

Anxiety-Depression Assessment (ADA) Training Manual

Courtesy of Behavior Data Systems, Ltd. and its subsidiaries
Risk & Needs Assessment, Inc.
and Professional Online Testing Solutions, Inc.

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PRODUCT DESCRIPTION

Early problem identification gives primary care physicians, mental health professionals and healthcare providers an opportunity to identify psychological problems early and to match problem severity with treatment intensity. The Anxiety-Depression Assessment ADA was developed to meet these needs.

The Anxiety-Depression Assessment ADA is a 138-item self-report test. It takes 20 to 25 minutes to complete, and 2½ minutes from data (answers) input, scored and printed ADA reports are generated.

The eight Anxiety-Depression Assessment ADA scales include: 1. Truthfulness Scale, 2. Depression Scale, 3. Anxiety Scale, 4. Agoraphobia, 5. Social Anxiety, 6. Panic Attack, 7. Specific Anxiety, and 8. Self-Esteem Scale.

INTERVIEWS VERSUS TESTS

The "interview" has been the mainstay in evaluations for many years despite its paradoxical lack of reliability, validity and accuracy. Most mental health professionals would agree that the interview has not been a good predictive instrument, and that it is notoriously time consuming. Many researchers and practitioners believe that the interview by itself does not present a defensible basis for making diagnostic or treatment decisions. Interviews are prone to error and the reasons are many, due to diversity in interviewer personalities, dissimilarities in training and equivocal motivation, among others. **Interviewers must repeat, paraphrase and probe for scorable answers, thereby introducing subjectivity and error.**

All interviewers are subject to the danger of patient's (client's) untruthfulness. In courts, evaluation settings and treatment programs, these interviewers are asked to give their opinions based upon "reasonable certainty." When interviewers provide opinions without knowing if the patient (client) was indeed truthful, many of their opinions are speculative, unfounded, unsupported and in error. The difficulty lies in that many interviewers believe they can tell when the client is truthful or lying. This is naïve, and such naïveté is harmful.

ANXIETY-DEPRESSION ASSESSMENT SCALES

The Anxiety-Depression Assessment ADA has eight scales (measures or domains). These scales include: **1.** Truthfulness Scale, **2.** Depression Scale, **3.** Anxiety Scale, **4.** Agoraphobia, **5.** Panic Attack, **6.** Social Anxiety, **7.** Specific Anxiety, and **8.** Self-Esteem Scale. Each ADA scale is defined, and attained risk ranges are set forth.

Truthfulness Scale

In assessment (evaluation, screening or testing), truthfulness is considered the antithesis of denial. This helps explain the juxtaposition of truthfulness and denial research. Truthfulness has been linked to positive treatment outcomes (Barber, Luborsky, Gallop, Crits-Christoph, Frank, Weiss, Thase, Connolly, Gladis, Foltz & Siqueland, 2001; Simpson, 2004). The impact of truthfulness on test scores is largely contingent upon the severity of client (patient) denial or untruthfulness.

Denial (refutation, problem minimization or lying) has been linked to negative treatment outcomes (Marshall, Thornton, Marshall, Fernandez & Mann, 2001); resistance (Simpson, 2004); problem minimization (Murphy & Baxter, 1997); treatment dropout (Daly & Pelowski, 2000; Evans, Libo & Hser, 2009); and recidivism (Grann & Wedin, 2002; Nunes, Hanson, Firestone, Moulden, Greenberg & Bradford, 2007).

As multidimensional as denial is (Brake & Shannon, 1997; Orlando, 1998), truthfulness is equally multifaceted. Yet, client truthfulness is integral to accurate assessment. That said, untruthfulness, when present, is a major hindrance to accurate assessment (Richards & Pai, 2002). **Interpretation of test results must take the severity of denial into account (Grossman, Haywood & Wasyliv, 1992).**

Anxiety-Depression Assessment ADA contains a built-in Truthfulness Scale. This Truthfulness Scale was influenced by MMPI Truthfulness Scale methodology. The ADA Truthfulness Scale can be viewed either as a self-report or interpreted as a co-occurring elevated scale interaction.

