Memory Information
Pack 2011

Pearson Assessment, the UK's leading publishers of standardised assessments

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Introducing our Memory Information Pack

Dear Colleague,

Please find enclosed up to date information on our range of products for professionals working with children, young people and adults who have memory difficulties.

Pearson (Assessment) is one of the UK’s leading publishers of standardised assessments, with over 90 years experience of test research and development. Our tools are used by a number of professionals in both clinical and educational settings, and can aid you in assessment and treatment planning.

We are committed to developing psychometrically sound and reliable tools to meet your assessment needs. Inside this pack you’ll find information about our new Brief Cognitive Status Exam (BCSE) which helps evaluate global cognitive functioning in patients with dementia, mild learning disabilities, or suspected Alzheimer’s disease. At a time when the government is launching a campaign to raise awareness of the early signs and symptoms of dementia, we believe this tool will greatly assist in your practice.

Plus, look out for Cogmed, a software-based intervention that can help support individuals with poor working memory. Recent studies have highlighted the links between poor working memory and attainment in reading and mathematics. This is an important tool that is already available for use in schools and will be launched for health professionals and private practices in the UK this September.

In this pack you will find:

- Individual assessment product bulletins - including case studies and technical reports
- Your Area Sales Consultant details - we offer free, no obligation product demos giving you a chance to see a test in more depth.

If you have any questions, or would like to see one or more of our products, please contact your Area Sales Consultant (contact details can be found in the pack).

For order and price enquiries, contact Customer Services on +44 (0) 845 630 88 88 or visit us at our new look website www.psychcorp.co.uk (UK) / www.psychcorpinternational.com (OS).

Yours faithfully,

Nicola Owens
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www.psychcorp.co.uk
Overview: Effectively screen for working memory impairments.

Age Range: 4 years to 22 years

Administration: Individual - Screener: 5 to 7 minutes; Short form: 10 to 15 minutes; Long form: 45 minutes

Qualification Code: CL3

Working memory abilities are closely associated with a wide range of measures of academic ability, including literacy and mathematics. The majority of those with recognised learning difficulties in these areas have working memory impairments. Poor working memory skills in the early years of education are also effective predictors of poor scholastic attainments over the subsequent school years. Screening is the first and very important step in being able to provide the appropriate intervention for children.

The AWMA is an innovative computer-based assessment of working memory skills, with a user-friendly interface. This tool provides a practical and convenient way for teachers and psychologists to screen for significant working memory problems from childhood through to early adulthood.

“The scoring being done for you is brilliant.” Judith, Educational Psychologist

The tool requires minimal training as the administration and scoring is fully automated. The testing sequence is pre-set, test scores are calculated by the computer program and an interpretation of how their working memory scores will affect their learning is provided.

There are three levels of assessment within AWMA:

1. AWMA Screener
   This is made up of two tests and is suitable for screening individuals with suspected working memory difficulties.

2. AWMA: Short Form (AWMA-S)
   This consists of four tests and is recommended to screen individuals who are suspected to have memory difficulties, but the specific area of their difficulties is not known.

3. AWMA: Long Form (AWMA-L)
   This consists of all 12 tests and is recommended for confirmation of significant working memory problems for individuals identified as having working memory problems in the classroom.

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The AWMA has also been used with students with Dyslexia, Specific Language Impairments, Developmental Coordination Disorder, Attention Deficit and Hyperactive Disorder, Developmental Dyscalculia, and Autistic Spectrum Disorder. It provides a useful ‘snapshot’ of how their impairments and working memory skills impact learning.

The practical implications of these findings are that educators have access to a tool to facilitate identification of poor working memory skills in children. The AWMA provides a detailed profile of working memory skills necessary for targeting early intervention strategies.

Test reliability of the AWMA was measured on 128 individuals randomly selected across schools and universities aged between 4.10 years to 22.5 years (mean=10.4 years, S.D.=5 years).

A period of four weeks separated the two successive testing administrations. There was a close relationship between the individual’s performance at the first and the second time of testing, which indicates that there was very little change in the scores at the two testing points (rs ranged from .69 to .90).

“With some of the staff now trained to identify problems, we have the knowledge and tools to carry out a proper assessment and have the skills to help these children be more successful in school. We are already beginning to see children in a different light knowing more about the difficulties faced by children with impaired working memory…We think these new ways of learning can help both the teacher and the children to successfully complete their work.” Chris Evans, Headteacher, Lakes Primary School in Redcar, Cleveland, The Guardian

“The AWMA also has significant value as a measuring tool…it is easy to use and because the scoring and profile are automatically generated valuable time is saved. The profiles can give a good indication of what the nature of the learning difficulty is likely to be. The children find this medium of assessment less threatening. There are no extra costs involved in replacing any score sheets etc. We are now in the process of adopting the AWMA as a generic tool for all the advisory teachers in the service to use as an integral part of any assessment they do.” Jennie Whelan, Head of SEN & Disability Inclusion Service (SENDIS)

Download a free demo of two of the AWMA subtests at www.psychcorp.co.uk, where you can find out more about the Working Memory Rating Scales also by Tracy Packiam Alloway.

Tracy Alloway was winner of the prestigious Joseph Lister Award in 2009, read her blog at http://tracyalloway.com/
Overview

Overview: Checklist to identify children with poor working memory skills.

Age Range: 5 years to 11 years

Administration: Individual - Untimed

Qualification Code: CL3

The Working Memory Rating Scale (WMRS) is a behavioural rating scale developed for teachers to facilitate easy identification of children with working memory deficits.

Teachers can rarely identify memory as a source of difficulty in children with working memory problems, despite their poor classroom functioning. Instead, children with memory problems are typically described as inattentive. The WMRS will increase the chances of the detection and subsequent effective support in school for children with deficits of working memory.

The WMRS was developed on the basis of interviews with teachers and consists of 22 items. It provides a quick and efficient way for early identification of working memory problems that will impair learning. It has also been co-normed with the Automated Working Memory Assessment (AWMA) to provide a reliable tool for routine screening of memory difficulties.

Teachers administering the WMRS rate how typical each behaviour is of the child on a scale ranging from Not typical at all (0) to Very typical (3).

Features and benefits

- Takes no longer than five minutes to complete
- Easy to score and interpret, requiring no psychometric training
- Valuable as a diagnostic screening tool for identifying children at risk of poor working memory, and in illustrating classroom situations in which memory working failure arises
- Enables you to profile to difficulties typically faced by children with low working memory
- A valuable first step in detecting possible working memory failures
- Identification can be followed up by examination of the individual’s detailed profile of working memory strengths and weaknesses i.e. AWMA.

www.psychcorp.co.uk
Working Memory Rating Scales (WMRS)

Scoring

Raw scores are converted to T scores, which describe an individual’s performance with respect to the performance of others in the same age band. Percentile scores are also available. Higher scores reflect more problematic behaviour in the classroom and are associated with difficulties in working memory.

Normative sample

A total of 417 children from primary schools in urban and rural settings in England participated in the study. These schools were selected to provide a nationally representative demographic sample on the basis of the national average of performance on national assessments in English, mathematics and science sat by children aged 10 or 11 years and in the final year of primary school. Schools selected represent a range of low, average or high performance in the combined score of the national test results.

For further information visit www.psychcorp.co.uk/wmrs which contains links to a BPS article on Working Memory in the Classroom.
Overview


Age Range: 4 years to 8 years
Administration: Individual - 15 minutes
Qualification Code: CL2R

The *Children’s Test of Nonword Repetition (CN REP)* is suitable for use with children between 4 and 8 years who are attending mainstream schools and can also be used for older children with language related learning difficulties.

CN REP provides a reliable indicator of short-term memory which correlates well with language and other difficulties. The easy to use tables supply standardised scores and centile points for ages four, five, six, seven and eight years which are derived from a sample of 612 unselected children attending primary schools in England.

Failure of children to progress readily through key areas of the primary curriculum is probably the most serious and most common problem faced by teachers and educational psychologists.

A common observation is that many of the children who are experiencing difficulties in English and reading have difficulties in remembering spoken language for even short periods of time. This often manifests itself as the apparent inability of a child to attend to and carry out simple instructions.

“It is quick and easy to use...and if truly predictive it should be exceptionally useful in mainstream school.”
Karen Davies, Clinical Coordinator for Speech and Language Therapy, RCSLT Bulletin, 2000

The most widely used technique of assessing a child’s short-term memory has been the digit span task. Unlike other measures, CN REP has been developed using unfamiliar spoken words which the child must attempt to repeat. The results have shown that this test is even more closely linked to important abilities such as vocabulary knowledge, understanding of spoken language and reading achievement than the digit span.

Features and benefits

- The test performance provides a better predictor than digit span of children’s later achievements in the key curriculum areas of English and reading.
- The test uses unfamiliar spoken items which are not part of the English language, it does not disadvantage children with a less rich environmental experience of language.
- It is rapid to administer and score, taking in total no more than 4 minutes with the average child.
- Tasks are simple, making the test very easy for children to understand.
- Has excellent correlation with later school performance.

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Children’s Test of Nonword Repetition (CN REP)

Standardisation and reliability

This test was based on data collected from a representative sample of 612 children in England. Scores from a minimum of 84 children were obtained in each age interval.

Test-retest reliability was assessed in an independent study of 70 children with a mean age of 5 years 3 months. Each child was given the CN REP on 2 occasions, separated by a 4 week interval. The test-retest coefficient was 0.77. A further sample of 83 children were tested on the CN REP on two occasions separated by a much longer interval of 14 months. The correlation coefficient for scores obtained on the two occasions was 0.72, showing good reliability and stability of test scores.

