how to identify a concussion, and often allow students to continue playing. However, we now know that if a student

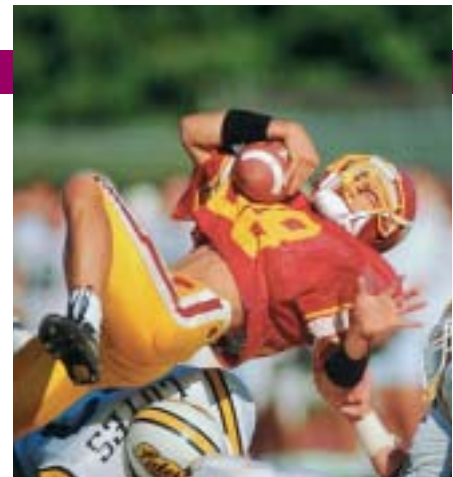
is not fully recovered from the first injury and continues to play, it is a second hit that puts the student at risk for brain damage or the prolonged Post Concussion Syndrome (PCS). In PCS, individuals may suffer from a variety of symptoms including attention and concentration difficulties, learning problems, fatigue, sleep disturbance, irritability, emotional distress, and headaches.

Lack of knowledge regarding the consequences of concussion puts coaches, trainers, school personnel and others at risk for liability and litigation. Second Impact Syndrome (SIS), a rare but potentially fatal consequence of head injury, has been documented in youth. SIS may occur when a youth athlete returns to play prior to full recovery from the first head impact. In certain cases, upon second impact, the vulnerable brain swells immediately, and can result in brain damage or death.

## Professional vs. High School Sports

Sports-related head injury has been spotlighted in professional sports, such as boxing, ice hockey, and football. Professional sports are high stakes endeavors that have over the past few years realized the necessity of good brain hygiene (Lovell, 1999). Both the National Hockey League and the National Football League have adopted preseason neuropsychological baseline screening programs to assist team physicians with return-to-play decisions and to ultimately protect players from the problems of concussions. By comparing preseason test results (from a short battery that samples cognitive areas tending to be sensitive to mild head injury) to post injury test results, neuropsychologists can help determine when a player is ready to return to play. Such testing is often more sensitive than a neurological exam, CT, or MRI scans and assesses areas of cognitive functioning such as attention, memory, verbal fluency, visual/spatial perception, mental speed and efficiency, and mental coordination.

What is available to professional athletes is now being brought to the high school level in a program of education, prevention, research and assessment for student athletes. In one program in Mercer County, New Jersey, participating school personnel, coaches, students, and parents are educated about concussion and its risks, and student athletes participate in preconcussion baseline testing and postconcussion assessment to aid in return-to-play decisions.



## Neuropsychological Screener

In this program, a short screening battery is being piloted for use with high school athletes aged 13 to 19 that includes the *Repeatable Battery for the Assessment of Neuropsychological Status* (RBANS), published by The Psychological Corporation. The RBANS is normed for use only in adults; however, it was used in this study because the tasks are appropriate for adolescents and the availability of alternate forms fit the pre/post test research paradigm. The RBANS samples a variety of cognitive areas with these subtests: 1) List Learning and Story Memory, that comprise an Immediate Memory Index; 2) Figure Copy and Line Orientation, that comprise the Visuoconstructional Index; 3) Picture Naming and Semantic Fluency, that comprise the Language Index; 4) Digit Span and Coding, that comprise the Attention Index; and 5) List Recall, List Recognition, Story Recall, and Figure Recall, that comprise the Delayed Memory Index. The RBANS conveniently offers two alternate forms, A & B, that facilitate retesting and address practice effects. Preliminary data suggest that the Battery holds promise for discrimination of both the short-term and long-term effects of concussion in adolescents.

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# The Beck Youth Inventories of Emotional and Social Impairment

Sandra Prince-Embury, PhD, Judith Beck, PhD, and John Jolly, PsyD

## Need for the Beck Youth Inventories

Disturbing recent events in our schools point to the fact that many children are in pain and do not feel that they are being heard. Children often lack the language skill, social skill, or sense of trust needed to express their distress directly. As recognized in the Individuals with Disabilities Education Act Amendments of 1997 (IDEA) legislation, children suffering with emotional disturbance are impaired in their ability to function adequately in regular school settings. If undetected, these children are likely to fail in the educational process as well as socially. Acting out behavior often erupts as a result of such an ongoing, insidious experience of failure.

In many cases, adequate resources for early identification of distress may not be available. The Surgeon General (U.S. Department of Health and Human Services, 1998) reported a shortage of qualified professionals to provide comprehensive assessment of children's mental health problems. The report suggested that gatekeepers, such as pediatricians and school counselors, using brief questionnaires, could identify children with problems and refer them for further assessment and services. *The Beck Youth Inventories of Emotional and Social Impairment (BYI)* were developed to aid in the identification and understanding, as well as in the treatment, of emotional distress in children.

