Greetings!
This has continued to be a busy and productive year. And, in terms of snowfall, it has been a record-setting winter for many of us. I, for one, am very ready for spring!

Excellence on the Joint Standards
Janet Wall, as Chair of the Joint Standards and Statements Committee has worked with Rick Balkin to initiate new joint standards with several other divisions. Recently, the National Career Development Association approved the AACE-NCDA joint standards developed by Janet (Chair), Cheri Butler of NCDA, Pat Nellor Wickwire, Chester Robinson, Rick Balkin, and Lori Ellison. In addition, Jeffrey Garrett (Chair), Rick Balkin, Brad Erford, Janet Wall, and Brandé Flamez, together with IAMFC representatives James Devlin, Robert Smith and Samantha Mendoza, completed the AACE-IAMFC (International Association for Marriage and Family Counseling) joint standards. Both sets of standards will be voted on at AACE’s Spring Executive Council meeting in Pittsburgh. All those involved have been diligent and tireless in crafting useful and current standards for assessment, both in career counseling and in marriage and family counseling.

Outstanding Contribution to Assessment
The Ad Hoc Committee on Evaluation and CACREP Competencies, initiated this past summer, is identifying best practices for assessing student learning outcomes (SLOs). They are also preparing recommended strategies for meeting CACREP assessment and evaluation standards related to SLOs. I want to thank Casey Barrio Minton and Donna Gibson, co-chairs of the Committee, for their commitment to completing this important set of tasks, especially given the many new responsibilities that both of them have in other arenas of their lives. The Committee also includes Jennifer Adams, Teresa Fletcher, Debbie Newsome, and Marinn Pierce. They have been consulting with Craig Cashwell and Robert Urofsky regarding CACREP needs and concerns, and will present their work at the ACA national conference (date and time included later in this newsletter).

ACA 2010 Annual Conference and Exposition
Speaking of the ACA conference, it is close upon us. If you haven’t purchased your registration for the 2010 ACA Annual Conference and Exposition, do so today! The conference is being held March 18-22 at the David L. Lawrence Convention Center in Pittsburgh, PA. AACE will be well-represented, with a number of AACE-sponsored presentations and many additional presentations by AACE members. The AACE Executive Board will meet the two days before the start of education sessions, and we have a number of ancillary events going on at the conference. On page 7, you will see the schedule of meetings and ancillary events. In addition, on page 2, you will see the dates, times and descriptions of the AACE-sponsored sessions at the ACA Conference.
AACE Sponsored Presentations

Saturday

11:00 am – 11:30 am
Program ID #131, CC, Exhibit Hall, Booth PS7
Self-injury: Assessment & Symptomatology
Amanda C. Healey, East Tennessee State, Rebekah J. Byrd, Kelly Emelianchik, & Stephanie Crockett, Old Dominion

3:45 pm – 4:45 pm
Program ID #251, CC, Room 302
Assessment Standards and Free Access Depression, Anxiety and Substance Abuse Inventories for Use in Counseling Practice
60-Minute Program
Bradley T. Erford, Loyola University Maryland, Timonium, MD, Danica G. Hays, & Cynthia J. Osborn

Sunday

11:00 am – 12:00 pm
Program ID #397, CC, Room 304
Assessment in Marriage, Couple/Partner and Family Counseling: Assessing Interethnic Couples
Jeff W. Garrett, Marshall University, Huntington, WV, & James Devlin

2:00 pm – 2:30 pm
Program ID #418, Convention Center, Exhibit Hall, Booth PS6
Development of the DSM-IV Disruptive Behavior Checklist
30-Minute Project Poster Session
Carl J. Sheperis, Walden University, Merigold, MS, Capri P. Brooks, Donna S. Sheperis, & Laura Simpson

4:00 pm – 4:30 pm
Program ID #513, CC, Exhibit Hall, Booth PS5
Assessment in Supervision: Identifying Counseling Students at Risk
30-Minute Project Poster Session
Lori L. Ellison, Marshall University Graduate College, Charleston, WV

JOIN US IN MEMPHIS!

AACE 2010 National Assessment and Research Conference
September 9-11, 2010
Currently accepting proposals!

Proposals due by July 1, 2010 to:
Dr. Richard Balkin
Richard.Balkin@tamucc.edu

For more information, proposal and conference registration forms, please visit the AACE website

AACE COMMITTEE INFORMATION

Executive Council:

President: Marie Shoffner, University of Virginia
mfs2f@virginia.edu

President-Elect: Joshua Watson, Mississippi State University - Meridian
JWatson@meridian.msstate.edu

Past President: Rick Balkin, Texas A&M University - Corpus Christi
Richard.Balkin@tamucc.edu

Treasurer: Savita Abrahams, Argosy University - Dallas
savita_abrahams@hotmail.com

Secretary: Amy McLeod, Argosy University - Atlanta
amymcleod1@gmail.com

Member-at-Large Membership: Danica Hays, Old Dominion University

Member-at-Large Publications: Bob Wilson, University of Cincinnati

Member-at-Large Awards: Susan Eaves, Weems Mental Health Center

ACA Governing Council Representative: Brad Erford, Loyola University Maryland

Graduate Student Representative: Mary Deacon, University of Virginia

Committees:

Standards and Statements Chair: Janet Wall
Diversity Issues Chair: Savita Abrahams
Bylaws and Ethics Chair: Rick Balkin
Conference Committee Chair: Danica Hays
Newsletter Committee Chair: Amanda Healey
President’s Message Continued...

The 2010 National Assessment & Research Conference in Memphis

Finally, AACE is excited to announce that the 2010 National Assessment and Research Conference will be held in Memphis, Tennessee at the Memphis Airport Holiday Inn September 10-11, 2010. On September 9, Donna Sheperis will present a preconference professional development workshop entitled “Ethical Challenges in Counseling and Assessment.” Our keynote speaker has not yet been chosen but we will have a complimentary Luncheon during the Keynote on Friday. Thank you to Josh Watson and Carl Sheperis, our 2010 Conference Chairs. We appreciate your hard work and commitment to preparing another outstanding conference. Watch your Newsnotes and the AACE website for a Call for Proposals in early March. All in all, these three days promise to be an exciting time with outstanding presentations and workshops and time to reconnect with friends and colleagues.

I hope to see you in Pittsburgh at the ACA conference and in Memphis next fall!