The four Truthfulness Scale risk ranges are: low risk (zero to 39th percentile); moderate (40 to 69th percentile); problem risk (70 to 89th percentile) and severe problem (90 to 100th percentile). A truthfulness-related problem is identified when its score is at or above the 70th percentile (problem threshold). Problem scorers are typically cautious, guarded and defensive. An ADA Truthfulness Scale score at or below the 89th percentile means all ADA scale scores are accurate. When the Truthfulness Scale score is in the problem risk (70 to 89th percentile) range, all other ADA scale scores are truth-corrected. This procedure is similar to the MMPI's truth-correction methodology. Severe problem Truthfulness Scale scorers (90 to 100th percentile) invalidate their tests, and all scale scores contained therein due to extreme denial, refutation of facts, attempts to "fake good" or lying. **Invariably, evaluators and test users must answer the question, "Was the respondent (patient/client) truthful while being tested?"** Evidence-based truthfulness scales help answer that question. One of the first things to do when reviewing an ADA report is to check the Truthfulness Scale score. **Without a Truthfulness Scale, how do you know if the patient (client) was truthful?**

Depression Scale

Depression is a disturbance in mood, thought and bodily functioning, characterized by varying degrees of loneliness, sadness, self-doubt and feelings of hopelessness. In some cases, depression can last months and even years. Low intensity and moderate intensity depressions are melancholic, discouraging and distressing, yet the depressed person is still able to carry out daily activities. In severe (90 to 100th percentile) depressions there may be extreme fluctuation in mood and even complete withdrawal from this person's daily activities. In extreme cases, feelings of hopelessness can be so intense that suicidal ideation (thoughts) may occur.

Mental health professionals use the term "clinical depression" to describe severe depressions. This is also referred to as "major depression." Symptoms of depression include: 1. Depressed mood, 2. Significantly diminished interest in activities, 3. Significant weight loss or gain, 4. Insomnia, 5. Psychomotor agitation or retardation, 6. Loss of energy, 7. Feelings of worthlessness, 8. Difficulty concentrating or thinking, and 9. Suicidal thoughts. Perhaps it should be noted that not everyone who is depressed has every depression symptom. Also symptom severity varies among individuals and over time. Depression symptoms usually improve with psychological counseling (e.g., cognitive behavioral therapy), antidepressant medicine (medically prescribed) or a combination of the two. In sum, depression is treatable and, over time, curable.

Anxiety Scale

The Anxiety Scale measures nervousness, apprehension and somatic correlates of anxiety. Raymond Corsini (Dictionary of Psychology, 1999) defined anxiety as "a pervasive and unpleasant feeling of tension, dread, apprehension and impending disaster." In years past, anxiety had been referred to as "non-directed fear."

There are several types of anxiety disorders, each with individual characteristics. These include generalized anxiety disorders (GAD), panic disorders, phobias, obsessive-compulsive disorders and PTSD. Generalized Anxiety Disorder (GAD) is the most frequent or common. A GAD diagnosis applies when there are three or more of the following symptoms that have been present for some months: 1. Restlessness or nervousness, 2. Difficulty concentrating, 3. is easily fatigued, 4. Irritability, 5. Muscle tension and 6. Difficulty sleeping.

A Generalized Anxiety Disorder can cause significant impairments in important social and occupational functions, as well as relationships. More specifically, sufferers of generalized anxiety disorder (GAD) are people experiencing more than normal anxiety. GAD is chronic, and involves exaggerated worry and tension. People with GAD worry excessively about their health, family, finances, relationships and normal daily activities. Even though they realize their anxieties are more severe than warranted, GAD sufferers can't seem to be able to overcome or manage their worries, fears and anxieties.

Usual impairments associated with GAD are mild to moderate in severity and these sufferers can complete their daily activities. However, severe GAD can be very debilitating. GAD treatment often includes cognitive behavioral therapy (CBT) and medically prescribed medication (anti-anxiety and anti-depressant medications). There are numerous psychotherapies to choose from (e.g., in-vivo desensitization, flooding techniques, interpersonal therapy, emotion based therapy, anxiety management therapy, adaptive coping strategies and cognitive restructuring). Research has demonstrated cognitive that behavioral therapy (CBT) can be very effective in treating GAD. The prospects for long term recovery are good for most people who seek appropriate professional treatment.