Validity

- A measure of short-term memory - there is a large body of evidence which establishes that both nonword repetition in general and the CN REP in particular provide sensitive measures of short-term memory skills.
- An indicator of vocabulary knowledge - the CN REP provides an excellent predictor of native vocabulary knowledge during the early school years with scores typically falling in the range of 0.4 to 0.7 across a range of different vocabulary measures.
- An indicator of language comprehension - close links have been established between CN REP Scores and a sure of children’s abilities to comprehend the syntax of spoken sentences, the Test for the Reception of Grammar (TROG) found highly significant correlations between the two measures both for a sample of 57 children with a mean age of 4.09 (r 0.45, P<0.001) and for a sample of 51 children with a mean age of 5.09 (r 0.51, P<0.001).
- An indicator of reading ability - CN REP provides a very useful indicator of children who are likely to underachieve at reading. As very poor test scores on the CN REP appear to persist across the full range of childhood years in children with severe literacy problems, the CN REP is particularly valuable as a means of assessing the short-term memory abilities of children of secondary school age who may be dyslexic.
- Children with impaired language development - Children with normal general intelligence but poor language development also perform poorly on the CN REP. The test is recommended as a tool for identifying children during the early school years who are at risk of experiencing generalised delay in language development.

Reference materials

Further information is available from CN REP authors Susan Gathercole and Alan Baddeley on the website of The Centre for Working Memory and Learning, based at the University of York and the University of Durham.

The website includes information for psychologists, teachers and parents as well as details of current research projects.

Professor Susan Gathercole of the University of York was awarded the 2007 Presidents’ Award for Distinguished Contributions to Psychological Knowledge.

www.psychcorp.co.uk
Cogmed Working Memory Training™
Fact Sheet 2011

An evidence-based intervention for improved working memory

Working memory and Cogmed

Working memory is the ability to keep information in your mind for a short time, focus on a task, and remember what to do next. By training your working memory, you will be better able to stay focused, ignore distractions, plan next steps, start and finish tasks, and remember instructions. Working memory is proven to be a strong indicator of academic success.

Cogmed Working Memory Training is an evidence-based program for helping children, adolescents, and adults sustainably improve attention by training their working memory.

The program is based on strong scientific research, is delivered under the supervision of a Cogmed Coach - trained by Pearson.

Cogmed for educational settings

Cogmed training in schools

Cogmed acts as a primer for improved learning, allowing the student to build the fundamental cognitive platform needed to learn and achieve adequate yearly progress.

Cogmed is a computer based program that students can complete during the school day. The program consists of 25 sessions over a 5-6 week period. Each session is between 30-45 min. The software adjusts its complexity level for each student and each exercise, in real time, for maximized training effects. The Cogmed program is highly structured, ensuring successful implementation.

Cogmed for health and private practice

Coming September 2011 in the UK

Computer-based training, using a PC at home or at a designated healthcare facility will be available for cogmed from September 2011. The software adjusts the complexity level for each exercise, in real time, for maximized training effect and requires 25 training sessions of 30-40 minutes each, done over 5 weeks.

The user or family sets the training schedule with the Cogmed Coach - trained by Pearson, ensuring there is plenty of flexibility. The programme is supported by a Cogmed Coach, who leads the training, tracks results, and gives support and motivation.

The complete package includes

Cogmed training programs

Cogmed Working Memory Training is built around three easy-to-use, age-specific software applications. Click on the image below to go to the demo page.

Cogmed JM

Preschool

Younger children use their working memory for a number of things, such as focusing on and following instructions, and remaining seated to complete independent activities.

Cogmed RM

School Age

Working memory is crucial for children and adolescents in school, and socially. Reading, solving maths problems, planning, and following a conversation all rely on working memory.

Cogmed QM

Adult

Working memory in adult and professional life is critical for challenges such as planning, focusing, resisting distraction, and meeting deadlines.

Cogmed training web

The Cogmed training web is a tool that allows coaches to monitor training data in detail. The training web also provides support material necessary for motivating and guiding students through the training.

Sign up for a free webinar

Learn more from experienced professionals on how Cogmed works. New dates have been added for this September and October, visit:

www.psychcorp.co.uk/cogmed
Working memory is a cognitive function critical for focusing, resisting distractions, and for complex thinking. Improved working memory capacity generalizes to improved attention, impulse control and learning capacity. 8 out of 10 users who complete training show measurable effects; working memory capacity is increased, leading to better ability to focus, follow instructions, and stay on task.

Benefits for children:
Cogmed training will improve working memory substantially. For students constrained by working memory capacity, this will allow them to absorb the curriculum-based instruction more effectively with the objective of improved academic performance in areas such as maths and reading comprehension.

Cogmed acts as a “primer” for improved learning, allowing the student to build the cognitive platform needed to learn successfully.

Cogmed training alone will not improve school results, and cannot replace skilled teaching and instruction. But for students with weak working memory, Cogmed can provide a missing piece of that critical learning foundation.

Benefits for adults:
By training your working memory, you are better able to stay focused, ignore distractions, plan next steps, remember instructions, and start and finish tasks. The objective is better performance and attentional stamina.

A substantial body of research shows Cogmed to be effective in improving working memory - leading to improved attention. It began with Klingberg’s 2005 study on school age children showing strong results in a placebo-controlled, multi-center trial on children with ADHD. Since then, leading research teams around the world have added to the Cogmed Research case. This includes prominent research from the University of York led by Joni Holmes and Susan Gathercole which demonstrated that Cogmed led to retained improvements in working memory and mathematical problem solving six months after completing Cogmed training.

Other published studies have demonstrated statistically and clinically significant treatment effects on non-trained measures of working memory, response inhibition and complex reasoning.

Visit www.cogmed.com/research for comprehensive research, the latest research references, articles, and ongoing studies.

Cogmed was founded in 2001 by neuroscientists at the Karolinska Institute in Stockholm, Sweden. Cogmed training has been in successful use in the United States and Canada since 2006. The Cogmed system is now applied in more than 20 countries and 10 languages.

In 2010, Cogmed joined the Clinical Assessment Group of Pearson. Pearson is the world’s leading education company, providing educational materials, technologies, assessments, and related services to teachers and students of all ages. Learn more at www.psychcorp.co.uk/cogmed.

Now available from Pearson
UK Customers, visit www.psychcorp.co.uk/cogmed for more information about Cogmed. Alternatively call 0845 630 8888 or email info@psychcorp.co.uk if you have any queries.

Overseas Customers, please visit www.cogmed.com in the first instance.
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<th>Year</th>
<th>Publication</th>
<th>Title</th>
<th>PI</th>
<th>Population</th>
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<tr>
<td>2002</td>
<td>Journal of Clinical and Experimental Neuropsychology</td>
<td>Training of WM in children with ADHD</td>
<td>Klingberg</td>
<td>Children w/ADHD</td>
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<td>2004</td>
<td>Nature Neuroscience</td>
<td>Increased prefrontal and parietal activity after training of WM</td>
<td>Olesen</td>
<td>Adults w/ normal WM</td>
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<tr>
<td>2005</td>
<td>Journal of the American Academy of Child and Adolescent Psychiatry</td>
<td>Computerized training of WM of children with ADHD</td>
<td>Klingberg</td>
<td>Children w/ADHD</td>
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<tr>
<td>2007</td>
<td>Brain Injury</td>
<td>Computerized working memory training after stroke – a pilot study</td>
<td>Klingberg</td>
<td>Adult stroke victims</td>
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<td>2007</td>
<td>Physiology and Behavior</td>
<td>Changes in cortical activity after training of WM – a single-subject analysis</td>
<td>Westerberg</td>
<td>Adults w/ normal WM</td>
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<td>2008</td>
<td>Developmental Science</td>
<td>Training and transfer effects of executive functions in preschoolers</td>
<td>Thorell</td>
<td>Preschool children</td>
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<td>2009</td>
<td>Science</td>
<td>Changes in cortical D1 receptor binding after cognitive training</td>
<td>McNab</td>
<td>Adults w/ normal WM</td>
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<td>2009</td>
<td>Developmental Science</td>
<td>Training leads to sustained enhancement of poor WM in children</td>
<td>Holmes</td>
<td>Children w/ poor WM</td>
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<td>2009</td>
<td>Applied Cognitive Psychology</td>
<td>Impacts of training and medication on WM on ADHD Children</td>
<td>Holmes</td>
<td>Children w/ poor WM</td>
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<td>2010</td>
<td>School Mental Health</td>
<td>Working memory training for children with attention problems</td>
<td>Mezzacappa</td>
<td>Children w/ADHD</td>
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<tr>
<td>2010</td>
<td>Reading and Writing</td>
<td>Effects of working memory training on reading in children with special needs</td>
<td>Dahlin</td>
<td>Children w/ special needs</td>
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<td>2010</td>
<td>Brain Injury</td>
<td>Computerized training of WM in a group of patients suffering from acquired brain injury</td>
<td>Lundqvist</td>
<td>Adult TBI / stroke victims</td>
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<tr>
<td>2010</td>
<td>Journal of Clinical Child &amp; Adolescent Psychology</td>
<td>A controlled trial of working memory training for children and adolescents with ADHD</td>
<td>Beck</td>
<td>Children w/ADHD</td>
</tr>
<tr>
<td>2010</td>
<td>The Journal of Pediatrics</td>
<td>Computerized working memory training improves function in adolescents born at extremely low birth weight</td>
<td>Løhaugen</td>
<td>Children born at ELBW</td>
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Overview:
Assess children’s memory abilities
Age Range: 5 to 16 years
Administration: Individual - 30 minutes
Qualification Code: CLI

This battery comprehensively assesses the integrity of memory functions in children and enables comparison with measures of both ability and achievement. In keeping with the high standards of technical quality, reliability, and validity established by the Wechsler series, the CMS links learning and memory directly to ability and achievement, as measured by the WISC-III, WPPSI-R, and WIAT.

The CMS parallels the structure of the adult Wechsler Memory Scales. Its 6 core subtests load onto scales tapping:
- Immediate Verbal Memory
- Delayed Verbal Memory
- General Memory
- Immediate Visual Memory
- Delayed Visual Memory.

It features minimal item bias and extensive clinical validation studies, making it appropriate as a process skills screening instrument for children with learning difficulties or memory/attentional deficits resulting from TBI, epilepsy, cancer, etc.

