COLR-3151-5
REV. 1-61
3

1. PATIENT IDENTIFICATION

MATERNAL BEHAVIOR IN TESTING SITUATION

2 EXAMINED BY

3. DATE OF EXAM.
MO. | DAY | YEAR

4. EXPRESSION OF AFFECTION

Negative		Warm		Extravagant
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

5. EVALUATION OF CHILD *(What mother says about child)*

Critical		Accepting		Effusive
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

6. PHYSICAL HANDLING OF CHILD *(General)*

Rough		Considerate		Overly cautious
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

7. MANAGEMENT OF CHILD *(During actual testing)*

No facilitation		Orienting		Overdirecting
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

8. REACTION TO CHILD'S NEEDS

Unresponsive		Recognized		Absorbed
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

9. REACTION TO CHILD'S TEST PERFORMANCE

Indifferent		Interested		Defensive
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

10. MOTHER'S FOCUS OF ATTENTION DURING EXAMINATION

Child		Situation		Self
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

11. CHILD'S APPEARANCE

Unkempt		Appropriate		Overdressed
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

12. CLINICAL IMPRESSION *(Optional)*

13. COMMENTS

Collaborative Research
Perinatal Research Branch, NINDB, NIH
Bethesda 14, Md.

MANUAL FOR RATING
MATERNAL BEHAVIOR IN TESTING SITUATION

(For Form PS-5, Revised January 1961)

THE COLLABORATIVE STUDY OF CEREBRAL PALSY AND
OTHER NEUROLOGICAL AND SENSORY DISORDERS OF
INFANCY AND CHILDHOOD

January 1961

MANUAL FOR RATING MATERNAL BEHAVIOR IN TESTING SITUATION
(PS-5, Rev. 1-61)

I. GENERAL. These ratings are designed to bring to light certain variables in the mother-child relationship which may affect the child's behavior during the Psychological Examination. It is possible that maternal handling of the child may affect his performance and behavior, and complicate or lead to confusion in evaluating the child as "abnormal," "suspect," or "normal." In an effort to evaluate the possible influences of the mother on the child's test performance, these scales have been formulated.

The continua being investigated were selected on the basis of empirical observation and search of the literature. It is recognized that the same incident seen in the behavior of the mother may form the basis for a rating on more than one scale, and that this may result in high correlations between some scales.

The information for completing the scales is to be obtained while the child and mother are with the psychologist. In some institutions the opportunity for observation also occurs while the mother is in the waiting room. Attitudes which the mother may verbalize at the time of observed interaction between the child and the mother may be utilized in determining a rating.

The examiner is asked to place a mark (X) in only one of the five boxes for each of the eight areas rated. He is to choose that box which best describes the behavior seen during the period with the psychologist. A certain amount of variability in the mother's behavior is to be expected but a single score can represent the mother's behavior quite adequately. When a single score will be misleading, as in those instances where the mother shows marked shifts in extremes of behavior (at one time completely accepting the child and at another time being completely hostile or angry; or, cooperating well with the examiner at one time and at another being quite antagonistic) this should be noted in the column marked COMMENTS. It is never permissible to mark two boxes on the same scale.

All entries must be determined only on the basis of behavior actually observed by the psychological examiner. It is a constant temptation to interpret behavior, but the ratings are not to be interpretations or inferences about psychodynamics or emotional problems of the mother; these may be entered under CLINICAL IMPRESSION with the psychologist specifying the behavior which led to the inference or interpretation made.

In the rare instances when it is not possible to rate a scale, write a brief explanation of why this is so under the section entitled CLINICAL IMPRESSION. For example, for Item 8 it is conceivable that an examiner might write "cannot rate - no needs became evident during the examination."

In making ratings, it is expected that the mother will be evaluated in terms of the item descriptions and the specified meanings of the scales given below and exemplified by critical incidents. It is not the examiner's function to make the ratings in terms of assumed norms for the mother's socio-economic level or in terms of the ethnic and cultural groups to which she may belong.

The eight scales call for observations. The behavioral descriptions given for each scale are intended to communicate to the rater the concepts which prompted these scale items to be adopted. Some critical incidents are reported to further clarify the intent of the scales. Please keep in mind that the critical incidents are only examples and are not the only behaviors which will influence the ratings. The full descriptions of the five points on each scale are given below under "Scale Items." The actual rating sheet has only a "cue" word at each extreme and at the mid-point of each scale. It is recognized that this will necessitate constant reference to the manual while the examiner is becoming familiar with the form. It is felt, however, that with these cue words the rater will rather quickly commit the anchor points on each scale to memory and will then need only occasional reference to the manual.