AACE Election Results

*Congratulations to the newly elected officers of AACE*

**Danica Hays**—President Elect-Elect

**Casey Barrio**—Secretary

**Amy McLeod**—Member-at-Large for Membership

**Dale Pietrzak**—Member-at-Large for Publications
Considerations for Using Survey Research in the Counseling Field
Student Perspective By Stephanie Crockett, Doctoral Student, Old Dominion University

Survey research is one of the most dominant types of quantitative research in social sciences, and is used in a high percentage of counseling studies (Erford, 2008). Survey research is appealing to social science researchers because it is inexpensive, amenable to administration in person, through the mail, by telephone, or over the internet, and provides an efficient means for collecting data from a large population (Roberts, 1999). While survey research designs offer several advantages, researchers must consider the intent and goals of their study before selecting this design in lieu of other research designs. To assist researchers in making informed decisions regarding the use of a survey design, this article aims to define survey research as well as to describe the design’s purpose and inherent limitations.

Broadly defined, survey research includes any measurement procedures that ask respondents to answer questions. Typically, the researcher uses an instrument composed of open or closed-ended items to gather quantitative data regarding trends, attitudes, or opinions from a sample that is assumed to be representative of a target population (Creswell, 2009). The primary purpose of survey research is to gather and analyze data regarding participant characteristics and perceptions relating to researcher-specified constructs (Creswell). Survey research also allows the researcher to collect data that is greater in scope, but limited in depth. Lastly, survey research attempts to describe naturally occurring variations between variables and, as a result, does not allow the researcher to manipulate research variables or introduce interventions into the study. Consequently, researchers who wish to study actual participant behaviors, gather in-depth data, and/or empirically test specific interventions must look to other research design methods.

Researchers should also be aware of the limitations inherent in survey design research. A significant limitation of survey research is the inability to determine causality. Survey research does not allow for the manipulation of study variables; as a result, the researcher cannot adequately establish causal connections among variables, and is only able to draw conclusions about the relationships between variables. The generalizability of survey research results is also limited. Researchers using a survey research design typically use sampling methods that are subject to error, and lead to a sample that is unrepresentative of the target population (Giuffre, 1997). Researchers must also consider the impact of nonresponse bias (i.e., differences between responders and nonresponders) on the generalizability of their results (Erford, 2008). Survey research is additionally susceptible to measurement error due to the use of unreliable instruments that lack validity. Lastly, the data collected during survey research is contingent on the information participants wish to reveal. Data reflects participant perceptions and attitudes, which have been found to be a poor predictor of behavior (Tartar, 1969).
In short, survey research has an explicit function and should only be used if a study’s purpose reflects the intent of survey research designs. The counseling field is also in need of research methods that can do more than provide inferences regarding the relationships among variables. Research that can examine the effectiveness of specific interventions and causality among variables is needed. In short, research quality should not be sacrificed for quantity, cost effectiveness, and ease of use.

References


Reminder: AACE Breakfast at ACA

The AACE Breakfast is scheduled for March 21st from 7:30—9am, and is currently sold out. You may still attend, but will not be provided with a meal. We look forward to see you all there!
Nominations for AACE Treasurer and President-elect 2011-2012

AACE is requesting nominations for President-elect and Treasurer to begin serving July 1, 2011. President elect is a three-year commitment, with a year of service as President-elect, President, and Past-president respectively. Treasurer is a two-year commitment.

Nomination should be emailed to Rick Balkin, AACE Past-president, at Richard.balkin@tamucc.edu by March 31, 2010. Both nominations and self-nominations are accepted and encouraged. A slate of candidates will be discussed at the AACE Board meeting in March 2010 at the ACA National Conference in Pittsburgh, PA and will be approved at the AACE business meeting also at that conference. Duties for each of these positions may be found below.

The duties of the President-Elect shall be to:

GENERAL RESPONSIBILITIES

1. Perform the duties of the President in the event of the resignation, absence, incapacity, or death of the President,
2. serve as a member of the AACE Executive Council and of the Executive Committee,
3. establish and maintain contact with the AACE President-Elect-Elect,
4. establish and maintain contact with the Presidents-Elect of other ACA divisions and with the President-Elect of ACA,
5. serve as chair of AACE luncheon program committee,
6. select and arrange for the speaker for the AACE luncheon program at the annual convention of ACA and work with the convention coordinating committee on luncheon details,
7. order the Award of Appreciation to be presented to the outgoing President during the AACE convention luncheon,
8. order certificates of recognition for meritorious service to the Association for outgoing officers and all committee chairs to be presented at the AACE convention luncheon meeting,
9. attend meetings of COPARC, as appropriate,
10. select Convention Program Chairperson for the following year to serve during the term of the President-Elect's presidency,
11. select committee chairpersons and editors (with Member-at-large for Publications) to replace those whose terms of office are expiring and make appointments by convention time,
12. serve as liaison between the Executive Council and assigned committees,
13. keep files of activities and transfer them to the succeeding President-Elect,
14. submit a written report of activities and recommendations to the President for each Executive Council Meeting and the AACE Annual Business Meeting,
15. pass on all relevant file material to her/his successor,
16. perform such other duties to promote and carry out the programs and objectives of AACE as may be requested or delegated by the President, or assigned by action of the Executive Council.

TERM OF OFFICE
One year, July 1 to June 30, as President-Elect
One year, July 1 to June 30, as President
One year, July 1 to June 30, as Past President

The duties of the Treasurer shall be to:

GENERAL RESPONSIBILITIES

1. serve as a member of the AACE Executive Council and of the Executive Committee,
2. review and approve requests for disbursements which have been authorized by the Executive Council,
3. present reports of the financial status of AACE to the Executive Council and to the AACE membership at the Business Meeting,
4. recommend limitations for individual budget categories,
5. prepare, duplicate, and distribute the budget,
6. present a recommended budget to the Executive Council for review and approval,
7. recommend changes in budget procedures for AACE and ACA,
8. report to the Executive Committee and/or Executive Council regarding unexpected budgetary problems,
9. maintain the financial record of AACE in permanent record form,
10. work closely with the President in preparing an annual financial report of the Association's status, subject to audit by the proper persons,
11. maintain a current balance for each budget item of the Association's activities,
12. file the proposed budget which has been approved by the Executive Council with ACA,
13. work with the Executive Committee to determine possible sources of income,
14. pass on all relevant file material to her/his successor,
15. attend ACA division/region Treasurers' workshops,
16. serve as AACE liaison to ACA Accounting Office,
17. forward AACE, minutes and appropriate documentation to the ACA Accounting Office when requested, and
18. notify President if any budget expense request exceeds 10% above the line item in the budget. Such an excess requires AACE Executive Committee approval prior to payment.
19. track sales of any products and services offered by AACEE and make payment of any royalties

TERM OF OFFICE
Two years, July 1 to June 30 (2007-2009, 2009-2011, 2011-2013, etc.)
2010 American Counseling Association Conference & Exposition

