BASC-2™

BASC-2 Parent Rating Scales - Child
Behavior Assessment System for Children, Second Edition
Clinical Report

Cecil R. Reynolds, PhD, & Randy W. Kamphaus, PhD

	Child Information		**Test Information**
ID:	123456789	Test Date:	10/30/2009
Name:	Timmy Sample	Rater:	Mr Sample
Gender:	Male	Gender:	Male
Birth Date:	03/01/2001	Relationship:	Father
Age:	8		
Grade:	3		
School:	Sample School		

Norm Group 1: General - Combined Sex

Results contained herein are confidential, and should only be viewed by those with proper authorization

The Behavior Assessment System for Children, Second Edition (BASC-2) is an integrated system designed to facilitate the differential diagnosis and classification of a variety of emotional and behavioral disorders of children and to aid in the design of treatment plans. This computer-generated report should not be the sole basis for making important diagnostic or treatment decisions.

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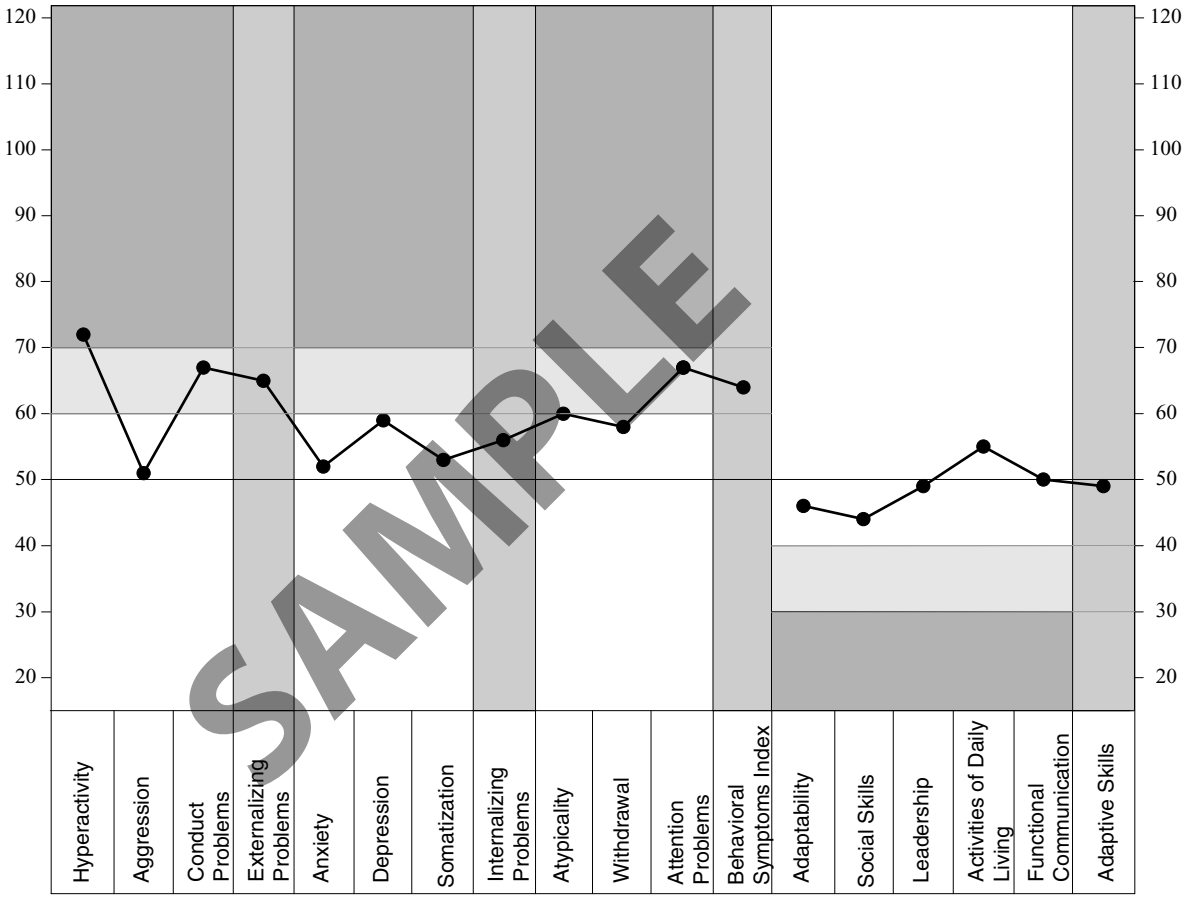
VALIDITY INDEX SUMMARY

F Index	Response Pattern	Consistency
Acceptable	Acceptable	Acceptable
Raw Score: 1	Raw Score: 113	Raw Score: 10

T-SCORE PROFILE



T Score (Plotted)	Hyperactivity	Aggression	Conduct Problems	Externalizing Problems	Anxiety	Depression	Somatization	Internalizing Problems	Atypicality	Withdrawal	Attention Problems	Behavioral Symptoms Index	Adaptability	Social Skills	Leadership	Activities of Daily Living	Functional Communication	Adaptive Skills
● Gen.-Comb. Sex	72	51	67	65	52	59	53	56	60	58	67	64	46	44	49	55	50	49

Percentile																		
Gen.-Comb. Sex	96	62	94	92	61	84	66	75	86	81	93	91	33	28	44	65	46	43

PRS SCORE SUMMARY: General - Combined Sex Norm Group

Composite Score Summary

	Raw Score	*T* Score	Percentile Rank	90% Confidence Interval
Externalizing Problems	190	65	92	61-69
Internalizing Problems	164	56	75	51-61
Behavioral Symptoms Index	367	64	91	60-68
Adaptive Skills	244	49	43	45-53

Composite Comparisons	Difference	Significance Level	Frequency of Difference
Externalizing Problems vs. Internalizing Problems	9	0.05	greater than 25%

Mean *T* score of the BSI	**61**
Mean *T* score of the Adaptive Skills Composite	**49**

Scale Score Summary

	Raw Score	*T* Score	Percentile Rank	90% Confidence Interval	Ipsative Comparison		
					Difference	Significance Level	Frequency of Difference
Hyperactivity	17	72	96	66-78	11	0.05	5% or less
Aggression	6	51	62	45-57	-10	0.05	10% or less
Conduct Problems	11	67	94	61-73	6	NS	
Anxiety	14	52	61	46-58	-9	NS	
Depression	11	59	84	53-65	-2	NS	
Somatization	6	53	66	45-61	-8	NS	
Atypicality	7	60	86	54-66	-1	NS	
Withdrawal	10	58	81	51-65	-3	NS	
Attention Problems	12	67	93	61-73	6	NS	
Adaptability	14	46	33	39-53	-3	NS	
Social Skills	12	44	28	38-50	-5	NS	
Leadership	13	49	44	42-56	0	NS	
Activities of Daily Living	18	55	65	47-63	6	NS	
Functional Communication	27	50	46	44-56	1	NS	

Note: All classifications of test scores are subject to the application of the standard error of measurement (SEM) when making classification decisions. Individual clinicians are advised to consider all case-related information to determine if a particular classification is appropriate. See the BASC-2 Manual for additional information on SEMs and confidence intervals.

CLINICAL VALIDITY SUMMARY

The BASC-2 F Index is a classically derived infrequency scale, designed to assess the possibility that a rater has depicted a child's behavior in an inordinately negative fashion. The F Index consists of items that represent maladaptive behaviors to which the rater answered "almost always" and adaptive behaviors to which the rater responded "never."

The F Index produced from the ratings of Timmy by the parent falls within the **Acceptable** range and does not indicate the presence of negative response distortion.

The Consistency Index identifies situations when the rater has given inconsistent responses to items that are typically answered in a similar way, based on comparisons made to raters from the general population. The Consistency Index was designed to identify ratings that might not be easily interpretable due to these response discrepancies.

The Consistency Index produced from the ratings of Timmy by the parent falls within the **Acceptable** range, and indicates the rater consistently answered items when completing the rating form.

SCALE SUMMARY

This report is based on Mr Sample's rating of Timmy's behavior using the BASC-2 Parent Rating Scales form. The narrative and scale classifications in this report are based on T scores obtained using norms. Scale scores in the Clinically Significant range suggest a high level of maladjustment. Scores in the At-Risk range may identify a significant problem that may not be severe enough to require formal treatment or may identify the potential of developing a problem that needs careful monitoring.

Externalizing Problems
The Externalizing Problems composite scale T score is 65, with a 90 percent confidence-interval range of 61-69 and a percentile rank of 92. Timmy's T score on this composite scale falls in the At-Risk classification range.

Timmy's T score on Hyperactivity is 72 and has a percentile rank of 96. This T score falls in the Clinically Significant classification range, and usually warrants follow-up. Timmy's 2 reports that Timmy engages in many disruptive, impulsive, and uncontrolled behaviors.

Timmy's T score on Aggression is 51 and has a percentile rank of 62. Timmy's 2 reports that Timmy tends not to act aggressively any more often than others of his age.

Timmy's T score on Conduct Problems is 67 and has a percentile rank of 94. This T score falls in the At-Risk classification range, and follow-up may be necessary. Timmy's 2 reports that Timmy sometimes engages in rule-breaking behavior, such as cheating, deception, and/or stealing.

Internalizing Problems
The Internalizing Problems composite scale T score is 56, with a 90 percent confidence-interval range of 51-61 and a percentile rank of 75.

Timmy's T score on Anxiety is 52 and has a percentile rank of 61. Timmy's 2 reports that Timmy displays anxiety-based behaviors no more often than others his age.

Timmy's T score on Depression is 59 and has a percentile rank of 84. Timmy's 2 reports that Timmy displays depressive behaviors no more often than others his age.

