Veteran Information Profile

Training Manual

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PRODUCT DESCRIPTION

The Veteran Information Profile (VIP) is a 163 question test that assesses veteran's military to civilian transition. The VIP takes 20 to 25 minutes to complete and scores and prints reports in 2 minutes on-site. The VIP has eight scales: Truthfulness, Civilian Reintegration, Suicide, PTSD, Self-Esteem, Depression, Alcohol and Drugs. All important areas of inquiry for assessing returning veterans.

Among mental health issues affecting veterans, post-traumatic stress disorder (PTSD) has attracted the most attention. According to the Department of Defense (DOD) only three percent (3%) of returning veterans reported serious mental health problems in their post-deployment questionnaire, which was completed as they were preparing to return home. As Scott Shane (New York Times, January 30, 2005) pointed out, "Many returning service members did not disclose their mental health concerns at the time of their discharge in order to avoid being detained or held over at their bases." This factor alone likely contributed to underreporting of mental health problems.

Upon their return home from deployment, the majority of veterans face daunting reintegration challenges. This is especially true for veterans returning from a combat zone. Some of these returning veterans will have to immediately address finding employment, facing financial difficulties, and dealing with familial, marital and/or domestic issues. Problems common among returning veterans include: Interpersonal conflict, depression, PTSD, anxiety, panic attacks, low self-esteem, suicide ideation and substance abuse. These problems can significantly hinder the already difficult transitional process for veterans readjusting to a civilian lifestyle.

The Veteran Information Profile (VIP) is a research-based assessment instrument or test with demonstrated reliability, validity and accuracy. The VIP was developed as a way to simultaneously address multiple veteran reintegration issues. Salient veteran mental health problems and concerns were identified and incorporated into the VIP. The VIP has eight measures (scales): Truthfulness Scale, Reintegration Scale, Depression Scale, PTSD scale, Self-Esteem Scale, Suicide Scale, Alcohol Scale and Drugs Scale. The VIP consists of 163 items and takes approximately 30 minutes to administer. The VIP is computer-scored and VIP reports are printed within 3 minutes. For more VIP information, visit **www.veteran-profile.com**. For Veteran Information Profile (VIP) understanding, a discussion of the eight (8) VIP scales (measures) follows.

The **Veteran Information Profile (VIP)**
Matching Problem Severity & Treatment Intensity

Objective, standardized and computer assisted assessment (screening, evaluation or testing) makes accurate, efficient and timely client screening possible. In most counseling and treatment settings, clients are screened to determine the presence of problems, and if problems are present to measure their severity. Contingent upon these assessment results, clients can then be referred to appropriate levels of intervention or treatment. Like emergency room triage, clients with serious problems are referred to more intensive treatment programs.

It has been shown that placing clients in wrong treatment intensity programs can be detrimental to both the client and society (Andrews, Bonta & Hoge, 1990). When low risk clients were placed in high risk (intensive) treatment programs, low risk clients had a higher likelihood of relapse. Low risk clients are better served in low intensity programs. Similarly, high risk (serious problems) clients benefit most when placed in intensive treatment programs.

This sounds obvious, yet is it? If an evaluator does not use a test containing a Truthfulness Scale, how does that evaluator determine if the client provided accurate and honest information? Some evaluators

maintain that their education and experience enables them to make these determinations. Other evaluators are not so naïve and rely more on test truthfulness measures that have demonstrated reliability and validity. Few would dispute the statement that "many clients" minimize their problems and attempt to "fake good." It is important to know if obtained information is accurate. Only then can we rely upon such information to identify problems and determine their severity. Accurate assessment must be done to refer clients to appropriate counseling and treatment programs.

Automated (computer scored) assessment instruments or tests can establish client truthfulness (while being tested) and concurrently identify problems and their severity. Truthfulness Scales are considered by many as a necessary condition for client placement in intervention and treatment programs that will be most effective for them.

Civilian Reintegration Scale

All veterans returning from deployment face civilian reintegration adjustments, and some of these adaptations or accommodations involve coming to terms with depression, impaired self-esteem, post-traumatic stress disorder (PTSD), substance (alcohol and other drugs) abuse and suicidal ideation. When veteran's (Army, Navy, Coast Guard, Marine Corps and Air Force) return from deployment, especially from war zones, they realize their civilian life is not the same as it was prior to their deployment. Post deployment transition or reintegration back into a veteran's civilian life is often more difficult then veterans and their loved ones expected.

Veterans face a myriad of changes after returning home from deployment. The prevalence of reintegration issues are often complicated with poor self-esteem, depression, alcohol abuse, drug abuse and increased suicide risk. More than ever there is a need to identify transitional problems early. Indeed, successful reintegration is often contingent upon adequate screening or identification of these problems and their severity.

