**BASC-2 Parent Rating Scales - Adolescent**  
**Behavior Assessment System for Children, Second Edition**  
**Clinical Report**  
*Cecil R. Reynolds, PhD, & Randy W. Kamphaus, PhD*

<table>
<thead>
<tr>
<th>Child Information</th>
<th>Test Information</th>
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<tbody>
<tr>
<td>ID: 0123456</td>
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<td>School: ABC Junior High</td>
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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.

TRADE SECRET INFORMATION

Not for release under HIPAA or other data disclosure laws that exempt trade secrets from disclosure.
VALIDITY INDEX SUMMARY

<table>
<thead>
<tr>
<th>F Index</th>
<th>Response Pattern</th>
<th>Consistency</th>
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<tbody>
<tr>
<td>Acceptable</td>
<td>Acceptable</td>
<td>Extreme Caution</td>
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</table>

Raw Score: 3

Raw Score: 103

Raw Score: 19

T-SCORE PROFILE

T Score (Plotted)

Gen.-Comb. Sex

Percentile

Gen.-Comb. Sex

75 93 86 89 58 99 93 93 96 77 93 21 16 8 23 7 10
## PRS SCORE SUMMARY: General - Combined Sex Norm Group

### Composite Score Summary

<table>
<thead>
<tr>
<th>Scale Type</th>
<th>Raw Score</th>
<th>T Score</th>
<th>Percentile Rank</th>
<th>90% Confidence Interval</th>
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<tr>
<td>Externalizing Problems</td>
<td>183</td>
<td>62</td>
<td>89</td>
<td>58-66</td>
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<td>Internalizing Problems</td>
<td>190</td>
<td>66</td>
<td>93</td>
<td>61-71</td>
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<td>Behavioral Symptoms Index</td>
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<td>65</td>
<td>93</td>
<td>61-69</td>
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<tr>
<td>Adaptive Skills</td>
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<td>33-41</td>
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### Composite Comparisons

<table>
<thead>
<tr>
<th>Comparison</th>
<th>Difference</th>
<th>Significance Level</th>
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<tr>
<td>Externalizing Problems vs. Internalizing Problems</td>
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**Mean T score of the BSI**

62

**Mean T score of the Adaptive Skills Composite**

39

### Scale Score Summary

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<thead>
<tr>
<th>Scale Type</th>
<th>Raw Score</th>
<th>T Score</th>
<th>Percentile Rank</th>
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<td>Difference</td>
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<td>6</td>
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<td>33</td>
<td>7</td>
<td>27-39</td>
<td>-6</td>
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</table>

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.
VALIDITY INDEX ITEM SUMMARY

Items contributing to Validity Indexes (except Response Pattern) with Caution or Extreme Caution ratings are presented below.

Consistency Index

5. Item Content Omitted (True)
65. Item Content Omitted (True)
10. Item Content Omitted (True)
34. Item Content Omitted (True)
18. Item Content Omitted (True)
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100. Item Content Omitted (True)
112. Item Content Omitted (True)
128. Item Content Omitted (True)
129. Item Content Omitted (True)
145. 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.
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 the child 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. It can be elevated for a variety of reasons, including a lack of effort or attention when completing the ratings, a rater changing his or her perspective regarding the child's behavior when completing the rating form, a rater having difficulty understanding the items due to a low reading ability or language comprehension problems, or different raters completing different parts of the form (e.g., the child's math teacher completing one part of the form, and a science teacher completing the other part of the form). All of these scenarios are highly likely to result in an elevated score, alerting the clinician to a high probability that the obtained ratings across BASC-2 scales might not be sufficiently reliable to interpret. Frequently, a brief interview with the person providing the ratings can provide valuable insights into the reasons for an elevated Consistency Index.

The parent's ratings of the child have produced a Consistency Index that falls within the Extreme Caution range. This may indicate that the parent experienced an unusual amount of difficulty when completing the rating form. Caution is warranted when interpreting the BASC-2 scale scores, and follow-up with the parent is recommended. A review of the item pairs contributing to the Consistency Index will be useful for understanding why the Consistency index is elevated, and can provide some helpful information that can be used when talking to the rater about his rating form responses.
SCALE SUMMARY

This report is based on the parent's rating of the child'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 62, with a 90 percent confidence-interval range of 58-66 and a percentile rank of 89. The child's T score on this composite scale falls in the At-Risk classification range.

The child's T score on Hyperactivity is 55 and has a percentile rank of 75. The child's parent/guardian reports that the child demonstrates a level of self-control that is similar to the levels displayed by other children his age.

The child's T score on Aggression is 68 and has a percentile rank of 93. This T score falls in the At-Risk classification range, and follow-up may be necessary. The child's parent/guardian reports that the child sometimes displays aggressive behaviors, such as being argumentative, defiant, and/or threatening to others. Because aggressive behaviors in children often are present with other externalizing behaviors and with diminished social relations, even moderately elevated Aggression scores such as this may warrant intervention.

The child's T score on Conduct Problems 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. The child's parent/guardian reports that the child sometimes engages in rule-breaking behavior, such as cheating, deception, and/or stealing.

Internalizing Problems
The Internalizing Problems composite scale T score is 66, with a 90 percent confidence-interval range of 61-71 and a percentile rank of 93. The child's T score on this composite scale falls in the At-Risk classification range.

The child's T score on Anxiety is 51 and has a percentile rank of 58. The child's parent/guardian reports that the child displays anxiety-based behaviors no more often than others his age.

The child's T score on Depression is 54 and has a percentile rank of 72. The child's parent/guardian reports that the child displays depressive behaviors no more often than others his age.

The child's T score on Somatization is 85 and has a percentile rank of 99. This T score falls in the Clinically Significant classification range, and usually warrants follow-up. The child's parent/guardian reports that the child displays an unusually high number of health-related concerns. When a serious health problem is not present, these concerns may be indications of an underlying emotional problem.
Behavioral Symptoms Index

The Behavioral Symptoms Index (BSI) composite scale T score is 65, with a 90 percent confidence-interval range of 61-69 and a percentile rank of 93. The child'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.

The child's T score on Atypicality 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. The child's parent/guardian reports that the child sometimes engages in behaviors that are considered strange or odd, and he at times seems disconnected from his surroundings.

The child's T score on Withdrawal is 70 and has a percentile rank of 96. This T score falls in the Clinically Significant classification range, and usually warrants follow-up. The child's parent/guardian reports that the child is generally alone, has difficulty making friends, and/or is unwilling to join group activities.

The child's T score on Attention Problems is 58 and has a percentile rank of 77. The child's parent/guardian reports that the child maintains an attention level similar to that of others his age.

Adaptive Skills

The Adaptive Skills composite scale T score is 37, with a 90 percent confidence-interval range of 33-41 and a percentile rank of 10. The child's T score on this composite scale falls in the At-Risk classification range.

The child's T score on Adaptability is 42 and has a percentile rank of 21. The child's parent/guardian reports that the child is able to adapt as well as most others his age to a variety of situations.

The child's T score on Social Skills is 39 and has a percentile rank of 16. This T score falls in the At-Risk classification range, and follow-up may be necessary. The child's parent/guardian reports that the child has difficulty complimenting others and making suggestions for improvement in a tactful and socially acceptable manner.

The child's T score on Leadership is 36 and has a percentile rank of 8. This T score falls in the At-Risk classification range, and follow-up may be necessary. The child's parent/guardian reports that the child sometimes has difficulty making decisions, lacks creativity, and/or has trouble getting others to work together effectively.

The child's T score on Activities of Daily Living is 43 and has a percentile rank of 23. The child's parent/guardian reports that the child is able to adequately perform simple daily tasks, in a safe and efficient manner.

The child's T score on Functional Communication is 33 and has a percentile rank of 7. This T score falls in the At-Risk classification range, and follow-up may be necessary. The child's parent/guardian reports that the child demonstrates poor expressive and receptive communication skills, and that the child has difficulty seeking out and finding information on his own.
BASC-2 PRS-A 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.