II. THE SCALES.

A. Expression of Affection - Item 4. This scale is intended to suggest the amount of affection shown by the mother toward the child during the entire visit. It is based on both the mother's physical and verbal behavior. It is theoretically possible for the mother's attitude to range from negative to effusively positive and over-demonstrative. At one extreme, the mother may slap the child's hands or address him as "you bad boy," etc. At the other, she may constantly kiss, caress, and fondle him, and use extravagant terms of endearment. At the mid-point, the mother will reassure the child by affectionate or supportive display when he is apprehensive, and demonstrate appropriate affection while meeting his physical needs.

Scale Items:

1. Mother's statements to child were negative or harsh; never used an affectionate term in addressing child; used physical actions to discipline child.

2. Mother occasionally spoke to child in a negative and harsh way, rarely used an affectionate term; handled the child in a remote and impersonal manner.

3. Mother was spontaneously warm and affectionate at appropriate times, without being over-demonstrative; called him by name and talked to him in terms appropriate to his development.

4. Mother frequently fondled and caressed child; spoke to him in terms of endearment only.

5. Mother was consistently over-demonstrative; constantly fondled, kissed, cuddled child; talked to the child in extravagantly affectionate terms, addressing him by pet names and sugary baby talk.

B. Evaluation of Child (What Mother Says about Child) - Item 5. This scale is intended to rate what the mother says about the child as opposed to what she says to him. Although this scale may be correlated with the Expression of Affection scale, it is possible that a mother who is trying to make a good impression on the psychologist may score high on this scale while obtaining a low score on the basis of her actual behavior toward the child. As with the previous scale, it is possible for the mother's comments to range from extremely critical to effusive. Incidents for rating the mother here are likely to occur if she has other children and makes comparisons between them; when the child is disruptive during the examination by being fatigued or fussy; or when the mother is evaluating the child's test performance. For example, a mother would score a rating of 1 if she consistently made comments of the following type: "He's just the worst baby I ever saw;" "He's really hard-headed when he don't want to do something;" "I just don't know what's wrong with him." A mother would score a rating of 5 if she consistently made such comments as: "He's just as good as gold all the time;" "I haven't had a minute's trouble with him;" "He's really the ideal baby."

Scale Items:

1. Mother constantly made critical and derogatory remarks about the child; could say nothing positive about him.

2. Mother generally made negative statements about the child, but grudgingly attributed a good quality to the child on occasion.

3. Mother saw both the positive and negative facets of the child; made appropriate and realistic evaluations of his assets and limitations.

4. Mother talked only about child's "good" qualities; tried to gloss over, ignore, or "explain away" less desirable behaviors.

5. Mother was unrealistically uncritical about child's perfection; expressed satisfaction with all aspects of his behavior in glowing terms; effusive.

C. Physical Handling of Child - Item 6. This dimension of behavior is rated on the basis of how gently the mother handles the child while in the examination room. It is to be distinguished from Expression of Affection in that it relates entirely to the mother's actual physical manipulation of the child in meeting his needs or moving him about. Some mothers assume an exaggerated fragility about their children. They are extremely cautious about laying them down, changing their diapers, dressing, or performing any other needed services. At the other extreme is the mother who literally "heaves" the child on to the examining table or playpen floor, or shoves a bottle into his mouth for feeding. When a child becomes irritable, some mothers will bounce the child around like a cocktail shaker. The average mother is somewhere between the two extremes using easy, relaxed movements which have a quieting effect. She shows appropriate care as far as physical handling of the child is concerned and at the same time recognizes a certain durability about children.