This scale identifies and measures common military-to-civilian transitional problems. This is the focal scale within the VIP, meaning that all other VIP scales intermesh with it to some degree. The Civilian Reintegration Scale pinpoints and assesses veterans' post-deployment challenges (independent of specific mental health or substance abuse issues measured by other VIP scales) such as work-related problems (inability to gain or maintain employment, etc.), interpersonal conflict (arguments, fights, etc.) and financial issues. As mentioned, this is the central scale within the VIP. Its relationship with other scales can be used to create a comprehensive profile of a returning veteran's needs and areas of concern. The Civilian Reintegration Scale can be interpreted independently or in terms of its interaction with other VIP scale scores. The transition phase for veterans returning to civilian life is challenging in itself, but if other co-occurring disorders are present, this stage of a veteran's life can become even more stressful and overwhelming. For example, a veteran with impaired self-esteem (identified by a VIP Self-Esteem Scale score at the 70th percentile or higher) may lack confidence in their own abilities. Self esteem is required to work through many civilian reintegration issues. This scenario can cause both reintegration problems and low self-esteem to worsen. A Civilian Reintegration Scale score in the elevated (at the 70th percentile or above) range represents serious reintegration problems. Severely elevated (90th percentile and higher) Civilian Reintegration Scale scores identify serious and possibly debilitating reintegration problems. A truism is, the higher a scale score the more serious the problem. The Civilian Reintegration Scale score can also help neutralize veterans' denial of their reintegration and transitional issues. Many people react more favorably to objective assessment results as opposed to others' subjective opinions. The VIP report lists any scale-related 'significant items', which can provide insight into the types of reintegration problems the veteran is experiencing.

Truthfulness

The Veteran Information Profile (VIP) incorporates a built-in Truthfulness Scale with impressive statistical features like reliability, validity and accuracy. This scale consists of 20 items. The VIP Truthfulness Scale measures client truthfulness while the veteran is completing the test. It identifies denial, excessive guardedness, attempt's to minimize problems or "fake good."

The VIP Truthfulness Scale has been validated with other tests, polygraph exams, and the Minnesota Multiphasic Personality Inventory (MMPI) L, F and K-scales. It consists of a number of items that most people agree or disagree with. The VIP Truthfulness Scale research is summarized in the "VIP: An Inventory of Scientific Findings." VIP Truthfulness Scale methodology resembles that used in the Minnesota Multiphasic Personality Inventory (MMPI), the most widely used psychological test in the United States and possibly the world. VIP Truth-Correction is comparable to the MMPI K-scale correction methodology. The Truthfulness Scale has been correlated with other VIP scales. A Truth-Correction equation then converts raw scores to Truth-Corrected scores. Raw scores reflect what the client wants you to know. In contrast, Truth-Corrected scores reveal what the client is trying to hide. Truth-Corrected scores are more accurate than raw scores.

The Truthfulness Scale score shows when the client's VIP answers can be trusted. Truthfulness Scale scores at or below the 89th percentile indicate that all VIP scales scores are accurate. Conversely, Truthfulness Scale scores at or above the 89th percentile indicate that all VIP scales scores are inaccurate due to denial, problem minimization and attempts to "fake good." Knowing whether-or-not the veteran provided truthful answers is important in and of itself. Elevated (70th percentile and higher) Truthfulness Scale scores can provide considerable insight into the veteran's motivation, attitude and defense mechanisms. Without a Truthfulness Scale, assessors' (interviewers and evaluators) opinions about client truthfulness, sincerity and trustworthiness would be little more than guesstimates, conjecture and assumptions.

Self-Esteem

Veteran self-esteem reflects how the individual feels about himself or herself. Self-esteem involves the veteran's explicit valuing and appraisal of self. Self-esteem incorporates an attitude of acceptance-approval versus rejection-disapproval of self. In other words, it is a person's perception of self. Self-esteem ranges from one extreme (very low score, narcissistic self-regard) to the other extreme (very high score, very critical of self). Setting the low (narcissistic) score aside, low Self-Esteem Scale scores (10th to 69th percentile range) are in the healthy self-esteem range. Veterans scoring in this range have a balanced and objective perception of themselves. They have a realistic and positive opinion of their abilities, while also recognizing their limitations. These veterans understand themselves and their worth.

Excessively low Self-Esteem Scale scores (0-9th percentile range) usually mean that the veteran has an unrealistically positive perception of self. These people often feel superior to those around them. Such people are called arrogant or self-indulgent and believe they deserve special privileges.

At the other extreme (90 to 100th percentile), veterans have very low or negative self-esteem. These veterans put very little value in their own ideas, opinions, decisions or acts. They perseverate on their self-perceived faults, weaknesses and mistakes. They put themselves down and believe others are better and more deserving than they are. Self-Esteem Scale scorers in the problem (70 to 89th percentile) range manifest negative self-esteem but aren't as severely critical of self as the 90 to 100th percentile scorers. Problem risk scorers can directly benefit from intervention and counseling, whereas severe problem scorers usually involve more intensive treatment. A general rule of thumb is "the higher the score the more serious the problem."

Co-occurring disorders often coexist with impaired self-esteem. These adjunctive disorders vary and can include depression, alcohol abuse, drug abuse, PTSD, and suicide ideation. When these disorders coexist with impaired self-esteem, self-esteem is often viewed as subordinate to or a symptom of the other accompanying disorder.

Positive thinking is one of the surest methods for effectively improving self-esteem. The fact is most negative self-esteem is self-inflicted. There are several good books on positive thinking. Counseling and psychotherapy help individuals improve their emotional state from negative to positive. There are many effective psychotherapies to choose from. These therapeutic approaches teach reframing of negative thoughts and thinking. Clients learn to correct their misperceptions, lessen their perseveration on their weaknesses, and recognize (or accept) their strengths, correct decisions and positive acts. When treating low self-esteem the goal is to teach realistically positive self-acceptance. A popular and effective psychotherapy is Cognitive Behavior Therapy (CBT), which is available in individual or group therapy settings. When left untreated, self-esteem issues can become progressively worse.

Depression

Many define depression as an emotional state of persisted dejection, ranging from mild discouragement to extreme despondency and despair. Most agree that depression can be a serious illness. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) list symptoms of major depression. Five or more of these symptoms are required over a 2-week period.