Schedule of AACE Ancillary Events

March 19, 2010  
**AACE Executive Council Meeting**  
Stonewall Boardroom  
9:00am – 4:30pm

March 20, 2010  
**AACE Executive Council Meeting (Old & New)**  
Stonewall Boardroom  
8:00am – 12:00pm

March 20, 2009  
**Division Reception**  
*(AACE, C-AHEAD, ASERVIC, IAOCC)*  
Trade  
5:30pm – 7:30pm

March 21, 2009  
**AACE Breakfast and Business Meeting**  
Independence  
7:30am – 9:00am

*Please check your conference program for more information about these events*
The advancement of technology has greatly impacted the way knowledge is shared among professionals. For instance, listservs have become an effective tool for professionals to quickly disseminate information and ideas as members simply e-mail their message to the listserv address in order for it to reach all other listserv members, (Collins, 2007; Hara & Hew, 2007; & Kennedy, 2007). Within the counseling profession, CESNET-L is recognized as a discussion group for counselor educators, supervisor, students, counseling practitioners, and other professionals. Members of this listserv often discuss and debate topics currently impacting the counseling field.

In a recent study, Neukrug, Cicchetti, Forman, Kyser, McBride, and Wisinger (2010) completed a content analysis of all CESNET-L messages between January 1, 2005 and December 31, 2008 in order to track salient issues and current trends within the counseling field. Overall, 9,197 messages were analyzed by researchers. Researchers placed each message into 1 of 20 categories (e.g. program promotions and announcements, credentialing, request for manuscripts, ethical issues, accreditation issues, current events, conference related info) that were previously developed using an inductive and collaborative approach. To establish minimum interrater agreement of 80%, each member of two teams of two researchers rated a sample of the e-mails. After interrater agreement was achieved, the first pair of raters independently examined all 4,828 emails of 2005 and of 2007 while the second pair independently rated all 4369 emails of 2006 and of 2008 obtaining interrater agreement of 87% and 96%, respectively.

Results showed that 50% of the 9,197 e-mails were represented by two main categories: Resource Requests and Recommendations (29%) and Personal Communication (21%) and that Program Development accounted for 15% of all e-mails followed by Employment Opportunities at 7% (Neukrug et al., 2010). Ten categories only contained 2%-4% of the e-mails. These ten categories included Ethical Issues, Clinical Issues, Social Justice Issues, Participation in Research, Workshop/Conference Announcements, Accreditation Issues, Multicultural Issues, Listserv Etiquette/Protocol, Current and Traumatic Crisis Events, and Professional Identity. The remaining six categories contained 1 percent or fewer of all the e-mails and included Professional Service Opportunities/Awards, Requests for Manuscripts, Credentialing, Miscellaneous, Program Promotions/Announcements, and Grant Announcements/Requests.

Two categories that generated much interest among listserv members were identified by researchers: Research Requests and Personal Communication. Although Research Requests accounted for a small percentage of all e-mails (3%), these types of requests appeared to have a negative impact on some CESNET members. For instance, during June of 2009 numerous CESNET members discussed the high percentage of research requests that were being placed on the listserv. Some members viewed these requests as bad research practice as it is impossible for researchers to know who they are sampling. Others believed these requests were clogging up the listserv and were surprised when told by Neukrug, et al., that preliminary results of their survey revealed they represented only 3% of e-mails. Relative to personal communication, in reviewing the almost 10,000 e-mails, reviewers noticed a number of personal communications in the form of disagreements and apologies taking place between members of this listserv. Neukrug, et al. suggested it was important that members of listservs, such as this one, avoid personal attacks, understand that e-mails can be misinterpreted, be respectful and courteous of others, and maintain a professional tone.
The expansion of listservs has been rapid and may have resulted in listservs developing too wide a function (Young, 2009). With this in mind, Neukrug et al. suggested the development of a multiple purpose website in lieu of a listserv. Such a website could include:

1. A listserv, with a purpose statement and instructions on how to join.
2. A Twitter with a purpose statement and instructions on how to join.
3. An etiquette statement to assure proper functioning of the listserv and twitter.
4. A daily blog to attract members to the website and increase discussion about cutting edge issues.
5. A self-monitoring contact list where individuals can post their email address and other contact information.
6. A professional resource depository.
7. Links to surveys and research studies so professionals can make informed decisions about whether they would like to participate in specific research studies.
8. Workshop and conference information.
10. Grant opportunities.

Overall, tracking trends within the counseling field is valuable as it identifies “hot topics” professionals are discussing. Although research such as this is limited because the researchers only gain a view of the small percentage of those on the listserv who actually respond and because some of the anecdotal information discussed (e.g., reactions of listserv members to personal communications) could be interpreted wrongly by researchers, this content analysis is valuable as it brings to the forefront certain issues and topics that are currently being discussed by professionals within the counseling field (Neukrug et al., 2010). Future content analyses of CESNET-L may identify topics that need to be addressed in continuing education as well as topics that counseling professionals are neglecting to discuss.

References


**STUDENT PERSPECTIVES: GET INVOLVED!**

Rebekah J Byrd, Student Perspectives Editor

Student Perspectives is a new column for the AACE Newsletter developed in response to a recommendation from the AACE executive council to increase participation by student members. In the age of managed care and limited fiscal resources, research-based practice is a growing need among counselors. In order to facilitate counselor development, students are encouraged to integrate assessment and research best practices throughout their education and emerging practice as counseling professionals. AACE assists students by providing resources for developing efficacious standards-based counseling practice among students. However, counselor educators and long-time practicing counselors often have a different perspective than those of new professionals and students who are in the process of becoming professional counselors.

Student Perspectives fills an important gap in the organization’s existing services by providing an outlet for students to identify, discuss, and make recommendations regarding research-based practice that may be less evident to experienced professional counselors. In this light, both master’s and doctoral level students are encouraged to submit contributions to the column editor, Rebekah J Byrd, at rebekah.byrd@gmail.com. Submissions should highlight issues related to the process of research proposal development; teaching methods they have experienced that have assisted their development as researchers and as users of assessment measures; topics related to research design, dissertation writing, and presentation of research; experiences as students learning research methods; perspectives on assessment use among counselors, particularly related to training and professional development in using assessment measures; experiences with finding funding support and writing small grants; as well as locating and participating in professional development activities related to the AACE mission. Submissions should range between 500-800 words, with a writing style that is consistent with the APA 5th edition Style Manual, and clearly indicate a student-based perspective on the topic featured. Further questions and comments regarding this column may be forwarded to the column editor. If you have thoughts about a particular experience or if you are unsure about a topic, you may email the column editor for assistance with further idea development. The approach taken will be developmental in nature, assisting emerging professionals with their first efforts at writing and publication in a less formal context, although with the opportunity for national exposure.