Agoraphobia

Agoraphobia is defined in the Diagnostic & Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Agoraphobia is a mental disorder in which individuals are fearful and anxious about two or more of the following situation: using public transportation (buses, subway system, trains, airplanes, etc.), being in open spaces (fields, shopping malls, etc.), being in enclosed places (elevators, movie theaters, etc.), standing in line alone, being in a crowd without a companion or being outside ones home-alone. The individual fears stress situations because help might not be available if the individual experiences panic symptoms. These situations almost always induce fear and anxiety and when possible are avoided or require the presence of a companion.

The agoraphobic situations almost always provoke intense fear or anxieties. The fear, anxiety or avoidance behaviors cause significant distress or impairments in the individuals social, occupational, interpersonal and recreational functioning. Agoraphobia is diagnosed irrespective of the presence of a panic disorder.

The essential feature of agoraphobia is intense fear or distressing anxiety caused by real or imagined exposure to a variety of situations. At least two of the agoraphobic symptoms referenced above (e.g. using public transportation). Individuals experiencing these agoraphobic situations typically believe something terrible may happen. The fear, anxiety and avoidance behavior exacerbated by these situations is out of proportion to the actual danger posed.

Social Anxiety

Social Anxiety or Social Phobia is defined in the Diagnostic & Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Social anxiety is characterized by intense fear or anxiety in one or more social situations. Examples are many and include social situations, social interaction, or being observed. The

individual fear their social symptoms will be negatively judged (e.g., embarrassing, humiliating or rejecting by others). Social situations almost always trigger fear and anxiety. This fear and anxiety is invariably out of proportion to the threat posed by the situation.

Social anxiety causes fear, anxiety or avoidance behaviors which impair social, interpersonal and other important areas of functioning. Social performance fears come in work, school or performance settings. In work situations performance may be related to setting in which an individual has to conduct public presentations. As noted earlier, the essential feature of social anxiety disorder is intense fear and anxiety in situations when the individual must present or socialize in a group. The individual is concerned they will be judged as anxious, weak, stupid or unlikeable. These individuals fear offending others and being rejected as a result.

Panic Attack

Panic Attack. Most people with agoraphobia also have other mental disorders. Panic attack is not a DSM-5 mental disorder. And panic attacks can occur with any anxiety disorder as well as other mental disorders. Panic attacks are characterized by an abrupt surge of intense fear or anxiety that reaches a peak within minutes. Common symptoms include but aren't limited to, a pounding heart rate, sweating excessively, chest pain or discomfort, feeling light-headed or faint, fear of losing control or "going crazy" and fear of dying. The course of a panic attack is often influenced by co-occurring mental disorders or stressful life events. Panic attacks should not be diagnosed if the episodes do not involve a surge of intense fear, anxiety of discomfort.

Panic attacks are exacerbated by various comorbid mental disorders, e.g., anxiety disorders and depression. Panic attacks are defined in the Diagnostic & Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Panic attacks are only diagnosed when the episode involves an abrupt surge of intense fear, anxiety and discomfort.

Specific Phobia

Specific Phobia's involve marked fear and anxiety about a specific object (e.g., snakes) or situation (e.g., heights or flying). The phobic object or situation invariably provokes immediate fear and anxiety. The individual actively avoids or endures the object/situation with intense fear and anxiety. This fear and anxiety is excessive for the danger posed by the "specific object" or situation.

"Specific phobia's" cause clinically significant distress or impaired social, interpersonal, or social areas of functioning. The diagnostic criteria for a specific phobia are set forth in the Diagnostic & Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). According to DSM-5 it is common for people with a specific phobia to have multiple specific phobias. For specific phobias the fear and anxiety must be intense or severe. It is possible for a specific phobia to develop at any age. According to DSM-5, people with a specific phobia are up to up to 60% or more likely to make a suicide attempt than are people without the diagnosis of "specific phobia."

Self-Esteem Scale

Self-esteem refers to a person's appraisal of self. The concept of self-esteem is often addressed in clinical settings because, according to many clinicians, an individual's actions or behaviors can be viewed as a reflection of their self-esteem. When needed, counseling and psychotherapy can be used to develop healthy self-acceptance. Self-esteem is an important area of inquiry for all patients because it

underlies and reflects depression, anxiety, substance (alcohol/drugs) abuse, PTSD and suicidal ideation (thoughts). There is considerable symptom overlap with many of these disorders.

Negative or low self-esteem has been associated with a person's impaired ability to adapt appropriately to their environment. Therefore, low self-esteem can serve as a precursor to other problematic behaviors. Poor self-esteem is often characterized by feelings of guilt, humiliation and/or remorse.