- Depressed Mood
- Lack of interest or Pleasure
- Weight Loss / Gain
- Insomnia
- Feeling Worthless
- Restless / Slowed Behavior
- Fatigued
- Trouble Concentrating
- Death / Suicide Thoughts
- Social / Occupational Problems

Depression often co-exists with other disorders and illnesses. Anxiety disorders such as post-traumatic stress disorder (PTSD), panic and generalized anxiety disorder often accompany depression. Substance (alcohol and other drugs) abuse may also co-occur with depression. Depression has also been identified as a suicide risk factor.

According to a Rand Corporation study (2008) of 300,000 military service members that have returned from Iraq and Afghanistan, nearly 20 percent report symptoms of depression and PTSD. A Rand researcher (Terri Tanielian, 2008) stated “Unless they (returning veterans) receive appropriate and effective care for these mental health conditions, there will be long term consequences for them and for the nation.” To summarize, one in five Iraq and Afghanistan veterans suffer from depression and PTSD.

These researchers concluded that a major effort is needed to improve the military and civilian health care systems to better meet the needs of returning veterans. Rand Corporation project co-leader Lisa Jaycox noted “If PTSD and depression go untreated there is a cascading set of consequences. Drug use, suicide, marital problems and unemployment are some of the consequences.”

These findings emphasize the need for evidence based quality assessment instruments to be used when screening returning veterans for barriers to civilian reintegration. Using self-report assessment instruments could assuage and perhaps alleviate some of the military and civilian health care providers assessment needs. Like battlefield triage, veterans with readjustment problems would be referred to

appropriate intervention and treatment programs. Sometimes further assessment would be needed, yet many veterans could be guided directly to appropriate treatment services.

That said, it is important to remember that depression is treatable. For mild depression, veterans should not overlook the basics for good mental health such as eating properly, getting adequate sleep, exercising regularly, and don't become socially isolated. Mind-body techniques can also help and these include meditation, yoga, guided imagery, tai chi, etc. Taking steps to control stress, to increase resilience and to boost self-esteem may help. More serious depressions are often treated with a combination of prescribed antidepressants and psychotherapy. There are several psychotherapies that are effective for depression. Cognitive Behavioral Therapy (CBT) is one of the most commonly used therapies. The important thing to remember is "depression is treatable."

Post-traumatic Stress Disorder (PTSD)

Symptoms of post-traumatic stress disorder (PTSD) include: re-experiencing traumatic events, nightmares, flashbacks, psychological reactions to fear, panic attacks, extreme avoidance of traumatic event reminders, an excessive startle response, emotional detachment, anhedonia and uncompromising anxiety.

The destructive effects of PTSD include: relationship/marital conflict, interpersonal communication issues, job/career problems, unemployment, social isolation, domestic violence, anxiety, alcohol abuse, licit and illicit drug abuse, impaired self-esteem and suicidal ideation.

"About 1.6 million men and women have served in Iraq and Afghanistan since the start of military operations in 2001. One-third of deployed soldiers have served at least two tours of duty; 70,000 have been deployed three times; and 20,000 have been deployed at least five times. The more times soldiers are deployed, the greater the likelihood of mental disorders. Multiple deployments are associated with a 50 percent greater prevalence of psychiatric disturbance. A RAND Corporation study estimated that as many as 300,000 returning veterans are suffering from post-traumatic stress disorder (PTSD) and/or depression. Approximately 1,000 returning veterans commit suicide each year, which is twice the likelihood of their civilian counterparts. The risk of suicide is significantly heightened when a PTSD, depression or substance use disorder is present. The need to conduct early identification and interventions with returning soldiers from Iraq and Afghanistan is underscored by the findings on Vietnam veterans. According to Donald Meichenbaum, Ph.D. (Trauma and Substance Abuse: Guidelines for Treating Returning Veterans, 2009) up to 50 percent of Vietnam veterans who developed PTSD continue to have it four decades later."

Post-traumatic stress disorder (PTSD) is an anxiety disorder that can occur after someone experiences a traumatic event that causes them intense fear, feelings of helplessness and/or horror. PTSD can result from personally experienced trauma, witnessing severe injury, observing death or learning about tragic events involving close friends and loved ones.

There are numerous causes of PTSD. Common links to PTSD include assault, rape, natural disasters, severe accidents and other life threatening situations. In terms of war zone experiences, precipitating factors include perceived threat, death of comrades and civilians, chronic stress, being a prisoner, torture, exposure to destruction, suffering, etc. PTSD symptoms include nightmares, heightened anxiety, intrusive memories, emotional numbing, interpersonal conflict, etc. PTSD is the most common mental health disorder among veterans returning from Iraq and Afghanistan.

According to the 2008 RAND Corporation study, approximately 20 percent of soldiers returning from Iraq and Afghanistan have PTSD and/or depression. It was also reported that veterans with PTSD have high rates of co-occurring disorders like depression, alcohol abuse, licit and illicit drug abuse, impaired

self-esteem and suicidal thoughts. These mental health problems have been found in all branches of military service veterans.

In men, the most common co-occurring disorder with PTSD is alcohol abuse, with depression a close second. Conduct disorders rank third and drug abuse ranks fourth. The most common co-occurring disorder for women with PTSD is depression, specific fears rank second with social anxiety and alcohol abuse ranking third and fourth. More than 160,000 soldiers have experienced sexual harassment and sexual assault. Sexually assaulted women are more likely to engage in substance (alcohol and other drugs) abuse than women that have never been assaulted. Rape is a traumatic experience that is likely to lead to PTSD and comorbid disorders in both men and women.