The recently published *Beck Youth Inventories* are five brief self-report inventories designed to tap symptoms of depression, anxiety, anger, disruptive behavior, and self-concept in children ages 7 through 14. The 20 items for each inventory were carefully composed on the basis of clinical experience (particularly, self-reports of children in treatment), as well as a review of the pertinent literature. Final item selection was based on rigorous analysis to assure a second grade reading level; specific affective disorder criteria of the American Psychiatric Association's *DSM-IV* (1994) were reflected; and internal consistency within each affective domain was maintained.

## The Authors

The inventories were developed by Judith S. Beck, PhD, and Aaron T. Beck, MD, with significant

contributions from John Jolly, PsyD. Dr. Judith Beck is a psychologist and former teacher who has worked with children in a variety of settings for many years. Director of the Beck Institute for Cognitive Therapy and Research, she is also Clinical Associate Professor of Psychology in Psychiatry at the University of Pennsylvania. Dr. Aaron Beck, internationally known as the founder of cognitive therapy, developed some of the most widely used adult psychopathology scales in the world, including the *Beck Depression Inventory*, *Beck Anxiety Inventory*, and *Beck Scale for Suicidal Ideation*. He is President, Beck Institute for Cognitive Therapy and Research and Emeritus Professor of Psychiatry, University of Pennsylvania School. Dr. Jolly is currently Associate Professor in Psychology and Counseling, Mississippi College.

## Beck Youth Inventories as Targeted Measures of Distress Severity

The *Beck Youth Inventories* provide considerable clinical flexibility for the clinician, depending on the needs of the child and the situational demands. The inventories may be administered separately when there is need for a targeted assessment and/or there are time constraints. Administration of one of the inventories provides a comprehensive view of the child's experience within an affective or self-concept domain.

Psychometrically, the severity of a child's response within each domain is expressed in terms of a *T* score that indicates the severity of that child's distress relative to a non-clinical sex and age-based standardization sample. Cumulative percentages are provided for each *T* value indicating the relative frequency or infrequency of scores at each level of severity. Clinical and severity ranges for each inventory are provided in the manual. These ranges are based on the variance of distress customarily reported by children in the normative sample and the relative frequency of a response and the distribution of that response by children drawn from a clinical or special education setting.

Individual items have psychometric meaning only when used as parts of the inventory total score. However, individual items do have



qualitative clinical meaning when used by a qualified professional within a clinical context. Specific items on selected inventories parallel criteria for specific *DSM-IV* disorders. These items may be tagged for further evaluation if the child's response is indicative of disturbance. Individual items may also serve as probes for further exploration in treatment and in design of specific intervention.

## The Beck Youth Inventories Defined

- The *Beck Depression Inventory for Youth* is consistent with *DSM-IV* criteria for depression and reflects children's negative thoughts about themselves, their lives, and their future. Several items tap children's emotional states and physiological symptoms.
- The *Beck Anxiety Inventory for Youth* reflects children's specific worries about school performance, the future, negative reactions of others, fears including loss of control, and physiological symptoms associated with anxiety.
- The *Beck Anger Inventory for Youth* assesses children's thoughts about being treated unfairly by others, and feelings of anger and hatred.
- The *Beck Disruptive Behavior Inventory for Youth* includes items associated with Conduct Disorder and oppositional-defiant behavior. Items reflect negative thoughts and negative or antisocial preferences.
- The *Beck Self-Concept Inventory for Youth* taps children's thoughts about their own competence, potency and positive self-worth.

## Profile Analysis with the BYI Combination Booklet

The BYI Combination Booklet allows for the administration of all five inventories and includes guidelines for scoring and profiling across inventories. This method is recommended for a more comprehensive understanding of the child and for treatment planning. For instance, the recognition

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## *The Beck Youth Inventories of Emotional and Social Impairment*, continued from page 4

that a child who presents with complaints of disruptive behavior may also be experiencing depression and low self-esteem is clinically important. The BYI manual includes examples of case profiles and how they were clinically useful. The manual also includes preliminary findings of group profiles for children in treatment who have been assigned *DSM-IV* diagnoses.

### Summary

The *Beck Youth Inventories of Emotional and Social Impairment* provide child friendly, brief, easy to administer tools that may be used in identifying, understanding and helping children in distress.