A Self-Esteem Scale score at the 70th percentile or higher (elevated risk range) identifies problematic negative or low self-esteem. The problem risk range is the 70 to 89th percentile range. A Self-Esteem Scale score at or above the 90th percentile (90 to 100th percentile range) identifies severely impaired or extremely low self-esteem.

Comorbidity or a co-occurring and elevated (70th percentile and higher) ADA scale scores with another elevated Self-Esteem Scale score represents impaired self-esteem. The problems represented by the other scale score(s) are likely interacting. Such comorbidity often becomes circular and more problematic. A general rule of thumb is, the higher the scale score, the more serious the problem. Untreated low self-esteem can grow, expand and worsen.

Self-esteem reflects a person's explicit valuing and appraisal of self. Self-esteem incorporates an attitude of acceptance-approval versus rejection-disapproval of self. Low self-esteem sufferers often report feeling of inadequacy, incompetence, being undeserving, hypersensitivity and having difficulty adapting or adjusting to change.

Self-esteem attacks are sometimes called "panic attacks," which often leads to remorse, depression and more anxiety. Self-esteem has been described as a person's opinion of self. Self-esteem fluctuates over time and affects virtually every facet of the person's life. The antithesis of low self-esteem is "realistic" self-acceptance.

Cognitive behavioral therapy (CBT) research demonstrates the efficiency of CBT treatment for low self-esteem, anxiety, depression and substance (alcohol/drug) abuse. CBT is a proven and popular treatment for low self-esteem.

RISK LEVEL CLASSIFICATION

Each Anxiety-Depression Assessment (ADA) scale score is classified in terms of the risk it represents. These risk level classifications are individually calculated for each of the eight empirically based scales each time an Anxiety-Depression Assessment (ADA) is scored.

RISK LEVEL CLASSIFICATION	
PERCENTILE RANGE	RISK RANGE
0 to 39th percentile	Low Risk
40 to 69th percentile	Medium Risk
70 to 90th percentile	Problem Risk
91 to 100th percentile	Severe Risk

A problem is not identified until a scale score (percentile) is at (or above) the 70th percentile. Percentile scores are obtained from a database of client score distributions. **Scores in the 70 to 90th percentile range represent problems for which specific intervention and/or treatment recommendations (or**

referrals) are made. **Severe problems are identified with scale scores in the 91 to 100th percentile range.** Recommendations are intensified for severe problem scale scores.

Alcohol, Drug, Self-Esteem and Stress Coping Scale scores in the 91 to 100th percentile range (severe problem) are frequently accompanied with a recommendation for a comprehensive psychological (or psychiatric) evaluation. Such a recommendation results in a licensed or certified health care provider conducting an evaluation and including a DSM-5 diagnoses, treatment plan and prognosis in their reports. With elevated scores (at or above the 91st percentile) it is very likely that formal DSM-5 diagnoses will apply to the clients being evaluated.

TRUTH-CORRECTED SCORES

When handed an Anxiety-Depression Assessment (ADA) report staff should check the Truthfulness Scale score. If the Truthfulness Scale score is at or below the 90th percentile -- test results are valid and accurate. However, if the Truthfulness Scale score is at or above the 91st percentile -- test results are not accurate and the report is invalid. Truthfulness Scale scores in the 70 to 90th percentile range are accurate due in part to Truth-Correction, but should be used cautiously and verified (corroborated) whenever possible.

Summary: Truthfulness Scale scores at or below the 90th percentile indicate that the Anxiety-Depression Assessment (ADA) report (and scale scores contained therein) is accurate and valid. Truthfulness Scale scores at or above the 91st percentile mean the client was overly guarded, defensive, minimizing problems or faking -- to the extent that the Anxiety-Depression Assessment (ADA) report is inaccurate and not valid.

When you have an inaccurate or invalid Anxiety-Depression Assessment (ADA) you might consider reviewing the oral instructions with the client before retesting. This is discussed under the heading "Oral Instructions." Approximately 10 percent of the people tested will provide Truthfulness Scale scores at or above the 91st percentile, i.e., an inaccurate or invalid Anxiety-Depression Assessment (ADA) report.