Suicide

Suicide is the 11th leading cause of death among Americans. According to Veterans Administration Secretary Eric Shinseki (2010) "of the more than 30,000 people that kill themselves each year, more than 20 percent are veterans." Suicide can affect anyone, but some groups are higher suicide risks than others. For example, men are four times as likely to die from suicide as women (American Foundation for Suicide Prevention, Facts and Figures). According to a RAND Corporation 2008 study, roughly one in five (20%) soldiers returning from Iraq and Afghanistan has PTSD symptoms and depression, which puts them at high risk of suicide. Soldiers that had been exposed to combat were most likely to have depression and PTSD. Suicides among active duty personnel have also risen. Suicide rates in all four services of the U.S. military are significantly higher than in the general (non-military or civilian) population.

Medscape Medical News (November 2007) quoted Dr. Evan Kanter as saying, "A study of the first 100,000 Iraq and Afghanistan veterans seen at VA facilities showed that 25 percent of them received a mental health diagnosis. Of these, 56 percent had two or more mental health diagnoses and the most common were depression, PTSD and substance (alcohol and other drugs) abuse. Each of these diagnoses increases suicide risk."

Combat leads to depression and stress disorders which are suicide risk factors. Combine that with post-deployment reintegration problems like marital stress, intrapersonal conflict, substance (alcohol and other drugs) abuse, financial problems along with service injuries and you have more stress. Hundreds of U.S. troops come home from war, leave the military and commit suicide (Associated Press, October, 1, 2007). The number of suicides among veterans of wars in Iraq and Afghanistan may exceed the combat death toll (Bloomberg, May 2008).

Dr. Mark Kaplan (Portland State University, 2007) said, "We need to do better screening among individuals who have served in the military . . . We can say quite confidently that veteran status alone is a risk factor for suicide." Representative Michael McMahon (13th Congressional District of New York) announced, "the Department of Defense and the Department of Veteran Affairs must be prepared to conduct post-deployment psychological screening with mental health professionals for all service men and women."

It may seem like an oversimplification, but before we can prevent suicide we need to know it is a problem. Barraclough, Bunch and Saineberry (Br J Psychiatry. 1974 Oct. 125 (0):355-73) reported that two thirds of suicide victims were seen by their physician (general practitioner) one month before their suicide. Forty (40%) percent were seen by their physicians within one week of their suicide. This touched off the controversy about doctors not being able to identify suicide risk in their patients. This controversy or debate continues today and underscores the need for objective suicide screening tests to be incorporated in veteran intake procedures.

In a 2006 study of 948 soldiers that made suicide attempts, it was found that 60 percent of these suicide attempts were made after the soldiers were seen by their doctor. Thirty-six (36%) percent were seen within 30 days of their suicide (Hartford Courant, Suicides: A Treatment Issue).

Suicide risk factors include depression, PTSD, alcohol abuse, drugs abuse (licit and illicit), impaired self-esteem and problematic post-deployment civilian reintegration. It's not by chance that Veteran Information Profile (VIP) scales (measures) include the Truthfulness Scale, PTSD Scale, Self-Esteem Scale, Depression Scale, Alcohol Scale, Drugs Scale, Suicide Scale and the Civilian Reintegration Scale.

Alcohol

Veterans of the Iraq and Afghanistan wars are increasingly turning to alcohol when they return home. Drunk driving, domestic violence and interpersonal conflict are among the consequences of increasing rates of veteran drinking. Recent post deployment (2008) Pentagon surveys reveal that 12 percent of active duty soldiers and 15 percent of reservists admit to having alcohol problems.

According to a National Survey on Drug Use and Health report, one fourth (25%) of veterans age 25 and under suffer from substance (alcohol and other drugs) abuse disorders. Dr. Richard T. Suchinsky (DVA, Chief for Addictive Disorders, 2008) emphasizes that "Substance abuse disorder remains one of the three most used diagnoses in the VA system." And in the Wounds of War conference (CASA, 2008), it was pointed out that excessive drinking remains a large scale problem among soldiers, sailors and airmen returning from Iraq and Afghanistan. Surveys released by the Pentagon in 2009 and 2010 disclosed the following information:

- Iraq and Afghanistan veteran's substance abuse is increasing.
- Veterans still in combat or returning home that have PTSD often manifest co-occurring substance abuse.
- Substance (alcohol and other drugs) abuse and PTSD are often intertwined, which requires integrated treatment.
- 43 percent of active duty military personnel reported "binge drinking" within the past month.
- Returning soldiers are reluctant to admit problems on discharge questionnaires due to career (in and outside the military) concerns.
- Treatment of substance abuse requires inclusion of co-occurring disorders.
- Common co-occurring disorders are PTSD, depression, substance abuse and suicidal thinking.
- NIAAA reported alcohol use disorders are significantly higher in returning veterans than in the general population.
- When co-occurring disorders are untreated, they can lead to major problems later.
- Returning veterans under report mental health problems in discharge checklists because they don't want to delay going home.