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## Assessment of Adaptive Behaviors and Skills

Thomas Oakland, PhD

### What Behaviors Constitute Adaptive Behavior and Skills?

Adaptive behavior refers to the general ability of an individual to take care of oneself as well as to interact with and assist others. Adaptive skills refer to the more specific qualities that comprise adaptive behavior. Adaptive skills include those associated with communication, community use, functional academics, school and home living, health and safety, use of leisure time, self-care, self-direction, social qualities, and work for older adolescents and adults. These 10 skills are important universal life qualities.

Adaptive behaviors and skills develop with age and typically reach their full development in late adolescence or early adulthood. Most individuals will develop adequate adaptive skills. However, some individuals will display deficits in adaptive skills due to mental or physical delays, environmental restrictions, illnesses, accidents, injuries, or other causes.

### Why Should Adaptive Behavior and Skills be Assessed?

Knowledge of an individual's adaptive behavior and skills allows professional users to evaluate the degree to which a client is developing these important qualities. Additional attention to individuals who display inadequate development in one or more skill areas may be warranted.

The assessment of adaptive skills constitutes sound professional practice. For example, standards promulgated by the American Association

on Mental Retardation (AAMR; 1992) and the American Psychiatric Association (*DSM-IV-TR*, 2000) underscore the need to assess adaptive skills when diagnosing individuals with mental retardation. In addition, assessment of adaptive behavior and skills is required under the Individual with Disabilities Education Act Amendments of 1997 (IDEA; 1999). The focus on limitations in major life activities under Section 504 of the Rehabilitation Act also suggests a legal need to assess adaptive skills. Thus, sound professional practice emphasized by professional standards and laws warrant the assessment of adaptive behavior and skills.

### What Diagnostic Groups are Likely to Demonstrate Adaptive Skill Deficits?

Individuals diagnosed with mental retardation, by definition, display below average adaptive behavior and skills. Individuals with other disabilities also are likely to display diminished adaptive skills. For example, students diagnosed with attention deficits, autism, behavior disorders, communication disorder, emotional disturbance, learning disabilities, or other childhood and school-related disorders often display below average adaptive skill development (Harrison & Oakland, 2000). Adults with physical or brain injury, prolonged drug and alcohol abuse, dementia or other cognitive deficiencies also are likely to display diminished levels of adaptive skills. Therefore, professionals who work with individuals diagnosed with these and other



chronic disorders are likely to find information on adaptive behavior and skills useful in diagnosis and essential in program planning and monitoring.

### How Should Adaptive Behavior and Skills be Assessed?

The accurate description of behavior constitutes the main goal of any assessment. An accurate assessment of adaptive behavior and skills is enhanced when standardized norm-referenced tests are used to acquire information from various knowledgeable people (e.g., teachers, parents, supervisors) who have observed the person in various settings (e.g., at school, home, work) for an extended period.

An accurate assessment of adults may occur through a self-report. However, when immaturity, a disability, or other conditions preclude an accurate self-report, it is necessary to retrieve information from other reliable sources. Information from parents and one or more teachers enhances an accurate assessment of children.

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**Assessment of Adaptive Behaviors and Skills,**  
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The use of standardized norm-referenced tests is required by professional and legal standards (IDEA, 1999). The use of a test that measures the more general trait of adaptive behavior and the more specific 10 adaptive skill areas is highly desirable.

**How May This Information be Used?**

Information on adaptive behavior and skills typically is acquired as part of a comprehensive assessment. Its primary value often lies in providing information as to whether important functional life skills are displayed. Tests measuring other qualities do not provide this broad perspective of functional day to day qualities. The AAMR (1996) and many professionals believe that information on adaptive skills, in contrast to information on adaptive behavior, is more useful when planning and monitoring interventions.

Information on adaptive behavior and skills often is necessary for diagnosis and classification. Although these issues are important, many professionals believe the ultimate value of test results occurs when they are utilized to promote

development through program planning and monitoring. The following five steps enhance this process.

First, after completing an assessment of adaptive skills, identify skill levels needed in the individual's current environment or the environment into which the individual is moving. Second, identify current areas of strengths and weaknesses relative to environmental requirements. Third, identify and prioritize intervention objectives based on discrepancies between environmental needs and personal attainment. Fourth, implement interventions to achieve the objectives of professional service. Finally, monitor the implementation and effectiveness of the interventions (AAMR, 1996).

**A New Instrument That Assesses Adaptive Behavior and Skills**

The *Adaptive Behavior Assessment System* (ABAS; Harrison & Oakland, 2000), recently published by The Psychological Corporation, meets these standards. For example, the ABAS allows clinicians to assess adaptive behavior and skills by obtaining information on the 10 adaptive

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skill areas from parents, teachers, and adults who are familiar with the individual's adaptive behavior and skills in a variety of settings. The ABAS research indicates its value in identifying skill deficits in children and youth who display various disabilities. The ABAS data also help professionals to promote development through program planning and monitoring.

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