<table>
<thead>
<tr>
<th>Primary Improvement Areas</th>
<th>Secondary Improvement Areas</th>
<th>Adaptive Skill Strengths</th>
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</thead>
<tbody>
<tr>
<td>Somatization</td>
<td>Aggression</td>
<td>None</td>
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<tr>
<td>Withdrawal (Anxiety)</td>
<td>Functional Communication</td>
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</tr>
<tr>
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<td>Atypicality</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Leadership</td>
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<td></td>
<td>Social Skills</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Conduct Problems</td>
<td></td>
</tr>
</tbody>
</table>

Johnny's scores on Somatization, and Withdrawal (Anxiety) fall in the clinically significant range, and probably should be considered among the first behavioral issues to resolve.

Note that the child has scores on Functional Communication, Atypicality, Leadership, Social Skills, and Conduct Problems that are areas of concern. Interventions for these areas are not provided in this report. However, these areas may require additional follow up.

The child's BASC-2 profile indicates significant problems with Somatization, Withdrawal (Anxiety), and Aggression. Based on the parent's ratings, the child is experiencing problems with the following behaviors:

**Somatization**
- complaining of sickness
- getting sick
- complains of discomfort
- complaining of pain

**Withdrawal**
- making friends
- joining activities
- being with others

**Aggression**
- speaking kindly to others
- treating others kindly
Primary Improvement Area: Somatization

Somatization problems are considered to be one of the child's most significant behavioral and emotional areas to address. In the absence of physical problems that may explain the scale elevation, such a score may indicate a tendency to be overly sensitive to and complain about relatively minor physical problems or ailments and to over report the occurrence of various physical complaints. It is important to note that somatization problems may be the "symptom" of a different problem a child is experiencing (e.g., anxiety). A full assessment of a child's situation is needed to determine what medical or nonmedical causes might help explain the scale elevation. School personnel should consider that a sudden increase in physical complaints from multiple children could indicate there is a specific individual (e.g., a new student, a new staff member) contributing to these complaints. Additional support on a playground or in a lunch room where a larger student population is less supervised may also prove helpful.

There are two groups of intervention strategies that have been shown to effectively remediate somatization problems, including:

- Behavioral Interventions (reinforcement and punishment)
- Multimodal Cognitive-Behavioral Therapy

Detailed summaries of these intervention strategies are provided below. See the BASC-2 Intervention Guide for additional detail about these strategies.

Somatization Intervention Option 1: Behavioral Interventions

Behavioral reinforcement strategies applied to somatization involve the systematic presentation or removal of stimuli to increase coping ability and healthy behavior. Positive reinforcement includes the immediate, contingent presentation of a reward for healthy behaviors that have been identified jointly by the child and adult. Negative reinforcement is the removal of an aversive stimulus contingent on the child engaging in an appropriate healthy behavior or coping behavior that has been jointly identified. In the literature, punishment for somatic symptoms frequently is reported as a form of timeout (removal) from preferred activities. When used appropriately, this method of punishment leads the child to see removal from enjoyable activities as a natural, automatic consequence of any sick episode. If timeouts do not result in a decrease of somatic complaints, it is possible the child desires to escape from the given activity, in which case, the timeout is actually functioning as a reinforcer rather than as punishment.

The goal of using behavioral interventions to address somatoform disorders is to reduce somatic behaviors that are interfering with functional activities and to increase healthy behavior, allowing the child to return to pre-illness functioning (e.g., attending school, demonstrating responsible behavior). The procedural steps for incorporating contingent reinforcement and timeout from preferred activities into the treatment of somatization are summarized below. Successful use of these strategies requires close communication with several persons, including parents, teacher, and physicians. See the BASC-2 Intervention Guide for a detailed discussion of this topic.

Procedural steps for the application of behavioral interventions
1. Consult with the child's physician (and psychiatrist, if applicable) to ensure that no medical cause exists for the child's complaints. Continue communication throughout the intervention.

2. Work with the multidisciplinary team to establish agreement between all key stakeholders (e.g., physician, parents, teachers, school administrators, counselor, school psychologist) that the use of contingent reinforcers and timeout from preferred activities is the intervention of choice.

3. Complete a functional behavioral assessment to clearly define and document the specific somatization behavior(s) to be changed. In addition, identify any activities or personal interactions (e.g., being able to watch movies while home sick, getting one-on-one attention from a parent) that are reinforcing the somatic behavior.

4. Work with the child and parent(s) to identify appropriate reinforcers and punishers for use in the intervention.

5. In collaboration with other members of the multidisciplinary team (e.g., physician, psychologist, counselor, teacher, parent), design an intervention plan to address the underlying cause of the somatic behavior, and communicate the plan to all stakeholders. The intervention should include these components:
   a. Psychoeducation
   b. Contingent reinforcement for engagement in alternative (i.e., healthy) behavior and reductions in illness-related behavior
   c. Contingent punishment (e.g., timeout from preferred activities) for engaging in illness-related behavior
   d. Parent training

6. Working with the multidisciplinary team, implement the intervention components. Keep in mind the following:
   a. In psychoeducational sessions, clearly explain somatization to the child and family, clarify the goals of behavioral treatment, and discuss the intervention methods to be implemented.
   b. Implement family training (or refer the family to an outside agency for training) on how to ignore somatic symptoms and reinforce healthy behaviors.
   c. Along with other team members, encourage the child to return to pre-illness functioning (e.g., attending school, completing homework and chores).
   d. Assist teacher(s) and parent(s) in implementing the program of contingent reinforcement and punishment with the child.
   e. Maintain communication with the family throughout treatment, including monitoring or surveying home practices to ensure compliance with the behavioral intervention.

7. Coordinate a plan for fading (gradual withdrawal) positive reinforcement and timeout from preferred activities as the child attains specified goals for reducing somatic behavior and increasing healthy behavior.

Considerations When Implementing a Behavioral Intervention Strategy

In order for behavioral intervention strategies for somatization to be successful, it is crucial for practitioners to recognize that effective reinforcers and punishments differ from person to person.
Likewise, attention may function as a reinforcer for some children but not for others. It is important to examine the function of the somatization; otherwise, inadvertent reinforcement of the maladaptive behavior may occur. Discussing the likes and dislikes of the child and conducting a reinforcement survey may be useful in identifying appropriate reinforcers.

For Communicating With Parents. The terms "reinforcement" and "punishment" are very loaded in the lay population. Some parents and practitioners may have a misconception that reinforcement is a form of bribery or mind control, or that it discounts feelings. Likewise, the word "punishment" can elicit frightening images of corporal punishment (such as spanking) or other harsh disciplinary measures. Therefore, accurate definitions of reinforcement and punishment, as they relate to the goals of the intervention, should be presented: Reinforcement is something that results in an increase in the target behavior, while punishment results in a decrease in the behavior. Parents should also understand that reinforcement may be accomplished either through providing something pleasant (positive reinforcement) or through removing something unpleasant (negative reinforcement). Clarifying these terms helps with team communication when implementing interventions or measuring the fidelity of an intervention.

Ongoing communication between school, family, and medical staff is critical to detect and effectively treat children's somatization. Nothing could be more damaging to the trust relationship between the child and the adults involved than if the child's accounts of somatization were ignored, minimized, or discounted as existing merely in the child's head. In addition, practitioners should keep in mind that young children may use physical descriptions (such as "a tummy ache") to talk about completely unrelated feelings or issues (such as fear) or to respond to a traumatic event. A young child may not be able to articulate an episode of sexual abuse but may describe "not feeling well" or "feeling funny." Open communication is important to maintain trust and to accommodate the development of appropriate interventions as symptoms occur.

For Culture, Gender, Age, and Developmental Level. Consider the age and developmental level of the child and the culture of the child's family. To what degree is the observed behavior to be expected or deemed within normal limits, based on the child's age, development, gender, and culture? Are there other disabling conditions, such as cognitive impairment, that could interfere with the child's ability to articulate physical complaints accurately enough to ensure a correct medical diagnosis? Normal physical changes may account for some behavior and should not be completely discounted. Replacement or coping strategies, rather than elimination of the behavior, may be called for in such cases.

Research Studies Supporting Use of Behavioral Intervention Strategies

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


Somatization Intervention Option 2: Multimodal Cognitive-Behavioral Therapy

Multimodal cognitive-behavioral therapy as an intervention for somatization is an approach that incorporates self-evaluation and one or more other methods of intervention based on the individual needs of the child. The approach emphasizes coping, which encourages children to continue functional activities with minimal complaints of illness. Cognitive-behavioral components are selected based on individual assessment data as well as the age and development of the child. The goal of this strategy is to decrease exaggeration of physical symptomatology and increase functional behavior. The procedural steps for incorporating multimodal cognitive-behavioral therapy into the treatment of somatization are summarized below. See the *BASC-2 Intervention Guide* for a detailed discussion of this topic.