A sophisticated psychometric technique involves "Truth-Corrected" scores which are individually calculated for each of the eight Anxiety-Depression Assessment (ADA) scales each time a test is scored. The Truthfulness Scale establishes how truthful the client was while completing the Anxiety-Depression Assessment (ADA). Correlations between the Truthfulness Scale and all other scales have been statistically determined. This score correcting procedure enables the Anxiety-Depression Assessment (ADA) to identify error variance associated with untruthfulness and then apply it to scale scores -- resulting in Truth-Corrected scores. **Raw scores may reflect what the client wants you to know. Truth-Corrected scores reveal what the respondent is trying to hide. Truth-Corrected scores are more accurate than raw scores.** Truth-Corrected scores are similar to Minnesota Multiphasic Personality Inventory (MMPI) T-scores. The MMPI correlates the K scale with selected clinical scales. The clinical scales are then weighted with the K scale correlation equation. The MMPI L (fake good) scale and the F (almost everyone agrees with) scale correlate significantly (.001 level) with the Anxiety-Depression Assessment (ADA) Truthfulness Scale.

Professionals across the country have endorsed the benefits of Truthfulness Scales and Truth-Corrected scores. This methodology is easy to use because the computer does all the work, actually calculating Truth-Corrected scores every time a test is scored. In the past many evaluators "turned off" on self-report tests because they were too easy to fake. Truthfulness Scales and Truth-Corrected scores have addressed this problem. And they are considered by many as very important to any self-report test.

ORAL INSTRUCTIONS

Many clients tend to minimize their problems by under-reporting their substance (alcohol and other drugs) abuse and other problems. This emphasizes the importance of oral instructions to the client before beginning the Anxiety-Depression Assessment (ADA). A straightforward approach is recommended. For example:

"This test contains a truthfulness measure to determine how cooperative and truthful you are while completing it. It is also important that you do not read anything into the questions that is not there. **There are no trick questions or "hidden meanings."** Your records may be checked to verify the accuracy of your answers. Just answer each question truthfully."

Giving the client an example often helps them understand. The example that you use will be influenced by your client population, experience, and intent. Your example should be individualized to your situation and needs. The following example is presented for clarification as to how an example might be included in your oral instructions to the client.

Last week a client told me while taking the MMPI that he could not answer this true-false question, "I am attracted to members of the opposite sex." When asked why, the client replied, "If I answer True, you will think I am a sex maniac. If I answer False, you will think I am a homosexual." I told the client that "this test item does not ask you about being a sex maniac or a homosexual. It simply asked if you are attracted to members of the opposite sex. When you interpreted it to refer to sex maniacs or homosexuals, you were answering a different question. **Do not read anything into these questions that isn't there, because if you do, you will invalidate the test and may have to take it over.** Simply answer the questions True or False. There are no trick questions or hidden meanings. If you misinterpret or change the questions in the test, you will invalidate the test."

Oral instructions are important. Do not just give the test to the client without providing some guidance as to how the client should proceed. We have found that when you treat clients with respect, and provide some direction or guidance as to what they are to do -- they cooperate positively. It's usually when a client feels he/she is not being dealt with respectfully or they are simply being told what to do -- that they become resistant, passive-aggressive or non-compliant.

RETEST

Test results are invalidated (not accurate, often due to problem minimization, denial and untruthful answers) when the Truthfulness Scale is at or above the 90th percentile. When this occurs, it is recommended that the client be given the opportunity to be retested. Retest interval is determined by the assessor's opinion of the client's attitude, behavior, emotional and mental state. Retesting can occur immediately or several days or weeks later.

Prior to retesting, the test administrator should review the retest instructions with the client. A straightforward approach is recommended. For example,

Please answer all questions truthfully. It is important that you do not read anything into a question that isn't there. Last week, while completing another test, a client involved in a custody case said, "I cannot answer this question true or false." The question was "There are times when I worry about my court case or the charges made against me." When asked why not, the client replied, "If I answer true, you'll tell the judge that I am guilty because I'm worried; if I answer false you'll tell the judge that I don't care and I'll never get my kids."

*I told the client, “This test item doesn’t ask you about your guilt or caring for your kids. The question simply asked if you are worried about your court case. When you interpreted the question to refer to your guilt or innocence, you were answering a different question. **Do not read anything into these questions that isn’t there**, because if you do you will invalidate the test. Simply answer the question as instructed, (i.e., True or False). There are no trick questions or hidden meanings. If you misinterpret or change questions you will invalidate the test.*

A few minutes of oral instructions can put the client at ease while providing structure and clarifying the client’s expectations. Do not tell the client they were lying – you will never win that argument. Note the above example reframes the issue from denial, problem minimization and noncompliance to reading questions correctly.