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**Conners-3 Test Review**

*By Janet Savin-Murphy, Loyola University Maryland*

**General Information:**

**Title:** Conners 3  
**Author:** C. Keith Conners, Ph.D.  
**Publisher:** Multi-Health Systems, Inc. P.O. Box 950, North Tonawanda, NY 14120-0950  
**Date of Publication:** 2008  
**Alternate Test Forms:** None  
**General Type:** Assessment of Attention-deficit/Hyperactivity Disorder (AD/HD) and related issues  
**Cost:** The Conners 3 manual can be obtained for $90, the software kit which contains the manual, scoring software, 25 full-length and 25 shorts for all three forms is about $525, and the hand-scoring kit is about $300.  
**Administration Time:** The full-length form takes about 20 minutes to complete, the short form takes about 10 minutes, and both the Conners 3 AI and Conners 3 GI take about 5 minutes to complete.

**Purpose and Nature of the Instrument:**

**Stated Purpose:** The Conners 3 focuses on the assessment of AD/HD and its most common comorbid problems and disorders in children and adolescents 6-18 years old. The test includes executive functioning assessment and takes into account home, social, and school settings. The Conners 3 can be used to make screening decisions about clinical issues, education eligibility for intervention planning and monitoring, and in research contexts.

**Description of the Test Items and Scoring:** The Conners 3 is a complex assortment of different length forms (full-length [99-115 items], short [S; 41-45 items], AD/HD Index [AI; 10 items], and Global Index [GI; 10 items]), with each form completed by diverse respondents (parents, teachers, or self-report)(Conners, 2008). All of these forms use Likert-type scales to measure item
responses. The short version subscales are composed of the 5-6 best items from the full-length scale and contain the following content subscales: Inattention, Hyperactivity/Impulsivity, Learning Problems (and/or Executive Functioning), Aggression, and Peer (or Family) Relations, and validity subscales Positive Impression and Negative Impression. The Conners-3 AI contains only 10 items from the full-length form. These 10 items are best at differentiating between youth with AD/HD and the youth of the general population. The Conners 3 GI, contains the best 10 items from the full-length test for sensitivity to symptoms of AD/HD. In addition to these indexes, content and validity subscales, the full-length version contains the following DSM-IV-TR symptom subscales: AD/HD Inattentive, AD/HD Hyperactive-Impulsive, Conduct Disorder, and Oppositional Defiant Disorder. The full-length version also contains a number of specialized items: screener items for anxiety and depression; severe conduct critical items; impairment items for schoolwork/grades, friendships/relationships, and home life; and additional questions related to strengths/skills and other concerns. It is advised that all raters (parent, teacher, and student) be administered the same version of the Conners 3 pertaining to the same student.

**Scoring Method and Score Reporting:** There are three scoring options for the Conners 3: online, scoring software, and hand-scoring. The Conners 3 manual (Conners, 2008) outlines all three, but the method for hand-scoring the full-length form will be described here. After the rater has completed the full-length form, which uses pressure-sensitive paper, the scorer separates the pages of the form and locates the response sheet, the scoring grid, the scoring tables, the male profile, the female profile, and the cover sheet. The scoring grid needs to be completed first. The two-page grid is set up so that each subscale is represented on both a left-hand scoring column and a right-hand scoring column. The scorer should make sure the rater’s responses have transferred successfully from the response sheet to the pressure-sensitive scoring grid. Beginning on the left-hand side, the scorer should transfer the circled number response to each unshaded box to the left of that number. Be sure to stay in the same row as the number. Note that some numbers do not have unshaded boxes in their row. After completing the left-hand side, complete the right-hand side in the same fashion. Add the numbers in each column and enter the total in the subtotal box at the bottom of the form. Transfer the subtotal column from the left-hand page to the appropriate boxes on the right-hand page, then sum the two subtotals to obtain the total raw score for each subscale. Once the scoring grid is complete, the scoring tables need to be completed. The front of the scoring tables includes the Validity Scales, DSM-TR-IV Symptom Counts, Impairment items, and the Conners 3 AI. Each of these tables has separate instructions in the manual for completing the tables. The back of the scoring tables includes the Anxiety and Depression Screener items, the Severe Conduct Critical items, and the relation of the Conners 3 results to the Individuals with Disabilities Education Improvement Act (IDEA). Each of these tables has separate instructions for completing the tables.

Once the scoring grid and scoring tables have been completed, the scorer can now complete the profile form to convert subscale raw scores to norm-referenced T-scores. The scorer should locate the proper profile form according to the age and gender of the child. Referring to the scoring grid, the total raw score for each scale should be circled under the appropriate scale for the age and gender of the youth. After the raw scores are transferred to the profile, the scorer should locate the T score columns displayed on the left, center, and right of the profile form to facilitate norm-referenced interpretation. In reporting results, the use of a table is recommended to efficiently summarize the results from all raters. Guidelines for understanding T-scores (M = 50, SD = 10) may be included, along with common characteristics of scorers achieving any high scores, since these characteristics tend to parallel tendencies of AD/HD. The computerized format also gives a feedback handout that can be printed and shared with other stakeholders who are not familiar with the Conners 3 (Conners, 2008).

Regardless of format, it is important to remind stakeholders of a number of things. First, the scores are a result of combined observations and the raters did not know of the different subscale categories when completing the forms. Second, the scores compare the youth of interest to other youth of the same age and gender. Third, the higher the students scores, the higher the level of concern in that area. Lastly, the labels for the scores describe what the scores mean for most people. However, high scores on a subscale may be due to a different attribute. The example given in the Conners 3 manual (Conners, 2008) is a high score in the Learning Problems label may not be due to actual learning problems, but could be due to a language disorder.

**Uses in Counseling:** The full-length form is recommended for initial evaluations and full re-evaluations. The short form is useful when there is limited time to complete the Conners 3 or if the rater will be completing the Conners 3 on a regular basis (i.e. there are several students of concern that a teacher will be rating throughout the school year). The Conners 3 AI form is best used for screening youth who may need more comprehensive evaluation or services related to AD/HD. The Conners 3 GI form is meant to be used as a measure of response to treatment, as well as a quick measure of general psychopathology. Overall, the Conners 3 can be used in counseling for clinical assessment, medication management, educational classification, and screening students to help identify those who may need further evaluation.
Practical Evaluation:

Adequacy of directions, training required to administer: The Conners 3 has a Level 1 requirement for administrators (no Master’s degree required), however, it is cautioned that administrators follow the guidelines carefully. For interpreting test results, a Level 2 qualification is required with graduate-level courses in tests and measurement or the equivalent in documented training. In addition, interpreters should be familiar with the educational and psychological testing standards developed by the American Educational Research Association, the American Psychological Association, and the National Council on Measurement in Education, as well as follow the ethical standards endorsed by the appropriate professional association of the interpreter.