**Procedural steps for the application of multimodal cognitive-behavioral therapy**

**Phase 1: Assessment/Information Gathering**

1. In collaboration with the multidisciplinary team, coordinate and consult with the child's primary care physician and/or psychiatrist, as well as with the child's parents or caregivers, to ensure that the child's symptoms have been thoroughly investigated for a possible medical diagnosis.

2. Conduct a functional behavioral assessment to clearly define and document the specific somatic behavior(s) to be changed. In addition, identify any factors that are currently reinforcing the somatic behavior.

3. Interview the child and parents, gathering a broad base of information about the child's background. During the interviews, explore the following issues:
   - child and family attitudes about the child's illness
   - possible anxieties and stressors in the child's life or prior experiences
   - any treatments that have been tried in the past and how effective they were
   - family complaints about the child's behavior
the extent to which the child has stopped normal activities
possible underlying emotional causes for the child's behavior
child and family fears

Phase 2: Problem Conceptualization
1. Assist the child in reconceptualizing the problem as less threatening, shifting attention from illness to treatment.
2. Reframe the problem for the parents and the child, from finding a cure to coping.
3. Assist the parents in evaluating and articulating the impact of the illness on the child and family, and in determining the steps necessary for the child to return to normal functioning.
4. Stress that the child's role in treatment is that of an active agent coping with a difficult but manageable problem, and that improvement is a personal success.
5. Stress that since doctors can't relieve symptomatology and the likely duration of the symptoms cannot be determined, the child must return to normal functioning.
6. Provide examples of others with severe illnesses who continue normal activities.
7. While emphasizing the need for improvement and normalization, assure the child and parents that the child's physical complaints are not being ignored.

Phase 3: Relationship/Rapport Building
1. Acknowledge the child's suffering, address any parental concerns, and provide reassurance to the family regarding the treatment plan.
2. Ensure that the parents, child, and physician all agree to the coping and behavioral techniques that will be implemented.
3. Provide information to the parents and the child in an honest and direct manner in order to build a trusting relationship.
4. Reassure the parents and the child that symptoms can be reduced.

Phase 4: Psychoeducation
1. Help the parents understand the somatization diagnosis, stressing the fact that the child's physical symptoms are not based on any known illness. Reassure the parents and child that coordination with the primary physician will be ongoing.
2. Educate the child and parents about the connection between distress and symptoms.
3. Help the child and parents to determine sources of stress and anxiety and to identify alternative coping strategies.
4. Educate the family members about how their habitual reactions to the child's sick role may, in fact, be reinforcing the maladaptive behavior. Help them develop a plan to remove such reinforcements.
5. Emphasize the importance of education and school attendance, and stress that the child is required to follow school district attendance policies.
6. Educate the child about the benefits and importance of participating in routine activities.

Phase 5: Implementation of Therapeutic Strategies
1. In collaboration with the multidisciplinary team, choose the therapeutic strategies to be implemented. Strategies may include:
Coping skills training, including self-instruction and self-monitoring training
Teaching the child to identify certain situations as antecedents (i.e., triggers for somatic complaints)
Training in problem-solving techniques
Removing reinforcement for illness-related behavior
Differential reinforcement of competing (healthy) behavior
Relaxation training
Parent training to teach contingency management, how to prompt and reinforce coping behaviors, how to use negative reinforcement to encourage healthy behavior, and the importance of withdrawing attention to sickness-related behavior

2. Work with the child and parents to establish a set daily or weekly time for the child to explain his or her pain to the parents.
3. Encourage the child to return to his or her usual activities and responsibilities.
4. Help the child develop and implement a plan for reducing or effectively coping with stressors.
5. In collaboration with the multidisciplinary team and the child's parents, implement strategies to support the child's return to previous activities and to encourage the child to increase social activities and exercise.
6. Enlist all members of the multidisciplinary team in actively discouraging the child's illness-related behaviors and providing positive reinforcement for healthy behaviors.
7. Decrease possible gains from illness-related behavior by insisting on school attendance.
8. Ensure that the parents remove attention and pleasant activities at home during sickness-related episodes.

Phase 6: Generalization
1. When effects of treatment appear to be evident independent of intervention, begin programming for generalization.
2. Integrate scenarios where the newly learned behaviors are transferred to other problem behaviors or other problem settings.
3. Provide support for successful generalization but fade as quickly as possible. Any relapse is supported with a reinstitution of the intervention.

Considerations When Implementing a Multimodal Cognitive-Behavioral Therapy Intervention Strategy

For Teaching. School personnel should remain in contact with the child's primary care physician and proceed with school-based interventions only with the approval of both the physician and the child's parent(s). Intervention by a pediatrician made early and explained clearly and with certainty to the child and parent(s) makes parental acceptance of the diagnosis, as well as the child's recovery, easier and faster.

For Differences in Culture, Gender, and Home Environment. The child's culture and home environment should be evaluated both to determine how they may have contributed to the maladaptive behavior and
to identify ways in which they may affect the child's response to the intervention. When prosocial repertoires are limited, avoidant behavior may be a function of limited skills or a culturally appropriate response to conflict. Gender and cultural differences may also account for familial belief systems about how illness (mental or physical) is viewed and handled. For example, some individuals and families may view occasionally calling in sick as an adaptive behavior (e.g., by considering the sick day a "mental health day" and dedicating the time off to activities that reduce stress and enhance coping), whereas in other families, the same behavior may be maladaptive (e.g., avoiding specific problems at work or at school). Practitioners should recognize that parental acceptance of the concept of somatization and parents' beliefs about which types of treatments are acceptable will vary. A preference for self-reliance versus community responsibility will vary by family, by culture, and by gender of the dominant parent. Consideration should also be given to cultural expectations about physical appearance and self-presentation, which may lead to behaviors that appear somatic.

For Age and Developmental Level. Attention should be given to developmental characteristics of youth, particularly since diagnosis of youth and adults with somatoform disorders is not differentiated. Age and development are key factors in creating and implementing any kind of self-evaluation or self-monitoring component of an intervention. For instance, considerations should be made for language development and cognitive development. If the verbal or cognitive abilities of the individual are not well suited to the task of comprehending and using self-awareness and self-regulatory strategies, these components will be less successful. Under conditions where age or developmental readiness are factors, more direct environmental approaches such as reinforcement and timeout from preferred activities would have a greater likelihood of success.

Research Studies Supporting Use of Multimodal Cognitive-Behavioral Therapy Strategies

The following studies support the use of multi-modal cognitive-behavioral therapy intervention strategies for dealing with somatization problems. Detailed annotations of these studies are included in the BASC-2 Intervention Guide.


**Primary Improvement Area: Withdrawal (Anxiety)**

Anxiety is considered one of the child's most significant behavioral and emotional problems. Anxiety disorders are characterized by excessive worry, nervousness, specific or general fears or phobias, and self-deprecation. Children who have anxiety disorders may feel overwhelmed easily, feel a sense of dread, and suffer from obsessive, intrusive, and bothersome thoughts. Anxiety disorders are often accompanied by somatic complaints, and anxiety may itself be a symptom of depression.

Interventions for childhood anxiety-in particular, fears and phobias-are among the oldest evidence-based psychological treatments. A variety of interventions have been shown to reduce, or show promise for reducing feelings of anxiety. Specific phobias (e.g., fear of dogs, school, water) are typically treated with behavioral interventions, while cognitive-behavioral interventions are often used for general anxiety disorders. Several intervention strategies have been shown to effectively remediate anxiety, including:

- Exposure-Based Techniques
- Contingency Management
- Modeling
- Family Therapy
- Integrated Cognitive-Behavioral Therapy

Detailed summaries of the Contingency Management and Modeling 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.

**Anxiety Intervention Option 1: Contingency Management**

As an intervention for anxiety, contingency management relies on the use of natural consequences and reinforcers for reducing anxieties associated with specific behaviors or events. Contingency management for anxiety includes shaping, positive reinforcement, and extinction. Its goal is to alter anxious or fear-based behavior, using rewards and consequences that match the needs and preferences of each child.