Timmy's T score on Somatization is 53 and has a percentile rank of 66. Timmy's 2 reports that Timmy complains of health-related problems to about the same degree as others his age.

Behavioral Symptoms Index
The Behavioral Symptoms Index (BSI) composite scale T score is 64, with a 90 percent confidence-interval range of 60-68 and a percentile rank of 91. Timmy's T score on this composite scale falls in the At-Risk classification range. Scale summary information for Hyperactivity, Aggression, and Depression (scales included in the BSI) has been provided above. Scale summary information for the remaining BSI scales is given next.

Timmy's T score on Atypicality is 60 and has a percentile rank of 86. This T score falls in the At-Risk classification range, and follow-up may be necessary. Timmy's 2 reports that Timmy sometimes engages

in behaviors that are considered strange or odd, and he at times seems disconnected from his surroundings.

Timmy's T score on Withdrawal is 58 and has a percentile rank of 81. Timmy's 2 reports that Timmy does not avoid social situations and appears to be capable of developing and maintaining friendships with others.

Timmy's T score on Attention Problems is 67 and has a percentile rank of 93. This T score falls in the At-Risk classification range, and follow-up may be necessary. Timmy's 2 reports that Timmy has difficulty maintaining necessary levels of attention at school. The problems experienced by Timmy might disrupt academic performance and functioning in other areas.

Adaptive Skills

The Adaptive Skills composite scale T score is 49, with a 90 percent confidence-interval range of 45-53 and a percentile rank of 43.

Timmy's T score on Adaptability is 46 and has a percentile rank of 33. Timmy's 2 reports that Timmy is able to adapt as well as most others his age to a variety of situations.

Timmy's T score on Social Skills is 44 and has a percentile rank of 28. Timmy's 2 reports that Timmy possesses sufficient social skills and generally does not experience debilitating or abnormal social difficulties.

Timmy's T score on Leadership is 49 and has a percentile rank of 44. Timmy's 2 reports that Timmy, when compared to others his age, demonstrates a typical level of creativity, ability to work under pressure, and/or an ability to bring others together to complete a work assignment.

Timmy's T score on Activities of Daily Living is 55 and has a percentile rank of 65. Timmy's 2 reports that Timmy is able to adequately perform simple daily tasks, in a safe and efficient manner.

Timmy's T score on Functional Communication is 50 and has a percentile rank of 46. Timmy's 2 reports that Timmy generally exhibits adequate expressive and receptive communication skills, and that Timmy is usually able to seek out and find new information when needed.

BASC-2 PRS-C INTERVENTION SUMMARY

Note. Information contained in the Intervention Summary section of this report is based on the *BASC-2 Intervention Guide*, authored by Kimberly J. Vannest, Cecil R. Reynolds, and Randy W. Kamphaus.

Primary Improvement Areas	Secondary Improvement Areas	Adaptive Skill Strengths
ı Hyperactivity	ı Conduct Problems ı Attention Problems ı Atypicality	ı None

Timmy's score on Hyperactivity falls in the clinically significant range, and probably should be considered among the first behavioral issues to resolve. His scores on Conduct Problems and Attention Problems are also elevated, and may warrant targeted interventions and/or further monitoring to ensure it doesn't worsen.

Note that Timmy had a score on Atypicality that is an area of concern. Interventions for this area are not provided in this report. However, this area may require additional follow up.

Timmy's BASC-2 profile indicates significant problems with Hyperactivity, Conduct Problems, and Attention Problems. Based on Mr Sample's ratings, Timmy is experiencing problems with the following behaviors:

Hyperactivity

- ı not waiting for turn
- ı disrupting others
- ı interrupting others
- ı having poor self-control

Conduct Problems

- ı breaking rules
- ı stealing

Attention Problems

- ı staying focused
- ı paying attention
- ı listening well

Primary Improvement Area: Hyperactivity

Hyperactivity problems are considered to be one of Timmy 's most significant behavioral and emotional areas to address. Hyperactivity is characterized as overactivity or excessive task-irrelevant physical (i.e.,

motor) movement. Children and adolescents with hyperactivity often make noises at inappropriate times, leave their assigned seats without permission, and talk during times designated for silence in the classroom. Hyperactivity problems can occur alone or can co-occur with attention problems and are usually exhibited by children in both home and school settings.

There are a variety of interventions that have been shown to reduce, or have shown promise for reducing, hyperactive behavior, including:

- Functional Assessment
- Contingency Management
- Parent Training
- Self-Management of Hyperactivity
- Task Modification
- Multimodal Interventions

Detailed summaries of the Contingency Management and Self-Management intervention strategies are provided below. See the *BASC-2 Intervention Guide* for additional detail about these strategies, along with the other intervention strategies listed above.

Hyperactivity Intervention Option 1: Contingency Management

In contingency management for hyperactivity, behavioral interventions are used to modify consequent events (i.e., events that occur after the behavior) that are often maintained through the reinforcement of overactive and impulsive behavior. The goal of contingency management is to decrease activity levels that negatively impact learning by shaping the child's existing behavior and providing opportunities for the new, desired behavior to become internalized. The procedural steps for incorporating contingency management strategies into the treatment of hyperactivity are summarized below. See the *BASC-2 Intervention Guide* for a detailed discussion of this topic.

Procedural steps for the application of contingency management

1. Define the behavior in operational terms.
2. Determine the behavioral goals.
3. Determine the reinforcers.
4. Explain the system to the child.
5. Implement the chosen reinforcement strategy (e.g., token system).
6. Adjust the reinforcement as needed.

Considerations When Implementing a Contingency Management Intervention Strategy

For Teaching. Teachers are generally adept at procedures that involve classwide prompting or acknowledgement and may need only minimal coaching to be more effective with students with hyperactivity. Some issues that typically frustrate teachers include the modification of systems, the immediacy of reinforcer use, the consistency in application, and the setting of goals that will encourage and change student behavior. Teachers must modify the structure of token economy systems when the

student loses more points than he or she earns, or students will not maintain an interest or be able to access the reinforcer. Reinforcement must be immediate for students with hyperactivity; contingencies that are hours, days, or weeks away are unlikely to be effective. Behavioral interventions for students with hyperactivity require long-term consistency, and once a student engages in appropriate behaviors, fading may occur but monitoring should also occur so that the intervention can be reapplied when necessary. Goal setting or criteria setting for access to reinforcers is as critical as immediate access. If a student is engaging in hyperactive behaviors 90% of the time, a goal of 0% is unrealistic. Goals need to be seen as gradual, and intermediate steps toward reaching a long-term solution are important for reducing hyperactivity. Goals should also be specific when possible, targeting the relevant behaviors that fit under the class of hyperactivity. For example, fidgeting and running around a classroom may have a differential impact on the setting and need to be addressed separately, even if both actions are part of hyperactivity.

For Culture and Language Differences. Home-school communication and the use of contingency management techniques in both settings will improve the application of any intervention. At minimum, attempt to provide communication in the primary language of the parent, and, if necessary, use an adult translator or bilingual staff person to articulate the program of intervention and describe how contingencies could be managed at home.

For Age and Developmental Level. Contingency and reinforcement choices should include the child or adolescent's preferences and should be age and developmentally appropriate.

Research Studies Supporting Use of Contingency Management Intervention Strategies

The following studies support the use of contingency management intervention strategies for dealing with hyperactivity problems. Detailed annotations of these studies are included in the *BASC-2 Intervention Guide.*

Ayllon, T., Layman, D., & Kandel, H. J. (1975). A behavioral-educational alternative to drug control of hyperactive children. *Journal of Applied Behavior Analysis, 8,* 137-146.

Ayllon, T., & Roberts, M. D. (1974). Eliminating discipline problems by strengthening academic performance. *Journal of Applied Behavior Analysis, 7,* 71-76.

DuPaul, G. J., Guevremont, D. C., & Barkley, R. A. (1992). Behavioral treatment of attention-deficit hyperactivity disorder in the classroom: The use of the Attention Training System. *Behavior Modification, 16,* 204-225.

Fabiano, G. A., & Pelham, W. E., Jr. (2003). Improving the effectiveness of behavioral classroom interventions for attention-deficit/hyperactivity disorder: A case study. *Journal of Emotional and Behavioral Disorders, 11,* 124-130.

McGoey, K. E., & DuPaul, G. J. (2000). Token reinforcement and response cost procedures: Reducing the disruptive behavior of preschool children with attention-deficit/hyperactivity disorder. *School Psychology Quarterly, 15* (3), 330-343.

Reitman, D., Hupp, S. D. A., O'Callaghan, P. M., Gulley, V., & Northup, J. (2001). The influence of a token economy and methylphenidate on attentive and disruptive behavior during sports with ADHD-diagnosed children. *Behavior Modification, 25* (2), 305-323.

Hyperactivity Intervention Option 2: Self-Management

Self-management as an intervention for hyperactivity is a process in which children monitor their own activity level, record the results, and compare this level to a predetermined, acceptable level of activity. The goal of self-management is for the child to become aware of his or her own level of activity in order to produce an automatic response without relying on external reinforcement or prompting. A child's ability to produce this automatic response through internalized controls can decrease his or her situation-specific, inappropriate overactivity. The procedural steps for incorporating self-management strategies into the treatment of hyperactivity are summarized below. See the *BASC-2 Intervention Guide* for a detailed discussion of this topic.