The Conners 3 is very easy to administer. The instructions are very clear and straightforward. Preparation to administer the test includes obtaining informed consent from the rater and the only materials needed for administration are the proper form and manual. The Conners 3 manual (2008) provides instructions for administration. When a rater expresses indecision about an item, Conners suggests providing the following response, “I know that for some questions, it is difficult to know how to respond, but please try your best and choose one of the responses.” The Conners 3 manual (Conners, 2008) provides administration, scoring, and technical instructions.

Technical Considerations:

Norms and Scoring: The normative sample (N = 3,400) includes 50 boys and 50 girls for each age level for each respondent version (e.g., 1,000 self-report responses, 1,200 teacher report responses, 1,200 parent report responses). These include ages 6-18 years for the parent and teacher forms and 8-18 years for the self-report form. The racial/ethnic distribution of the sample reflected the U.S. population. The sample included youth from various educational levels and geographical regions. Also, youth with various diagnoses were included in a clinical sample and stringent data collection procedures were employed to ensure accuracy of the diagnoses.

Validity: The purpose of the Conners 3 is to adequately differentiate youth with AD/HD from others in the general population and those in other clinical groups. Validity of the Conners 3 was analyzed using factorial validity, across-informant correlations, convergent and divergent validity, and discriminative validity. The factorial validity of the parent, teacher and self-report versions was assessed using exploratory factor analysis, confirmatory factor analysis, and scale intercorrelations. Exploratory factor analysis helped reveal the five factors that should be used in the analysis, and confirmatory factor analysis confirmed the fit of these factors. The scale intercorrelations for the parent, teacher and self-report versions of the Conners 3 were moderate.

Across-informant correlations assess the similarity in scores across similar constructs among the three versions of the Conners 3. Again, all correlations were of a moderate size with a p-value < .001. The size of the correlation indicates consistency between different raters of the same youth without redundancy.

Convergent and divergent validity were used to determine if the Conners 3 correlates with other variables it should correlate with and if it does not correlate with other variables it should not correlate with, respectively. The other variables used to determine these validities were the Conners’ Rating Scales-Revised, the Behavior Assessment System for Children, Second Edition, the Achenbach System of Empirically Based Assessment, and the Behavior Rating Inventory of Executive Functioning. Overall, Marocco and Rzepa (2008) found the correlations to appropriately converge and diverge and establish the convergent and divergent validity of the Conners 3.

Discriminant validity involves the ability of the Conners 3 to distinguish between youth with AD/HD Predominantly Inattentive Type, AD/HD Predominantly Hyperactive-Impulsive Type, or AD/HD Combined Type and the general population. Three comparisons were examined: a) target clinical group versus the general population group; b) target clinical group versus other clinical groups; and c) target clinical groups compared to each other if there were more than one target group. A variety of classification results were reported, including overall correct classification rate, sensitivity, specificity, positive-predictive power, negative-predictive power, false-positive rate, false negative rate, and kappa. Overall, it was found that the Conners 3 can accurately differentiate clinical groups from the general population as well as between various clinical groups.
Reliability: The Conners 3 has been analyzed for internal consistency, test-retest reliability, and inter-rater reliability. Results showed high levels of internal consistency, excellent test-retest reliability, as well as high inter-rater reliability. Gallant, Conners, Rzepa, Pitkanen, Marocco, and Sitarenios (2007) assessed the internal consistency of the Conners 3 parent version (3-P), the Conners 3 teacher version (3-T), and the Conners 3 youth self-report version (3-SR), determining median reliabilities of .88-.94 for the content scales, .85-.90 for the DSM-IV-TR symptom scales, and .56-.72 for the validity scales across informant versions.

Gallant (2008) examined the test-retest reliability of the Conners-3 using a sample of 84 parents, 136 teachers, and 80 youth, and a 2- to 4-week time interval. For the Conners 3-P, the mean adjusted test-retest correlation for the Content scales was .85 and for the DSM-IV-TR Symptom scales, was .89. For the Conners 3-T, the mean adjusted test-retest correlation for the Content scales was also .85 and the DSM-IV-TR correlation was .85. The Conners 3-SR mean adjusted test-retest correlation was .79 and the DSM-IV-TR correlation was .76.

The third type of reliability assessed by the Conners 3 manual is inter-rater reliability. Two parents rated 198 youth and two teachers rated 110 youth. The mean adjusted inter-rater correlation was .81 for the Conners 3-P Content scales and .84 for the DSM-IV-TR Symptom scales. For the Conners 3-T, the mean adjusted inter-rater correlation was .73 for the Content scales and .70 for the DSM-IV-TR Symptom scale.

Cross Cultural Fairness: Like its earlier versions, the Conners 3 can be applied to a variety of populations and settings given the inclusion of teacher, parent and self-report versions. School, clinical, and research settings are probably the most likely contexts of use. Schools can use any combination of forms versions and raters to screen for AD/HD or to track students’ progress throughout the school year. Clinical settings can use the Conners 3 Global Index as a screening tool to determine what further testing a child might need. The full-length form can also be used to help determine an AD/HD diagnosis. Researchers can use any combination of form versions and raters to determine population samples for studies regarding AD/HD and youth. A Spanish version of the parent and self-report forms is available to accommodate those who are more comfortable speaking/reading Spanish.

Evaluation:

Due to the recent publication date of the Conners 3, research exploring the strengths and weaknesses of the test is just beginning. The high validity and reliability of test scores greatly contribute to the strength of the test. The factorial validity, across-informant correlations, convergent and divergent validity, and discriminative validity were all used in establishing the validity of the Conners 3. Discriminative validity, however, seems to be the most valuable of these. The fact that the test can consistently distinguish between youth with AD/HD and youth without AD/HD makes the Conners 3 a valuable tool in helping students receive needed assistance. Scores on the Conners 3 were also analyzed for internal consistency, test-retest reliability, and inter-rater reliability, and were found to have acceptable reliability coefficients. The validity and reliability of scores on the Conners 3 appears to be just as strong, or stronger, than the previous edition and attests to the strength of the test for screening youth who may have AD/HD.

There are various forms of the Conners 3, each of which can accommodate various needs for time demands and comprehensiveness of the evaluator or rater(s). The full-length form gives the most detailed, comprehensive results, but takes quite a bit longer than the other forms. The short forms contain only a subset of items from the full-length forms and are more conducive to testing with time constraints or when there is a concern with the practicality of administering the full-length forms. Both of the index forms are preferred when the raters will be completing the forms several times over a short time period. The index forms are both short and focused to either differentiate youth with AD/HD from the general population who may need additional testing or to monitor treatment progress over time. Each of these forms all have confirmed high score reliability and validity.