To be effective, reinforcers must be perceived as desirable by the child, and consequences must be focused on changing maladaptive behavior (e.g., truancy, avoidance, lying to escape) rather than punishing the anxiety. Over time, reinforcers (e.g., tangible rewards) are gradually replaced by social reinforcers (e.g., attention, praise) and ultimately by internal management and reinforcement (e.g., feeling good about the situation and accomplishments). The fading out of reinforcers is important because it increases the likelihood that the desired behaviors will continue beyond the period of direct intervention and that the child will learn how to handle future anxiety.
The procedural steps for incorporating contingency management strategies into the treatment of anxiety problems 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. Identify the specific anxiety-related behaviors that need to be addressed.
2. Ask the child to choose from an existing list of preferred reinforcers.
3. Determine a reinforcement schedule, and review it with the child. During the initial stages, use shaping techniques (i.e., reinforce successive approximations to engage in the desired behavior).
4. Determine appropriate consequences for maladaptive behaviors, and review them with the child (i.e., what will happen if the child responds to anxiety by throwing a tantrum, destroying property, or refusing to do something).
5. Replace tangible reinforcers with social reinforcers. This transition should be planned and should happen gradually, at a pace designed to meet the needs of the child while maintaining the effect of the reinforcement for appropriate behavior.

Considerations When Implementing a Contingency Management Intervention Strategy

For Age and Developmental Level. When asking children to generate a list of desired reinforcers, it is important to remind them to list things that are both realistic and age-appropriate. In order to avoid problems, consider asking a parent to provide some examples of attainable reinforcers and then give the child the option to choose from such a list. When generating a list of reinforcers, consult with teachers or other adults because they can sometimes provide clues about preferences and high-interest activities. Young children may be more comfortable with small numbers of choices such as a fruit snack, rocking in a chair, or choosing a song for circle time. Older children may prefer access to music on an MP3 player, social time with peers, or one-on-one time with a parent. Consider also the effects of satiation; if the child has unlimited and extensive access to the reinforcer, the item will have less reinforcement strength.

For Culture and Language Differences. Be aware that what looks like anxiety may be post-traumatic stress for an individual who may have immigrated under stressful conditions. Consider that a new culture, a new language, and the accompanying expectations may create performance anxiety that is difficult to escape at school, where both academic and social expectations are tied to a specific culture. Use careful consideration of all factors that may contribute to anxious behavior.

For Health and Safety. Some case studies indicate that anxiety or phobic reactions to certain events may be rooted in violence, abuse, or neglect. Consider carefully the antecedents to anxiety. For example, fear of showering may be an indication that the child views undressing and showering as risky activities or associates them with something anxiety producing.

Research Studies Supporting Use of Contingency Management Intervention Strategies

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


Anxiety Intervention Option 2: Modeling

Showing children examples of successful outcomes in anxiety-provoking situations can effectively reduce anxiety-related beliefs and behaviors. The goals of modeling are to reduce the child's anxiety by demonstrating the event and consequences in a nonanxiety-provoking manner and to help the child acquire a new skill to handle the anxiety. The essential concept of modeling is to present an anxiety-provoking scenario in a way that demonstrates a desirable and successful outcome.

The procedural steps for incorporating modeling strategies in the treatment of anxiety problems are summarized below. See the *BASC-2 Intervention Guide* for a detailed discussion of this topic.

**Procedural steps for the application of live, filmed, or participant modeling**

1. Identify, describe, and discuss the anxiety problem and the concept of watching a video or modeling. Reassure the child that nothing bad will happen during the demonstration.
2. Show the child an anxiety-provoking situation or event using video or live models.
3. Discuss with the child the events in the demonstration, identifying the antecedents to the event, the event itself, and the consequences of the event.
4. Identify the responses and behaviors used by the models that the child would feel comfortable using. Ask the child to describe how he or she would engage in such responses and behaviors.
5. Practice the desired responses and behaviors with the child.

**Considerations When Implementing a Modeling Intervention Strategy**

The primary concept in modeling-critical to the effectiveness of the intervention-is a successful experience with the anxiety-provoking event. At any time, if the modeling or video becomes stressful for the participant, the session should stop. The idea should be to build resistance by gradual exposure. Videos or models should be sensitive to culture, language, and age appropriateness. Subjects who are similar to the child are more likely to resonate with the child (e.g., an adult male is unlikely to be a good
model for a 6-year-old girl).

Research Studies Supporting Use of Modeling Intervention Strategies

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


Secondary Improvement Area: Aggression

Aggression is considered one of the child's most significant behavioral and emotional problems. It is characterized by hostile or destructive behaviors that can be both physical and verbal. Children and adolescents who exhibit aggressive behaviors may have inadequacies with problem solving and deficiencies in the specific areas of identifying alternatives, considering consequences, and determining causality, and may also engage in means-ends thinking and have difficulty with seeing other perspectives.

There are a number of intervention strategies that have been shown to effectively remediate aggression problems, including:

- Problem-Solving Training
- Cognitive Restructuring
- Verbal Mediation
- Social Skills Training
- Peer-Mediated Conflict Resolution and Negotiation
Replacement Behavior Training

Detailed summaries of the Problem-Solving and Replacement Behavior 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.

Aggression Intervention Option 1: Problem Solving Training

Problem solving training for aggression requires the application of a set of skills to address situations that have multiple choices for resolution. A goal of this strategy is to develop skills that can be internalized and transferred to a variety of problems and settings.

Teaching problem-solving skills to children with aggression problems may be best achieved using examples from the school setting that can be real or contrived, provided they are relevant to situations the child has experienced. Skits or role-plays involving a teacher with one or more students can be used for demonstration, although written examples or video may also be appropriate. Such examples should provide background regarding the situation, model the behaviors that are to be learned, and lead students through a problem scenario that is solved. Upon completion of the examples, children can be asked to answer questions about the scenarios or to review the main points of the example. Children can provide answers in a variety of ways, including on a chalk or white board, a worksheet, large index cards, or a flip chart. When children provide answers, it is important that they are recognized for their contributions each step of the way. Initially, all efforts are encouraged, and later, correct answers are deemed most important. This support for participation will allow the adult to assess where children are in their problem solving skills.

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

Procedural steps for the application of problem-solving training

1. Provide a list of steps for problem-solving.
2. Demonstrate or present a problem scenario. Have the child role-play a real or contrived example and then respond to the subsequent steps. Alternatively, a teacher may role-play an example and have the child respond.
3. Identify the problem in the scenario. Prompt as necessary to encourage the child to include all emotional, social, and environmental features of the situation.
4. Ask questions to determine the goals of the problem behavior. Common questions may include:
   a. What is the person featured in the example hoping to get out of the social exchange?
   b. What is(are) the other person(s) hoping to get out of the social exchange?
5. List a number of alternative solutions.
   a. Think of at least three different ways to handle the given situation.
   b. Include all ideas that the child thinks of, regardless of how realistic.
c. Be sure to include at least one solution that represents a "desired" response (i.e., one that most people would consider appropriate) to demonstrate how the person featured can get what he or she needs without using aggression.

6. Evaluate the list by asking questions such as:
   a. Which potential solutions will get the person in the example what he or she needs?
   b. Which solutions will probably work? Which solutions probably will not work?
   c. What are the costs and benefits of each solution?

7. Choose the best solution.

8. Design a plan to achieve the solution.
   a. Does the child think the solution will get what the person in the example needs? Discuss why or why not.
   b. Does the child believe the person featured can perform the new behavior? Discuss why or why not.

9. Practice the plan. The teacher (or a peer) may need to model or role-play the plan before the child can practice it.

10. Implement the plan. The teacher may test the child on the plan by engaging in the problem behavior to assess the child's ability to respond in accordance with the plan.

11. Create a reinforcement and evaluation plan. The child should report back on using the plan, and reinforcement and feedback should be provided when the child reports engaging in the newly learned behaviors. Reinforcement and corrective feedback should occur at a 1-to-1 ratio for any new behavior. A 1-to-1 ratio occurs when praise, support, or reinforcement occurs relative to each occurrence of a new behavior. In this case, the child's reported use of part or all of the steps for problem-solving in dealing with a specific conflict.

Considerations When Implementing a Problem-Solving Training Intervention Strategy

For Teaching. When teaching problem-solving skills, instructors should be sure to allow time for modeling and guided practice. These steps are frequently skipped when teaching time gets compressed, but modeling and guided practice are critical for teaching problem-solving skills, for they are not learned from worksheets or in discussions. They must be practiced. Students learn problem-solving most effectively by doing—primarily through role-play and practice situations. Teacher behavior may affect student outcomes. As such, supportive practices are a critical component, and teachers who involve students in identifying problems and constructing solutions will see better results.