Procedural steps for the application of self-management of hyperactivity

1. Teach self-monitoring procedures to the child.
   a. Identify the problem behavior and the new behavior to replace it.
   b. Model the replacement behavior, and indicate the level (i.e., the frequency and/or intensity) at which it should occur.
   c. Role-play the expected level and behavior with the child.
   d. Ask the child and the person modeling the behavior (e.g., teacher) to record either a plus (+), indicating appropriate activity level, or a minus (-), indicating overactivity.
   e. Compare both sets of ratings.
   f. Provide reinforcement for accurate child recordings.
   g. Continue this process until the child masters self-recording (i.e., typically with 90% accuracy).
2. Determine if the replacement behavior is happening in the desired setting.
3. As needed, prompt the child to monitor activity (e.g., a beep on a tape recorder).
4. Ask the child to self-record the occurrence of the replacement behavior.
5. Graph the occurrence of the replacement behavior in order to demonstrate success or failure of the targeted behavior and activity level.
6. Provide consistent feedback and appropriate reinforcement.

Considerations When Implementing a Self-Management Intervention Strategy

For Teaching. When teaching children to self-manage, it is important to thoughtfully consider the goal of the intervention. If the objective is to reduce fidgety behaviors, the intervention and outcome will be different than improving a class of behaviors, such as listening or assignment completion. For example, targeting fidgety behaviors may result in solely monitoring and recording the tapping of a foot or pencil, which may not produce the same results that monitoring on-task behavior or task completion might. However, reducing fidgety behaviors may be the primary goal in other situations. For example, if a student's behavior interrupts the other students' class work or creates a negative relationship with the

teacher, it may be best to focus on reducing those behaviors, even if the student's overall academic performance is not targeted and, therefore, does not improve.

Research Studies Supporting Use of Self-Management Intervention Strategies

The following studies support the use of self-management intervention strategies for dealing with hyperactivity problems. Detailed annotations of these studies are included in the *BASC-2 Intervention Guide.*

Christie, D. J., Hiss, M., & Lozanoff, B. (1984). Modification of inattentive classroom behavior: Hyperactive children's use of self-recording with teacher guidance. *Behavior Modification, 8* (3), 391-406.

Horn, W. F., Chatoor, I., & Conners, C. K. (1983). Additive effects of Dexedrine and self-control training. *Behavior Modification, 7,* (3), 383-402.

Kern, L., Ringdahl, J. E., Hilt, A., & Sterling-Turner, H. E. (2001). Linking self-management procedures to functional analysis results. *Behavioral Disorders, 26* (3), 214-226.

Varni, J. W., & Henker, B. (1979). A self-regulation approach to the treatment of three hyperactive boys. *Child Behavior Therapy, 1* (2), 171-192.

Secondary Improvement Area: Conduct Problems

Conduct problems are considered one of Timmy 's most significant behavioral and emotional problems. In general, conduct problems are characterized by a variety of behaviors, including aggressive conduct, nonaggressive conduct, deceitfulness and theft, and rule violations. Dealing with children and adolescents with conduct problems can be extremely challenging and frustrating for professionals and caregivers. There is enormous resistance to change, in part, due to the intrinsically rewarding nature of these behaviors for the individuals. Prevention for children at risk and treatment for those already identified as having conduct problems are critical in interrupting the progression of the disorder and thus preventing serious long-term consequences.

Several intervention strategies have been shown to effectively remediate conduct problems, including:

- Token Economy Systems
- Interdependent Group-Oriented Contingency Management
- Anger Management Skills Training
- Problem-Solving Training
- Social Skills Training
- Moral Motivation Training
- Parent Training
- Multimodal Interventions

ι Multisystemic Therapy

Detailed summaries of the Social Skills Training and Parent Training intervention strategies are provided below. See the *BASC-2 Intervention Guide* for additional detail about these strategies, along with the other intervention strategies listed above.

Conduct Problems Intervention Option 1: Social Skills Training

Social skills training is a cognitive-behavioral approach that involves teaching the prosocial skills and concepts needed for children and adolescents to function successfully in their environments. Social skills training is necessary for students with deficits in social competency, which are commonly found among those with conduct problems. The goal of social skills training is to prevent and remediate components of conduct problems for at-risk children and adolescents by teaching them prosocial skills that can be used as an alternative to maladaptive behaviors. Social skills are taught through a process that involves visually representing and modeling the skill, role-playing and practicing the skill, and then transferring and maintaining the skill in the natural social environment of the child.

The procedural steps for incorporating social skills training into the treatment of conduct problems are summarized below. See the *BASC-2 Intervention Guide* for a detailed discussion of this topic.

Procedural steps for the application of social skills training

1. Determine group membership based on common social skills deficits.
2. Establish group norms and post them in a highly visible area.
3. Set well-defined boundaries by establishing the consequences for engaging in antisocial behavior during group sessions, and post the consequences in a highly visible area.
4. Teach one social skill per session. At the beginning of each subsequent session, review the skill taught during the previous session.
5. Visually represent the steps involved in demonstrating the social skill.
6. Ask the children to write the steps on note cards or paper.
7. Have the children verbally recite the steps.
8. Model the steps to achieve the skill.
9. Brainstorm a recent event that required the use of the skill.
10. Ask two children to role-play the skill while the others coach them.
11. Have the children journal about experiences with the skill outside of the sessions, providing generalization of the skill.
12. Send a written copy of the skill steps to the children's teachers and parents, asking them to practice and reinforce the appropriate use of the skill.
13. Maintain skill acquisition by holding periodic refresher sessions.

Considerations When Implementing a Social Skills Training Intervention Strategy

For Teaching. Deficits can occur in a variety of commonly used social skills that are seen as standards in the classroom. Social skills that can be targeted for development during daily instruction include

preparing for a stressful conversation, expressing a complaint to others, dealing with group pressure, responding to the anger of others, avoiding fights with peers, dealing with an accusation from adults or peers, responding to the feelings of others, expressing affection, helping others, and dealing with failure. Many of these social skills lessons can be incorporated into regular curriculum through readings for literature or social studies, assigned topics for language arts or story writing, or even problems for mathematics where a narrative or paragraph is used.

For Culture and Language Differences. Social skills training, although effective in small groups, might be more effective in one-on-one settings with children from cultures where public discussion of individual challenges, emotions, and choice-making is perceived as inappropriate, or where social skills expectations differ based on gender or age group. Some children may not be expected to be assertive, discuss feelings, or respond to stress or anger. Even helpfulness may be interpreted as subservience, weakness, or a lack of such culturally esteemed qualities such as independence or strength.

Research Studies Supporting Use of Social Skills Training Intervention Strategies

The following studies support the use of social skills training intervention strategies for dealing with conduct problems. Detailed annotations of these studies are included in the *BASC-2 Intervention Guide.*

Bierman, K. L., Miller, C. L., & Stabb, S. D. (1987). Improving the social behavior and peer acceptance of rejected boys: Effects of social skill training with instructions and prohibitions. *Journal of Consulting and Clinical Psychology, 55* (2), 194-200.

Kamps, D. M., Tankersley, M., & Ellis, C. (2000). Social skills interventions for young at-risk students: A 2-year follow-up study. *Behavioral Disorders, 25* (4), 310-324.

Webster-Stratton, C., & Hammond, M. (1997). Treating children with early-onset conduct problems: A comparison of child and parent training interventions. *Journal of Consulting and Clinical Psychology, 65* (1), 93-109.

Webster-Stratton, C., Reid, J., & Hammond, M. (2001). Social skills and problem-solving training for children with early-onset conduct problems: Who benefits? *Journal of Child Psychology and Psychiatry, 42* (7), 943-952.

Conduct Problems Intervention Option 2: Parent Training

Parent training is a parent-focused, psychoeducational (or social learning) intervention that facilitates appropriate interactions between children and parents, leading to an increase in positive interactions and a decrease in coercive interactions. Parent training teaches specific parenting skills and effective child management techniques by focusing on the thought processes and behaviors of the parent. This type of instruction assists parents in avoiding the use of coercive disciplinary procedures to obtain behavioral compliance. The combination of parental coercive behavior and child coercive behavior results in a negative cycle of reinforcement that begins with a directive given by the parent that is often followed by a negative response by the child. The goal of parent training is to decrease antisocial behavior and prevent conduct problems in at-risk populations by increasing the use of effective parenting skills and positive disciplinary techniques.

There are a number of skill sets that can be taught through modeling in a parent training strategy, including: effective reinforcement strategies and reinforcers, observation skills, play skills, response-cost techniques, timeout procedures, punishment and extinction, relationship enhancement skills, self-regulation/monitoring skills, token economy and reward charts, contingency contracts, mood management, self-determination, relaxation techniques, stress reduction techniques, anger management techniques, and self-monitoring/reward.

The procedural steps for incorporating parent training into the treatment of an individual child with conduct problems are summarized below. See the *BASC-2 Intervention Guide* for a detailed discussion of this topic.

Procedural steps for the application of parent training

1. Find a mutually satisfactory time for meeting, and determine the appropriate number of trainings that might be needed. Consider creating a partnership contract to agree to the number of sessions and the number of techniques that will be taught.
2. Begin each session by reviewing the effective parenting technique discussed in the previous session, reviewing the homework assignment, and answering specific parental questions.
3. Teach a specific parenting technique, using descriptions and examples to demonstrate relevance to the individual.
4. Verbally describe the technique.
5. Discuss parental concerns about using the technique, and provide evidence of its effectiveness so that families know what to expect.
6. Give specific verbal examples.
7. Model the technique.
8. Ask the parents for an example of a time when the technique could have been effective, and role-play the technique using the given example. If conducting training in after-school or parent groups, be sure to do role-play examples with several parents so everyone who attends is involved and contributes.
9. For individual family sessions in the home rather than large parent groups at school, bring the child into the session and briefly explain the technique to him or her. Have the parents role-play the technique with the child. Provide feedback after the performance, highlighting positive statements regarding the parents' implementation.
10. Encourage independent implementation by requesting the use of the technique a specific number of times by the next session. Additionally, request that the parents document the effects, including any problems encountered, and note any questions they have.