Reliability
Average reliability coefficient: E.G. .91 (general memory)
Test-retest reliability: E.G. .89 (attention/concentration ages 9-12)
Inter-rater reliability: E.G. .94 (delayed word lists ages 5-8)

Norms
1,000 normally functioning children. Subtest scaled scores and index scored representing critical domains of learning, attention and memory.
Scoring software is available for the CMS and enables users to enter an individual’s age and CMS raw scores into their computer. The Scoring assistant will automatically convert the data into the appropriate scaled scores, index scores and graphs. Users have the option of printing select pages of the entire report. Selected pages can also be copied to a clipboard and pasted into your word processor.

Sample reports are available at www.psychcorp.co.uk
Overview:
Predict everyday memory problems in children
Age Range: 5 years to 10 years 11 months
Administration: Individual - 25 to 30 minutes
Qualification Code: CL2

While existing memory tests provide examiners with useful answers to theoretical questions, the RBMT-C has been devised to provide information that will be useful in establishing and alleviating difficulties encountered by a child in everyday life. The RBMT-C comprises of a number of subtests, each attempting to provide an objective measure of one of a range of everyday memory problems reported and observed in subjects with memory difficulties.

Features of subtests

The RBMT-C includes 10 subtests assessing aspects of visual, verbal, recall, recognition, immediate and delayed everyday memory. Retesting can be completed with Version 2 of the tool.

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<th>Subtest</th>
<th>Task</th>
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<tbody>
<tr>
<td>Remembering First and Second Names - Delayed Recall</td>
<td>The examinee is shown two photographic portraits and asked to remember the first and second names of both people in the photographs at a later point.</td>
</tr>
<tr>
<td>Remembering the Hidden Belonging - Delayed Recall</td>
<td>A packet containing gold stars is hidden. The examinee is required to ask for these stars at the end of the test and remember where these have been hidden.</td>
</tr>
<tr>
<td>Remembering an Appointment - Delayed Recall</td>
<td>An alarm is set. The examinee is required to ask some specified questions when the alarm sounds.</td>
</tr>
<tr>
<td>Picture Recognition - Delayed Recall</td>
<td>The examinee is shown a set of ten line drawings and then is asked to recognise them from a further set of pictures at a later time in the testing session.</td>
</tr>
<tr>
<td>Prose Recall - Immediate Recall</td>
<td>A story is read to the examinee and they have to recall it immediately.</td>
</tr>
<tr>
<td>Prose Recall - Delay Recall</td>
<td>The examinee is asked to recall the prose passage read earlier in the test.</td>
</tr>
<tr>
<td>Face Recognition - Delayed Recall</td>
<td>The examinee is shown a set of faces and then is asked to recognise them from a further set of faces at a later time in the testing session.</td>
</tr>
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Features of subtests continued...

<table>
<thead>
<tr>
<th>Subtest</th>
<th>Description</th>
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<tr>
<td>Route - Immediate Recall</td>
<td>The examiner shows the examinee a route to walk around the room and then asks the examinee to demonstrate it</td>
</tr>
<tr>
<td>Route - Delayed Recall</td>
<td>The examinee is asked to demonstrate the route the examiner took around the room earlier, this time without it being demonstrated to them</td>
</tr>
<tr>
<td>Messages - Immediate Recall</td>
<td>The examinee is required to take a message and book with them when they demonstrate the route and put them in the same place that the examiner did</td>
</tr>
<tr>
<td>Messages - Delayed Recall</td>
<td>The examinee is required to take a message and book with them when they demonstrate the route again and put them in the same place that the examiner did</td>
</tr>
<tr>
<td>Orientation</td>
<td>The examinee responds to a number of questions relating to person, time and place</td>
</tr>
</tbody>
</table>

Technical information

Sample
Nine mainstream schools (3 urban 3 suburban and 3 rural) from Hampshire took part in the study. A total of 335 children were assessed on two versions of the RBMT. The sample comprised 63 children aged between 5 and 6 years, 63 aged between 6 and 7 years, 57 aged between 7 and 8 years, 50 aged between 8 and 9 years, 53 aged between 9 and 10 years and 49 aged between 10 and 11 years. Just under half the children in the sample were boys and just over half were girls.

Validity
The RBMT-C has been validated using the observations of houseparents of children with severe epilepsy. The houseparents rated everyday memory failures. 0.71 was the correlation between houseparents’ ratings and children’s scores on the RBMT-C.

Norms
335 controls, 36 patient clinical study.

Scoring
For each subtest the raw score is converted into a standardised profile score depending on the age of the child, and these are summed to give an overall profile score. There are four parallel versions of the test to allow for repeated assessments.
The NEPSY Second Edition (NEPSY-II) is the revision of the NEPSY (Korkman, Kirk, & Kemp, 1998), a comprehensive instrument designed to assess neuropsychological development in preschool and school-age children. Results obtained from a NEPSY-II assessment inform diagnoses and aid in intervention planning for a variety of childhood disorders. In particular, the NEPSY-II provides the clinician with insight regarding academic, social and behavioural difficulties.

The NEPSY-II consists of a series of neuropsychological subtests that can be used in various combinations according to the needs of the child and the experience of the examiner. A broad range of subtests is included to assess neuropsychological development across six functional domains: Attention and Executive Functioning, Language, Memory and Learning, Sensorimotor, Social Perception, and Visuospatial Processing.

Several features of the NEPSY-II make it particularly useful for assessing children and adolescents. First, the subtests were designed specifically for children between the ages of 3 and 16, providing the clinician with age-appropriate assessment of cognitive functioning. Second, the subtests were normed on a single, well-stratified sample. This provides a comprehensive view of neuropsychological processes in children and patterns of age-related quantitative and qualitative changes in neuropsychological performance. Third, it was developed using four different subtest administration orders to limit the effects of subtest order on the normative data. This allows for flexibility in subtest selection and administration order. Finally, the NEPSY-II is designed to help identify cognitive deficits related to disorders that are typically first diagnosed in childhood and that may limit a child’s academic success.

The most common types of assessment using the NEPSY-II are a General Assessment for an overview of a child’s neuropsychological status, a Diagnostic Assessment based on the primary diagnostic concerns or referral questions, a Selective Assessment with the examiner selecting subtests based on clinical needs, and a Full Assessment for a comprehensive neuropsychological evaluation. The NEPSY-II enables the clinician to focus on specific cognitive abilities related to general referral questions (e.g. school readiness). The examiner is not required to administer every subtest, only those relevant to the current referral question. Subtest scores, rather than global index or domain scores, are used to determine a child’s strengths and weaknesses.

> > visit: www.psychcorp.co.uk
Scores Provided

Scores on NEPSY-II are classified as primary, process, or contrast scores, or as behavioural observations. Primary scores are available on all subtests and describe the overall or main abilities involved in the subtest. Process scores provide more specific information on the component skills required to complete or influence performance on the task. Contrast scores apply a scaled score metric to score comparisons within or between subtests, providing information on the performance of a higher-level skill or ability controlling for a lower-level or more basic skill. Behavioural observations provide quantitative data on common behaviours observed in children. Scores are expressed as scaled scores, percentiles or cumulative percentages.

New Domain: Social Perception

Social perception is one aspect of social cognition, the study of how people process social information about individuals, groups, and social context and the attribution of intent in social interactions. Social cognition comprises those mental functions that operate in understanding social contexts, including the ability to interpret non-verbal communication, form impressions of others, and use contextual information to make inferences about others and their behaviour.

A concerted effort to include measures of social ability was made during the development of the NEPSY-II. Upon review of the literature, it was decided to focus on two particular areas of social perception: identification of facial expressions and the ability to understand others’ perspectives and points of view and understand how these influence the behaviours of others (e.g., theory of mind).

The subtests in the social perception domain assess recognition of facial affect, affect in relation to contextual cues, and theory of mind. Affect Recognition assesses the ability to determine if two different children demonstrate the same affect and to match different children with the same affect. Theory of Mind assesses the child’s ability to comprehend the perceptions and experiences of others and apply that knowledge to questions.

Psychometric Properties

Normative Data

The NEPSY-II normative data were collected from 2005 to 2006. The sample was stratified on key demographic variables according the US census data (2003). Several subtests were not modified in any way from the 1998 NEPSY. These subtests were not renormed in the NEPSY-II and the norms collected for the 1998 NEPSY are reprinted.

Evidence of Reliability and Validity

Along with special group studies, a number of concurrent studies were conducted to provide evidence of the battery’s reliability and validity. Retest data are reported for all scaled scores for all ages, and by smaller age bands. Evidence of convergent and discriminant validity is provided by correlation studies with the following instruments: NEPSY, Wechsler Intelligence Scale of Children - Fourth Edition (WISC-IV; Wechsler, 2003), Differential Abilities Scales - Second Edition (DAS-II; Elliott, 2007), Wechsler Nonverbal Scale of Ability (WNV; Wechsler and Naglieri, 2006), Wechsler Individual Achievement Test - Second Edition (WIAT-II; Harcourt Assessment, 2005), Children’s Memory Scale (CMS; Cohen, 1997), Delis-Kaplan Executive Function System (D-KEFS; Delis et al., 2001), Bracken Basic Self Concept Scale - Third Edition: Receptive (BBCS-3-R; Bracken, 2006a), Bracken Basic Self Concept Scale - Third Edition: Expressive (BBCS-3-E: Bracken, 2006b), Devereux Scales of Mental Disorders (DSMD; Naglieri, LeBuffe & Pfeiffer, 1994), Children’s Communication Checklist - Second Edition, United States Edition (CCC-2; Bishop, 2006), Brown Attention-Deficit Disorder Scales for Children and Adolescents (Brown ADD Scales; Brown, 2001), and Adaptive Behaviour Assessment System-Second Edition (ABAS-II; Harrison & Oakland, 2003).

NEPSY-II Complete kit: Includes pack of 25 record forms (3-4 yrs), pack of 25 record forms (5-16 yrs), pack of 25 response booklets (3-4 yrs), pack of 25 response booklets (5-16 yrs), stimulus bk 1, stimulus bk 2, clinical and interpretive manual, administration manual, training CD with WAV files.

