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**
- ID: 123456789
- Name: Timmy Sample
- Gender: Male
- Birth Date: 03/01/2001
- Age: 8
- Grade: 3
- School: Sample School

**Test Information**
- Test Date: 10/30/2009
- Rater: Mr Sample
- Gender: Male
- Relationship: Father

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._
VALIDITY INDEX SUMMARY

<table>
<thead>
<tr>
<th>$F$ Index</th>
<th>Response Pattern</th>
<th>Consistency</th>
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<tbody>
<tr>
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<td>Raw Score: 1</td>
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T-SCORE PROFILE

T Score (Plotted) | Gen.-Comb. Sex
--- | ---
72 | 51
56 | 60
53 | 59
65 | 67
52 | 55
66 | 75
59 | 84
65 | 86
67 | 92
56 | 61
60 | 62
58 | 94
64 | 93
61 | 81
59 | 33
53 | 33
59 | 44
65 | 49
57 | 55
56 | 44
57 | 55
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62 | 55
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106 | 55
107 | 55
108 | 55
109 | 55
110 | 55
111 | 55
112 | 55
113 | 55
114 | 55
115 | 55
116 | 55
117 | 55
118 | 55
119 | 55
120 | 55

Percentile

| Gen.-Comb. Sex | 96 | 62 | 94 | 92 | 84 | 66 | 75 | 86 | 81 | 93 | 91 | 33 | 28 | 44 | 65 | 46 | 43 |
PRS SCORE SUMMARY: General - Combined Sex Norm Group

Composite Score Summary

<table>
<thead>
<tr>
<th>Scale Score</th>
<th>Raw Score</th>
<th>T Score</th>
<th>Percentile Rank</th>
<th>90% Confidence Interval</th>
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<td>65</td>
<td>92</td>
<td>61-69</td>
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<td>Behavioral Symptoms Index</td>
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<td>91</td>
<td>60-68</td>
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<td>Adaptive Skills</td>
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Composite Comparisons

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<th>Difference</th>
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<th>Frequency of Difference</th>
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<tr>
<td>Externalizing Problems vs. Internalizing Problems</td>
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<td>0.05</td>
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Mean T score of the BSI: 61
Mean T score of the Adaptive Skills Composite: 49

Scale Score Summary

<table>
<thead>
<tr>
<th>Scale Score</th>
<th>Raw Score</th>
<th>T Score</th>
<th>Percentile Rank</th>
<th>90% Confidence Interval</th>
<th>Difference</th>
<th>Significance Level</th>
<th>Frequency of Difference</th>
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<tbody>
<tr>
<td>Hyperactivity</td>
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<td>Aggression</td>
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<td>Anxiety</td>
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<td>61-73</td>
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<td>Adaptability</td>
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<td>Activities of Daily Living</td>
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<td>47-63</td>
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<td>46</td>
<td>44-56</td>
<td>1</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.
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.

<table>
<thead>
<tr>
<th>Primary Improvement Areas</th>
<th>Secondary Improvement Areas</th>
<th>Adaptive Skill Strengths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyperactivity</td>
<td>Conduct Problems</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Attention Problems</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Atypicality</td>
<td></td>
</tr>
</tbody>
</table>

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

Conduct Problems
- breaking rules
- stealing

Attention Problems
- staying focused
- paying attention
- 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.


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*.


**Secondary Improvement Area: Conduct Problems**

Conduct problems are considered one of Timmy’s most significant behavioral and emotional problems. 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
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.


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.

**Considerations When Implementing a Parent Training Intervention Strategy**

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.


**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.


**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.


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.


**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.

<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>62</td>
<td>45</td>
<td>66</td>
<td>63</td>
<td>54</td>
<td>42</td>
</tr>
</tbody>
</table>

| Percentile        | Gen.-Comb. Sex | 91 | 88 | 36 | 92 | 89 | 70 | 22 |
Summary: General - Combined Sex Norm Group

<table>
<thead>
<tr>
<th></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>11</td>
<td>64</td>
<td>91</td>
<td>56-72</td>
</tr>
<tr>
<td>Bullying</td>
<td>9</td>
<td>62</td>
<td>88</td>
<td>56-68</td>
</tr>
<tr>
<td>Developmental Social Disorders</td>
<td>8</td>
<td>45</td>
<td>36</td>
<td>39-51</td>
</tr>
<tr>
<td>Emotional Self-Control</td>
<td>8</td>
<td>66</td>
<td>92</td>
<td>59-73</td>
</tr>
<tr>
<td>Executive Functioning</td>
<td>15</td>
<td>63</td>
<td>89</td>
<td>56-70</td>
</tr>
<tr>
<td>Negative Emotionality</td>
<td>6</td>
<td>54</td>
<td>70</td>
<td>46-62</td>
</tr>
<tr>
<td>Resiliency</td>
<td>19</td>
<td>42</td>
<td>22</td>
<td>35-49</td>
</tr>
</tbody>
</table>

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
  - ADHD Probability: 59
  - EBD Probability: 59
  - Functional Impairment: 59

Percentile

- Gen.-Comb. Sex
  - ADHD Probability: 83
  - EBD Probability: 81
  - Functional Impairment: 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