<u>Considerations When Implementing a Parent Training Intervention Strategy</u>

For Teaching. Parent training is effective as a preventative measure and as an intervention, and in both uses, certain factors should be considered when implementing them. First, it may be best to limit training groups to no more than 16 participants or eight families. Parents will benefit most by spending approximately 45 hours in training. Also, it is critical to establish maintenance procedures after the intervention has ended because behavioral difficulties often resurface. There may be certain barriers to achieving success with behavioral parent training, including family stressors, a lack of parent

compliance with expectations of therapy, the necessity for treatment flexibility due to heterogeneous family characteristics, and therapist feelings of hopelessness and ineffectiveness.

For Age and Developmental Level. Parent training is most effective when the children are between 5 and 10 years old. Parent training is certainly appropriate for children at the pre-K level, but conduct problems are unlikely to appear at very early ages. Additionally, there would be less learned behavior to address and parent-child relationship history to consider for children who are younger.

For Culture and Language Differences. Some research suggests therapists can be insensitive to cultural differences in parenting attitudes and parental expectations of child behavior and the intervention process. Parents might bring preconceived notions about therapy that are not cognitive-behavioral in nature. Moreover, many parents have strong beliefs about child-rearing practices, and overcoming resistance for successful implementation may prove difficult. Because of these and other barriers, additional techniques to encourage parent participation are often necessary. Parents may also need specific assistance with implementing interventions in the home, and at times, parental issues may emerge that require alternate treatment methods or referrals to different agencies. While some of these issues are not specific to culture or language, they would certainly be influenced by differences.

Research Studies Supporting Use of Parent Training Intervention Strategies

The following studies support the use of parent training intervention strategies for dealing with conduct problems. Detailed annotations of these studies are included in the *BASC-2 Intervention Guide*.

Dadds, M. R., & McHugh, T. A. (1992). Social support and treatment outcome in behavioral family therapy for child conduct problems. *Journal of Consulting and Clinical Child Psychology, 60* (2), 252-259.

Dean, C., Myors, K., & Evans, E. (2003). Community-wide implementation of a parenting program: The South East Sydney Positive Parenting Project. *Australian e-Journal for the Advancement of Mental Health, 2* (3). Retrieved June 4, 2006, from http://www.auseinet.com/journal/vol2iss3/dean.pdf

Dishion, T. J., & Andrews, D. W. (1995). Preventing escalation in problem behaviors with high-risk young adolescents: Immediate and 1-year outcomes. *Journal of Consulting and Clinical Psychology, 63* (4), 538-548.

Kazdin, A. E., Siegel, T. C., & Bass, D. (1992). Cognitive problem-solving skills training and parent management training in the treatment of antisocial behavior in children. *Journal of Consulting and Clinical Psychology, 60* (5), 733-747.

Reid, M. J., Webster-Stratton, C., & Baydar, N. (2004). Halting the development of conduct problems in Head Start children: The effects of parent training. *Journal of Clinical Child and Adolescent Psychology, 33* (2), 279-291.

Webster-Stratton, C. (1998). Preventing conduct problems in Head Start children: Strengthening parenting competencies. *Journal of Consulting and Clinical Psychology, 66* (5), 715-730.

Webster-Stratton, C., & Hammond, M. (1997). Treating children with early-onset conduct problems: A comparison of child and parent training interventions. *Journal of Consulting and Clinical Psychology, 65* (1), 93-109.

Secondary Improvement Area: Attention Problems

Attention problems are considered to be one of Timmy 's most significant behavioral and emotional areas to address. Attention problems are defined as chronic and severe inconsistencies in the ability to maintain and regulate focus to tasks for more than short periods of time, and are characterized by distractibility, an inability to concentrate, an inability to maintain attention to tasks for long periods of time, disorganization, failure to complete tasks, and a lack of study skills. Children and adolescents with attention problems exhibit an inability to control and direct attention to the demands of a task and are frequently distracted by irrelevant stimuli even in a relatively quiet classroom environment or by internal distractions.

The interventions presented below are behaviorally based, and involve strategies that include learning new behaviors and learning how to monitor existing behavior periodically. These interventions include:

- Contingency Management
- Daily Behavior Report Cards
- Modified Task Presentation
- Self-Management of Attention
- Classwide Peer Tutoring
- Computer-Assisted Instruction
- Multimodal Interventions

Detailed summaries of the Daily Behavior Report Card and Modified Task Presentation intervention strategies are provided below. See the *BASC-2 Intervention Guide* for additional detail about these strategies, along with the other intervention strategies listed above.

Attention Problems Intervention Option 1: Daily Behavior Report Cards

Daily behavior report cards (DBRCs) are used to record a child's behavior each day. The goal in implementing a DBRC strategy is to change behavior by providing systematic feedback on performance and progress to students and parents, followed by appropriate reinforcement. The result is increased attention (or decreased inattention) during specific tasks and conditions. The procedural steps for incorporating DBRC strategies into the treatment of attention problems are summarized below. See the *BASC-2 Intervention Guide* for a detailed discussion of this topic.

Procedural steps for application of daily behavior report cards to improve attention

1. Identify the target behaviors for improving attention. Include other adults who will help, such as behavioral consultants, teachers, or parents. Decide who will participate in rating.

2. Ask the rater to assign a letter grade (A, B, C, or D) to the child's performance for each day. Each target behavior is rated each day. Use letter grades (instead of frequency of behavior, for example) are preferable because they are usually more meaningful to students and families. Explain the behavioral "anchors" (i.e., typical behavior for earning each grade) to avoid drift among raters or differences in personal tolerance levels. For example, attending during 10 out of 20 minutes of class time may earn a "C," 15 minutes may earn a "B," and 17 minutes of attention or more might earn an "A."
3. Give feedback to the student using a check-in/check-out daily system (where the child "checks in" to receive the day's goals and "checks out" to receive his or her grade), a home-note correspondence system, or a teacher conference with graphing/charting.
4. Reward the student, either at home or school, for meeting performance goals. This may or may not be needed depending on the child.

Considerations When Implementing a Daily Behavior Report Card Intervention Strategy

Consideration should be given to who does the rating and who hands out the praise and reinforcement for any child. Effectiveness of the contingency is indicative of whether or not the interaction with the adult is a positive or negative (i.e., punitive) one. DBRCs are not meant as a channel for communicating punishment or for reporting daily bad behavior; they are ideally used to provide objective and frequent feedback to the student and to communicate progress to the family.

For Culture and Language Differences. The DBRC is only as effective as the reinforcement or contingency attached to it, and the communication with families can be a component of that reinforcer or contingency. Therefore, effective communication with the family may necessitate use of the home language or extra consideration may need to be given to accurately explain the purpose and process of the DBRC.

For Age and Developmental Level. Age may also be a consideration with younger children responding quickly to teacher attention and feedback, while adolescents may need consideration for the potential embarrassment of getting daily grades on behavior that would indicate to peers that the child had a problem.

Research Studies Supporting Use of Daily Behavior Report Card Intervention Strategies

The following studies support the use of DBRC intervention strategies for dealing with attention problems. Detailed annotations of these studies are included in the *BASC-2 Intervention Guide*.

Drew, B. M., Evans, J. H., Bostow, D. E., Geiger, G., & Drash, P. W. (1982). Increasing assignment completion and accuracy using a daily report card procedure. *Psychology in the Schools, 19* (4), 540-547.

Fabiano, G. A., & Pelham, W. E., Jr. (2003). Improving the effectiveness of behavioral classroom interventions for attention-deficit/hyperactivity disorder: A case study. *Journal of Emotional and Behavioral Disorders, 11* (2), 124-130.

Karraker, R. J. (1972). Increasing academic performance through home-managed contingency programs. *Journal of School Psychology, 10* (2), 173-179.

Kelley, M. L., & McCain, A. P. (1995). Promoting academic performance in inattentive children: The relative efficacy of school-home notes with and without response cost. *Behavior Modification, 19* (3), 357-375.

McCain, A. P., & Kelley, M. L. (1993). Managing the classroom behavior of an ADHD preschooler: The efficacy of a school-home note intervention. *Child & Family Behavior Therapy, 15* (3), 33-44.

Attention Problems Intervention Option 2: Modified Task Presentation

Modified task presentation strategies refer to a collection of specific options that can be used to increase the interest level of an activity, which will increase the amount of time the child attends to learning the task or activity. Based on information obtained through a functional assessment, tasks are altered using antecedent instructional modifications. A number of modification strategies have been recommended by researchers, including:

- Offering a choice of instructional activities
- Providing guided notes and instruction in attending to relevant information
- Using high-interest activities and hands-on demonstrations
- Modifying in-class assignments and responses
- Modifying homework
- Highlighting relevant material or key information with colors, symbols, or font changes
- Providing increased opportunities to respond
- Varying the pace of instruction

A summary of each of these strategies is provided below. See the *BASC-2 Intervention Guide* for a more detailed discussion of each strategy.

Offering a Choice of Instructional Activities. Encouraging students to engage in active decision-making and exercise control over making choices can help increase their level of attention. Using this approach, students are allowed to choose activities, materials, or a task sequence within a set of instructional material outlined by the teacher. This approach is most successful when the choices offered for student selection are relevant to the curriculum or learning objectives, so consideration should be given to ensure that learning goals are not compromised.

Providing Guided Notes and Instruction in Attending to Relevant Information. In this strategy, the teacher provides "guided notes" to help the student follow along during lectures and class presentations. Guided notes contain some information about the lecture or presentation, but spaces are left for students to fill in the most relevant and important ideas.

Using High-Interest Activities and Hands-on Demonstrations. Activities and tasks that are novel and interesting to students can increase work productivity. Teachers can begin lessons with high-interest activities that require participation and facilitate attention.