Scale Items:

1. Mother was rough, inconsiderate, and treated child like an inanimate object.

2. Mother was awkward and clumsy, but aware of child's discomfort in process of handling him.

3. Mother handled child carefully and considerately, but firmly and efficiently.

4. Mother was extremely careful and gentle, not recognizing child's sturdiness and adeptness.

5. Mother treated child like extremely fragile china; was overly cautious and concerned when handling child.

D. Management of Child (During Actual Testing) - Item 7. This dimension deals with the ability of the mother to assist the child in doing his best in the examination without allowing herself to become involved in examination. Some mothers, as they hold the child, may not even orient him so that he can reach the test materials unless the examiner repeatedly suggests that she move the child up to the table, etc. At one extreme, mothers have been seen to hold the child by his upper arms while the child was trying to reach for test material. At the other extreme, a mother may overdirect the child's behavior by holding a block in the child's hand and moving it over the cup, etc. In the middle of the range, mothers orient the child so as to facilitate his manipulations and may even make suggestions to the examiner as to the best way to get the child's attention and cooperation.

Scale Items:

1. Mother made no effort to facilitate testing by keeping child comfortable and oriented toward table; held child in such a position as to make it difficult or impossible for him to reach test materials; continued to handle child in this manner in spite of examiner's suggestions.

2. Mother made no spontaneous effort to facilitate testing but followed examiner's suggestions and consciously held child facing table.

3. Mother spontaneously held child comfortably oriented toward table so that he could reach for and handle test objects with ease and freedom; facilitated testing.

4. Mother frequently interfered with testing, but showed self-restraint at suggestion of examiner.

5. Mother disrupted the testing by "helping" the child with given tasks, taking things away from him, and generally overdirecting his behavior regardless of examiner's disapproval.

E. Reaction to Child's Needs - Item 8. This scale deals with the mother's ability to determine the child's actual needs as they occur during the testing-interviewing session. It is not uncommon for children to have runny noses, wet diapers, or to become hungry or fatigued. The point in the middle of the scale represents the mothers who are aware of these conditions and handle them appropriately. Some mothers, however, show no awareness of the needs of the child unless the examiner makes a suggestion that she pick the child up, feed or change him, etc. The child not only indicates physical needs during the examination but frequently indicates emotional needs as well. When apprehension or a need for comforting arises, does the mother ignore it, give suitable support to the child or become overly concerned? Average mothers correctly interpret fretfulness as an indication of hunger, stating that it is time for his bottle. Over-solicitous mothers, however, may make a great deal out of minor situations or force attention on a child which is not warranted. One mother was seen to give a child his bottle, which he took and then went to sleep. The mother then woke him to give him his orange juice. This mother would fall into the extreme category, "absorbed".

Scale Items:

1. Mother seemed unaware of and unresponsive to any needs child showed during visit (discomfort, fatigue, hunger, soiled diaper, etc.).

2. Mother was slow in recognizing and responding to child's needs.

3. Mother quickly recognized child's needs and responded appropriately.

4. Mother responded to child's behavior immediately, without trying to identify existence of a need.

5. Mother gave child care for needs which were not evident.

F. Reaction to Child's Test Performance - Item 9. Mothers react differently toward the performance which their children show on test materials. It is felt that the average mother shows an interest in what is being done and will indicate that she would like to know how the child is doing. She also shows an appreciation of his skill or awkwardness in his reactions to new material. From this appropriate interest in the situation, maternal attitude can vary from complete apathy to marked overconcern to the point where she is almost belligerently defensive about his behavior and overly critical of test material and "psychology."

Scale Items:

1. Mother seemed completely indifferent to child's performance.

2. Mother showed brief and fleeting interest in child's performance, but this was done "politely" as though she felt this was expected of her; played role of a passive observer throughout.

3. Mother seemed pleased with child's successes and indicated this by smiling, etc.; accepted failures realistically when material and requests were obviously beyond child's abilities.

4. Mother responded with excessive pride to child's successes; minimized any failures by child.

5. Mother was overly absorbed in child's performance; defended child's failures as due to unfamiliarity with material; demanded constant praise from examiner; criticized examiner and test procedures for being unfair to child; rejected testing as "not proving anything."