In addition to substance (alcohol and other drugs) abuse, co-occurring disorders like depression, impaired self-esteem, PTSD and suicidal thinking greatly complicate diagnostic procedures and treatment. Troops returning from Iraq and Afghanistan often experience alcohol use disorders and PTSD simultaneously. Some (Reuters, 8-12-2010) theorize that alcohol abuse during civilian reintegration reflects veterans' attempts to self-medicate or cope with their traumatic memories. Several

studies show that younger servicemen and women in the National Guard and reserves are the most likely to increase their drinking. Active duty Marines were also found to be at risk of alcohol abuse. Other statistics are helpful in better understanding the etiology of veteran drinking. Combat veterans were 31 percent more likely to begin binge drinking than non-veterans. Women were significantly more likely to begin drinking heavily, but in comparison to their male counterparts were less likely to have alcohol-related problems. There seems to be consensus that 12 percent of active duty soldiers had alcohol problems, whereas 15 percent of the National Guard and reserve soldiers had alcohol abuse problems.

Drugs (Licit and Illicit)

Substance abuse includes both alcohol and drugs. The National Institute on Drug Abuse (NIDA) found a high correlation between PTSD and substance abuse. Drug (licit and illicit) abuse is a common co-occurring disorder with alcohol abuse, impaired self-esteem, PTSD and suicidal ideation. And when drug abuse is a co-occurring disorder with other mental health disorders, drug treatment should be integrated in the veteran's treatment.

According to mental health professionals, drug abuse can emerge as a self-medication or coping mechanism for other mental health problem like anxiety, PTSD, depression, panic attacks, etc. Therapies for these disorders are available, but some veterans are turning to drugs and alcohol for relief.

An Office of National Drug Control Policy newsletter (2010) noted that use rates of illicit drugs such as marijuana, cocaine, heroin and methamphetamines among servicemen and women has remained around 3 percent, while misuse of prescription drugs, particularly pain relievers, has risen sharply. According to a Department of Defense survey, use of prescription drugs among active duty soldiers from 2005 to 2008 almost tripled to 11 percent. This trend reflects the widespread misuse of prescription drugs. Pentagon and other surveys supplied the following facts:

- The percentage of men and women reporting prescription drug misuse in all U.S. military services combined are 11.5 percent.
- Military personnel misused prescription drugs more than twice as much as the civilian population (ages 18 to 64).
- Active duty service women's prescription drug abuse was more than four times that of civilian women.
- Except for the Marines, military women are more likely than their male counterparts to use illicit drugs.
- Army women are more than twice as likely as men in the Navy, Coast Guard and Air Force to have used illicit prescription drugs.
- Sexual harassment and sexual assault treatment, when warranted, needs to be integrated in a holistic treatment approach.

According to a Pentagon health survey (2009), a one year study involving 28,500 U.S. troops showed that 25 percent of soldiers and 20 percent of Marines abused prescription drugs (mostly painkillers). Pain relievers are the most abused drugs used illicitly, about three times more frequently (abuse) than marijuana and amphetamines, which are the next most used drugs. A USA Today story (2009) reported prescriptions for narcotic pain relief for injured and wounded U.S. troops increased from 30,000 to 50,000 a month since the Iraq war began.

A Department of Defense (December 2009) survey revealed that 1 in 8 active duty service members (11.9%) in all branches of the military, including the Coast Guard, reported using drugs in the past

month. Today's returning soldiers are more likely to be addicted to prescription medications. These are often the very opiates prescribed by military medical professionals to ease their stress and pain. Other prescribed stimulants were used by some soldiers to remain alert in combat.

TRUTH-CORRECTED SCORES

A sophisticated psychometric technique involves "Truth-Corrected" scores which are individually calculated for each of the eight Veteran Information Profile Scales each time a test is scored. The Truthfulness Scale establishes how truthful the client was while completing the Veteran Information Profile. Correlations between the Truthfulness Scale and all other Scales have been statistically determined. This score correcting procedure enables the Veteran Information Profile 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 Veteran Information Profile 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 to 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 problems. This emphasizes the importance of oral instructions to the client before beginning the VIP. 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 information you provide. 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 different questions**. 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

When a client's Truthfulness Scale score is at or above the 91st percentile that test is inaccurate or invalid. It is recommended that clients with invalid tests be given the opportunity to retest. Prior to retesting the oral instructions should be reviewed with the client. It helps to explain that the client may have inadvertently read things into questions that aren't there (refer to oral instructions, pg. 9). It gains you nothing to make the client angry or defensive by saying "you weren't truthful." It helps to discuss the example (oral instructions) presented earlier. If this is a retest, the client may not be testable at this time.

Sometimes a client is not testable if the client is reading impaired. If a client can read the newspaper, they can be tested with the Veteran Information Profile. The Veteran Information Profile is written at a high 5th grade -- low 6th grade reading level. A very resistant, angry or defiant person is usually not testable. Compassionate understanding, acceptance and rapport are often effective in relaxing the client, if sincere. Sometimes it helps to explain "These are established procedures for everyone . . . " When dealing with denial, minimizing problems and faking simply discuss how the client "may have inadvertently read things into questions that isn't there." And some clients are emotionally disturbed or unstable. This is usually apparent in their demeanor, appearance and behavior. An emotionally upset or "stressed out" client may be appropriate for rescheduling.

Any Truthfulness Scale score at or above the 91st percentile invalidates that test **and all Scale scores included in the test.** If a client invalidates their Veteran Information Profile (and we estimate that 10 percent will) consideration should be given to a retest so that accurate Veteran Information Profile Scales scores are obtained.

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.

RISK LEVEL CLASSIFICATION

Each Veteran Information Profile Scale score is classified in terms of the risk it represents. These risk level classifications are individually calculated for each of the empirically based Scales each time a Veteran Information Profile is scored.