978 0 158234 27 4 £760.00 exc VAT

NEPSY-II Complete kit with scoring assistant is also available
See website for further information and pricing.
Case Study: Completed by Sue Harrison, Educational Psychologist

I recently used the NEPSY-II as part of the psychological assessment of Ben, a 6.6 year old boy who had experienced nocturnal seizures since the age of 4. An area of developmental abnormality in his left frontal lobe was identified on an MRI scan. His parents and school were puzzled by his learning profile. They felt that he was an able, sociable boy, nevertheless he was struggling to keep up with his classmates and was falling further behind with literacy and numeracy. This picture was reflected in initial psychological assessment, which showed average to above-average verbal and non-verbal intellectual ability, but poor academic attainments.

Ben enjoyed the fun game-like presentation of the NEPSY-II assessment tasks; their short, practical activities and colourful pictures suited his developmental stage. Examination of a range of cognitive domains revealed that Ben had normal memory and motor abilities for his age, but he demonstrated weak performance on attention measures and mild difficulties with language tasks. In Ben’s case the NEPSY-II illuminated the problems with attention and language function that provided barriers to him achieving his full potential. This helped solve the puzzle of why he was doing so poorly at school. Feedback was given to Ben’s family, school and school educational psychologist on Ben’s profile of strengths and weaknesses.

A school visit was made and interventions to support his language problems and attention difficulties were drawn up and incorporated into an Individual Education Plan by the Special Educational Needs Co-ordinator. A referral was made to the school speech and language therapist and the education authority’s language impairment team. Teaching strategies and classroom seating were adapted so that Ben’s attention difficulties were supported. The information gained from the assessment helped his teachers and parents to see that, whilst he was an able boy, he needed specific interventions and strategies to support his problems with attention and language to be put in place.

Case Study: Completed by Dr Kathryn Bond, Principal Clinical Psychologist, Great Ormond Street Hospital

I recently used the NEPSY-II to assess a 6 year old girl presenting with an inborn error of metabolism following concerns about her lack of progress at school and behavioural needs, such requiring constant adult attention and support. Following a normal birth and neonatal progress, a urea cycle disorder had been diagnosed at 2.6 years subsequent to a long period of recurrent illness, failure to thrive and evidence of developmental plateau; following diagnosis, her condition had been well managed with medication and a restricted diet, and she had gone on to attain developmental milestones within the appropriate age ranges.

Assessment with the WISC-IV had indicated that her intellectual abilities fell in the average to low average range, with working memory subtests reflecting an area of personal weakness. I then used the NEPSY-II to provide information about attention and response inhibition skills, memory for faces and verbal material, in addition to assessing motor, visuo-perceptual and finger sensorimotor skills. This enabled me to test out hypotheses about the causes of her learning problems with short, fun, interesting tasks. The results indicated a profile of significant attention difficulties, consistent with my observations that she struggled throughout the assessment to maintain her attention, to monitor and regulate her responses and to prevent herself from becoming distracted. The assessment proved to be useful in identifying specific management recommendations for home and school, such as how to structure learning tasks, adjusting her learning environment at school, and developing I.E.P targets to promote her organisational skills. It was also advised that she should be reassessed in 12 months to monitor her progress.

The NEPSY-II is an easily accessible, attractive test; I was able to gather specific information about aspects of neuropsychological function in a brief amount of time and the results proved to be useful in formulating a profile of cognitive strengths and difficulties and in developing specific recommendations for home and school.
More information / Related products

FREE SAMPLE REPORTS ONLINE
Visit our website to download our NEPSY-II Presentation, sample reports and a snap shot of our training CD.

NEPSY-II WORKSHOPS
If you would be interested in attending a FREE NEPSY-II Training Workshop with author Sally Kemp, please email us at marketing@psychcorp.co.uk

Raven’s - Educational
Raven’s Progressive Matrices and Vocabulary Scales

The recent re-standardisation means that you can confidently use the Raven’s to assess non-verbal and verbal aspects of general ability for children in the UK.

Along with this standardisation, Pearson Assessment has completed an extensive redesign of the product, simplifying and updating materials. This makes the test more attractive and easier to use.

Vineland Adaptive Behavior Scales, Second Edition (Vineland-II)

This flexible edition features:
• Expanded age range
• Updated content
• Increased coverage
• More complete coverage
• Semi-structured interview format
• Parent/Caregiver Rating Form

Kaufman Assessment Battery for Children, Second Edition (KABC-II)

The KABC-II provides an extensively updated version of one of the most well-respected tests of cognitive function available.

Subtests are designed to minimise verbal instructions and responses, which gives you in-depth data with less ‘filtering’ due to language.

Communication Checklist - Self Report (CC-SR)

This 70-item questionnaire is suitable for older children, adolescents or adults who have adequate literacy skills. 50 behavioural statements focus on communicative weaknesses and 20 on communicative strengths.

To circumvent lack of self-awareness, some items are rated on the feedback the informant has received from other people (e.g., ‘People tell me that I talk too much’).
Overview

Overview: Assess verbal and non-verbal memory abilities in adults.
Age Range: 16 years to 90 years 11 months
Administration: Individual - 75 minutes
Qualification Code: CL1

Offering significant enhancements the new Wechsler Memory Scale® – Fourth UK Edition (WMS-IVUK) has evolved to give you the most comprehensive adult memory measure. WMS-IVUK helps clinicians evaluate memory capabilities as part of a standard adult psychological evaluation. This new edition of the test is brief, easier to administer, and places an increased focus on older adults in response to the increasing average age of clients.

Developments

WMS-IVUK developments:
► improved assessment of visual memory with the addition of the NEW Design Memory subtest:
  ► Containing four items of increasing difficulty, Design Memory evaluates immediate and delayed recall as well as delayed recognition. It does not include drawing and reduces the opportunity to guess the correct response. You can obtain scores for spatial, details, and correct content in the correct location as well as contrast scores for spatial versus detail, immediate versus delayed, and recognition versus delayed.
► enhanced working memory is now completely visual with the addition of the NEW Symbol Span and Spatial Addition subtests (WAIS-IVUK is completely auditory so there is no overlap):
  ► Spatial Addition - Based on “N-Back Paradigm”, Spatial Addition requires minimal motor function as the client must:
    ► remember location of dots on two separate pages
    ► add or subtract locations
    ► hold and manipulate visual spatial information
  ► Symbol Span
    ► A “Visual Analogue to Digit Span”, clients are asked to remember the design and the left to right sequence of the design. The clients are then asked to select the correct design from foils and choose them in the correct sequence.
► expanded clinical studies
► inclusion of a NEW cognitive screener which can be used to quickly evaluate significant cognitive impairment. This new screener can be used to quickly evaluate significant cognitive impairment. You can assess: Temporal orientation; Mental control; Clock drawing; Memory; Inhibitory control; Verbal productivity.
► increased focus on older adults with a brief older adult battery to reduce fatigue, and reduce visual motor demands
Wechsler Memory Scale®
– Fourth UK Edition
(WMS-IV®UK)

Features and benefits

Expanded Clinical utility
► Improved floors across subtests
► Included a general cognitive screening tool
► Enhanced assessment of visual memory
► Co-normed with the Wechsler Adult Intelligence Scale®-IV UK

Enhanced User Friendliness
► Included a brief older adult battery
► Reduced subtest administration time
► Minimised visual motor demands
► Assessed working memory
► Modified story content and administration process

Improved Psychometric Properties
► Updated normative data for ages 16-90 years
► Improved floors
► Improved subtest and composite reliability
► Reduced item bias

Endorsement

Professor Jane L Ireland, School of Psychology, University of Central Lancashire

The first difference that will undoubtedly be noted between the fourth edition of this test and its predecessor is its complete revision. It would be more aptly described as a revolution of this test than an evolution. The timing for such a significant change was perfect with regards to advances in the literature over recent years, and a growing application of such tests to a range of diverse populations, including forensic groups.

The only downside, however, is for the avid users of the WMS-III who will have to break from their well-developed administration skills and learn what is effectively a ‘new’ test. Previous knowledge of the WMS-III is simply not required: WMS-IV is more than a simple updating, it is an impressive revision. For example, a range of subtests have been removed from the WMS-III to create the WMS-IV, namely Faces, Family pictures, Word Lists, Letter-Number Sequencing, Digit Span, Spatial Span, Information and Orientation, and Mental Control.

This has proven very helpful for administration to forensic populations since what appears to have been removed are the subtests which can, advertently, cause considerable frustration to forensic clients with impulsivity or affect

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disorders – anyone who has tried to administer Letter-Number Sequencing to an offender with a low tolerance threshold will certainly appreciate the sentiment here.

What comes with this revolution in revision, however, is an entirely updated administration manual that now provides an excellent core basis for both clinical and research interpretation and application. The manual includes invaluable detail on the rationale for the changes, and the importance of such a significant revision. In addition to the removal of tests, three of the original tests have also been modified, with four new tests developed, one of which includes a Brief Cognitive Status Exam. This latter test will be particularly helpful to practitioners who are after a quick ‘sketch’ of initial ability.

The WMS-IV has also sought to solve some of the previous difficulties across a range of areas such as the rather limited previous range of normative samples available, to enhance the practical interpretation of the scores, to increase the comparability with broader tests such as the WAIS-III, and to improve content, reliability and, importantly, clinical application.

Within forensic practice there is certainly a need to assess more routinely the full extent of memory difficulties that our clients present with. Too often such assessments are either not completed, are rudimentary in nature, or do not respond to the engagement style of such a client group. The value of obtaining a full assessment of immediate memory (auditory and visual), delayed (auditory, visual and auditory recognition), general and working memory is essential both for research and practice purposes, and is aptly provided via the WMS-IV.