For Culture and Language Differences. Practitioners should remember to choose language carefully when role-playing. In general, the use of the word need should be avoided, except when truly meant as a need. Also, when working with students whose primary language and culture differ from the adult, show discretion and sensitivity in encouraging and affirming student responses to identifying problems and creating alternative solutions to those problems. The identification of feelings in others, or problems in others, or taking the perspective of others may be a little known or new experience or task demand for some students. Using language to identify feelings will also be different for different cultures, not only just the direct translation of emotional words but also the existence of a vocabulary for emotion, motives, and feelings. In some cases, these differences may require additional teaching.
For Age and Developmental Level. Students who are younger, developmentally delayed or who lack communicative skills will have additional difficulties in creating language to explain the actions of others; therefore, symbols or puppets might be alternatives for instructional or communicational needs. In addition, fixed choices, such as "which is the problem x or y," can help bridge this functional gap. Younger students will need both stories and exemplars that are well matched to their age and developmental level. For example, early childhood participants will respond more readily to stories about the toys and tangibles around them, while high school-aged children will identify with the emotions and problems associated with adolescence.

For Safety. When working with physical aggression, role-playing should be used with caution. Adults should know the personal and social histories of each individual with whom they are working. For example, two adolescents who have a long standing turf war as gang members would not make good independent role-play partners reenacting a problem-solving scenario about avoiding a fight. Also, students should not be coerced into participation. Successful intervention for aggression using problem-solving techniques requires a degree of willing participation from those being treated.

Research Studies Supporting Use of Problem-Solving Intervention Strategies

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


Aggression Intervention Option 2: Replacement Behavior Training

Replacement behavior training focuses on teaching new skills and behaviors that can be used to replace undesirable behaviors. Replacement behaviors are taught and reinforced to promote their adoption,
maintenance, and generalization. When dealing with aggression, the aggressive behavior (e.g., hitting or name-calling) is replaced with an alternate behavior that fulfills the same need for the individual. The replacement behavior is thought to be functionally equivalent to the initial behavior because it serves a similar purpose and allows the individual access to the same or greater contingencies of reinforcement.

The goal of implementing replacement behavior training is to reduce aggressive behavior by teaching and reinforcing (immediate reinforcement with gradual fading) an alternate behavior that serves the same function (i.e., meets the same need) as the aggressive behavior.

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

**Procedural steps for the application of replacement behavior training**

1. Conduct a functional behavioral assessment using a team approach when appropriate (parents, teachers, authority figures, administrators, any other key stakeholders) to determine the function of the aggressive behavior.
2. Review the problem behavior with the child (when appropriate) to promote agreement on what the problem behavior is.
3. Identify and teach the child several replacement behaviors that will be suitable for extinguishing the aggressive behavior and the reinforcers to support them. These behaviors may include:
   a. Functional communication, such as pictorial representations or sign language
   b. Effective social skills (e.g., clarifying another person's complaints or anger, expressing anger)
4. Work with the child to determine the appropriate use of the replacement behavior and the antecedents that may prompt its use; this may include developing temporary prompts from teachers or others that can be used to help the child identify when to use a replacement behavior.
5. Model the replacement behavior (and antecedent, if one is used) for the child.
6. Allow the child to demonstrate understanding of and ability to perform the new behavior.
7. Let all adults who may be working with the child know what the appropriate replacement behaviors are so behaviors can be monitored and generalized across settings (e.g., home, extracurricular activities, cafeteria, library, and community).
8. Fade prompts being given by teachers or others gradually.
9. Reinforce new behaviors using a one-to-one ratio initially, and then gradually fade the reinforcement.

**Considerations When Implementing a Replacement Behavior Intervention Strategy**

For Teaching. In using replacement behavior training as an intervention for aggression, it is important to consider the function of the maladaptive behavior, the effort that will be expended in learning and using a new behavior, and the ability of the new behavior to provide the same benefit as the maladaptive
behavior provided. In addition, this intervention's use of reinforcement must involve the recognition that, by definition, a reinforcer is something reinforcing to that individual. Therefore, the person distributing the reinforcer should have an awareness of reinforcement saturation. For example, a student who has 10 chocolate bars in her lunch may not be motivated by a small treat from the teacher. Likewise, peer attention as a motivator will only be as effective as long as one has control over the reinforcer. Reinforcer strength should also be considered. A student who ditches class to spend time with a boyfriend may not be interested in a candy bar for staying in class.

For Age and Developmental Level. Functional language and communication abilities are often precursors to aggressive behaviors. Language abilities should be assessed and, when determined to be a component in the aggressive behavior, communication skills (verbal or pictorial), should be a primary replacement.

Research Studies Supporting Use of Replacement Behavior Intervention Strategies

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


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 Aggression and Conduct Problems scales, you may choose to use the BASC-2 Progress Monitor Externalizing and ADHD Problems form. For interventions that include the Somatization scales, you may choose to use the BASC-2 Progress Monitor Internalizing Problems forms. For interventions that include the Social Skills and Withdrawal scale you may choose to use the BASC-2 Progress Monitor Social Withdrawal forms. For interventions that include the Functional Communication and Social Skills scales, you may choose to use the BASC-2 Progress Monitor Adaptive Skills form.

Regardless of the method used to monitor progress, it is important to document the effectiveness of the interventions you have tried with the child. 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.
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.

<table>
<thead>
<tr>
<th>T Score (Plotted)</th>
<th>Anger Control</th>
<th>Bullying</th>
<th>Developmental Social Disorders</th>
<th>Emotional Self-Control</th>
<th>Executive Functioning</th>
<th>Negative Emotionality</th>
<th>Resiliency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gen.-Comb. Sex</td>
<td>64</td>
<td>82</td>
<td>62</td>
<td>49</td>
<td>56</td>
<td>47</td>
<td>38</td>
</tr>
</tbody>
</table>

| Percentile        | Gen.-Comb. Sex | 91      | 99    | 87    | 54    | 76    | 42    | 13        |
Summary: General - Combined Sex Norm Group

<table>
<thead>
<tr>
<th>Scale</th>
<th>Raw Score</th>
<th>T Score</th>
<th>Percentile Rank</th>
<th>90% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger Control</td>
<td>12</td>
<td>64</td>
<td>91</td>
<td>56-72</td>
</tr>
<tr>
<td>Bullying</td>
<td>15</td>
<td>82</td>
<td>99</td>
<td>75-89</td>
</tr>
<tr>
<td>Developmental Social Disorders</td>
<td>17</td>
<td>62</td>
<td>87</td>
<td>55-69</td>
</tr>
<tr>
<td>Emotional Self-Control</td>
<td>3</td>
<td>49</td>
<td>54</td>
<td>42-56</td>
</tr>
<tr>
<td>Executive Functioning</td>
<td>13</td>
<td>56</td>
<td>76</td>
<td>49-63</td>
</tr>
<tr>
<td>Negative Emotionality</td>
<td>4</td>
<td>47</td>
<td>42</td>
<td>39-55</td>
</tr>
<tr>
<td>Resiliency</td>
<td>16</td>
<td>38</td>
<td>13</td>
<td>31-45</td>
</tr>
</tbody>
</table>

**Content Scales**

The child'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. The child's parent/guardian reports that the child has a tendency to become irritable quickly and has difficulty maintaining his self-control when faced with adversity.

The child's T score on Bullying is 82 and has a percentile rank of 99. This T score falls in the Clinically Significant classification range, and usually warrants follow-up. The child's parent/guardian reports that the child has a tendency to be disruptive, intrusive, and/or threatening toward other students.

The child's T score on Developmental Social Disorders is 62 and has a percentile rank of 87. This T score falls in the At-Risk classification range, and follow-up may be necessary. The child's parent/guardian reports that the child has some problems concerning social skills and communication.

The child's T score on Emotional Self-Control is 49 and has a percentile rank of 54. The child's parent/guardian reports that the child is able to control his reactions to environmental changes about as well as others his age.

The child's T score on Executive Functioning is 56 and has a percentile rank of 76. The child's parent/guardian reports that the child is able to control and maintain his behavior and mood as capably as others his age.