G. Mother's Focus of Attention During Examination - Item 10. During the psychological examination, the most facilitating relationship is between the examiner and the child, with the mother intervening only to assist this examiner-child relationship. This relationship cannot develop in all instances. At one extreme, some mothers compete openly with the child for the examiner's attention. They bring up specific personal problems not related to the child, viz., financial problems, trouble with their husbands, neighborhood arguments, personal health, etc. Other mothers may indulge in an excess of social conversation about topics of the day, or the "fascination" with the "science of psychology." They brag about their capabilities as mothers, housewives, musicians, etc., or go into details as to their ambitions and/or philosophies. All of these forms of behavior strongly suggest that the mother is utilizing the time with the examiner for her own aggrandizement. They should be rated as focussing on self. The opposite extreme is the mother who monopolizes the child throughout the examination, refusing to let the examiner establish any rapport with the child. This mother constantly diverts the child's attention by introducing irrelevant stimuli. She may insist on repeating and rewording all instructions, and/or presenting materials in her own way before the child has a chance to respond to orthodox administration of test material. In short, this mother tries to get the child's undivided attention, thereby eliminating the examiner as an individual from the psychological environment.

Scale Items:

1. Mother centered all attention on child and tried to keep child's attention on her, excluding both the examiner and test material from the situation.

2. Mother accepted presence of examiner and the fact that test material was interesting to the child, but mother tried to involve herself with these foci of interest.

3. Mother was comfortable in letting child respond to examiner and materials.

4. Mother occasionally interrupted examination to talk about her own perceptions of and reactions to the situation.

5. Mother demanded that all attention be centered on her, distracting the examiner from the child; disregarded test materials and focussed on events and problems extraneous to the situation.

H. Child's Appearance - Item 11. The rating on this scale should not be influenced by the socio-economic level of the parents. It is intended to get at the amount of attention and adornment the child receives. Some children are found to be frankly neglected in grooming, while others are highly overdressed. The clothing worn by the child is one source of rating. The child whose clothes are clean although well worn would receive an "appropriate" rating at the mid-point, whereas the child with good quality clothes, but soiled (more than one "usually" sees) would rate on the "unkempt" side of this scale. Presence of strong body odor about the child would also bring about an "unkempt" rating. Other things that may be seen are sores and rashes. Another indication of neglect is failure of the mother to bring clean diapers to the visit.

Scale Items:

1. Child's clothing appeared soiled; grooming suggested neglect or minimal perfunctory attention.

2. Clothing and appearance were marred by helter-skelter dressing; appeared inadequately dressed.

3. Child was clean, neat, and comfortably dressed. Seems appropriately dressed for the occasion.

4. Child had extra "polish" and seemed somewhat overdressed.

5. Child seemed excessively dressed up, to the point of discomfort; child seemed to be a vehicle for clothes of which the mother was very proud.

MANUAL OF DIRECTIONS FOR EIGHT-MONTH PSYCHOLOGICAL EXAMINATION

(For Forms PS-1-5 Revised 1/61)

THE COLLABORATIVE STUDY OF CEREBRAL PALSY AND OTHER NEUROLOGICAL AND SENSORY DISORDERS OF INFANCY AND CHILDHOOD

January 1961

MANUAL OF DIRECTIONS
FOR THE EIGHT-MONTH PSYCHOLOGICAL EXAMINATION
(For Forms PS-1-5 Rev. 1/61)

I. THE TESTING ROOM AND EQUIPMENT. Each institution should have at least one separate examining room that is large enough to include a table, chairs for adults (including a comfortable, padded chair for the mother), a playpen, some free floor space for motor tests, and either a crib or examining table for those infants whose development seems retarded. This room should be pleasant and not austerely office-like, but without too many distracting items. Draperies at the window, a picture or two, a potted plant, etc., are appropriate. If there are several examiners, two examining rooms will facilitate scheduling of tests.

The recommended size for the testing table is one with a 2 X 4 foot surface and 29 inches high. The height of table and chairs should be such that when the child sits on his mother's lap he will comfortably have his elbows at table top height. An extra cushion or a footstool will help to make a short mother more comfortable. To allow ample "leg-room," a flat slab-like table without a "skirt" is preferable (small dinette tables are satisfactory). The playpen should have a firm floor covered with a washable pad and bars which the child can use for pulling himself up. It is also advisable to have an easy-access storage cabinet in which the test materials can be kept; examples are a Flexishelf metal file with slide-out shelves or a metal desk tray with three or four shelves, placed on a small table or chair adjacent to the testing table.