With regards to the research, there is a need for research exploring memory in depth, with the majority of alternative tests tending to focus on working memory, immediate recall and inattention. For offenders, research application is broad, and we can use tests such as the WMS-IV to explore how memory correlates with substance disorders, information processing (e.g. hostile interpretations; and regulation disorders that result in anger loss and impulsivity etc), offence recall and denial, witness recall, suggestibility and compliance, executive functioning, cognitive interviewing, and a range of clinical disorders, to name but a view.

The potential research application of tests such as the WMS-IV are thus significant, and could assist with the development of theories into offence engagement and treatment responsivity. With regards to this area, specifically the area of practice, the value in assessing memory in detail has application to the whole remit of forensic practice, whether this involves completing treatment or assessments with victims, perpetrators and/or witnesses.

Tests such as the WMS-IV can provide practitioners with a detailed individual profile that can assist with an indication of how treatment, assessments or interviews can be best matched to an individual’s learning style. Treatment and interviews can sometimes suffer from a lack of information on memory profile which the practitioner can then utilise to ensure that they attend to the responsivity needs of their clients. The WMS-IV now provides one possible solution to this.

As noted earlier, although other memory tests do exist, none provide the depth of memory assessment in such an accessible form for use with forensic clients, as does the WMS-IV. This is an important point, particularly when you are dealing with offenders who present with attention and/or impulsivity difficulties, where being able to focus their attention for long periods of time can be challenging for even the most skilled practitioner.

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Wechsler Memory Scale®
– Fourth UK Edition
(WMS-IVUK)

The WMS-IV has such a variety of tests that the management of these challenges are really assisted, with tests presented to clients in an engaging fashion, and importantly, in a way which does not automatically engender ‘failure’. The latter is a vital area to be aware of when dealing with clients who may routinely present with a self-depreciating style and/or a proneness to feeling ‘punished’.

Thus, I warmly recommend the WMS-IV to any practitioner or researcher who has a keen interest in understanding the complexities of memory, and in applying the most up-to-date assessments to benefit their clinical and research practice. It should provide an invaluable further tool in the repertoire of clinical and research assessments available.

Scoring

- Scores are now derived for Older Adult Battery (65–90) and Adult Battery (16–69)
- Ability / Memory Discrepancy Scores (for use with WAIS–IV UK)
- Index Scores
  - Auditory Memory
  - Visual Memory
  - Visual Working Memory
  - Immediate Memory
  - Delayed Memory
- NEW – Contrast Scores
  - Scaled scores contrasting performance across scores
  - Provide information on clinical significance of changes in scores across subtests or indexes

The WMS-IVUK can be scored using the WAIS-IV / WMS-IV UK Scoring Software and Report Writer, simply enter raw scores, and the software does the following:
- Generates concise score reports and statistical reports with graphs and tables.
- Raw to scaled score conversions
- Strength and weakness discrepancies
- Interprets statistically significant discrepancies between scores.
- Includes comprehensive user manual.

View Sample Reports at www.psychcorp.co.uk/WMS

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Overview

Overview: Assess everyday memory
Age Range: Adult
Administration: Individual - 30 minutes
Qualification Code: CL2

The Rivermead Behavioural Memory Test – Third Edition (RBMT-3) is the latest edition of the popular memory test developed by Barbara Wilson and colleagues. This test has continued the tradition of ecologically valid assessment and provides an updated version of the test which includes more contemporary materials, more difficult items than the RBMT-II, a new subtest and new normative data and scoring studies.

Features

- Ecologically valid tool which gives information about everyday memory problems
- 2 versions of tool allowing retesting
- New subtest ‘Novel Task’ which assesses new learning
- New easel-bound Stimulus Book which contains instructions for ease of administration
- Rehabilitation chapter to help you think about possible interventions with your client
- Improved Record Form with a Subtest Scaled Score Profile to help you understand a person’s strengths and weaknesses
- New scoring examples included for subtests to aid scoring
- Normative data on a demographically representative sample of the UK matched by Age and Education
- Scoring studies mean that subtest raw scores can be converted to scaled scores with a mean of 10 and a standard deviation of 3. An overall General Memory Index can also be derived which has a mean of 100 and standard deviation of 15
- New tests of reliability and validity demonstrate the utility of the tool.
The RBMT-3 includes 14 subtests assessing aspects of visual, verbal, recall, recognition, immediate and delayed everyday memory. Additionally prospective memory skills and the ability to learn new information are measured. It takes approximately 30 minutes to complete and retesting can be completed with Version 2 of the tool.

<table>
<thead>
<tr>
<th>Subtest</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>First and Second Names - Delayed Recall</td>
<td>The examinee is shown two photographic portraits and asked to remember the first and second names of both people in the photographs at a later point.</td>
</tr>
<tr>
<td>Belongings - Delayed Recall</td>
<td>Two possessions belonging to the examinee are borrowed and hidden. The examinee is required to remember where these have been hidden at a later point.</td>
</tr>
<tr>
<td>Appointments - Delayed Recall</td>
<td>An alarm is set. The examinee is required to ask some specified questions when the alarm sounds.</td>
</tr>
<tr>
<td>Story - Immediate Recall</td>
<td>A story is read to the examinee and they have to recall it immediately</td>
</tr>
<tr>
<td>Picture Recognition - Delayed Recall</td>
<td>The examinee is shown a set of pictures and then is asked to recognise them from a further set of pictures at a later time in the testing session</td>
</tr>
<tr>
<td>Face Recognition - Delayed Recall</td>
<td>The examinee is shown a set of faces and then is asked to recognise them from a further set of faces at a later time in the testing session</td>
</tr>
<tr>
<td>Route - Immediate Recall</td>
<td>The examiner shows the examinee a route to walk around the room and then asks the examinee to demonstrate it</td>
</tr>
<tr>
<td>Route - Delayed Recall</td>
<td>The examinee is asked to demonstrate the route the examiner took around the room earlier; this time without it being demonstrated to them</td>
</tr>
<tr>
<td>Messages - Immediate Recall</td>
<td>The examinee is required to take a message and book with them when they demonstrate the route and put them in the same place that the examiner did</td>
</tr>
<tr>
<td>Messages - Delayed Recall</td>
<td>The examinee is required to take a message and book with them when they demonstrate the route again and put them in the same place that the examiner did</td>
</tr>
<tr>
<td>Orientation</td>
<td>The examinee responds to a number of questions relating to person, time and place</td>
</tr>
<tr>
<td>Novel Task - Immediate Recall</td>
<td>The examinee uses different coloured pieces to make a shape as demonstrated by the examiner</td>
</tr>
<tr>
<td>Novel Task - Delayed Recall</td>
<td>The examinee uses different coloured pieces to make the same shape at a later time in the testing session, this time without demonstration from the examiner</td>
</tr>
</tbody>
</table>
Mrs B: a woman with particular difficulties in visual memory functioning

Mrs B was a 60-year-old woman who suffered a right-hemisphere stroke 18 months prior to the assessment. She had been working as a librarian at the time. At the time of the assessment she reported ongoing problems with memory. On Version 1 of the RBMT-3 she showed mild problems with several of the RBMT-3 subtests, but her scores on the Picture Recognition - Delayed Recognition subtest, Face Recognition - Delayed Recognition subtest, Route subtests (Immediate and Delayed Recall), and the Novel Task subtests (Immediate and Delayed Recall) were particularly low. On the Route - Immediate Recall, she only managed to score 2 points and remembered nothing after a delay. She failed to score on the Face Recognition - Delayed Recognition, saying that she had not seen any of the faces before. She was unable to learn the Novel Task (see Figure 1).

On a number of verbal and prospective tasks (Story - Immediate and Delayed Recall; Names - Delayed Recall; Belongings - Delayed Recall; Appointments - Delayed Recall), Mrs B’s scores were in the low average range (see Figure 1). Her General Memory Index was below the 2nd percentile.

Given her relative strengths on the verbal subtests, rehabilitation focused on utilizing these strengths, i.e. visual tasks were turned into verbal tasks as far as possible. Compensatory strategies also emphasized verbal rather than visual skills. For learning new tasks errorless learning and spaced retrieval were used. Mrs B’s poor visual memory was probably comprised of perceptual difficulties and a degree of unilateral neglect. Strategies for reducing neglect and improving perceptual functioning should be used in conjunction with the memory rehabilitation strategies.

Figure 1.1

<table>
<thead>
<tr>
<th>Summary of Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raw Score</td>
</tr>
<tr>
<td>First and Second Names - Delayed Recall (N)</td>
</tr>
<tr>
<td>Belongings - Delayed Recall (B)</td>
</tr>
<tr>
<td>Appointments - Delayed Recall (A)</td>
</tr>
<tr>
<td>Picture Recognition - Delayed Recognition (PR)</td>
</tr>
<tr>
<td>Story - Immediate Recall (S)</td>
</tr>
<tr>
<td>Story - Delayed Recall (SD)</td>
</tr>
<tr>
<td>Face Recognition - Delayed Recognition (FR)</td>
</tr>
<tr>
<td>Route – Immediate Recall (RI)</td>
</tr>
<tr>
<td>Route – Delayed Recall (RD)</td>
</tr>
<tr>
<td>Messages – Immediate Recall (MI)</td>
</tr>
<tr>
<td>Messages – Delayed Recall (MD)</td>
</tr>
<tr>
<td>Orientation and Date (O)</td>
</tr>
<tr>
<td>Novel Task – Immediate Recall (NI)</td>
</tr>
<tr>
<td>Novel Task – Delayed Recall (ND)</td>
</tr>
<tr>
<td>Sum of Scaled Scores</td>
</tr>
</tbody>
</table>

Index Score
- Sum of Scaled Scores: 59
- General Memory Index: 55
- Percentile Rank: 2.1
- Confidence Interval: 95% ± 90%

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Sample Characteristics

The core standardisation sample consisted of 333 people (172 females, 161 males) ranging in age from 16 to 89, with a mean age of 44.3 years (SD = 18.17). The extent to which the standardisation sample matched the general adult population was examined using data from the UK 2001 census. Chi-square goodness-of-fit tests revealed that the actual sample distribution of age, education, gender and ethnicity did not differ significantly from the expected census figures.