That said, nobody wants an invalid test. That is why problem tests (tests whose truth-corrected scores are in the problem risk range) are “truth-corrected” so test results are accurate and usable. Truthfulness Scale scores at or below the 89th percentile are accurate. **Truthfulness Scale scores at or above the 90th percentile are inaccurate due to client denial or attempts to fake good.**

If this was a retest, this person may not be “testable” at this time. However, an alternative approach includes using the Human Voice Audio program. Human Voice Audio is an automated computer presentation in which the questions are verbally read to the client (in English, Spanish, etc.) while simultaneously being presented on the computer monitor (screen). The Human Voice Audio program is available to you free or at no additional cost. For more information on the Human Voice Audio program it is discussed in this Training Manual. And additional information can be provided upon request. Our email address is info@bds ltd.com and our toll free number is 1 (800) 231-2401.

PRESENT, PAST OR FUTURE TENSE

Clients should answer test items as the questions are stated -- in present, past or future tense. Questions are to be answered exactly as stated. There are no trick questions. If an item inquires about the past -- it will be stated in past tense. If the item inquires about the present -- it will be stated in present tense. And if an item asks about the future -- it will be stated in future tense.

STAFF MEMBERS SHOULD NOT TAKE THE ASSESSMENT -TEST

Sometimes a staff member wants to simulate the client and take the Anxiety-Depression Assessment (ADA). **It is strongly recommended that staff do not take the Anxiety-Depression Assessment (ADA).** The Anxiety-Depression Assessment (ADA) is not standardized on staff. And staff does not have the same mental set as a client. Staff would likely invalidate, distort or otherwise compromise their Anxiety-Depression Assessment (ADA) profile.

CONTROL OF ANXIETY-DEPRESSION ASSESSMENT REPORTS

Anxiety-Depression Assessment (ADA) reports contain sensitive and confidential information. And some of the terms used in the report may be misunderstood by the respondent and others. For these reasons clients should not be given his/her Anxiety-Depression Assessment (ADA) report to read. Instead it is recommended that staff review Anxiety-Depression Assessment (ADA) results with the respondent, but does not give the Anxiety-Depression Assessment (ADA) report to the client to read. Anxiety-Depression Assessment (ADA) test booklets and reports are privileged, highly sensitive and confidential. **No Anxiety-Depression Assessment (ADA)-related materials should be allowed to be removed from your office.**

CHECK ANSWER SHEETS FOR COMPLETENESS

Check the client's answer sheet to be sure it has been filled out correctly when it is turned in and before the client leaves. No items should be skipped and both true and false should not be answered for the same question. The client should be informed that each question must be answered in accordance with the instructions. And if necessary, be given the opportunity to correct or complete their answer sheet. **Skipped answers are scored by the computer in the deviant direction, as it is assumed that an item is omitted or skipped to avoid admitting a "negative" answer.**

HOW DOES THE ASSESSMENT TEST PROTECT AGAINST RESPONSE SETS?

Response “sets” are relatively rare and encountered when the clients answer all items true or false. Such “sets” can occur when the client doesn’t care about test results, or in very rare cases the response set may reflect psychopathology. The Anxiety-Depression Assessment (ADA) is designed to guard against response sets. When 85 percent of Anxiety-Depression Assessment (ADA) answers are all true (or all false), the Truthfulness Scale score is automatically set at the 99th percentile. This is to alert the evaluator that something unusual (like a response set) has occurred. A negative response set would result in an elevated (91st percentile or higher) Truthfulness Scale score, whereas a positive response set would result in all scale scores being elevated (91st percentile or higher). Also the type of items is deliberately varied (True-False, Ratings and Multiple Choice). Different types of items and responses help avoid response sets.

DELETE CLIENT NAMES (CONFIDENTIALITY)

You have the option to delete client names from the diskette before returning it to Behavior Data Systems, Ltd. Once you delete client names from a diskette -- they are gone and cannot be retrieved. Deleting client names does not delete demographic information or test data. Deleting client names protects client’s confidentiality. This procedure is explained in the Computer Operating Guide or manual. This procedure ensures compliance with HIPAA regulation (45 C.F.R. 164.501).