Modifying In-Class Assignments and Responses. There are many ways assignments can be modified to accommodate students who struggle with attention problems, including: allowing students to use a computer or tape recorder when completing written assignments, dividing longer assignments into multiple shorter ones, reducing the number and types of items, allowing oral responses, and giving written directions of expectations for completing the assignment. However, keep in mind that modifications are not a permanent solution for many students. While modifications and supports are in place, interventions to increase attention on a long-term basis must also be implemented.

Modifying Homework. Homework requires good attention skills on many levels. Homework can be modified very successfully in a number of ways, including decreasing the amount of it given, giving extended time for its completion, teaching and using routine procedures (e.g., homework planners), providing assistance through one-on-one or group tutoring or via the telephone or internet, and allowing it to be completed at school instead of at home.

Highlighting Relevant Material or Key Information with Colors, Symbols, or Font Changes. Providing cues so that students can easily attend to the most relevant material in large or complex tasks or lessons helps students with attention problems to filter out unnecessary stimuli and prevents them from attending to the wrong information. Possible cues include using highlighters and using larger or different fonts or graphics. Increasing intratask stimulation by adding novelty through color can increase important task features. Teachers may also do this with the class as a group by leading students through exercises where main ideas are highlighted in one color, vocabulary words in another color, etc.

Providing Increased Opportunities to Respond. In this strategy, students are given increased opportunities to respond to academic material using varied response methods (e.g., written responses, the class answering in unison, individual student answer cards, etc.) This increased opportunity to respond increases engagement and attention and improves academic performance as a secondary benefit.

Varying the Pace of Instruction. Briskly paced instruction increases levels of on-task behavior because rapid pacing is thought to require more attending effort. Teachers can increase the pacing of their instruction either by increasing their rate of presenting material or by decreasing the length of instructional pauses.

Considerations When Implementing Modified Task Presentation Intervention Strategies

For Teaching. Instructional interventions require a certain degree of match between teacher disposition and skill. A teacher may be less willing to make changes because he or she is committed to a particular style or teaching method based on personal values and beliefs about education. A teacher may also view attention problems as lack of effort rather than a valid learning problem. He or she may feel threatened, or appear insensitive, when instructional changes are suggested for students who are already demanding, and who are a fraction of the children they must serve. A well-intentioned teacher, on the other hand, may simply not have enough time or computer (or other) resources to adapt his or her lesson plans. Always keep the complicated relationship between teachers and students in mind. Teachers and students often have reciprocal behaviors that may reinforce or punish the type of teaching used in the classroom. Rely on the experience of the classroom teacher and his or her appraisal of the situation, and anticipate the level of control and choice teachers will expect when recommending changes in instructional behaviors.

Because there are many different types of instructional modification interventions for attention, they have the largest likelihood of success when implemented after a functional assessment. Such an assessment can help to uncover the antecedents and consequences, describe the topography of the attention problems, and reveal the environmental and setting events for the attention problems. For example, using guided notes won't help a student who is out of his or her seat for the majority of the lecture. Likewise, a student who struggles to bring back completed homework will not find high-interest, novel or engaging classroom activities helpful in learning the specific attention skill needed to improve his or her grades.

Research Studies Supporting Use of Modified Task Presentation Intervention Strategies

The following studies support the use of modified task presentation intervention strategies for dealing with attention problems. Detailed annotations of these studies are included in the *BASC-2 Intervention Guide.*

Abikoff, H., Courtney, M. E., Szeibel, P. J., & Koplewicz, H. S. (1996). The effects of auditory stimulation on the arithmetic performance of children with ADHD and nondisabled children. *Journal of Learning Disabilities, 29* (3), 238-246.

Belfiore, P. J., Grskovic, J. A., Murphy, A. M., & Zentall, S. S. (1996). The effects of antecedent color on reading for students with learning disabilities and co-occurring attention-deficit/hyperactivity disorder. *Journal of Learning Disabilities, 29* (4), 432-438.

Clarke, S., Dunlap, G., Foster-Johnson, L., Childs, K. E., Wilson, D., White, R., et al. (1995). Improving the conduct of students with behavioral disorders by incorporating student interests into curricular activities. *Behavioral Disorders, 20* (4), 221-237.

Dunlap, G., dePerczel, M., Clarke, S., Wilson, D., Wright, S., White, R., et al. (1994). Choice making to promote adaptive behavior for students with emotional and behavioral challenges. *Journal of Applied Behavior Analysis, 27* (3), 505-518.

Ervin, R. A., DuPaul, G. J., Kern, L., & Friman, P. C. (1998). Classroom-based functional and adjunctive assessments: Proactive approaches to intervention selection for adolescents with attention deficit hyperactivity disorder. *Journal of Applied Behavior Analysis, 31* (1), 65-78.

Evans, S. W., Pelham, W., & Grudberg, M. V. (1995). The efficacy of notetaking to improve behavior and comprehension of adolescents with attention deficit hyperactivity disorder. *Exceptionality, 5* (1), 1-17.

Kern, L., Bambara, L., & Fogt, J. (2002). Class-wide curricular modification to improve the behavior of students with emotional or behavioral disorders. *Behavioral Disorders, 27* (4), 317-326.

Kern, L., Childs, K. E., Dunlap, G., Clarke, S., & Falk, G. D. (1994). Using assessment-based curricular intervention to improve the classroom behavior of a student with emotional and behavioral challenges. *Journal of Applied Behavior Analysis, 27* (1), 7-19.

Powell, S., & Nelson, B. (1997). Effects of choosing academic assignments on a student with attention deficit hyperactivity disorder. *Journal of Applied Behavior Analysis, 30* (1), 181-183.

Skinner, C. H., Johnson, C. W., Larkin, M. J., Lessley, D. J., & Glowacki, M. L. (1995). The influence of rate of presentation during taped-words interventions on reading performance. *Journal of Emotional & Behavioral Disorders, 3* (4), 214-223.

Sutherland, K. S., Alder, N., & Gunter, P. L. (2003). The effect of varying rates of opportunities to respond to academic requests on the classroom behavior of students with EBD. *Journal of Emotional and Behavioral Disorders, 11* (4), 239-248.

Zentall, S. S. (1985). Stimulus-control factors in search performance of hyperactive children. *Journal of Learning Disabilities, 18* (8), 480-485.

Zentall, S. S. (1989). Attentional cuing in spelling tasks for hyperactive and comparison regular classroom children. *The Journal of Special Education, 23* (1), 83-93.

Zentall, S. S., Falkenberg, S. D., & Smith, L. B. (1985). Effects of color stimulation and information on the copying performance of attention-problem adolescents. *Journal of Abnormal Child Psychology, 13* (4), 501-511.

Zentall, S. S., & Kruczek, T. (1988). The attraction of color for active attention-problem children. *Exceptional Children, 54* (4), 357-362.

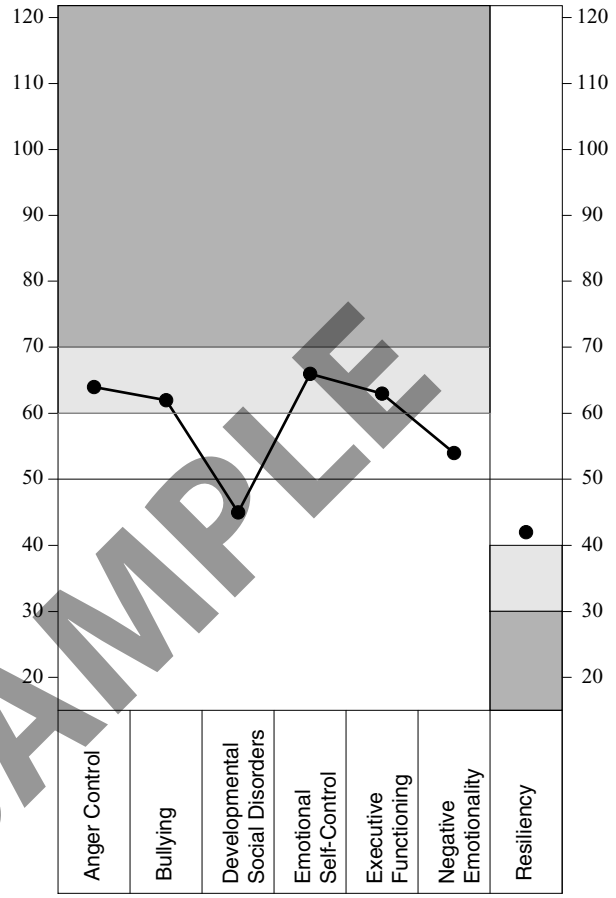
Concluding Recommendations

When using any intervention, it is important to monitor the effectiveness of the interventions you are trying. For intervention areas that include the Attention Problems, Hyperactivity, and Conduct Problems scales, you may choose to use the BASC-2 Progress Monitor Externalizing and ADHD Problems form.

Regardless of the method used to monitor progress, it is important to document the effectiveness of the interventions you have tried with Timmy. The *BASC-2 Intervention Guide Documentation Checklist* is designed to facilitate the recording of the steps that have been taken to remediate or manage a child's behavioral or emotional problems. It also includes a section to record the fidelity of the intervention approaches that have been used, a factor that is critical to the success of any intervention program.