RISK LEVEL CLASSIFICATION

PERCENTILE RANGE	RISK RANGE
0 to 39th percentile	Low Risk
40 to 69th percentile	Medium Risk
70 to 89th percentile	**Problem Risk**
90 to 100th percentile	**Severe Risk**

A problem is not identified until a Scale's score (percentile) is at (or above) the 70th percentile. Percentile scores are obtained from a database of victim 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.

STAFF MEMBERS SHOULD NOT TAKE THE VIP

Sometimes a staff member wants to simulate the client and take the Veteran Information Profile. **It is strongly recommended that staff do not take the Veteran Information Profile.** The Veteran Information Profile is not standardized on staff. And staff do not have the same mental set as a client. Staff would likely invalidate, distort or otherwise compromise their Veteran Information Profile profile.

CONTROL OF VETERAN INFORMATION PROFILE REPORTS

Veteran Information Profile 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 Veteran Information Profile report to read. Instead it is recommended that staff review Veteran Information Profile results with the respondent, but does not give the Veteran Information Profile report to the client to read. Veteran Information Profile test booklets and reports are privileged, highly sensitive and confidential. **No Veteran Information Profile-related materials should be allowed to be removed from your office.**

DELETE CLIENT NAMES (CONFIDENTIALITY)

You have the option to delete client names, once you delete client names -- 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 on the website www.online-testing.com. 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.

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 the 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.

VETERAN INFORMATION PROFILE (VIP)

Scale Interpretation

There are several approaches to Veteran Information Profile (VIP) scale interpretation, ranging from viewing the VIP as a self-report to examining elevated scale scores and relationships between scale scores.

These eight VIP scale links are provided so that parties interested in a particular VIP scale can go directly to its discussion. Each VIP scale name is a link to that scales' discussion.

8 Veteran Information Profile (VIP) Scales

1. Truthfulness Scale
2. Civilian Reintegration
3. Self-Esteem Scale
4. Depression Scale
5. PTSD Scale
6. Alcohol Scale
7. Drugs Scale
8. Suicide Scale

Taken together, these 8 VIP scales or measures produce a "veteran reintegration" profile. The Truthfulness Scale establishes the accuracy of provided information. The Civilian Reintegration Scale is the hub, or focal point, around which commonly occurring disorders revolve. Co-occurring disorders such as impaired self-esteem, depression, PTSD, suicidal ideation and substance (alcohol and other drugs) abuse can make civilian reintegration more difficult.

SCALE RANGES

Risk Category	Risk Range Percentile	Total Percentage
Low Risk	0-39%	39%
Medium Risk	40-69%	30%
Problem Risk	**70-89%**	**20%**
Severe Problem	**90-100%**	**11%**

With any VIP scale, a problem is not identified unless a scale score is at or above the 70th percentile. Scores at the 70th percentile or higher are referred to as elevated scores. Scores at the 70th to 89th percentile are in the problem range, and scale scores at or above the 90th percentile are in the severe problem range. Severe problems represent the "highest" 11% of veterans evaluated with the VIP. In other words, this 11% is composed of veterans that have attained the highest (most severe) scores on the VIP scale.

SCALE INTERPRETATION

Post-deployment veteran screening is advocated by most health professionals and researchers that work with veterans. The Veteran Information Profile (VIP) is designed to augment veteran screening protocols that are already in use by organizations such as the VA. No decision, diagnosis or act should be based solely on VIP test results. This caveat applies to all interviews, tests and mental health assessments.

The VIP measures problematic disorders common among veterans returning to civilian life after deployment. In addition to identifying civilian reintegration problems, the VIP also assesses

substance (alcohol or drugs) abuse, PTSD and depression, suicide ideation (suicidal thoughts) and self-esteem. Description and discussion of each VIP scale follows.

Truthfulness Scale:
One of the first things to check when reviewing VIP results is the Truthfulness Scale score. This scale measures the respondent's level of truthfulness while completing the VIP. It identifies attempts at problem minimization and guarded, evasive or defensive response patterns. The VIP Truthfulness Scale has been correlated with other VIP scales. A truth-correction equation then converts raw scale scores to truth-corrected scores. Raw scores reflect what the respondent wants you to know, whereas truth-corrected scores reveal what the respondent is attempting to minimize or hide. The truth-correction methodology used in the VIP is similar to that used in the Minnesota Multiphasic Personality Inventory (MMPI), which is the most widely-used psychological assessment in the US and likely the world. Truthfulness Scale scores at or below the 89th percentile mean that all VIP scale scores are accurate; in contrast, a Truthfulness Scale score at or above the 90th percentile means that all other VIP scale scores are invalid. A score at the 90th percentile or higher is so distorted that it invalidates all other scale scores. An invalid test can occur due to severe denial, uncooperativeness, problem minimization, a reading impairment or thinking that there are 'trick questions'. It may also be a manifestation of a veteran's symptomatology. A veteran attaining a severe problem Truthfulness Scale score (at the 90th percentile or higher), might be considered for a retest at a later time. The Truthfulness Scale is a unique feature of the VIP not found in most other assessment procedures.