TEST DATA INPUT VERIFICATION

You have the option of verifying the accuracy of test data input into the computer. In brief, the test data input verification procedure involves entering the test data twice. If the test data entry is the same the first and second (verification) time, then the test data was accurately entered. If there is a discrepancy between the first and second (verification) time the test data is entered, each discrepancy (or inconsistent answer) will be highlighted until corrected. You can’t proceed until all entries from the first and second data entries match. Test data entry takes less than two minutes. This verification procedure is discussed in the Anxiety-Depression Assessment (ADA) Computer Operating Guide or manual.

EXPANDING DATABASE

A database is a large collection of data in a computer, organized so that it can be expanded, updated and retrieved rapidly for statistical analysis or annual summary reports. A database of test-related information can be very useful.

Used Anxiety-Depression Assessment (ADA) diskettes are returned (without client names) to Behavior Data Systems and test data is downloaded into the Anxiety-Depression Assessment (ADA) expanding database. Annual database analysis ensures ongoing research and accuracy of assessment. And, the Anxiety-Depression Assessment (ADA) database enables presentation of ongoing test program summary reports which describe the population that was tested in terms of demographics, assessment accuracy and much more.

SIGNIFICANT ITEMS

Some answers represent direct admissions to a problem or are highly unusual answers. These “significant” items are identified for easy reference. On the last page of the report significant items are printed for the Alcohol Scale and Drug Scale. Sometimes seeing these self-admissions or important self-report answers helps in understanding the client. **Significant items alone do not determine scale scores.** There may be several significant items for a scale and a low scale score or vice versa. Significant items are only presented in the report to highlight or dramatize some answers.

SPECIAL (99% SCORES) REPORTS

When the Truthfulness Scale score is at or above the 95th percentile all other scale scores are automatically set to the 99th percentile. In other words the Anxiety-Depression Assessment (ADA) report is modified due to the extremely inaccurate test protocol. And in place of the scale description or paragraphs explaining scale scores, a one-page explanation of validity - invalidity is printed. A test protocol is inaccurate and invalid when the Truthfulness Scale score is at or above the 91st percentile. The special 99% procedure only occurs when Truthfulness Scale scores are at or above the 95th percentile.

TECHNICAL SUPPORT

If you have a problem or question, call Behavior Data Systems, Ltd.: 1 (800) 231-2401. This number is operational during 8 a.m. to 4 p.m. (Mountain Standard Time), Monday through Friday. You can also fax to (602) 266-8227 or email info@bdsltd.com.

When prompted your secret code is “y”

www.online-testing.com

How to Login

With your Username and Password you are now ready to login and begin testing. To login click the LOGIN button in the upper right corner.

Type in your username and password (both are case sensitive). Below these boxes click on the Login button, this takes you to your account page. On your first visit to this page you will see that you have 1 test credit in your account. We give you one free test credit to enable you to familiarize yourself with our tests and our website.

Click on the "Continue" button or the "Account Summary" button to go to your Account Summary Page.

The Account Summary Page shows Account History, Test Credits Used and Test Credits Available.

There is a drop down box to show the list of available tests and a link to print test booklets and answer sheets.

How to Administer a Test

Before you proceed, please be aware that there are *two test administration options described*.

1. Paper/Pencil Test Administration (Data Entry Method)

The first option is to print the test booklet and answer sheet, both of which are available in English and Spanish. The client then answers the questions on the answer sheet in pencil. The paper-pencil test administration option allows you to test in groups which can save considerable time. Some evaluators do not want to tie up their computers administering tests and prefer paper-pencil testing. When testing is completed the answer sheet data is entered online and a report is generated.

If the paper-pencil method is selected, click on the "Print Test Booklets" link on the screen and print the test booklet and answer sheet; both are available in English, Spanish and other languages.

2. On Screen Online (Internet) Test Administration

The second option is online (on the screen) test administration. This allows the client to sit at the computer and answer the test questions on the screen. Regardless of how tests are administered, all tests are scored and reports generated and printed while online.

Click on the name of the test to be administered. This takes you to the Main Menu page for the test selected.

How to Score a Test and Print a Report

When you have selected your preferred method of test administration click either "Administer Test to Client" (in which case the client would enter his/her answers on the screen), or "Enter Test from Answer Sheet" (client will use the paper/pencil method).