In addition to the core standardisation sample, a mixed clinical sample of participants with cerebral pathology was recruited (n=75). All clinical participants completed both versions of the RBMT-3. In order to examine possible score differences on the RBMT-3 for different types of clinical disorder, this sample contained participants from each of the following clinical categories:

- Traumatic Brain Injury
- Stroke
- Encephalitis
- Progressive conditions such as Alzheimer’s Disease

Generating norms for the RBMT-3

Raw scores on the 14 RBMT-3 subtests are converted into subtest scaled scores with a mean of 10 and a standard deviation of 3. Percentile ranks for scaled scores are also provided. Subtests take into account an individual’s age and data is reported for the following age bands: 16-24 years of age; 25-34 years of age; 35-44 years of age; 45-54 years of age; 55-64 years of age; 65-74 years of age; 75-89 years of age.

In addition to providing scaled scores for the RBMT-3 subtests, a General Memory Index (GMI), representing overall memory performance, was also created. This index is standardised to have a mean of 100 and a standard deviation of 15. GMI scores are calculated by summing the scaled scores on the RBMT-3 subtests and then converting this sum to a GMI using the appropriate conversion table. These conversion tables also report the confidence intervals and percentile ranks for each GMI.

Alternate form reliability for each subtest was measured for Version 1 and Version 2 of the sample with the normative and clinical sample combined. Reliability coefficients ranged from 0.57 to 0.86. The reliability coefficient of the GMI was 0.87 for both Versions 1 and 2.

With the exception of the Messages Delayed subtest the inter-scorer reliability for the RBMT-3 subtests were 0.9 or higher, indicating a high level of agreement between scorers. The lower level of agreement on the Messages Delayed subtest was attributable to only two of the 18 pairs who completed the inter-scorer study and is thought to be due to two examinees whose results were particularly difficult to score on this subtest.
The RBMT-3 demonstrated good construct and ecological validity (as supported by performance against the Prospective and Retrospective Memory Questionnaire; Smith et al., 2000). In assessing the clinical validity of the tool the results provided strong evidence of the sensitivity of the RBMT-3 to memory problems.


Where did you study/what did you study/what are your qualifications?
My bachelor’s degree in psychology was awarded by Reading University. I went to university at the age of 30 as a mature student, married and with three school aged children. From Reading I went to the Institute of Psychiatry in London to complete my M.Phil. training in clinical psychology. I also registered for a PH.D at the Institute of Psychiatry and completed this while working full time as a clinical psychologist (it took me six years).

Professional experience?
I have worked in brain injury rehabilitation for over 32 years. I have won several awards for my work, including an OBE for services to medical rehabilitation in 1998 and two lifetime achievement awards: one from the British Psychological Society and one from the International Neuropsychological Society.

In 2011 I will receive the Ramon Y Cahal award from the International Neuropsychiatric Association. I have published 18 books, over 270 journal articles and chapters and 8 neuropsychological tests. I am editor-in-chief of the journal “Neuropsychological Rehabilitation”, which I established in 1991. In 1996 I founded the Oliver Zangwill Centre| for Neuropsychological Rehabilitation.

This is a centre for people with non–progressive brain injury. It aims to provide high quality rehabilitation for the individual cognitive, social, emotional and physical needs of people with acquired brain injury. It was named after Oliver Zangwill, the founder of British neuropsychology who carried out important work with brain injured soldiers during World War II. A rehabilitation centre in Quito, Ecuador is named after me. It was opened by Drs Martha De La Torre and Guido Enriquez Bravo. It is called CENTRO DE REHABILITACION NEUROLOGICO INTEGRAL CERENI “BARBARA A. WILSON”. This centre accepts people with non-progressive brain injury and is staffed by neuropsychologists, physiotherapists, occupational therapists and speech and language therapists.

I am currently president of the Encephalitis Society, Vice president of the Academy for Multidisciplinary Neurotrauma and on the management committee of The World Federation of Neuro Rehabilitation. The Division of Neuropsychology has named a prize after me, the Barbara A Wilson prize for distinguished contributions to neuropsychology. I am a Fellow of The British Psychological Society, The Academy of Medical Sciences and The

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What are your current projects?
In September 2007 I officially retired. However, I still spend about three days a month at the Oliver Zangwill Centre and another three days a month at The Raphael Medical Centre in Kent. At these two centres I perform a mixture of clinical work, staff training and advising on research projects. I also travel overseas at least once a month to give lectures and workshops on neuropsychological rehabilitation. I am currently writing my memoirs for my grandchildren.

Who have you worked with?
When I first qualified as a clinical psychologist I worked with children with severe learning difficulties and three excellent psychologists: Janet Carr, Glynis Murphy and Pat Howlin. In 1979 I moved to Rivermead Rehabilitation Centre in Oxford and began my career in brain injury rehabilitation. Soon after this I started working with Alan Baddeley and continued this collaboration for a number of years. I have also worked with Narinder Kapur, Karalyn Patterson and Jonathan Evans. Jonathan was a trainee of mine who came to work with me after training and we worked together for 14 years. Other students and trainees whom I am proud to have known are Nick Alderman, Jane Powell and Linda Clare.

What inspired you to get into this field?
During my clinical training, I was taught neuropsychology by Tony Buffery. I also spent four months completing a clinical placement with him. He was a good teacher and a very funny man (he had once been in the “Cambridge Footlights”). He made neuropsychology fascinating.

I knew I wanted to work in this field but there were no jobs available within commuting distance when I qualified so, instead, I worked in what was then called “mental handicap”. Two years later, the post in neuropsychological rehabilitation came up in Oxford. I moved there in 1979 and knew from my first day that this was the work I wanted to do for the rest of my career.

If you weren’t a clinical neuropsychologist, what would you be?
For many years I wanted to be a midwife. I think that delivering babies must be a very rewarding job. My pipe dream is to have been musically talented and be a world class cellist.

Find out more at www.psychcorp.co.uk/rbmt3
Overview

Overview: Assess long-term memory
Age Range: 5 years and 1 month to adult
Administration: Individual - 35 to 40 minutes
Qualification Code: CL1*

The Doors and People is a test of long-term memory. It yields a single age-scaled overall score which can be ‘unpacked’ to give separate measures of visual and verbal memory, recall and recognition, and forgetting. It is designed for use both as a clinical tool and as a research instrument; enabling the clinician to analyse the nature of any underlying deficit with memory and learning.

The Doors and People is an individually administered assessment for use with individuals from 5 years 1 month to adult (child norms were added in 2006). This provides the clinician with the flexibility of using the tool across a wide range and different settings. The test will appeal to those working with adults and / or children in neuropsychological, educational, academic and mental health settings.

*The test is available to professionals other than Psychologists, in particular Occupational Therapists, Psychiatrists and neurologists. However, further training will be required. Please contact Customer Services on 0845 630 88 88 for more details on the Cognitive Assessment Training - Online.

Features

The test comprises four subcomponents:

Visual Recognition: The Doors Test:
The respondent is presented with coloured photographs of doors from different buildings (e.g. houses, garages, sheds, barns, churches) in a random order. They are then asked to recognise these doors from a page with photographs of 4 different doors; these are presented in a different random order. Doors were chosen for this subtest as they have the advantage of being meaningful, visually rich and yet, provided the distracters are carefully chosen, allow little help from verbal cues.

Visual Recall: The Shapes Test:
The stimuli for this test are four line drawings of crosses. These vary systematically on three dimensions, overall shape (elongated or square), presence of features at the end of the arms, and the presence of a feature at the intersection of the arms. The shapes chosen were judged to be easy to copy; and although they have obvious significance, this is unhelpful in remembering the detail for adequate performance. A total of 3 learning trials are allowed for this, followed by a delayed recall to measure forgetting.

Verbal Recognition: The Names Test:
The subject is presented with forename / surname pairs. They are shown one name to read aloud, they then have to select that name from a group of names later. They are presented with twelve names before they are asked to recognise them from a set of four names. Names were chosen as this offered material that is ecologically meaningful, but where coding in terms of meaning or visual imagery seems much less likely than would be the case for unrelated words.

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Verbal Recall: The People Test

This subtest asks the respondent to recall the forename / surname of 4 different people who have been paired together with an occupation. i.e. Jim Green - is the Doctor, Cuthbert Cattermole is the minister, Tom Webster is the Postman, and Philip Armstrong is the Paperboy. They are then asked to recall the Doctor’s name, the Ministers name etc. This offers an ecologically plausible task which can be readily scored. Again, three learning trials are allowed for this, followed by a delayed recall to measure forgetting.

Scores provided by this assessment are:
- Overall score
- Visual-verbal discrepancies
- Recall-recognition discrepancies
- Forgetting scores.

Data was collected from a stratified sample of 238 subjects comprising equal numbers of subjects from each of the six social class categories as defined in the Office of Population Censuses and Surveys ‘Classification of Occupations 1980’, and balanced so as to have equal numbers of men and women in each category. These were divided into five age groups, 16 - 31, 32 - 47, 48 - 63, 64 - 79, and a similarly balanced group of 80 - 97.

Studies indicate that the Doors and People test is a robust and sensitive memory assessment for use across a wide range of abilities, from elderly patients with Alzheimer’s disease, stroke, schizophrenia, of low educational level to young graduate students. For the Children’s performance norms - data was collected from a group of 148 children aged between 5 years 1 month and 16 years 1 month.

The Doors and People is really what it states: Doors, and People. It is an assessment of long-term memory, specifically episodic memory, taking a broad-based view. It has the benefit of a number of studies that have explored its...
applicability, and it comprises of four parts. The first is an assessment of an individual’s ability to recognise visual stimuli, in this instance coloured photographs of doors that they have seen before, and provided as part of the assessment. The second is the recall of visual stimuli, in this instance the drawing of four patterns, and their ability to do this from memory. The third is an assessment of their ability to recognise verbal information. Here the individual is asked to read a series of names, and to then recognise these names from a list. Finally, it assesses the ability to recall verbal information, and where the individual is asked to recall the names of four people that they are given.