The child's T score on Negative Emotionality is 47 and has a percentile rank of 42. The child's parent/guardian reports that the child reacts to changes in everyday activities or routines in a manner that is typical of others his age.

The child's T score on Resiliency is 38 and has a percentile rank of 13. This T score falls in the At-Risk classification range, and follow-up may be necessary. The child's parent/guardian reports that the child has difficulty overcoming stress and adversity.
CLINICAL INDEXES

T Score (Plotted)

- Gen.-Comb. Sex
  - ADHD Probability: 56
  - EBD Probability: 61
  - Functional Impairment: 66

Percentile

- Gen.-Comb. Sex
  - 75
  - 86
  - 93
Clinical Summary

The BASC-2 items endorsed by the child's parent/guardian resulted in a clinically significant Somatization scale, a pattern that occurred in 4.4% of the standardization sample. This profile typically indicates high levels of internal distress that manifest as physical symptoms such as headaches, stomachaches, or pain, many of which are unlikely to have a physiological basis. Given this profile, diagnostic considerations will likely include somatoform disorders (e.g., somatization disorder, conversion disorder, etc.). Because depression and anxiety may manifest as somatic complaints, depressive disorders (e.g., major depression and bipolar disorder) and anxiety disorders (e.g., generalized anxiety disorder, panic disorder, and obsessive compulsive disorder) may be additional diagnostic possibilities.

Somatic complaints are often interpreted as reflecting emotional distress and can be associated with depression and anxiety. In fact, this may be true even in cases such as the child's, in which these scales are not elevated on the BASC-2. Thus, thorough history taking in order to clarify the relationship the child's somatic symptoms and these other areas may be an important clinical goal. Furthermore, somatic symptoms can sometimes be a response to an environmental stressor (e.g., bullying, learning difficulties, separation anxiety, etc.). In these cases, somatization may serve to reduce distress through functions such as avoidance, and identifying and addressing these environmental factors can be an effective means of reducing somatic complaints.

The child also exhibited elevations on BASC-2 externalizing scales of Aggression and Conduct Problems, a pattern that occurred in 32.9% of the BASC-2 standardization sample with a clinically significant Somatization scale. This suggests that he is exhibiting significant behavioral difficulties in conjunction with his emotional distress and indicates that additional diagnostic considerations might include oppositional defiant disorder (ODD), and conduct disorder (CD). Disruptive behavior disorders and mood disorders are both characterized by heightened levels of irritability, defiance, and anger. It may be the case that internal emotional distress is causing the child to act out, or that negative feedback related to his behavioral issues may be resulting in anxiety, depressed mood, or somatic complaints. An important clinical goal will likely be clarifying the relationship between the child's mood and behavioral symptoms. Understanding the onset, course, and function of these symptoms, through thorough clinical interviews and history taking, will likely be helpful in determining whether behavior or mood is the primary concern for the child.

Concurrent elevations on Aggression, Conduct Problems, and Anxiety scales may seem counterintuitive; children with these types of behavioral problems do not typically appear to be outwardly anxious. However, anxiety disorders can co-occur with ADHD, ODD and CD at a higher than expected rate, and it is possible that elevations on the Anxiety scale reflect negative affect as opposed to the fearfulness and shyness that may characterize other childhood anxiety disorders. However, the child's Negative Emotionality content scale does not necessarily support this interpretation, as he was rated below the at-risk range with respect to temperamental variables that may be related to high negative affect (e.g., irritability, poor emotional regulation). Further investigation will likely be warranted in order to determine the relationship between the child's anxiety and behavioral issues, perhaps through detailed clinical interviews aimed at clarifying potential sources of fear, worry, or negative mood that might be influencing his externalizing behaviors.

The pattern of BASC-2 item endorsements by the child's parent/guardian resulted in a clinically significant Withdrawal scale. Items from the Withdrawal scale measure several core behaviors commonly described in autism spectrum disorders, but it is also possible for this scale to be elevated due to behavioral or mood
difficulties. For children who are presenting with internalizing problems, elevated Withdrawal scores may reflect timidity, low prosocial drive, or peer rejection. It is noteworthy that the child appears to exhibit below average social skills, as evidenced by his low Social Skills score. This suggests his functioning in this area may be related to his withdrawn behavior. Thus, further investigation of this domain would likely be helpful in order to guide diagnostic formulation, risk assessment, and treatment planning.

The BASC-2 items endorsed by the child's parent/guardian resulted in an at-risk Developmental Social Disorders content scale score. This suggests that the child may be exhibiting problems with self-stimulation, withdrawal, and inappropriate socialization. This is consistent with his elevated Atypicality and Withdrawal scale scores. Diagnostic considerations given this elevated content scale may include pervasive developmental disorders such as Autism and Asperger's; however, high scores on this scale may also represent poor socialization. Thus, given the complexity of an Autism or Asperger's diagnosis, additional clinical interviewing and history-taking will likely be necessary before rendering diagnostic conclusions.

Several parenting variables are associated with somatization. These include overcontrolling parenting. Furthermore, parents are often involved in the therapy process. They may be especially important in cases where somatic symptoms are a primary concern, as they play a major role in ensuring that these somatic symptoms are not reinforced. 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-A rating form. Each section presents a list of symptoms as described in the DSM-IV-TR, along with PRS-A 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-A 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).

Asperger's Disorder 299.80

Symptoms for Area 1: Impaired Social Interaction

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Parent's Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>Has not developed peer relationships appropriate to developmental level</td>
<td>14. Item Content Omitted (True) 134. Item Content Omitted (True)</td>
</tr>
<tr>
<td>X</td>
<td>Does not seek to share interests, enjoyment, or achievements with others</td>
<td>74. Item Content Omitted (True) 88. Item Content Omitted (True) 148. Item Content Omitted (True)</td>
</tr>
<tr>
<td>X</td>
<td>Does not reciprocate emotionally/socially</td>
<td>6. Item Content Omitted (True) 84. Item Content Omitted (True)</td>
</tr>
</tbody>
</table>

_ Shows notable impairment in more than one type of nonverbal behavior

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 Area 2: Stereotypical Behavior Patterns, Interests, and Activities

<table>
<thead>
<tr>
<th>Relevant BASC-2 PRS-A Items and the parent's Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>__ Rigidly adheres to routines/rituals</td>
</tr>
<tr>
<td>__ Stereotypical, repetitive physical movements (e.g., finger flapping, hand twisting)</td>
</tr>
<tr>
<td>__ Preoccupation with parts of objects</td>
</tr>
<tr>
<td>__ Stereotypical pattern of abnormally intense or focused interest in particular topic(s)/thing(s)</td>
</tr>
</tbody>
</table>

Considerations for Diagnosis of Asperger's Disorder (Mark answers as appropriate.)

| Does the individual display at least two behaviors from Area 1 and at least one behavior from Area 2? [YES] | Yes | No |
| Do symptoms cause clinically significant social, occupational, or other impairment? [YES] | Yes | No |
| Have other specific Pervasive Developmental Disorders and Schizophrenia been ruled out? [YES] | Yes | No |
| Has development of spoken language been significantly delayed? [NO] | Yes | No |
| Has development of cognitive skills, self-help skills, adaptive behaviors (other than social interaction), and curiosity about the environment been significantly delayed? [NO] | Yes | No |

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

Asperger's Disorder Diagnostic Summary
(Mark answers as appropriate.)
• Was a diagnosis of Asperger's Disorder made? Yes No Date:__________

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.
### Autistic Disorder 299.00

*Symptoms for Area 1: Impaired Social Interaction*

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Parent's Responses</th>
</tr>
</thead>
</table>
| X    | Has not developed peer relationships appropriate to developmental level | 14. Item Content Omitted (True)  
134. Item Content Omitted (True) |
| X    | Does not seek to share interests, enjoyment, or achievements with others | 74. Item Content Omitted (True)  
88. Item Content Omitted (True)  
148. Item Content Omitted (True) |
| X    | Does not reciprocate emotionally/socially | 6. Item Content Omitted (True)  
84. Item Content Omitted (True) |
| ___   | Shows notable impairment in more than one type of nonverbal behavior | |

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**Special Note:**

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*ITEMS NOT SHOWN*
Symptoms for Area 2: Impaired Communication

Relevant BASC-2 PRS-A Items and the parent's Responses

X If speech ability is adequate, considerable difficulty initiating/sustaining conversations