A significant advantage is that the Conners 3 is offered not only in the traditional pencil-and-paper format, but also in an online format for those who are more comfortable on a computer. There also are forms in Spanish for further rater comfort and accommodations.
While the software or online methods are the most accurate scoring methods, hand-scoring is a convenient and reliable option so long as the scorer is careful and aims to eliminate any scoring errors. The scoring and interpretation of the scores can be accomplished quickly and the results can be easily communicated to individuals not familiar with the Conners 3. While the scoring options ensure speedy and accurate results, the high cost of the software and the hand-scoring kit software may impede the accessibility of the test. In addition, in instances where the full-length form may be the most appropriate, time constraints may only allow for a shorter form to be administered. One final weakness of the Conners 3 is while it has a high level of ease in administration, some graduate level work is required for interpreting the results. Thus, in a school setting, the Conners 3 could be administered at any time, but could not be scored or interpreted until the appropriate personal became available. Regardless, the improvements made to the Conners 3 are likely to maintain its place as the most commonly administered behavior rating scale for the assessment of AD/HD in North America.

References


Review of the Achenbach System of Empirically Based Assessment

By Brenda Haack, University of South Dakota

General Information:

**Title:** Achenbach System of Empirically Based Assessment (ASEBA)

**Authors:** Thomas M. Achenbach, Leslie A. Rescorla, Stephanie H. McConaughey, Peter J. Pecora, Kathleen M. Wetherbee, and Thomas M. Ruffle

**Publisher:** The Research Center for Children, Youth, and Families

**Date of publication:** 1980, 2003

**Forms, groups to which applicable:** The ASEBA may be used for people 18 months old to 90+ years old. There are four levels of this assessment. The levels include Preschool for ages 1 1/2-5, School-Age for ages 6-18, Adult for ages 18-59, and Older Adult for ages 60-90+. These levels are also broken down by gender. There is also a distinction made between referred and non-referred children. (Flannagan, 2005; Watson, 2005)

**General Type:** The ASEBA was developed to evaluate and assess the performance, personality and behavior of children and adults.
Practical features: The ASEBA may be administered to an individual or to a group. There are many settings that the ASEBA can be used in to assist in assessing the concerns and needs of children and adults. Some of these include schools, mental health settings, medical settings, forensic settings and child/family service settings. The forms are filled out by parents, teachers, caregivers, and the child. (Flannagan, 2005; Watson, 2005)

Cost: The Hand-Scoring Starter Kits for all ages range in price from $160 - $245. The Computer-Scoring Starter Kits for all ages range in price from $255 - $395. A variety of materials using software for Windows at each level may also be purchased with prices ranging from $170 - $895. Individual forms for various materials may be purchased in groups of 50 for $25 - $60. Reusable templates cost $9 and Quick Reference Guides cost $12. The manuals range in price from $30 to $55. (ASEBA, 2009)

Time required to administer: The estimated time to complete the ASEBA ranges from 10-90 minutes. The Child Behavior Checklist (CBCL) that is filled out by the parent and teacher/caregiver can be completed in 15-20 minutes. The Youth Self-Report (YSR) takes approximately 20 minutes to complete. The Semi-structured Clinical Interview for Children and Adolescents (SCICA) takes about 60-90 minutes to complete. It will take experienced examiners about 15 minutes to hand-score each instrument. Computerized scoring is much simpler and provides several different types of reports. (Flannagan, 2005; Watson, 2005)

Purpose and Nature of the Instrument:

Stated Purpose: The ASEBA was developed to evaluate and assess the performance, personality, and behavior of children and adults. The results will be used to make a plan to help the individual be successful in the appropriate setting.

Description of test items and scoring: There are four levels of this assessment. The levels include Preschool for ages 1 1/2-5, School-Age for ages 6-18, Adult for ages 18-59, and Older Adult for ages 60-90+. These levels are also broken down by gender. There is also a distinction made between referred and non-referred children. (Flannagan, 2005; Watson, 2005)

The ASEBA is a multiple-rater system with informants including parents, teachers or caregivers, and self. The CBCL is filled out by the parents. Teachers fill out the Teacher Report Form (TRF) and the caregivers fill out the Caregiver-Teacher Report Form (C-TRF). These come in the preschool level with 100 items to be rated and the school-age level contains 113 items. The YSR is filled out by the student ages 11-18. The YSR contains 112 items to be rated by the individual. The YSR is written at the fifth grade reading level. (Flannagan, 2005; Watson, 2005)

The informants filling out the CBCL or the YSR are asked to rate each item as it describes the child in the past six months. The scales and scores on these two forms are identical. The informants filling out the TRF are to rate each item as it describes the child in the last two months. The rating scale on the CBCL, TRF, and YSR has three choices for each item. The choices are 0, 1, or 2. You can choose a 0 if the item is not true, a 1 if the item is somewhat or sometimes true, and a 2 if the item is very true or often true.

Another component of the ASEBA for 1 1/2-5 year-olds is the Language Development Survey (LDS). This should be completed for all children under the age of 3 and any child over 3 who is experiencing language delays. Parents provide some personal data about their child, medical history that may have affected language development, and family history of speech problems. The parents choose the words their child uses from a list of 310 words. The child is given a score that incorporates the age of the child and the number of words the child uses. Another score is given for the average length of phrases a child utters. The addition of this assessment helps the clinician to evaluate the impact of the child’s language development on other problem areas that may have been previously notated by the parent or teacher. (Flannagan, 2005; Watson, 2005)

The last component of the ASEBA, the SCICA, is only used for 6 to 18 year-olds.

This assessment is used by experienced clinicians only and includes an interview, tasks, observations, and self-reporting by the child. The scores for the SCICA can be split into two groups, which are the 6-11 age group and the 12-18 age group. (Flannagan, 2005; Watson, 2005)
Practical Evaluation:

**Adequacy of directions, training required to administer:** The ASEBA may be administered to an individual or to a group. There are many settings that the ASEBA can be used in to assist in assessing the concerns and needs of children. Some of these include schools, mental health settings, medical settings, forensic settings and child/family service settings. The forms are filled out by parents, teachers, caregivers, and the child. The SCICA should only be used and completed by an experienced clinician. (Flannagan, 2005; Watson, 2005) Minimal instruction is needed to fill out the assessment forms. Demographic information is reported first and informants are instructed to proceed onto the assessment section of the form. Directions are printed on the assessment forms for the informant.