I have used this assessment for a number of years, with a range of clients both in the community and closed settings. One of the real strengths of this tool is its accessibility to the client. In my experience of conducting cognitive assessments, this test does not appear overwhelming for the client in regard to presentation and content. As such, its layout appears accessible to the client, and it is one which clients tend to enjoy and engage with. The clinical data provided by the Doors and People is very helpful. For example, with my client group, it can be helpful to know if they are able to recognise information reasonably or extremely well, or if they have a real challenge in recalling information. This ensures I tailor any interventions to meet the client’s needs, and in order to maximise success. Furthermore, the test is straightforward to use, and does not appear to disengage the client. It is relatively quick to administer, taking around 40 minutes. This can be a real advantage when working with some clients who benefit from shorter engagement sessions.

The scoring of the assessment can at first seem a little tricky, and can be overly complex. As such, there needs to be care when scoring, and any later interpretation. As a recommendation, this assessment should not be used without a reasonable knowledge of memory theory. Yet, such an observation would not be unique to the Doors and People, and any interpreter of a tool is required to know the theories upon which the tool is developed, as well as the limitations of any such approaches. There can also be some occasional instances where the scores achieved can fall outside of the normed sample. Yet, this is not frequent. Ultimately, it can offer a wealth of information for the clinician, and can be a real asset to understanding a client’s long-term memory. It can further offer the opportunity to explore any potential patterns in the client’s episodic memory, whilst reducing any potential sense of failure in a client who may present with challenges in their ability.

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Overview

Overview: Assess prospective memory.
Age Range: 16 years and older
Administration: Individual - 25 minutes
Qualification Code: CL2

The most common memory complaints are concerned with failures of prospective memory, yet this aspect of memory function is rarely assessed formally. Prospective memory is the ability to remember to do things at a particular time or within a given interval of time or when a certain event happens. In other words, prospective memory is remembering to do things rather than remembering things that have already happened. For people with brain injury, failures in prospective memory, such as forgetting to take medication, can have devastating effects on everyday life and are likely to threaten independence.

CAMPROMPT is the first standardised test to have been designed to assess prospective memory in an ecologically plausible context. Following a pilot study (Groot et al, 2002), the authors developed the CAMPROMPT and now offer a test that comprises three time-based and three event-based tasks.

Test description

In the test examinees are asked to work on a number of ‘background’ distractor pencil and paper tasks such as a general knowledge quiz or word-finder puzzle for a 20 minute period. While they are doing this, and shortly after the 20-minute period is up, they carry out 6 prospective memory tasks. These tasks are cued in 2 ways: three are cued by time, three are cued by events. The type of prospective memory tasks that the examinee is asked to do includes such tasks as remembering to change tasks at a certain time and reminding the examiner to do something (e.g. “do not forget your keys”).

Time-based tasks
Remind the tester to ring the garage five minutes after the tasks are completed.
Remind the tester not to forget his/her keys when there are 7 minutes left on the timer.
Change distracter task seven minutes after the examiner asks them to.

Event-based tasks
Remind the tester about the 5 hidden objects at the end of the test.
Give the examiner a book when they come to an EastEnders question in the quiz.
Give the tester a message envelope when they are told there are five minutes left.
In all, the test will take about 25 minutes to administer. Three types of scores are obtained: prospective memory time-based score, event-based score and total score.

**Features and benefits**

- Will be of use to psychologists, geriatricians, research assistants*, occupational therapists, speech and language therapists and other health professionals* working with people with memory impairments who need a sensitive, reliable and valid tool for identifying prospective memory problems. * Further training may be required
- UK Norms
- Provides valid data for planning programmes aimed at remediating difficulties.

**Technical information**

Norms were collected from 212 controls and 72 patients (TBIs and patients with degenerative neurological conditions).

The test has good reliability and validity. Tests of validity have looked at the relationship of the CAMPROMPT to other tests of memory (RBMT) and other cognitive measures (Modified Six Elements (BADS), Map Search (TEA), Speed of Comprehension test (SCOLP)).

There are significant correlations between the CAMPROMPT total score and profile and screening scores of the RBMT, between the RBMT and the CAMPROMPT event-based tasks, but not between the RBMT and time-based tasks.

The 1-minute Map Search subtest correlated with all three CAMPROMPT measures (time-based, event-based and total prospective memory score) and the 2-minute Map Search test score correlated with the total and time-based scores, confirming the involvement of the attentional system in prospective memory, especially the time-based tasks. The Modified Six Elements Test correlated with the total score and the event-based tasks, confirming the role of executive processing in prospective memory, especially the event-based tasks, and the Speed of Comprehension Processing Test correlated with only the event-based tasks, confirming that speed of verbal information processing plays only a minor part in these prospective memory tasks.
Overview

Overview: An effective test for predicting a person’s pre-injury IQ & memory abilities
Age Range: 16 years to 89 years
Administration: Less than 10 minutes
Qualification Code: CL1

A revised and updated version of the Wechsler Test of Adult Reading, the TOPFUK enables clinicians to estimate an individual’s level of intellectual functioning before the onset of injury or illness.

This new assessment tool is:

► An effective method for predicting full-scale IQ and memory performance
► For use by clinicians who wish to develop appropriate treatment plans
► An initial estimation of premorbid intellectual and memory abilities
► Composed of a list of 70 words that have atypical grapheme to phoneme translations
► Time-effective, taking less than 10 minutes to complete.

Features

Revision goals of the TOPFUK, included:

► Adding items to increase the difficulty of the test
► The use of technically correct and optimal statistical methods for analysing the discrepancy between estimated premorbid scores and scores obtained on testing
► In keeping with the contemporary emphasis on the use of confidence intervals in psychology, the discrepancy between an individual’s estimated and obtained scores, are supplemented with interval estimates
► Scoring and analysis of the equations have been implemented into a computer programme. This markedly reduces the risk of clerical errors, provides repaid scoring and permits the application of optional statistical methods.

UK development

The UK project involved data collection which was formed as part of the UK validation study of the WAIS-IVUK and WMS-IVUK. Initial stages consisted of an anglicisation of item pronounciations and the creation of a sampling matrix to ensure an accurate representation of the UK population. The TOPFUK standardisation sample for the WAIS-IVUK consisted of 248 people (132 females, 116 males) ranging in age from 16 to 90 with a mean age of 44.20 years.

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Overview

Overview: Assess cognitive abilities quickly and reliably.
Age Range: 17 years and older
Administration: Individual - 15 to 20 minutes
Qualification Code: CL2

The Brief Cognitive Status Exam (BCSE) helps evaluate global cognitive functioning in patients with suspected memory deficits or who are diagnosed with a wide range of neurological, psychiatric and developmental disorders. Including those with dementia, mild learning difficulties, or suspected Alzheimer’s disease.

This brief, reliable screening tool is a stand-alone version of the optional Brief Cognitive Status Exam found in the WMS®-IV (Wechsler Memory Scale®, Fourth Edition).

Features and benefits

- BCSE covers seven content areas: Orientation, Time Estimation, Mental Control, Organisation - Planning, Incidental Recall, Inhibitory Control and Verbal Production
- Examinees are asked to perform simple tasks to create an overall picture of cognitive functioning
- 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
- UK adaptation with notes for scoring and interpretation
- Can be administered individually in approximately 15 to 20 minutes
- Brevity makes it useful for repeated evaluations and for individuals unable to tolerate longer examinations
- Data collected as part of the new WAIS-IV/WMS-IV project
- Value as a research instrument
- Can be used for general clinical evaluations and for rehabilitation evaluations.
The BCSE is composed of 12 items in seven content areas:

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<tr>
<th>Content Area</th>
<th>Description</th>
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<tbody>
<tr>
<td>Orientation</td>
<td>Contains five items that measure orientation to time e.g. current date including day, month, year.</td>
</tr>
<tr>
<td>Time Estimation</td>
<td>A measure of orientation to time of day.</td>
</tr>
<tr>
<td>Mental Control</td>
<td>Two items measure attention and the ability to manipulate commonly known sequences in memory.</td>
</tr>
<tr>
<td>Clock Drawing</td>
<td>Measurement of organisation and planning</td>
</tr>
<tr>
<td>Incidental Recall</td>
<td>Measurement of recall for images without a prompt to recall the item at time of presentation.</td>
</tr>
<tr>
<td>Inhibition</td>
<td>Measure of the patient’s ability to inhibit a leaner response in order to provide a novel response.</td>
</tr>
<tr>
<td>Verbal Production</td>
<td>Measure of the patient’s ability to produce words within a semantic category within a 30-second period.</td>
</tr>
</tbody>
</table>

The BCSE is organised into the seven domain sections on the record form, each of which clearly details individual administration, recording and scoring instructions.

A conversion table is included that enables you to covert section-specific scores to weighted raw scores, which in turn contribute to the Total Raw Score.

Scores are weighted to increase the sensitivity of the measure of cognitive dysfunction. Measures of processing speed and mental control are frequently impaired in individuals with significant cognitive impairment, and scores are more heavily weighted in measures of these abilities.

A BCSE Total Raw Score can be converted to provide a classification level that indicates the patient’s level of cognitive functioning. This classification is based on four broad age categories and five education levels.

For more information visit www.psychcorp.co.uk
Overview

Overview: A test that distinguishes between malingered and true memory impairments.
Age Range: 16 years to 84 years
Administration: Individual - 15 to 20 minutes
Qualification Code: CL1

The TOMM is a visual recognition test that provides a method to assist neuropsychologists in discriminating between real memory impaired patients and malingerers. Research has found the TOMM to be sensitive to malingering and insensitive to a wide variety of neurological impairments, which makes it very reliable.

Consisting of two learning trials and an optional retention trial, the TOMM uses two cutoff scores: 1) below chance and 2) criteria based on head injured and cognitively impaired clients. It is not transparent as a malingering test.