II. LIST OF TEST MATERIALS.

A. Material Currently Supplied by Central Office:

1. A snapper (light switch).

2. A small two candle power pocket flashlight with transparent red shield over the light.

3. A red plastic hoop, $4\frac{1}{4}$ inches in diameter, with ten inches of white plastic string attached.

4. A ten-inch piece of white plastic string (in addition to string on the red hoop).

5. Twelve red one-inch plastic cubes.

6. A dumb-bell shaped rattle, about four inches long, middle range sound.

7. A metal hand bell with wooden handle.

8. Sugar pellets, 8 mm. in diameter, both surfaces slightly convex.

9. A plastic cup, $2\frac{1}{2}$ inches high, $3\frac{1}{2}$ inches in diameter at top.

10. A metal mirror, 10 X 14 inches (cover edges with adhesive tape).

11. A rubber doll $5\frac{1}{2}$ inches high with a whistle in its back.

12. A picture book with stiff cardboard pages.

13. A plastic box, 2 X 2 X $2\frac{1}{2}$ inches, with one solid lid; to go with this box, $8\frac{1}{2}$ inch beads.

14. A Gesell-type three hole form-board and blocks made of plastic.

15. A Wallin pegboard made of plastic.

16. A Bayley form-board.

17. One Quackie Family toy.

When these items are lost or broken and replacements are needed, write to:

Mr. Lawrence Watson
National Institute of Neurological
Diseases and Blindness
National Institutes of Health
Bethesda 14, Maryland
(Robin Building, Room 424)

B. <u>Materials to be Added by Each Institution</u>:

1. Two metal spoons.

2. One red crayon.

3. One red rubber ball, two inches in diameter.

4. One toy automobile.

5. One clear plastic bottle, about three inches high, one inch in diameter.

6. One pencil, full length, yellow.

7. A supply of small handkerchiefs or pieces of cloth, roughly ten inches square.

8. A supply of paper 8½ X 11 inches. This should be of a quality which does not easily disintegrate if put in child's mouth.

III. GENERAL DIRECTIONS. The tests are given with the mother (or mother surrogate) sitting at the table and holding the child on her lap. Every effort should be made to put both mother and infant at ease in order to elicit natural and spontaneous activities by the infant. A brief explanation of the kind of examination that is to take place should be given to the mother after she is seated at the table and the baby has been given a toy to play with. An explanation similar to the following is suggested:

> "Perhaps you have already been told that this is a different kind of examination than previous ones the baby has had--it is not a medical exam. We are interested in seeing how (name) is growing and developing, what he has learned, what he is interested in. We shall give him many kinds of objects and toys. Some of these may not interest him, some may be too difficult for him to use, but we will try a wide variety of things to see how he reacts to them.
>
> "You are not required to try to persuade him to do anything. You just relax and enjoy watching him play. During this period we will also discuss what (name) is like at home. Babies usually act somewhat differently when they are in a strange place, so I shall have to depend on you to tell me what he is like in his own home and with his own things."

Care should be taken to insure optimal performance by the child. This includes making the appointment for testing at a time when the baby is usually awake. The test should be given immediately on arrival, unless the baby is asleep or needs time to become acquainted. Take time out, when indicated, for such things as nursing, toileting, or rest from stimulation, to facilitate optimal over-all performance.

It is recommended that the wearing of professional white coats be avoided since these are so closely identified with medical examinations. While many young infants may be unaffected by white-coated personnel, all mothers probably associate them with medical examinations. Some of the stereotyped "yes, doctor" responses may be prevented by omission of the white coat.

It should be standard practice for the examiner to sit across the table from the infant, rather than beside him. Facing the child enables the examiner to see responses not as easily visible from the side. It may also help the timid, non-responsive child to have the width of the table between

himself and the unfamiliar examiner. With many eight-month babies there is an initial period of shyness or fearfulness of the strange situation and examiner which is often dissipated by ignoring the baby for awhile. Give the baby a toy, and the examiner can talk quietly with the mother until the baby begins to play freely, at which time the testing toys may be presented. A "head-on," over-friendly approach to babies of this age is to be avoided. In testing, toys that the child can explore and manipulate should be offered first. Later, when the child is responding freely, those which involve social responsiveness can be presented.

A change of pace is often indicated if a child becomes restless or unresponsive to a given type of stimulus. For example, the examiner could change from tests with the cubes, even if they have not all been done, to a test of social interaction and later resume the unfinished tests, or he could let the child rest from stimulation for a few minutes, with a toy, while he makes notations or talks with the mother. The examiner's approach will necessarily be adapted to the temperament of the individual infant, as far as it can be observed: e.g., the hyperactive, easily upset infant needs a quiet, soothing sort of handling, where the placid, under-reactive baby may need stronger stimulation.