The next screen will be "Client Information" (name, age, sex, education etc.). When you have completed this information, click the "Information Correct" button which will take you to the "Court History" page. Depending on the test you have chosen some tests have a court history section, some do not. Each screen allows the option to choose "Cancel" or "Information Correct" to proceed.

After completing Court History, the next screen is for client answers to the test questions. If the client has used the on-screen method, the questions and answers will be displayed to the client on the screen. If the paper/pencil method was used to test the client, you may enter the answer sheet data at your convenience by typing 1 for true, 2 for false, etc. For multiple choice questions, enter 1, 2, 3 or 4.

Again, this screen allows the option to choose "Cancel" or "Information Correct." If "Information Correct" is chosen the option is still available to cancel or abort the entry and not charge the account. At the end of the test a notice will appear alerting you that one test credit is about to be used. To save the test record to the database click "Yes." To cancel or discard the test entry, click "No." ***When "Yes" is selected, your account will then be charged 1 test credit.***

Highlight the client's name and click on the "Supervisor Options" button to proceed to that client's supervisor options page. Here you can print the report, verify the answer sheet data entered and delete the client's name. The default page that appears is the Print Report page. To print the report, click the "Continue" button. To verify the data entered or delete the client's name, click on the appropriate tab at the top and follow the instructions.

In summary, procedures are designed to be concise, easily followed and swiftly executed, so that they will not detract from test administration.

The test administration is now complete. However, you are still in the test Main Menu screen and if you wish to administer another test, click on the "Account Summary" link on the right of the screen. This will take you back to your account summary page where you may check for available test credits,

purchase additional test credits, select other tests to administer or edit previously administered tests. Otherwise just close your browser window to exit the website.

How to Verify Data Entry

The Verify Data Input procedure allows you to enter the answers a second time for any particular client. This feature insures that the responses are input into the computer correctly.

From the main menu select the client's name and then click on the "Supervisor Options" button. This will take you to the Supervisor Options page. Click on the tab labeled "Verify Data Entry" and then click on the "Continue" button. You will now be presented with the answer grid so that you can re-input the answers.

As you input each answer, the computer will verify that it matches the answer you originally entered. If it does, the computer will automatically move on to the next response. However, if the answer you input does not match the original answer, you will be immediately alerted to the discrepancy between the two responses via a message box.

The message box will notify you as to which answer did not match the original input. The message box will display what the current answer is and what the original response was.

At this point you should review the answer sheet to verify what the correct response for that particular question is. You will then click "OK" if the answer input this second time is correct and the computer will accept this response and move on to the next answer.

If, after reviewing the answer sheet, you discover that you have erroneously input the wrong answer, click the "Cancel" button and the computer will allow you to enter the response again.

Continue with these steps until all answers have been input. Using this feature insures the accuracy of the data input.

How to Delete Client Names

This procedure allows the user to delete the client's name from the test record. Use this option to protect client confidentiality once you are done with the test record.

From the main menu select the client' name and then click on the "Supervisor Options" button. This will take you to the Supervisor Options page. Click on the tab labeled, "Delete Client Name" and then click on the "Continue" button. You will be given the opportunity to cancel this procedure at this time. **USE WITH CAUTION!** Once the name has been deleted it **CANNOT** be restored. When you are absolutely certain that you are ready to proceed, click on the "Continue" button. That's all there is to it. The name will be deleted from the record and you will be returned to the main menu. Notice that the name you just deleted is no longer visible in the client list.

Live Support Chat

Throughout our site, after you have logged in, you will find "Live Support" buttons. Clicking on these buttons will open a "Live Support" chat window that puts you in touch with an Online-Testing.com technical support staff member.

Support staff is available for these "Live Support" sessions between the hours of 8:00 a.m. and 4:00 p.m. Mountain Standard Time, Monday through Friday. If you need to leave your computer during the chat session, you can return within 24 hours and resume your online conversation.

TECHNICAL SUPPORT

If you have any questions Professional Online Testing Solutions, Inc. is only a telephone call away. Our telephone number is **(800) 231-2401**, fax **(602) 266-8227**, and E-mail info@online-testing.com. Our offices are open 8:00 a.m. to 4:00 p.m. Mountain Standard Time, Monday through Friday.

When prompted your secret code is “y”