Civilian Reintegration Scale:
This scale identifies and measures common military-to-civilian transitional problems. This is the focal scale within the VIP, meaning that all other VIP scales intermesh with it to some degree. The Civilian Reintegration Scale pinpoints and assesses veterans' post-deployment challenges (independent of specific mental health or substance abuse issues measured by other VIP scales) such as work-related problems (inability to gain or maintain employment, etc.), interpersonal conflict (arguments, fights, etc.) and financial issues. As mentioned, this is the central scale within the VIP. Its relationship with other scales can be used to create a comprehensive profile of a returning veteran's needs and areas of concern. The Civilian Reintegration Scale can be interpreted independently or in terms of its interaction with other VIP scale scores. The transition phase for veterans returning to civilian life is challenging in itself, but if other co-occurring disorders are present, this stage of a veteran's life can become even more stressful and overwhelming. For example, a veteran with impaired self-esteem (identified by a VIP Self-Esteem Scale score at the 70th percentile or higher) may lack confidence in their own abilities. Self esteem is required to work through many civilian reintegration issues. This scenario can cause both reintegration problems and low self-esteem to worsen. A Civilian Reintegration Scale score in the elevated (at the 70th percentile or above) range represents serious reintegration problems. Severely elevated (90th percentile and higher) Civilian Reintegration Scale scores identify serious and possibly debilitating reintegration problems. A truism is, the higher the scale scores the more serious the problem. The Civilian Reintegration Scale score can also help neutralize veterans' denial of their reintegration and transitional issues. Many people react more favorably to objective assessment results as opposed to others' subjective opinions. The VIP report lists any scale-related 'significant items', which can provide insight into the types of reintegration problems the veteran is experiencing.

Self-Esteem Scale:
This scale measures veterans' feelings of self-acceptance and self-worth. Self-esteem refers to a person's appraisal of self. Positive self-esteem levels fall somewhere between self-centeredness

and self-hatred. Neither extreme is healthy. 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. Counseling and psychotherapy can be used to develop healthy self-acceptance. Self-esteem is an important area of inquiry for returning veterans because it underlies and reflects depression, PTSD, substance (alcohol and other drugs) abuse and suicidal ideation. There is considerable symptom overlap with many of these disorders. Negative or low self-esteem has been associated with an impaired ability to adapt appropriately to one's environment. Therefore, low self-esteem can adversely impact veterans' military-to-civilian transition and serve as a precursor to other self-destructive behaviors such as substance abuse or suicide ideation. Poor self-esteem can often be characterized by feelings of guilt, shame, humiliation or remorse. A Self-Esteem Scale score at the 70th percentile or higher (elevated risk range) represents impaired self-perception; a score at or above the 90th percentile indicates severely impaired self-esteem. Other elevated scale scores (at the 70th percentile or higher) in conjunction with an elevated Self-Esteem Scale score represent the generalization of negative self-esteem. Untreated negative self-esteem can grow and expand. An elevated Self-Esteem Scale score co-occurring with elevated Suicide, Alcohol, Drugs or Depression Scale scores underlies the seriousness of these disorders. The Self-Esteem scale score can be interpreted in conjunction with other VIP scale scores.

Depression Scale:

Signs of depression include chronic sadness, loss of interest or pleasure in daily activities, decreased concentration and feelings of worthlessness. Depression is one of the most commonly-occurring mental health disorders affecting the general population and has become increasingly prevalent among veterans returning from Iraq and Afghanistan. The VIP Depression Scale identifies veterans' depression and quantifies symptom severity. The Depression Scale score can be interpreted as a self-report or in terms of its interaction with other VIP scale scores. A higher Depression Scale score represents more severe depression. Elevated (70th percentile and higher) Depression Scale scores identify veterans in the early to middle stage of depression. A Depression Scale score at the 90th percentile or above represents severe depression. Veterans with depression symptoms are at greater risk for suicide. Alcohol and/or drug abuse can also reflect attempts at self-medication. Other elevated (at the 70th percentile or above) VIP scale scores co-occurring with an elevated Depression Scale score usually mean there is an interaction effect that can result in exacerbated reactions among elevated scale scores. Depression symptoms are especially dangerous when combined with comorbid mental health problems such as suicide ideation, posttraumatic stress disorder (PTSD), alcohol or drug abuse and/or impaired self-esteem. Depression is treatable. Depending on symptom severity, treatment approaches often combine psychotherapy with prescribed medication. When depression treatment is warranted, an integrated treatment approach should be used to incorporate comorbid disorders. Cognitive Behavioral Therapy (CBT) is a popular psychotherapy when treating depression.

Posttraumatic Stress Disorder (PTSD) Scale:

High rates of PTSD have been found among returning veterans. While deployed, military men and women see and experience horrific events that can be a devastating shock to their state of mind. However, with proper identification, treatment and intervention, PTSD is treatable. PTSD is an anxiety disorder characterized by nightmares, flashbacks, physiological fear reactions, extreme avoidance of traumatic event reminders, an excessive startle response, emotional detachment, anhedonia, panic attacks and severe anxiousness. Civilian reintegration problems can worsen from the debilitating effects of PTSD. A PTSD Scale score at the 70th percentile or above indicates that the veteran is experiencing PTSD symptoms that are affecting his or her quality of life. The higher the scale score is, the more severe the PTSD problem. A PTSD score

in the elevated (70th percentile or higher) range in combination with other elevated VIP scale scores means that these problems could exacerbate PTSD symptomatology and vice versa. PTSD symptoms are particularly dangerous when co-occurring with disorders such as depression, suicidal ideation and substance abuse. The association between the prevalence of PTSD in veterans and veteran suicide rates is particularly alarming. An elevated PTSD Scale score with an elevated Suicide Scale score warrants prompt and immediate intervention. The PTSD Scale can be interpreted as a self-report or in terms of its interaction with other VIP scale scores. A comprehensive review of all other elevated VIP scale scores in relation to an elevated PTSD Scale score is always appropriate. When PTSD treatment is required, an integrated treatment approach should incorporate all other identified comorbid disorders.