32. Item Content Omitted (True)

116. Item Content Omitted (True)

__ Delayed development of spoken language (with no attempt to compensate through gesture/mime)

__ Repetitive or idiosyncratic language

__ Lack of make-believe or social imitative play appropriate to developmental level

Special Note:
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Symptoms for Area 3: Stereotypical Behavior Patterns, Interests, and Activities

Relevant BASC-2 PRS-A Items and the parent's Responses

__ Rigidly adheres to routines/rituals 31. Item Content Omitted (True)
__ Stereotypical, repetitive physical movements (e.g., finger flapping, hand twisting) 71. Item Content Omitted (True)
__ Stereotypical pattern of abnormally intense or focused interest in particular topic(s)/thing(s)
__ Preoccupation with parts of objects

Considerations for Diagnosis of Autistic Disorder (Mark answers as appropriate.)

| Does the individual display a total of six or more behaviors from the three areas listed above, with at least two from Area 1, one from Area 2, and one from Area 3? [YES] | Yes | No |
| Has the individual displayed abnormal functioning or delays in one or more of the following areas, with onset prior to age 3? (a) social interaction; (b) use of language for social communication; (c) symbolic/imaginative play [YES] | Yes | No |
| Have Rett's Disorder and Childhood Disintegrative Disorder been ruled out? [YES] | Yes | No |

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

Autistic Disorder Diagnostic Summary (Mark answers as appropriate.)

- Was a diagnosis of Autistic Disorder made? Yes No Date:_____________

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.
Conduct Disorder 312.8x

Symptoms for Conduct Disorder

X Bullies, intimidates, or threatens others 40. Item Content Omitted (True)
94. Item Content Omitted (True)

X Has inflicted physical harm on people 70. Item Content Omitted (True)
130. Item Content Omitted (True)

__ Lies to obtain things or favors or to avoid obligations 79. Item Content Omitted (True)
119. Item Content Omitted (True)

X Has committed theft of money or items of nontrivial value without confronting a victim 19. Item Content Omitted (True)

X Has inflicted physical harm on animals 25. Item Content Omitted (True)

__ Has deliberately set a fire to intentionally cause serious damage 121. Item Content Omitted (True)

X Has run away from home overnight at least twice (or once for a lengthy period) 140. 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:
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Considerations for Diagnosis of Conduct (Mark answers as appropriate.)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>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]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do symptoms significantly impair academic, social, or occupational functioning? [YES]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has Antisocial Personality Disorder been ruled out (age 18 and older)? [YES]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.)

1. 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)
Oppositional Defiant Disorder 313.81

Symptoms for Oppositional Defiant Disorder

<table>
<thead>
<tr>
<th></th>
<th>Relevant BASC-2 PRS-A Items and the parent's Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loses temper</td>
<td>100. Item Content Omitted (True)</td>
</tr>
<tr>
<td>Argues</td>
<td>64. Item Content Omitted (True)</td>
</tr>
<tr>
<td>Defies rules or refuses to comply with requests</td>
<td>108. Item Content Omitted (True)</td>
</tr>
<tr>
<td>Deliberately annoys others</td>
<td>4. Item Content Omitted (True)</td>
</tr>
<tr>
<td>Is easily annoyed by others</td>
<td>10. Item Content Omitted (True)</td>
</tr>
<tr>
<td>Is vindictive/spiteful</td>
<td>34. Item Content Omitted (True)</td>
</tr>
<tr>
<td>Blames other people for his/her own misbehavior or mistakes</td>
<td>144. Item Content Omitted (True)</td>
</tr>
<tr>
<td>Is resentful/angry</td>
<td>124. Item Content Omitted (True)</td>
</tr>
</tbody>
</table>

Considerations for Diagnosis of Oppositional Defiant Disorder (Mark answers as appropriate.)

<table>
<thead>
<tr>
<th>Consideration</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the individual shown a pattern of hostile, defiant behavior for at least six months, during which four or more of the symptoms listed above have been present? [YES] (Note. Only count a symptom if the individual displays the given behavior more frequently than others of a similar age and developmental level.)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do the symptoms significantly impair social, academic, or occupational functioning? [YES]</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Have Conduct Disorder and (for individuals age 18 or older) Antisocial Personality Disorder been ruled out? [YES]</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do the symptoms occur solely during the course of a Psychotic or Mood Disorder? [NO]</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Note. The qualifying answer pertaining to the diagnostic criteria for Oppositional Defiant Disorder is indicated in square brackets [ ].
Oppositional Defiant Disorder Diagnostic Summary (Mark answers as appropriate.)

1. Was a diagnosis of Oppositional Defiant Disorder made?  
   Yes  No  Date:_____________
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

15. Item Content Omitted (True)
34. Item Content Omitted (True)
130. Item Content Omitted (True)
40. Item Content Omitted (True)
73. Item Content Omitted (True)
95. Item Content Omitted (True)
10. Item Content Omitted (True)
13. Item Content Omitted (True)
19. Item Content Omitted (True)
25. Item Content Omitted (True)
49. Item Content Omitted (True)
70. Item Content Omitted (True)
94. Item Content Omitted (True)
100. Item Content Omitted (True)

Adaptive/Social Behavior Issues

17. Item Content Omitted (True)
120. Item Content Omitted (True)
33. Item Content Omitted (True)
63. Item Content Omitted (True)
92. Item Content Omitted (True)
114. Item Content Omitted (True)
116. Item Content Omitted (True)
80. Item Content Omitted (True)
CRITICAL ITEMS

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

11. Item Content Omitted (True)
25. Item Content Omitted (True)
27. Item Content Omitted (True)
29. Item Content Omitted (True)
40. Item Content Omitted (True)
41. Item Content Omitted (True)
49. Item Content Omitted (True)
59. Item Content Omitted (True)
60. Item Content Omitted (True)
70. Item Content Omitted (True)
90. Item Content Omitted (True)
94. Item Content Omitted (True)
95. Item Content Omitted (True)
101. Item Content Omitted (True)
103. Item Content Omitted (True)
110. Item Content Omitted (True)
114. Item Content Omitted (True)
121. Item Content Omitted (True)
125. Item Content Omitted (True)
132. Item Content Omitted (True)
138. Item Content Omitted (True)
140. Item Content Omitted (True)
144. Item Content Omitted (True)
149. Item Content Omitted (True)
### ITEMS BY SCALE - CLINICAL SCALES

#### Aggression
- 4. Item Content Omitted (True)
- 10. Item Content Omitted (True)
- 34. Item Content Omitted (True)
- 40. Item Content Omitted (True)
- 64. Item Content Omitted (True)
- 70. Item Content Omitted (True)
- 94. Item Content Omitted (True)
- 100. Item Content Omitted (True)
- 124. Item Content Omitted (True)
- 130. Item Content Omitted (True)

#### Anxiety
- 12. Item Content Omitted (True)
- 23. Item Content Omitted (True)
- 28. Item Content Omitted (True)
- 42. Item Content Omitted (True)
- 53. Item Content Omitted (True)
- 58. Item Content Omitted (True)
- 72. Item Content Omitted (True)
- 83. Item Content Omitted (True)
- 102. Item Content Omitted (True)
- 113. Item Content Omitted (True)
- 143. Item Content Omitted (True)

#### Attention Problems
- 5. Item Content Omitted (True)
- 35. Item Content Omitted (True)
- 65. Item Content Omitted (True)
- 76. Item Content Omitted (True)
- 106. Item Content Omitted (True)
- 136. Item Content Omitted (True)

#### Atypicality
- 21. Item Content Omitted (True)
- 27. Item Content Omitted (True)
- 51. Item Content Omitted (True)
- 57. Item Content Omitted (True)
- 71. Item Content Omitted (True)
- 87. Item Content Omitted (True)
- 101. Item Content Omitted (True)
- 117. Item Content Omitted (True)

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Conduct Problems
13. Item Content Omitted (True)
19. Item Content Omitted (True)
29. Item Content Omitted (True)
43. Item Content Omitted (True)
49. Item Content Omitted (True)
59. Item Content Omitted (True)
73. Item Content Omitted (True)
79. Item Content Omitted (True)
89. Item Content Omitted (True)
103. Item Content Omitted (True)
109. Item Content Omitted (True)
119. Item Content Omitted (True)
133. Item Content Omitted (True)
139. Item Content Omitted (True)