CONTENT SCALES

The information provided below is based on content scales that have been theoretically and empirically developed. This information is considered to be secondary to the clinical, adaptive, and composite scale information provided previously. An elevated content scale score may warrant additional follow-up



T Score (Plotted)	Anger Control	Bullying	Developmental Social Disorders	Emotional Self-Control	Executive Functioning	Negative Emotionality	Resiliency
● Gen.-Comb. Sex	64	62	45	66	63	54	42

Percentile							
Gen.-Comb. Sex	91	88	36	92	89	70	22

Summary: General - Combined Sex Norm Group

	Raw Score	*T* Score	Percentile Rank	90% Confidence Interval
Anger Control	11	64	91	56-72
Bullying	9	62	88	56-68
Developmental Social Disorders	8	45	36	39-51
Emotional Self-Control	8	66	92	59-73
Executive Functioning	15	63	89	56-70
Negative Emotionality	6	54	70	46-62
Resiliency	19	42	22	35-49

Content Scales

Timmy's T score on Anger Control is 64 and has a percentile rank of 91. This T score falls in the At-Risk classification range, and follow-up may be necessary. Timmy's 2 reports that Timmy has a tendency to become irritable quickly and has difficulty maintaining his self-control when faced with adversity.

Timmy's T score on Bullying is 62 and has a percentile rank of 88. This T score falls in the At-Risk classification range, and follow-up may be necessary. Timmy's 2 reports that Timmy has a tendency to be disruptive, intrusive, and/or threatening toward other students.

Timmy's T score on Developmental Social Disorders is 45 and has a percentile rank of 36. Timmy's 2 reports that Timmy has social and communication skills that are typical of others his age.

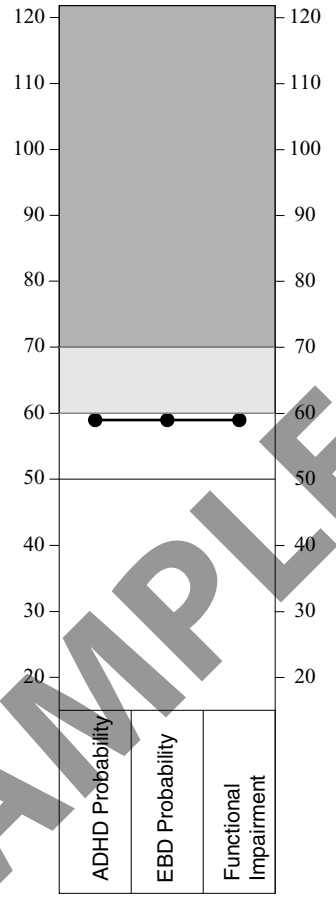
Timmy's T score on Emotional Self-Control is 66 and has a percentile rank of 92. This T score falls in the At-Risk classification range, and follow-up may be necessary. Timmy's 2 reports that Timmy can become easily upset, frustrated, and/or angered in response to environmental changes.

Timmy's T score on Executive Functioning is 63 and has a percentile rank of 89. This T score falls in the At-Risk classification range, and follow-up may be necessary. Timmy's 2 reports that Timmy sometimes has difficulty controlling and maintaining his behavior and mood.

Timmy's T score on Negative Emotionality is 54 and has a percentile rank of 70. Timmy's 2 reports that Timmy reacts to changes in everyday activities or routines in a manner that is typical of others his age.

Timmy's T score on Resiliency is 42 and has a percentile rank of 22. Timmy's 2 reports that Timmy is able to overcome stress and adversity about as well as do others his age.

CLINICAL INDEXES



T Score (Plotted)			
● Gen.-Comb. Sex	59	59	59

Percentile			
Gen.-Comb. Sex	83	81	81

Clinical Summary

The BASC-2 items endorsed by Timmy's parent/guardian resulted in a clinically significant Hyperactivity scale, a pattern that occurred in 4.7% of the standardization sample. Children with this profile may exhibit problems with behavioral regulation and be overactive, impulsive, and disruptive. Given this profile, possible diagnostic considerations might include attention-deficit/hyperactivity disorder (ADHD). These problems are likely to occur across multiple settings (e.g., school, home, etc.) and be worse in situations requiring sustained mental effort. In addition to a clinically significant Hyperactivity scale, Timmy exhibits an at-risk Conduct Problems scale. This suggests that oppositional defiant disorder (ODD) and conduct disorder (CD) are additional diagnostic possibilities.

A number of considerations could be useful in differentiating between behavioral disorders. ADHD is characterized by increased levels of inattention, behavioral activity, and impulsivity that often disturb others and result in rule violations; similarly, the core features of ODD include frequent defiance and rule violations. In both cases, these behaviors will be relatively mild in severity compared to CD, which is characterized by more serious forms of misbehavior such as physical violence, truancy, or theft, which deviate from societal standards and represent violations of others' rights. Children with ADHD may exhibit oppositionality secondary to problems with attention and hyperactivity (e.g., refusing homework because it is difficult to sit still and stay on track), but they are unlikely to exhibit the same level of purposeful defiance, vindictiveness, and deliberate annoyance of others seen in children with ODD. Understanding the functions and causes of these behaviors, perhaps through methods such as thorough history taking and detailed clinical interviewing, can be helpful in distinguishing whether they are more characteristic of ADHD or ODD. Neither ODD nor CD requires symptoms of inattention or hyperactivity to make a diagnosis; thus, it is possible to have an additional diagnosis of ADHD in the context of either ODD or CD when the criteria for both have been met. However, because all of the features of ODD are also characteristic of CD, a CD diagnosis takes precedence over ODD.

Timmy's profile is characterized by an at-risk Attention Problems scale score in addition to a clinically significant Hyperactivity scale score. In making diagnostic considerations regarding the possibility of ADHD, such a profile is probably more consistent with a diagnosis of ADHD - combined type, as opposed to primary hyperactive/impulsive or inattentive type.

Children who experience difficulties with hyperactivity, conduct problems, and attention problems present as a unique challenge to parents. They may require frequent redirection, more consistent parenting practices, and stronger reinforcements/consequences in order to manage their behavior. They may also defy parent requests, be angry and irritable compared to other children, and commit serious rule violations. The relationship can be characterized by communication and problem solving deficits, and the parent and child may experience fewer feelings of warmth and closeness. Parents may also struggle with discipline and feel frustrated, and thus family involvement is often a core component of interventions for behavioral problems. Thus, an evaluation of the parent-child relationship (e.g., BASC-2 Parenting Relationship Questionnaire) might be helpful in developing and implementing a comprehensive treatment plan. Specifically, identifying areas of weakness in the parent-child relationship (e.g., conflict, communication, etc.) might help the therapist prioritize treatment goals.

DSM-IV-TR™ Diagnostic Considerations

Listed below are DSM-IV-TR Diagnostic Considerations based on the ratings obtained from the parent on the PRS-C rating form. Each section presents a list of symptoms as described in the DSM-IV-TR, along with PRS-C items that correspond to these symptoms. While this information will likely be helpful for making a diagnosis, clinicians are strongly encouraged to use additional information that is gathered outside of the BASC-2 PRS-C form (e.g., observations of behavior, clinical interviews) when making a formal diagnosis. Adapted with permission from the Diagnostic and Statistical Manual of Mental Disorders, Text Revision, Fourth Edition (American Psychiatric Association, 2000).

Attention-Deficit/Hyperactivity Disorder 314.0x

Symptoms for ADHD: Inattention

		Relevant BASC-2 PRS-C Items and Mr Sample's Responses
X	Has difficulty sustaining attention	9. Item Content Omitted (True) 17. Item Content Omitted (True) 49. Item Content Omitted (True)
X	Seems not to be listening when spoken to	41. Item Content Omitted (True) 105. Item Content Omitted (True)
X	Is easily distracted	73. Item Content Omitted (True)
__	Has trouble organizing activities/tasks	
__	Is often forgetful	
__	Does not play close attention to details	
__	Makes careless mistakes	
__	Fails to finish tasks (not due to defiance or failure to understand)	
__	Dislikes/avoids tasks that involve sustained mental effort	
__	Loses needed materials	

Special Note:
The content of the test items is included in the actual reports. To protect the integrity of the test, the item content does not appear in this sample report.

Symptoms for ADHD: Hyperactivity/Impulsivity

		Relevant BASC-2 PRS-C Items and Mr Sample's Responses
__	Acts as if "driven by a motor "	20. Item Content Omitted (True) 84. Item Content Omitted (True)
__	Blurts out answers	116. Item Content Omitted (True)
X	Has trouble waiting his/her turn	6. Item Content Omitted (True)
X	Interrupts others' conversations or activities	38. Item Content Omitted (True) 102. Item Content Omitted (True) 134. Item Content Omitted (True)
__	Fidgets or squirms excessively	70. Item Content Omitted (True)
__	Leaves seat inappropriately	
__	Runs around or climbs excessively/inappropriately	
__	Has difficulty engaging in activities quietly	
__	Talks excessively	

Special Note:
The content of the test items is included in the actual reports. To protect the integrity of the test, the item content does not appear in this sample report.

Considerations for Diagnosis of ADHD (Mark answers as appropriate.)

1. Have six or more of the symptoms of inattention listed above persisted for at least six months to a degree that is maladaptive and inconsistent with the individual's developmental level? [YES]	Yes	No
2. Have six or more of the symptoms of hyperactivity/impulsivity listed above persisted for at least six months to a degree that is maladaptive and inconsistent with the individual's developmental level? [YES]	Yes	No
3. Were some symptoms that caused impairment present before 7 years of age? [YES]	Yes	No
4. Has impairment from the symptoms been observed in at least two settings? [YES]	Yes	No
5. Is social, academic, or occupational functioning significantly impaired? [YES]	Yes	No
6. Have Mood Disorder, Anxiety Disorder, Dissociative Disorders, and Personality Disorder been ruled out? [YES]	Yes	No

7. Do symptoms occur solely during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder? [NO]	Yes	No

Note. The qualifying answer pertaining to the diagnostic criteria for ADHD is indicated in square brackets[ ].

ADHD Diagnostic Summary (Mark answers as appropriate.)