Alcohol Scale:
Measures alcohol (beer, wine and other liquor) use and the severity of abuse. Alcohol is a licit or legal substance. An elevated (70th percentile or higher) scale score on the Alcohol Scale is indicative of an emerging drinking problem. A severe problem Alcohol Scale score at the 90th percentile or above represents serious alcohol-related problems and probable alcoholism. Because a history of alcohol problems could result in a 'recovering' alcohol abuser (a current non-drinker) to attain a low-to-medium risk Alcohol Scale score, precautions have been built into the VIP to identify 'recovering' alcohol abusers. If a respondent affirmatively answers the 'recovering' alcoholic test item (#132), this response and any other noteworthy alcohol-related responses ('significant items') are printed in the VIP report. Most respondents will accept their objective Alcohol Scale score as accurate and apropos to their personal drinking patterns. This is especially true when it is explained that elevated Alcohol Scale scores do not occur by chance. A definitive pattern of problem drinking behavior must be admitted to before an elevated score can be attained. In intervention and treatment settings, the Alcohol Scale score can help staff work through veterans' denial about having alcohol-related problems. Many people more easily accept objective, standardized assessment results as opposed to someone's subjective opinion, especially when dealing with the sensitive subject of alcohol abuse. An elevated Alcohol Scale score in conjunction with other elevated VIP scale scores means that a drinking problem likely exacerbates other co-occurring disorders. For example, an elevated Alcohol Scale score with an elevated Depression Scale score is a cause for concern, as an alcohol problem can negatively interact with problematic depression symptoms. The Alcohol Scale score can be interpreted independently or in terms of its interrelationships with other VIP scales.

Drugs Scale:
Measures drug (marijuana, ice, crack, cocaine, amphetamines, barbiturates, heroin, etc.) use and the severity of abuse. This measure may also incorporate prescription drug abuse. An elevated Drugs Scale score (at the 70th percentile or above) represents growing drug involvement and emerging drug-related problems. A general rule of thumb, is the higher the scale score the more serious the problem. A Drugs Scale score in the severe problem (90th percentile or higher) range indicates severe drug-related problems. As with the Alcohol Scale, the VIP has built-in precautions - in the form of 'recovery'-related test items - to identify 'recovering' drug abusers. This safeguard is included in the VIP to prevent misclassification of veterans that once had a drug problem but currently abstain from drug use. If a respondent affirmatively answers the 'recovering' drug abuser test item (#132), this response and other notable drug-related responses ('significant items') are printed in the VIP report. Most veterans will accept their objective Drugs Scale score as accurate and relevant to their personal drug use patterns. This is especially true when it is explained that elevated Drugs Scale scores do not occur by chance. An established pattern of drug abuse must be identified before an elevated score can be attained. An elevated Drugs Scale score in conjunction with other elevated VIP scale scores means that the drug-related problem likely aggravates and exacerbates other co-occurring disorders. For example,

comorbid disorders such as suicide ideation can interact dangerously with an elevated Drugs Scale score and can increase a veteran's suicide risk. When used in intervention and treatment settings, the VIP Drugs Scale score can help staff work through veterans' denial about having drug-related problems. Many people find it easier to accept objective, standardized assessment results as opposed to someone's subjective opinion, especially when dealing with the sensitive subject of drug abuse or addiction. The Drugs Scale can be interpreted independently or in terms of its interaction with other VIP scale scores.

Suicide Scale:
Suicide among veterans is a critical area of concern for health care professionals and other veteran support personnel. The literature on veteran suicide shows that the suicide rate of veterans far exceeds that of non-veterans. Hints of suicidal thinking and behavior are often present before a suicidal person attempts or commits suicide. Recognizing these precursors to suicide is imperative for suicide prevention. While some suicidal individuals are very aware of their self-destructive intentions, others are unaware of their own danger to themselves. The majority of suicidal acts stem from feelings of isolation and some intolerable emotion. Unfortunately, what is considered 'intolerable' differs from person to person. The VIP Suicide Scale does not predict suicide, but it does identify the presence of suicidal thoughts and behavior and classifies suicide risk level. A problem risk Suicide Scale score (at the 70th percentile or higher) is representative of recurring thoughts of suicide, emotional isolation and/or poor self-esteem. A severe problem (at the 90th percentile or higher) Suicide Scale score indicates heightened suicide risk. A severe problem score does not occur by chance; a definitive pattern of suicide-related admissions must occur in order to attain a severe problem score. The higher the Suicide Scale score is, the more severe the risk of suicide. When a Suicide Scale score is at the 70th percentile or higher, the assessor should consider suicide attempts as a possibility and take appropriate steps. Substance abuse is often associated with suicidal acts, as is depression. Other VIP scale scores in the elevated range are probable exacerbating factors when present with an elevated Suicide Scale score. Comorbid disorders such as PTSD, depression, alcohol or drug abuse and impaired self-esteem are particularly ominous when combined with thoughts of suicide. The Suicide Scale score can be interpreted as a self-report or in terms of its interaction with other VIP scale scores, but with either interpretation method, a Suicide Scale score at the 70th percentile or higher is an explicit warning and cause for concern.

In summary, the Veteran Information Profile (VIP) is a veteran military to civilian transition assessment instrument or test. The VIP is designed to help assessment staff, veterans, treatment professionals and others (family, the courts, probation departments, etc.) better understand the veteran's reintegration situation, challenges and needs.

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 on this page.***

1. Paper/Pencil Test Administration

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 on the screen and a report is generated and may be printed while online.

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. 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 will 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.

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Registered clients have the option to use “Live Chat” from their account page.