Depression
8. Item Content Omitted (True)
22. Item Content Omitted (True)
30. Item Content Omitted (True)
38. Item Content Omitted (True)
52. Item Content Omitted (True)
60. Item Content Omitted (True)
68. Item Content Omitted (True)
82. Item Content Omitted (True)
90. Item Content Omitted (True)
98. Item Content Omitted (True)
112. Item Content Omitted (True)
128. Item Content Omitted (True)
142. Item Content Omitted (True)

Hyperactivity
15. Item Content Omitted (True)
20. Item Content Omitted (True)
45. Item Content Omitted (True)
50. Item Content Omitted (True)
75. Item Content Omitted (True)
80. Item Content Omitted (True)
105. Item Content Omitted (True)
135. Item Content Omitted (True)

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Somatization
9. Item Content Omitted (True)
16. Item Content Omitted (True)
39. Item Content Omitted (True)
46. Item Content Omitted (True)
55. Item Content Omitted (True)
69. Item Content Omitted (True)
85. Item Content Omitted (True)
99. Item Content Omitted (True)
115. Item Content Omitted (True)
129. Item Content Omitted (True)
145. Item Content Omitted (True)

Withdrawal
14. Item Content Omitted (True)
44. Item Content Omitted (True)
74. Item Content Omitted (True)
88. Item Content Omitted (True)
104. Item Content Omitted (True)
118. Item Content Omitted (True)
134. Item Content Omitted (True)
148. Item Content Omitted (True)

ITEMS BY SCALE - ADAPTIVE SCALES

Activities of Daily Living
3. Item Content Omitted (True)
33. Item Content Omitted (True)
63. Item Content Omitted (True)
81. Item Content Omitted (True)
93. Item Content Omitted (True)
111. Item Content Omitted (True)
123. Item Content Omitted (True)
141. Item Content Omitted (True)

Adaptability
1. Item Content Omitted (True)
18. Item Content Omitted (True)
31. Item Content Omitted (True)
48. Item Content Omitted (True)
61. Item Content Omitted (True)
78. Item Content Omitted (True)
91. Item Content Omitted (True)

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ITEMS NOT SHOWN

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108. Item Content Omitted (True)

Functional Communication
  2. Item Content Omitted (True)
  26. Item Content Omitted (True)
  32. Item Content Omitted (True)
  56. Item Content Omitted (True)
  62. Item Content Omitted (True)
  86. Item Content Omitted (True)
  92. Item Content Omitted (True)
  107. Item Content Omitted (True)
  116. Item Content Omitted (True)
  122. Item Content Omitted (True)
  137. Item Content Omitted (True)
  146. Item Content Omitted (True)

Leadership
  7. Item Content Omitted (True)
  17. Item Content Omitted (True)
  37. Item Content Omitted (True)
  47. Item Content Omitted (True)
  67. Item Content Omitted (True)
  77. Item Content Omitted (True)
  97. Item Content Omitted (True)
  120. Item Content Omitted (True)
  127. Item Content Omitted (True)
  150. Item Content Omitted (True)

Social Skills
  6. Item Content Omitted (True)
  24. Item Content Omitted (True)
  36. Item Content Omitted (True)
  54. Item Content Omitted (True)
  66. Item Content Omitted (True)
  84. Item Content Omitted (True)
  96. Item Content Omitted (True)
  126. Item Content Omitted (True)

ITEMS BY SCALE - CONTENT SCALES

Anger Control
  1. Item Content Omitted (True)
  15. Item Content Omitted (True)
35. Item Content Omitted (True)
40. Item Content Omitted (True)
64. Item Content Omitted (True)
67. Item Content Omitted (True)
70. Item Content Omitted (True)
90. Item Content Omitted (True)
108. Item Content Omitted (True)

Bullying
15. Item Content Omitted (True)
34. Item Content Omitted (True)
40. Item Content Omitted (True)
70. Item Content Omitted (True)
73. Item Content Omitted (True)
75. Item Content Omitted (True)
94. Item Content Omitted (True)
130. Item Content Omitted (True)
135. Item Content Omitted (True)

Developmental Social Disorders
6. Item Content Omitted (True)
14. Item Content Omitted (True)
24. Item Content Omitted (True)
31. Item Content Omitted (True)
32. Item Content Omitted (True)
35. Item Content Omitted (True)
84. Item Content Omitted (True)
93. Item Content Omitted (True)
118. Item Content Omitted (True)
131. Item Content Omitted (True)
134. Item Content Omitted (True)
147. Item Content Omitted (True)

Emotional Self Control
45. Item Content Omitted (True)
68. Item Content Omitted (True)
75. Item Content Omitted (True)
82. Item Content Omitted (True)
100. Item Content Omitted (True)

Executive Functioning
13. Item Content Omitted (True)
15. Item Content Omitted (True)
20. Item Content Omitted (True)
64. Item Content Omitted (True)
68. Item Content Omitted (True)
70. Item Content Omitted (True)
71. Item Content Omitted (True)
78. Item Content Omitted (True)
80. Item Content Omitted (True)
82. Item Content Omitted (True)
97. Item Content Omitted (True)
136. Item Content Omitted (True)

Negative Emotionality
48. Item Content Omitted (True)
64. Item Content Omitted (True)
68. Item Content Omitted (True)
82. Item Content Omitted (True)
108. Item Content Omitted (True)

Resiliency
7. Item Content Omitted (True)
14. Item Content Omitted (True)
31. Item Content Omitted (True)
38. Item Content Omitted (True)
61. Item Content Omitted (True)
67. Item Content Omitted (True)
78. Item Content Omitted (True)
82. Item Content Omitted (True)
111. Item Content Omitted (True)
134. Item Content Omitted (True)
144. Item Content Omitted (True)

ITEMS BY SCALE - CLINICAL INDEXES

ADHD Probability
3. Item Content Omitted (True)
63. Item Content Omitted (True)
64. Item Content Omitted (True)
65. Item Content Omitted (True)
77. Item Content Omitted (True)
80. Item Content Omitted (True)
91. Item Content Omitted (True)
93. Item Content Omitted (True)
100. Item Content Omitted (True)
106. Item Content Omitted (True)
113. Item Content Omitted (True)
136. Item Content Omitted (True)

**EBD Probability**
- 1. Item Content Omitted (True)
- 18. Item Content Omitted (True)
- 31. Item Content Omitted (True)
- 37. Item Content Omitted (True)
- 45. Item Content Omitted (True)
- 62. Item Content Omitted (True)
- 66. Item Content Omitted (True)
- 67. Item Content Omitted (True)
- 84. Item Content Omitted (True)
- 97. Item Content Omitted (True)
- 116. Item Content Omitted (True)
- 126. Item Content Omitted (True)
- 139. Item Content Omitted (True)
- 150. Item Content Omitted (True)

**Functional Impairment**
- 2. Item Content Omitted (True)
- 3. Item Content Omitted (True)
- 5. Item Content Omitted (True)
- 8. Item Content Omitted (True)
- 14. Item Content Omitted (True)
- 15. Item Content Omitted (True)
- 20. Item Content Omitted (True)
- 26. Item Content Omitted (True)
- 32. Item Content Omitted (True)
- 33. Item Content Omitted (True)
- 35. Item Content Omitted (True)
- 36. Item Content Omitted (True)
- 44. Item Content Omitted (True)
- 45. Item Content Omitted (True)
- 47. Item Content Omitted (True)
- 56. Item Content Omitted (True)
- 58. Item Content Omitted (True)
- 62. Item Content Omitted (True)
- 63. Item Content Omitted (True)
- 68. Item Content Omitted (True)
- 69. Item Content Omitted (True)
- 71. Item Content Omitted (True)
- 72. Item Content Omitted (True)
- 74. Item Content Omitted (True)
- 77. Item Content Omitted (True)
- 81. Item Content Omitted (True)

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End of Report

NOTE: This and previous pages of this report contain trade secrets and are not to be released in response to requests under HIPAA (or any other data disclosure law that exempts trade secret information from release). Further, release in response to litigation discovery demands should be made only in accordance with your profession's ethical guidelines and under an appropriate protective order.
ITEM RESPONSES

31: 3 32: 3 33: 2 34: 4 35: 3 36: 3 37: 3 38: 3 39: 4 40: 3
41: 3 42: 2 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
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