Was a diagnosis of ADHD made? Yes No Date:_____

If yes, indicate code based on type:

— 314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type (if criteria for BOTH inattention and hyperactivity/impulsivity were met over the past six months)

— 314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type (if ONLY criteria for inattention were met over the past six months)

— 314.01 Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type (if ONLY criteria for hyperactivity/impulsivity were met over the past six months)

__ In Partial Remission (check if the individual's current symptoms no longer meet full criteria)

Conduct Disorder 312.8x

Symptoms for Conduct Disorder

		Relevant BASC-2 PRS-C Items and Mr Sample's Responses
__	Bullies, intimidates, or threatens others	24. Item Content Omitted (True) 58. Item Content Omitted (True)
__	Has inflicted physical harm on people	26. Item Content Omitted (True) 136. Item Content Omitted (True)
__	Lies to obtain things or favors or to avoid obligations	79. Item Content Omitted (True) 111. Item Content Omitted (True)
__	Has committed theft of money or items of nontrivial value without confronting a victim	29. Item Content Omitted (True)
__	Has inflicted physical harm on animals	97. Item Content Omitted (True)
__	Has deliberately set a fire to intentionally cause serious damage	143. Item Content Omitted (True)
__	Has run away from home overnight at least twice (or once for a lengthy period)	147. Item Content Omitted (True)
__	Starts physical fights	
__	Has used a weapon that can seriously injure others(e.g., knife, bat, broken bottle, gun)	
__	Has committed theft while confronting a victim (e.g., mugging, armed robbery)	
__	Has forced someone to participate in a sexual act against their will	
__	Has deliberately destroyed others' property (by means other than fire)	
__	Has broken into someone else's car, house, or other building	
__	Stays out past parent-imposed curfew (beginning before age 13)	
__	Often skips school (beginning before age 13)	

Special Note:
The content of the test items is included in the actual reports. To protect the integrity of the test, the item content does not appear in this sample report.

Considerations for Diagnosis of Conduct (Mark answers as appropriate.)

Has the individual exhibited three or more of the behaviors listed above in the past 12 months, with at least one behavior present in the past six months? [YES]	Yes	No
Do symptoms significantly impair academic, social, or occupational functioning? [YES]	Yes	No
Has Antisocial Personality Disorder been ruled out (age 18 and older)? [YES]	Yes	No

Note. The qualifying answer pertaining to the diagnostic criteria for Conduct Disorder is indicated in square brackets[ ].

Conduct Disorder Diagnostic Summary (Mark answers as appropriate.)

l Was a diagnosis of Conduct Disorder made? Yes No Date:_____

If yes, indicate code based on type:

— 312.81 Conduct Disorder, Childhood-Onset Type (at least one characteristic behavior prior to age 10)

— 312.82 Conduct Disorder, Adolescent-Onset Type (no characteristic behaviors observed prior to age 10)

__ 312.89 Conduct Disorder, Unspecified Onset (age of onset unknown)

__ Severity

— Mild (minimum criteria present to make the diagnosis AND behaviors cause only minimal harm to others)

— Moderate (number and harmfulness of problem behaviors in between "mild" and "severe" labels)

— Severe (many more problem behaviors present than needed to make the diagnosis OR behaviors cause significant harm to others)

TARGET BEHAVIORS FOR INTERVENTION

The behaviors listed below were identified by the rater as being particularly problematic. These behaviors may be appropriate targets for intervention or treatment. It can be useful to readminister the BASC-2 in the future to determine progress toward meeting the associated behavioral objectives.

General Behavior Issues

6. Cannot wait to take turn. (Almost always)
38. Disrupts other children's activities. (Often)
27. Item Content Omitted (True)
47. Item Content Omitted (True)
90. Item Content Omitted (True)
111. Item Content Omitted (True)

Special Note:
The content of the test items is included in the actual reports. To protect the integrity of the test, the item content does not appear in this sample report.

Adaptive/Social Behavior Issues

102. Interrupts others when they are speaking. (Often)
66. Speaks in short phrases that are hard to understand. (Sometimes)

CRITICAL ITEMS

This area presents items that may be of particular interest when responses include Sometimes, Often, or Almost always.

2. Eats too much. (Never)
7. Is easily annoyed by others. (Sometimes)
22. Item Content Omitted (True)
24. Item Content Omitted (True)
26. Item Content Omitted (True)
27. Item Content Omitted (True)
58. Item Content Omitted (True)
92. Item Content Omitted (True)
97. Item Content Omitted (True)
107. Item Content Omitted (True)
115. Item Content Omitted (True)
120. Item Content Omitted (True)
129. Item Content Omitted (True)
135. Item Content Omitted (True)
137. Item Content Omitted (True)
138. Item Content Omitted (True)
139. Item Content Omitted (True)
143. Item Content Omitted (True)
146. Item Content Omitted (True)
147. Item Content Omitted (True)
152. Item Content Omitted (True)
155. Item Content Omitted (True)

Special Note:
The content of the test items is included in the actual reports. To protect the integrity of the test, the item content does not appear in this sample report.

ITEMS BY SCALE - CLINICAL SCALES

Special Note:
The content of the test items is included in the actual reports. To protect the integrity of the test, the item content does not appear in this sample report.

Aggression

8. Teases others. (Never)
24. Bullies others. (Never)
26. Item Content Omitted (True)
40. Item Content Omitted (True)
56. Item Content Omitted (True)
58. Item Content Omitted (True)
72. Item Content Omitted (True)
88. Item Content Omitted (True)
90. Item Content Omitted (True)
104. Item Content Omitted (True)
136. Item Content Omitted (True)

Anxiety

5. Worries. (Sometimes)
12. Worries about what teachers think. (Never)
13. Item Content Omitted (True)
32. Item Content Omitted (True)
37. Item Content Omitted (True)
44. Item Content Omitted (True)
45. Item Content Omitted (True)
64. Item Content Omitted (True)
69. Item Content Omitted (True)
77. Item Content Omitted (True)
101. Item Content Omitted (True)
109. Item Content Omitted (True)
133. Item Content Omitted (True)
141. Item Content Omitted (True)

Special Note:
The content of the test items is included in the actual reports. To protect the integrity of the test, the item content does not appear in this sample report.

Attention Problems

9. Has a short attention span. (Sometimes)
17. Pays attention. (Never)
41. Item Content Omitted (True)
49. Item Content Omitted (True)
73. Item Content Omitted (True)
105. Item Content Omitted (True)

Atypicality

11. Does strange things. (Sometimes)
23. Babbles to self. (Sometimes)
43. Item Content Omitted (True)
55. Item Content Omitted (True)
75. Item Content Omitted (True)
87. Item Content Omitted (True)
96. Item Content Omitted (True)
107. Item Content Omitted (True)
119. Item Content Omitted (True)
128. Item Content Omitted (True)
139. Item Content Omitted (True)
151. Item Content Omitted (True)
160. Item Content Omitted (True)

Conduct Problems

15. Disobeys. (Almost always)
29. Steals. (Never)
47. Item Content Omitted (True)
61. Item Content Omitted (True)
79. Item Content Omitted (True)
93. Item Content Omitted (True)
111. Item Content Omitted (True)
125. Item Content Omitted (True)
157. Item Content Omitted (True)

Depression

10. Is easily upset. (Sometimes)
18. Complains about being teased. (Sometimes)
28. Item Content Omitted (True)
42. Item Content Omitted (True)
50. Item Content Omitted (True)
60. Item Content Omitted (True)
74. Item Content Omitted (True)
82. Item Content Omitted (True)
92. Item Content Omitted (True)
106. Item Content Omitted (True)

114. Item Content Omitted (True)
124. Item Content Omitted (True)
138. Item Content Omitted (True)
156. Item Content Omitted (True)

Special Note:
The content of the test items is included in the actual reports. To protect the integrity of the test, the item content does not appear in this sample report.

Hyperactivity

6. Cannot wait to take turn. (Almost always)
20. Is unable to slow down. (Sometimes)
38. Item Content Omitted (True)
52. Item Content Omitted (True)
70. Item Content Omitted (True)
84. Item Content Omitted (True)
102. Item Content Omitted (True)
116. Item Content Omitted (True)
134. Item Content Omitted (True)
148. Item Content Omitted (True)

Somatization

30. Expresses fear of getting sick. (Sometimes)
54. Complains of pain. (Sometimes)
59. Item Content Omitted (True)
62. Item Content Omitted (True)
86. Item Content Omitted (True)
91. Item Content Omitted (True)
94. Item Content Omitted (True)
118. Item Content Omitted (True)
123. Item Content Omitted (True)
126. Item Content Omitted (True)
150. Item Content Omitted (True)
158. Item Content Omitted (True)

Withdrawal

16. Makes friends easily. (Often)
21. Refuses to join group activities. (Never)
25. Item Content Omitted (True)
48. Item Content Omitted (True)
53. Item Content Omitted (True)
57. Item Content Omitted (True)
80. Item Content Omitted (True)
89. Item Content Omitted (True)
112. Item Content Omitted (True)
121. Item Content Omitted (True)
144. Item Content Omitted (True)
153. Item Content Omitted (True)

ITEMS BY SCALE - ADAPTIVE SCALES

Special Note:
The content of the test items is included in the actual reports. To protect the integrity of the test, the item content does not appear in this sample report.