The child needs to be given ample time to respond to each test item, i.e., he should not be rushed through the examination. The examiner must take care that his conversations with mother and/or baby do not interfere with optimal testing conditions.

IV. PARTICIPATION OF MOTHER. Note that in such items as Frolic Play, or Responds Selectively to Name or Nickname, the mother is asked to participate. Also, the mother is asked to place the baby in the playpen (or crib) and to assist with certain motor items when her help is needed to elicit desired behavior from the infant.

V. NUMBER OF DEMONSTRATIONS PERMISSIBLE. The number of demonstrations for such items as "Stirs with spoon in imitation" or "Puts cube in cup" must be uniform with all testers. Three demonstrations are permissible, with the examiner making sure that the baby is attending to the demonstrations. They should not be in consecutive order.

Otherwise, the examiner may well be teaching the infant through repeated demonstrations and encouragements, thus changing the nature of the item from a developmental one to a learning experience.

VI. PROCEDURE WITH ITEMS INVOLVING IMITATION. For items involving imitation, the item can be scored as Pass only if the infant performs adequately at the time the item is demonstrated. For instance, if the infant rings the bell during the free play period in the playpen, but failed to do so when the item was presented, he does not obtain a Pass score.

On the following items involving imitation this direction must be followed:

Rings bell imitatively.
Fingers holes in pegboard. (Allow baby to explore before demonstration)
Puts cube in cup.
Attempts to imitate scribble.
Stirs with spoon in imitation.
Pushes car along. (Allow baby to explore before demonstration)
Imitates words.
Puts three or more cubes in cup.
Uncovers square box.
Dangles ring.
Places one peg.
Pats doll.
Builds tower of two cubes.

VII. SCORING OF ITEMS. Each item must be scored either Pass or Fail. Note that the category Marginal is now omitted. Any marginal or minimal responses are now counted as failures, but should be noted under "Comments."

The exception to this directive is for vocalization items on the Mental Scale where the mother's report must often be relied on. For such items where a score of Report is permissible, Rpt is printed under the item. For all other items where a baby actually tries and fails in the testing situation, a score of Fail is given, even if the mother reports that he does this at home. Note that the Rpt score is retained on the Motor Scale for many items, although only for the vocalization items on the Mental Scale.

When it is impossible to score an item Pass or Fail, it is permissible to indicate that the item was Omitted or Refused in the Comments column.

VIII. RANGE OF TESTING. The "basal" for the Mental Scale may be considered established when six consecutive items are passed, and the "ceiling" when six consecutive items are failed. For the Motor Scale, which is more limited, one month's items passed or failed are sufficient for basal age and ceiling, provided that both fine and gross motor abilities have been tested.

A period of free activity for the child in the playpen is part of the test situation. During this time, spontaneous motor activities and vocalizations often can be observed.

IX. TIME REQUIRED FOR TESTING. No definite requirements can be set up regarding time for each examination. However, from reported experience of various institutions, 40 minutes appears to be the average time needed for actual testing, and about 20 minutes for filling in the forms. Difficult or abnormal infants may, of course, require more time for testing and evaluation. It is possible that with the revised scales and forms, less time will be required.

The consensus of opinion appears to be that three infants is an adequate number for one examiner in a day, although occasionally four may be seen, if properly scheduled. It is essential that all record forms for one infant be completed before another infant is seen.

X. ORDER OF RECORD FORMS. When returning the completed set of forms to NINDB, they should be arranged in the following order: Mental Scale, Motor Scale, Infant Behavior Profile, Additional Observations, Maternal Rating Scale. Make sure that the sheet containing full information with regard to child's name and birth date, sex, race, examiner's name and date of testing are on top.

XI. RANGE OF AGE FOR TESTING. Appointments should be scheduled to test the Study baby between $7\frac{1}{2}$ and $8\frac{1}{2}$ months of age. When such appointments are failed or cancelled, attempts should be made to reschedule them as soon as possible, preferably before the baby becomes nine months old, but no older than ten months. If the baby has not been tested by the age of ten months, the next examination scheduled is the twelve month neurological. The exact age of the child at the time of testing is recorded on the test forms.