Technical Considerations:

**Norms and Scoring:** The computer-scoring option has software in Windows and is called the Assessment Data Manager (ADM). The authors have recommended the computer-scoring program versus hand-scoring as there will be less errors and the computer-scoring readily provides the cross-informant comparisons. When the information is cross-referenced with comparisons between informants, a complete picture of the child is provided and a plan can be made to assist the child in the best possible way. (Flannagan, 2005; Watson, 2005)

The Syndrome scales provide information that will show patterns of problems to be addressed. The Syndrome scales include Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Social Problems, Thought Problems, Attention Problems, Rule-Breaking Behavior, and Aggressive Behavior. These scales are further analyzed and grouped by syndromes according to Total Problems, Internalizing Problems, and Externalizing Problems. The Internalizing scale is produced by adding the scores of the Anxious/Depressed, Withdrawn/Depressed, and the Somatic Complaints together. The Externalizing scale is produced by adding the scores of the Rule-Breaking Behavior and the Aggressive Behavior together. The Total Problem score is calculated by adding the scores of all 113 items on the assessment forms (CBCL, TRF, and YSR). (Flannagan, 2005; Watson, 2005)

In order for the DSM-oriented scales to be used, 64% of the highly experienced raters had to rate these specific items on the assessment as very consistent with a particular DSM diagnosis. The six DSM scales include Affective Disorder, Anxiety Disorder, Attention Deficit/Hyperactivity Disorders, Conduct Disorder, Oppositional Defiant Disorder, and Somatic Disorder. If a child receives a relatively high score on one of the DSM scales, it does not provide you enough information for a DSM diagnosis. More information would be needed to make this type of diagnosis. (Flannagan, 2005; Watson, 2005)

The LDS norms are based on the mean length of the phrases the child utters and their vocabulary development. The Syndrome scales for the Preschool assessment are Emotionally Reactive, Somatic Complaints, Sleep Problems, Anxious/Depressed, Withdrawn, Attention Problems, and Aggressive Behavior. These scales are also analyzed and grouped into Internalizing Problems, Externalizing Problems, and Total Problems. (Flannagan, 2005; Watson, 2005)

The information from the SCICA is divided into nine areas which include Activities, Friends, Family Relations, Fantasies, Self-Perception, Parent/Teacher Reported Problems, and Achievement tests (which are optional). An option for 6-11 year-olds is a screening for any fine and gross motor concerns. For ages 12-18 the areas of somatic complaints, alcohol use, drug use, and legal trouble are also assessed. More information is attained by having children ages 6-11 provide a drawing of their family doing something. Additional testing may include short versions of standardized achievement tests, writing samples, and assessing gross motor functions. (Flannagan, 2005; Watson, 2005)

**Adequacy of norms:** In order to limit false negatives on the CBCL, TRF, and YSR, the borderline for the clinical range begins at T = 65. Any T scores that are above 70 are in the clinical range. This correlates to the borderline area being the 93rd to the 97th percentile. Scores about the 97th percentile are considered to be in the clinical range. Scores below the 93rd percentile are considered in the normal range. (Flannagan, 2005; Watson, 2005)
When looking at the Activities, Social, and School scores, the borderline range T-score is between 31 and 35. If the score is below 31 it is considered to be in the clinical range. For Total Competence, the borderline range T-score is between 37 and 40 and a score below 37 is considered to be in the clinical range. The Syndrome and DSM-Oriented scales borderline range T-score is between 65 and 69 and a score above 69 is considered to be in the clinical range. Total Problems, Internalizing Problems, and Externalizing Problems have a borderline range T-score of 60 to 63 and if the T score is considered to be in the clinical range if it is above 63. Norms for boys and girls are reported separately for 6-11 year-olds and 12-18 year-olds. (Flannagan, 2005; Watson, 2005)

Reliability: The internal consistency reliability for the CBCL for ages 6-18 ranges from .55-.90 for the Competence scales, from .71-.97 for the Syndrome scales, and from .67-.94 for the DSM-Oriented scales. The mean stability for the CBCL 6-18 year-olds at 12 months is .65, .51 for the YSR at 7 months, and .65 for the TRF at 2 months. The mean test-retest reliability for 8 or 16 day intervals for the CBCL 6-18 year-olds range from .88-.90, for the YSR the range is from .79-.88, and the TRF ranges from .85 -.90. (Flannagan, 2005; Watson, 2005)

The internal consistency reliability for the CBCL for ages 1 ½-5 range from .66-.96 for the Syndrome scales and from .63-.93 for the DSM-Oriented scales. The test-retest reliability for an eight day interval ranged from .68-.92 for the Syndrome scales and from .57-.87 for the DSM-Oriented scales. The mean stability at a 12 month interval is .61 and .59 for the C-TRF at a three month interval. (Flannagan, 2005; Watson, 2005)

Validity: The criterion validity of all of the items on the Parent Report Form (PRF or parent CBCL), YSR, and TRF significantly discriminated at p<.01. Criterion validity for the LDS has been demonstrated. Content validity for the CBCL and the LDS have been examined and evaluated. Construct validity for the CBCL and the LDS have been researched and studied. There are many demonstrations of validity in the manual. Overall, the ASEBA is an instrument that shows strong validity. (Flannagan, 2005; Watson, 2005)

Cross-cultural fairness: Information was collected from all 48 contiguous states. This information was then analyzed using socioeconomic status, ethnicity, region, and urban-suburban-rural residence. The assessment scores are divided by gender, age group, and referred vs. non-referred children. (Flannagan, 2005; Watson, 2005)

Evaluation:

Practicality and Aids to user: Overall the ASEBA is a well-researched instrument that consists of a number of individual instruments that assess a wide range of behaviors in a number of settings employing a range of informants. The ASEBA demonstrates strong reliability and validity.

References


Review of the Myers-Briggs Type Indicator

By Sally R. Lawes, The University of Alabama

General Information:

Title: Myers-Briggs Type Indicator (MBTI)

Authors: Briggs, Katherine C.; Myers, Isabel Briggs; Quenk, Naomi L.; Kummerow, Jean; Hammer, Allen L.; Majors, Mark S.

Publisher: Consulting Psychologists Press, Inc, Palo Alto, CA

Date of publication: 1943-1998; 2001

Forms, groups to which applicable: The MBTI has been through multiple revisions since its original publication in 1943. The latest revision is Step II- Form Q which was published in 2001 (Hess, 2004). Form M can be administered to individuals age 14 and up (Schaubhut, Herk, & Thompson, 2009), while Step II-Form Q is suitable for those 18 and up (Hess, 2004). The Manual for Form M was last revised in 2009 (Schaubhut, Herk, & Thompson, 2009). There are also versions available in European English, German, French, Spanish, and Chinese (Schaubhut, et al., 2009). In each form, respondents choose responses from forced-choice items connected to the dichotomous typology preferences: Extraversion (E) or Introversion (I), Sensing (S) or Intuition (N), Thinking (T) or Feeling (F), and Judging (J) or Perceiving (P) (Fleenor, 2004; Schaubhut, et al., 2009; Furnham, Crump, Batey, & Chamorro-Premuzic, 2008).