Activities of Daily Living

3. Has trouble following regular routines. (Sometimes)
35. Acts in a safe manner. (Often)
39. Item Content Omitted (True)
67. Item Content Omitted (True)
71. Item Content Omitted (True)
99. Item Content Omitted (True)
103. Item Content Omitted (True)
131. Item Content Omitted (True)

Adaptability

1. Shares toys or possessions with other children. (Sometimes)
14. Recovers quickly after a setback. (Sometimes)
33. Item Content Omitted (True)
46. Item Content Omitted (True)
65. Item Content Omitted (True)
78. Item Content Omitted (True)
110. Item Content Omitted (True)
142. Item Content Omitted (True)

Functional Communication

34. Provides own telephone number when asked. (Almost always)
66. Speaks in short phrases that are hard to understand. (Sometimes)
76. Item Content Omitted (True)
81. Item Content Omitted (True)
98. Item Content Omitted (True)
108. Item Content Omitted (True)
113. Item Content Omitted (True)
122. Item Content Omitted (True)
130. Item Content Omitted (True)
140. Item Content Omitted (True)
145. Item Content Omitted (True)
154. Item Content Omitted (True)

Leadership

4. Gives good suggestions for solving problems. (Never)
19. Joins clubs or social groups. (Sometimes)
36. Item Content Omitted (True)
51. Item Content Omitted (True)
68. Item Content Omitted (True)
83. Item Content Omitted (True)
100. Item Content Omitted (True)

132. Item Content Omitted (True)

Social Skills

31. Congratulates others when good things happen to them. (Often)
63. Encourages others to do their best. (Often)
85. Item Content Omitted (True)
95. Item Content Omitted (True)
117. Item Content Omitted (True)
127. Item Content Omitted (True)
149. Item Content Omitted (True)
159. Item Content Omitted (True)

Special Note:
The content of the test items is included in the actual reports. To protect the integrity of the test, the item content does not appear in this sample report.

ITEMS BY SCALE - CONTENT SCALES

Anger Control

1. Shares toys or possessions with other children. (Sometimes)
6. Cannot wait to take turn. (Almost always)
9. Item Content Omitted (True)
26. Item Content Omitted (True)
56. Item Content Omitted (True)
58. Item Content Omitted (True)
65. Item Content Omitted (True)
92. Item Content Omitted (True)
142. Item Content Omitted (True)

Bullying

1. Shares toys or possessions with other children. (Sometimes)
6. Cannot wait to take turn. (Almost always)
8. Item Content Omitted (True)
24. Item Content Omitted (True)
26. Item Content Omitted (True)
38. Item Content Omitted (True)
47. Item Content Omitted (True)
52. Item Content Omitted (True)
58. Item Content Omitted (True)
136. Item Content Omitted (True)

Developmental Social Disorders

9. Has a short attention span. (Sometimes)
16. Makes friends easily. (Often)
39. Item Content Omitted (True)
46. Item Content Omitted (True)
53. Item Content Omitted (True)

63. Item Content Omitted (True)
75. Item Content Omitted (True)
87. Item Content Omitted (True)
95. Item Content Omitted (True)
121. Item Content Omitted (True)
149. Item Content Omitted (True)
151. Item Content Omitted (True)
154. Item Content Omitted (True)
160. Item Content Omitted (True)

Special Note:
The content of the test items is included in the actual reports. To protect the integrity of the test, the item content does not appear in this sample report.

Emotional Self-Control

10. Is easily upset. (Sometimes)
52. Acts out of control. (Sometimes)
90. Item Content Omitted (True)
148. Item Content Omitted (True)
151. Item Content Omitted (True)
156. Item Content Omitted (True)

Executive Functioning

6. Cannot wait to take turn. (Almost always)
10. Is easily upset. (Sometimes)
26. Item Content Omitted (True)
36. Item Content Omitted (True)
56. Item Content Omitted (True)
73. Item Content Omitted (True)
78. Item Content Omitted (True)
102. Item Content Omitted (True)
116. Item Content Omitted (True)
156. Item Content Omitted (True)

Negative Emotionality

10. Is easily upset. (Sometimes)
56. Argues when denied own way. (Often)
110. Item Content Omitted (True)
142. Item Content Omitted (True)
156. Item Content Omitted (True)

Resiliency

7. Is easily annoyed by others. (Sometimes)
10. Is easily upset. (Sometimes)
14. Item Content Omitted (True)
16. Item Content Omitted (True)
33. Item Content Omitted (True)
46. Item Content Omitted (True)
67. Item Content Omitted (True)

68. Item Content Omitted (True)
74. Item Content Omitted (True)
78. Item Content Omitted (True)
121. Item Content Omitted (True)

Special Note:
The content of the test items is included in the actual reports. To protect the integrity of the test, the item content does not appear in this sample report.

ITEMS BY SCALE - CLINICAL INDEXES

ADHD Probability

6. Cannot wait to take turn. (Almost always)
9. Has a short attention span. (Sometimes)
20. Item Content Omitted (True)
39. Item Content Omitted (True)
55. Item Content Omitted (True)
66. Item Content Omitted (True)
70. Item Content Omitted (True)
73. Item Content Omitted (True)
81. Item Content Omitted (True)
84. Item Content Omitted (True)
102. Item Content Omitted (True)
154. Item Content Omitted (True)

EBD Probability

1. Shares toys or possessions with other children. (Sometimes)
14. Recovers quickly after a setback. (Sometimes)
16. Item Content Omitted (True)
21. Item Content Omitted (True)
26. Item Content Omitted (True)
31. Item Content Omitted (True)
35. Item Content Omitted (True)
36. Item Content Omitted (True)
52. Item Content Omitted (True)
65. Item Content Omitted (True)
78. Item Content Omitted (True)
80. Item Content Omitted (True)
85. Item Content Omitted (True)
90. Item Content Omitted (True)
104. Item Content Omitted (True)
114. Item Content Omitted (True)
117. Item Content Omitted (True)
121. Item Content Omitted (True)
138. Item Content Omitted (True)
149. Item Content Omitted (True)
157. Item Content Omitted (True)

Functional Impairment

3. Has trouble following regular routines. (Sometimes)
5. Worries. (Sometimes)
6. Item Content Omitted (True)
9. Item Content Omitted (True)
10. Item Content Omitted (True)
16. Item Content Omitted (True)
17. Item Content Omitted (True)
21. Item Content Omitted (True)
25. Item Content Omitted (True)
28. Item Content Omitted (True)
31. Item Content Omitted (True)
33. Item Content Omitted (True)
34. Item Content Omitted (True)
35. Item Content Omitted (True)
39. Item Content Omitted (True)
43. Item Content Omitted (True)
48. Item Content Omitted (True)
57. Item Content Omitted (True)
66. Item Content Omitted (True)
67. Item Content Omitted (True)
71. Item Content Omitted (True)
75. Item Content Omitted (True)
76. Item Content Omitted (True)
77. Item Content Omitted (True)
79. Item Content Omitted (True)
80. Item Content Omitted (True)
81. Item Content Omitted (True)
85. Item Content Omitted (True)
89. Item Content Omitted (True)
90. Item Content Omitted (True)
91. Item Content Omitted (True)
94. Item Content Omitted (True)
98. Item Content Omitted (True)
99. Item Content Omitted (True)
100. Item Content Omitted (True)
103. Item Content Omitted (True)
108. Item Content Omitted (True)
112. Item Content Omitted (True)
113. Item Content Omitted (True)
116. Item Content Omitted (True)
121. Item Content Omitted (True)
122. Item Content Omitted (True)
124. Item Content Omitted (True)
128. Item Content Omitted (True)

Special Note:
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130. Item Content Omitted (True)
131. Item Content Omitted (True)
132. Item Content Omitted (True)
140. Item Content Omitted (True)
144. Item Content Omitted (True)
145. Item Content Omitted (True)
148. Item Content Omitted (True)
153. Item Content Omitted (True)
154. Item Content Omitted (True)
156. Item Content Omitted (True)
157. Item Content Omitted (True)

Special Note:
The content of the test items is included in the actual reports. To protect the integrity of the test, the item content does not appear in this sample report.

End of Report

ITEM RESPONSES

1: 2	2: 1	3: 2	4: 1	5: 2	6: 4	7: 2	8: 1	9: 2	10: 2
11: 2	12: 1	13: 2	14: 2	15: 4	16: 3	17: 1	18: 2	19: 2	20: 2
21: 1	22: 1	23: 2	24: 1	25: 2	26: 1	27: 2	28: 2	29: 1	30: 2
31: 3	32: 3	33: 2	34: 4	35: 3	36: 3	37: 3	38: 3	39: 4	40: 3
41: 2	42: 1	43: 2	44: 1	45: 2	46: 3	47: 2	48: 2	49: 2	50: 1
51: 4	52: 2	53: 1	54: 2	55: 2	56: 3	57: 2	58: 1	59: 1	60: 1
61: 2	62: 1	63: 3	64: 1	65: 3	66: 2	67: 3	68: 2	69: 3	70: 2
71: 2	72: 1	73: 3	74: 3	75: 1	76: 3	77: 2	78: 3	79: 1	80: 2
81: 1	82: 1	83: 4	84: 2	85: 2	86: 1	87: 1	88: 2	89: 2	90: 2
91: 2	92: 2	93: 2	94: 2	95: 3	96: 1	97: 1	98: 1	99: 4	100: 2
101: 1	102: 3	103: 1	104: 1	105: 2	106: 1	107: 1	108: 2	109: 2	110: 4
111: 2	112: 1	113: 3	114: 3	115: 2	116: 2	117: 2	118: 1	119: 2	120: 1
121: 1	122: 4	123: 2	124: 2	125: 3	126: 2	127: 2	128: 2	129: 1	130: 4
131: 2	132: 3	133: 1	134: 4	135: 1	136: 1	137: 2	138: 1	139: 1	140: 2
141: 4	142: 2	143: 1	144: 2	145: 2	146: 1	147: 1	148: 3	149: 3	150: 1
151: 2	152: 1	153: 3	154: 3	155: 1	156: 3	157: 3	158: 1	159: 2	160: 1