The TOMM is a 50 item recognition test. It includes two learning trials and a retention trial.

During the learning trials the patient is shown 50 line drawings (target pictures) of common objects for 3 seconds each. They are then shown 50 recognition panels one at a time. Each recognition panel has the target picture and a new picture. The patient must select the picture they have seen before. The same pictures are used for the retention trial but the target pictures are not re-administered.

The retention trial is optional – the two learning trials alone are usually sufficient to assess malingering. However the retention trial does not take long and helps corroborate the results.

Features and benefits

Why TOMM is useful for detecting malingering:

► Administration of a large number of stimuli gives the impression the test is more difficult than it actually is. Malingers think the test would be difficult for people with genuine memory impairments and intentionally perform poorly. Non-malingers will put full effort in and do well.

► Presenting 50 pictures gives TOMM good face validity as a test of learning and memory. Therefore decreases transparency as a test of malingering.

► Feedback to patients on response correctness after each item widens the gap between scores of people with memory impairment and malingeres. Feedback provides a learning opportunity and highly motivated patients should increase their response accuracy whereas it allows malingeres to more accurately track and adjust their performance.

► Sensitive to malingering but insensitive to neurological impairments. All individuals (including those with neurological impairments) have a remarkable capacity for storing and retrieving pictures of everyday common objects.

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Scoring:
Clients score one point for correct recall, none for incorrect.

Two decision rules are used in the interpretation of the TOMM:

1. **Scoring lower than chance on any trial indicates possible malingering:** This rule is based on the fact that a person can correctly identify 50% of the pictures by guessing. Thus, a score of 25 represents a chance level of responding on the TOMM. Scores of below 18 are unlikely to occur by chance.

2. **Any score below 45 on trial 2 indicates malingering:** Since most malingerers do not obtain below-chance scores, most interpretations will replace on this second decision rule. Any score lower than 45 on Trial 2 or the Retention Trial should raise concern that the individual is not putting forth maximum effort and is likely malingering.

Standardization of the TOMM was based on 475 people aged 16 years to 84 years.

**Research**

**TOMM Research Monograph: Summary Application in Clinical and Research Settings**

The TOMM Research Monograph includes recent research on the sensitivity of the TOMM, including research that addresses the use of the TOMM with specific populations, such as children and elderly adults, and those with psychotic disorders, psychiatric illness, affective disorders, temporal lobe dysfunction, and chronic toxic encephalopathy.
Severe Impairment Battery (SIB) & Severe Impairment Battery - Short Form (SIB-S)

Overview

Overview: SIB Assess severe dementia in the elderly; SIB-S Assess people with very severe dementia
Age Range: SIB 51 years to 91 years; SIB-S Older Adults
Administration: SIB Individual, 20 minutes; SIB-S Individual, 10 to 15 minutes
Qualification Code: CL2

The SIB has become a benchmark assessment used extensively in worldwide clinical trials by drug companies seeking to develop treatments to combat Alzheimer’s disease. The SIB gathers direct performance-based data on a wide variety of low level tasks which take into account the specific behavioural and cognitive deficits associated with severe dementia. This objective assessment of the relative impairment of different areas of cognitive functioning enhances understanding of the disease process and provides valuable clinical information regarding the later stages of dementia.

The Severe Impairment Battery – Short Form (SIB-S) has been developed to meet the assessment needs for people with very severe dementia. It includes a number of items from the original SIB and takes only 10-15 minutes to administer.

Features and benefits

The SIB evaluates cognitive abilities at the lower end of the range. Composed of very simple one-step commands that are presented in conjunction with gestural cues, the SIB allows for non-verbal and partially correct responses as well as for simpler response modes such as matching.

There are 40 items and the SIB takes approximately 20 minutes to complete. It is composed of very simple one-step commands which are presented in conjunction with gestural cues. Example questions include:

► ‘What’s your name?’
► ‘Please write your name here’
► ‘What do you call the thing you drink coffee from?’

There are six major subscales, and each yields scores that are downward extensions of instruments used to assess mild to moderate dementia: Attention; Orientation; Language; Memory; Visuospatial Ability and Construction. In addition, there are also brief evaluations of Praxis, Social Interaction and Orienting to Name.

The SIB-S contains subscale scores for nine cognitive domains can be calculated: Attention, Memory, Praxis, Concentration, Visuospatial Ability, Social Interaction, Language, Construction, Orientating to Name.

The SIB-S can enhance your assessments for people with severe dementia and is a supplement to the original SIB.

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Severe Impairment Battery (SIB) & Severe Impairment Battery - Short Form (SIB-S)

Technical information

The range of possible scores is 0-100. There is no cut-off for normal as the test should only be used with patients known to be severely impaired. However, it is possible to grade the severity of impairment by rating those who score less than 63 on the SIB (corresponding to less than 4 on the MMSE) as ‘very severely impaired’.

In validation studies the SIB was administered along with the MMSE and Mattis Dementia Rating Scale. A Pearson product-moment correlation coefficient of 0.76 (p<0.001) was obtained for the relationship between performance on the SIB and performance on the MMSE (n=70). For those patients who completed the SIB and the Mattis DRS (n=55) a correlation of 0.88 was obtained. The correlation between the Mattis DRS and MMSE was 0.77.

It has a high inter-rater and test-retest reliability.

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Overview

Overview: Assess and monitor recovery of cognitive function after severe head injury
Age Range: 16 years and older
Administration: Individual - Untimed
Qualification Code: CL2

The Wessex Head Injury Matrix (WHIM) is designed for the accurate assessment of patients in and emerging from coma and in the vegetative and minimally conscious states. The 62 item observational matrix can be used to assess the patient and set goals for rehabilitation from the outset of coma.

The WHIM provides a sequential framework of observation covering:

- Communication ability
- Cognitive skills
- Social interaction.

The 62 item observational matrix collects data by observation and by testing tasks used in everyday life.

Features and benefits

- Patients can be assessed and goals for rehabilitation set from the outset of coma.
- Bridges the gap between tests available for the very acute stages after head injury and those helpful in later stages of recovery. Improvements from the initial state of coma may be gradual and, unless accurate assessment takes place, small gains may be missed or misinterpreted.
- Picks up minute indices demonstrating recovery, providing objective evidence for realistic prediction.
- Is easy and quick to administer by any qualified member of a multidisciplinary team.
- Focuses on what the patient does or does not do rather than upon clinical diagnostic features.
- The tightly defined categories of observation contained in the WHIM overcome the limitations of previously published scales which, amongst other drawbacks, are largely dependent upon subjective views.

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Vegetative patient ‘communicates’

A recent vegetative patient reported in *Science* and also featured on the BBC website was assessed on the WHIM. This patient was unable to respond behaviourally but could respond neurally when asked to imagine she was playing tennis while being scanned with fMRI.

This illustrates how we need behavioural, imaging and neurophysiological measures when assessing patients in states of reduced consciousness.

Visit: [http://news.bbc.co.uk/1/hi/health/5320234.stm](http://news.bbc.co.uk/1/hi/health/5320234.stm) for more details
Overview

Overview: Investigate retrograde amnesia
Age Range: 18 years and older
Administration: Individual - Untimed
Qualification Code: CL2

Retrograde amnesia often leads to an impairment of autobiographical memory, the capacity to recollect the facts and incidents of one’s earlier life. Although not measured by standard memory tests, it is valuable to assess autobiographical memory for at least three reasons:

► To understand the nature of any memory deficit observed
► To allow more adequate counselling
► To provide an individual focus for subsequent treatment, such as reminiscence therapy.

Many important clinical disorders give rise to impairment in autobiographical memory. These include the organic amnesic syndrome, dementing disorders, and possibly various psychiatric disorders, including depression and schizophrenia.

The Autobiographical Memory Interview (AMI) provides a useful research tool for investigating retrograde amnesia.

Features and benefits

Patients who may be very similar on standard memory tests can differ markedly in their autobiographical memory performance. The AMI has a semi-structured interview consisting of 2 parts:

1. ‘Personal Semantic’ Schedule – assesses subjects recall of facts from their own past life.
2. ‘Autobiographical Incidents’ Schedule – assesses subjects recall of specific events/incidents in their earlier life.

These areas are assessed across 3 broad time bands:

► Childhood
► Early adult life
► Recent facts/events
Thus, the AMI provides an assessment of a subject’s personal remote memory, in contrast to existing tests which probe memory for public events and personalities. The benefit of the AMI is the test is not dependent on the level of the patient’s habitual interest in current affairs and news events, and does not require regular updating in the same way as remote memory tests based on public events.

### Technical information

**Scoring**

The Personal Semantic Schedule is scored out of 21 points, whilst the Autobiographical Incident Schedule is scored in terms of the descriptive richness of the account of an incident, and its specificity in time and place.

**Verification**

The verification of memories can be done by talking to relatives or friends; noting inconsistencies in the subjects responses; checking hospital notes and talking to care staff (in the case of patients).

AMI has a high interrater reliability and has been validated by looking at four areas:

- To see how well the test discriminated amnesic patients from healthy controls
- The intercorrelation between different remote memory tasks in the total patient group
- Comparison of the pattern of temporal gradients across the different tests of remote memory
- Checking the authenticity of memories produced.

Three raters also independently scored written descriptions of the memories recalled. The correlations between pairs of testers varied between 0.83 and 0.86.
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<td>£103.00</td>
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<td>Complete Kit: Includes manual and pack of 25 scoring sheets in a case 978 0 749129 00 2</td>
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<td>Complete Kit: Includes manual, scorebook, program (CD software with one year’s licence) and free copy of Understanding Working Memory: A Classroom Guide 978 0 749141 95 0</td>
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<td>Brief Cognitive Status Exam (BCSE)</td>
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<td>Complete Kit: Includes 25 UK record forms, notes for UK user, manual and WMS-IV scoring template 978 0 749162 24 5</td>
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<td>Cambridge Prospective Memory Test (CAMPROMPT)</td>
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<td>Children’s Memory Scale™ (CMS)</td>
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