General Type: The MBTI is a personality instrument commonly used in career counseling (Pulver & Kelly, 2008), team development (Kuipers, Higgs, Tolkacheva, & de Witte, 2009) and in other settings to facilitate general self-awareness (Fleenor, 2004).

Practical features: The MBTI yields a typology based on individuals’ preferences from four dichotomies (E-I, S-N, T-F, J-P) (Schaubhut, et al., 2009). Each type is seen as equally valuable, and this feature differentiates the MBTI from other personality assessments (Schaubhut, et al., 2009). The results are intended to be viewed in terms of an individual’s total type, rather than as a breakdown of individual traits (Fleenor, 2004).

Cost: The MBTI Complete, which includes an assessment and interactive interpretation, is available for $53.95 (Consulting Psychologists Press, 2010). The MBTI Profile, which includes an online assessment and interpretation, is available for $11.70 per administration (Consulting Psychologists Press, 2010). The MBTI Self-Scorable is available for only $9.75 per booklet (Consulting Psychologists Press, 2010).

Time required to administer: According to the Buros Mental Measurement Yearbook (2004), administration time ranges from 15-35 minutes depending on form used.

Purpose and Nature of the Instrument:

Stated Purpose: The MBTI is designed to identify and describe personality types based on individual preferences on each of the four dichotomies developed from Jung’s theory (Mastrangelo, 2004). The result is one of 16 personality types reflective of the interactions of those preferences (Schaubhut, et al., 2009, Lanning, 2004).

Description of test items and scoring: The MBTI is comprised of forced choice items representative of the four dichotomies (Furnham, et al., 2008). Form M has 93 items (Schaubhut, et al., 2009), while Step II-Form Q uses those 93 items plus an additional 51 items for a total of 144 (Hess, 2004). There are a variety of scoring options including self-scoring, template scoring, software on-site scoring, and mail-in scoring (Fleenor, 2004). An additional option is web administration and scoring (Fleenor, 2004). In the hand-scored version, each response counts as one point. The higher score on each dichotomy represents the respondents’ preference (Fleenor, 2004). The computer scored versions use item-response theory (IRT) to determine scores, and this method is seen as a more accurate indication of preference (Fleenor, 2004).

Practical Evaluation:

Adequacy of directions, training required to administer: The manual (Form M) and its supplement offer clear directions, thorough explanation of the theory behind the instrument, and interpretation of the instrument (Fleenor, 2004, and Schaubhut, et al., 2009). The instrument is used in a variety of settings, and purchase of the instrument requires at least a master’s degree in counseling, social work, psychology or a related field or certification from CPP (Consulting Psychologists Press, 2010). This range of training background does however create some disdain among psychometric purists (Mastrangelo, 2004).
Technical Considerations:

Norms and Scoring: IRT was used to select items for Form M, and differential item function (DIF) analysis was used to eliminate items that produced significantly different responses according to gender (Fleenor, 2004). A representative sample of 3009 U.S. adults over age 18 was used for item analysis and weighting (Fleenor, 2004).

Reliability: The MBTI Form M Manual Supplement reports reliability as both internal consistency and test-retest reliability (Schaubhut, et al., 2009). Internal consistency was evaluated in samples of differing employment status, ethnicity, age, and country of origin (Schaubhut, et al., 2009). Cronbach’s alpha across employment status ranged from .86 to .92 (Schaubhut, et al., 2009). Internal consistency across ethnic groups had Cronbach’s alpha scores ranging from .80 to .92 (Schaubhut, et al., 2009). Age and international samples produced similar internal consistency scores (Schaubhut). Test-retest reliability was gathered at different intervals (< 4 weeks, 4 weeks-6 months, 6-12 months, and >1 year); these correlations ranged from .57 (S-N, 6-12 months interval) to .81 (T-F, <4 weeks) (Schaubhut, et al., 2009). The manual supplement also reports reliability of the MBTI in comparison to other personality assessment instruments, and the MBTI had Cronbach’s alpha scores equal to or greater than those instruments (Schaubhut, et al., 2009). These scores must be viewed with caution; however, as they are reported per dichotomy which stands in contrast to the intent of the instrument to sort individuals into types rather than to measure traits along continuous scores (Fleenor, 2004).

Validity: Schaubhut, et al. (2009) report validity of the MBTI Form M in terms of construct validity. They correlated MBTI dichotomies with the scales of the CPI 260, FIRO-B, Adjective Check List, Strong Interest Inventory, Thomas-Kilmann Conflict Mode Instrument (TKI), and the Birkman Method (Schaubhut, et al., 2009). The manual supplement also reports best-fit type or verified-type validity (Schaubhut, et al., 2009). Similar caution must be used with these reports as well given that they continue to rely on continuous scores in opposition to the theory behind the instrument (Fleenor, 2004).

Cross-cultural fairness: The use of varying ethnic groups, age groups, and international samples to demonstrate reliability suggests that this instrument has significant value in multicultural settings (Schaubhut, et al., 2009). In addition, a variety of forms are available to best serve those with different language needs (Schaubhut, et al., 2009).

Evaluation:

Practicality: The MBTI is a user-friendly personality assessment. The directions for administration are very clear, and the instrument itself is written at a seventh grade reading level. The variety of scoring and administration methods (paper and pencil, web administration) makes this a particularly appealing instrument for counselors in a variety of settings.

Aids to user: While some caution must be used in evaluating the reliability and validity of the MBTI (Fleenor, 2004), the popularity and ease with which this instrument can be interpreted make it an effective instrument for counselors working with clients in a variety of settings. Though no specialized training is required for administration, some knowledge of the Jungian theory behind the instrument is helpful in making appropriate interpretations from the results (Mastrangelo, 2004). Since no personality type is viewed as negative, the assessment provides a helpful lens for counselors to use in helping clients identify career paths, address conflict management, and improve relationships.

References


Hess, A. (2004), Myers-Briggs Type Indicator (r) Step II (Form Q). Retrieved from Buros Mental Measurement Yearbook database.


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**AACE NEWSNOTES**

**Editor:**
Amanda C. Healey, Ph.D., LPC-MHSP, NCC
East Tennessee State University
303 Warf-Pickel Hall, Box 70548
Johnson City, TN 37614-1707
Phone: 423-439-7672
Fax: 423-439-7790

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(dsheperis@deltastate.edu)