<table>
<thead>
<tr>
<th>Item</th>
<th>Relevant BASC-2 PRS-C Items and Mr Sample's Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>X Has difficulty sustaining attention</td>
<td>9. Has a short attention span. (Sometimes)</td>
</tr>
<tr>
<td></td>
<td>17. Pays attention. (Never)</td>
</tr>
<tr>
<td></td>
<td>49. Pays attention when being spoken to. (Sometimes)</td>
</tr>
<tr>
<td>X Seems not to be listening when spoken to</td>
<td>41. Listens to directions. (Sometimes)</td>
</tr>
<tr>
<td></td>
<td>105. Listens carefully. (Sometimes)</td>
</tr>
<tr>
<td>X Is easily distracted</td>
<td>73. Is easily distracted. (Often)</td>
</tr>
<tr>
<td>__ Has trouble organizing activities/tasks</td>
<td></td>
</tr>
<tr>
<td>__ Is often forgetful</td>
<td></td>
</tr>
<tr>
<td>__ Does not play close attention to details</td>
<td></td>
</tr>
<tr>
<td>__ Makes careless mistakes</td>
<td></td>
</tr>
<tr>
<td>__ Fails to finish tasks (not due to defiance or failure to understand)</td>
<td></td>
</tr>
<tr>
<td>__ Dislikes/avoids tasks that involve sustained mental effort</td>
<td></td>
</tr>
<tr>
<td>__ Loses needed materials</td>
<td></td>
</tr>
</tbody>
</table>
Symptoms for ADHD: Hyperactivity/Impulsivity

- Acts as if "driven by a motor"
  - 20. Is unable to slow down. (Sometimes)
  - 84. Is overly active. (Sometimes)
- Blurts out answers
  - 116. Acts without thinking. (Sometimes)
- Has trouble waiting his/her turn
  - 6. Cannot wait to take turn. (Almost always)
- Interrupts others' conversations or activities
  - 38. Disrupts other children's activities. (Often)
  - 102. Interrupts others when they are speaking. (Often)
  - 134. Interrupts parents when they are talking on the phone. (Almost always)
- Fidgets or squirms excessively
  - 70. Fiddles with things while at meals. (Sometimes)
- Leaves seat inappropriately
- Runs around or climbs excessively/inappropriately
- Has difficulty engaging in activities quietly
- Talks excessively

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

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

- Bullies, intimidates, or threatens others
  - Relevant BASC-2 PRS-C Items and Mr Sample's Responses
  - 24. Bullies others. (Never)
  - 58. Threatens to hurt others. (Never)

- Has inflicted physical harm on people
  - 26. Hits other children. (Never)
  - 136. Is cruel to others. (Never)

- Lies to obtain things or favors or to avoid obligations
  - 79. Deceives others. (Never)
  - 111. Lies. (Sometimes)

- Has committed theft of money or items of nontrivial value without confronting a victim
  - 29. Steals. (Never)

- Has inflicted physical harm on animals
  - 97. Is cruel to animals. (Never)

- Has deliberately set a fire to intentionally cause serious damage
  - 143. Sets fires. (Never)

- Has run away from home overnight at least twice (or once for a lengthy period)
  - 147. Runs away from home. (Never)

- 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)
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.)

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)
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. Eats things that are not food. (Sometimes)
47. Breaks the rules. (Sometimes)
90. Loses temper too easily. (Sometimes)
111. Lies. (Sometimes)

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. Has seizures. (Never)
24. Bullies others. (Never)
26. Hits other children. (Never)
27. Eats things that are not food. (Sometimes)
58. Threatens to hurt others. (Never)
92. Says, “I want to die” or “I wish I were dead.”. (Sometimes)
97. Is cruel to animals. (Never)
107. Hears sounds that are not there. (Never)
115. Has a hearing problem. (Sometimes)
120. Sleeps with parents. (Never)
129. Throws up after eating. (Never)
135. Has toileting accidents. (Never)
137. Falls down. (Sometimes)
138. Says, “I want to kill myself.”. (Never)
139. Sees things that are not there. (Never)
143. Sets fires. (Never)
146. Eats too little. (Never)
147. Runs away from home. (Never)
152. Has eye problems. (Never)
155. Wets bed. (Never)
ITEMS BY SCALE - CLINICAL SCALES

Aggression
- 8. Teases others. (Never)
- 24. Bullies others. (Never)
- 26. Hits other children. (Never)
- 40. Argues with parents. (Often)
- 56. Argues when denied own way. (Often)
- 58. Threatens to hurt others. (Never)
- 72. Annoys others on purpose. (Never)
- 88. Seeks revenge on others. (Sometimes)
- 90. Loses temper too easily. (Sometimes)
- 104. Calls other children names. (Never)
- 136. Is cruel to others. (Never)

Anxiety
- 5. Worries. (Sometimes)
- 12. Worries about what teachers think. (Never)
- 13. Is too serious. (Sometimes)
- 32. Worries about making mistakes. (Often)
- 37. Worries about what parents think. (Often)
- 44. Worries about schoolwork. (Never)
- 45. Is fearful. (Sometimes)
- 64. Tries too hard to please others. (Never)
- 69. Is nervous. (Often)
- 77. Worries about things that cannot be changed. (Sometimes)
- 101. Says, “I'm afraid I will make a mistake.”. (Never)
- 109. Says, “I'm not very good at this.”. (Sometimes)
- 133. Says, “It's all my fault.”. (Never)
- 141. Worries about what other children think. (Almost always)
Attention Problems
  9. Has a short attention span. (Sometimes)
17. Pays attention. (Never)
41. Listens to directions. (Sometimes)
49. Pays attention when being spoken to. (Sometimes)
73. Is easily distracted. (Often)
105. Listens carefully. (Sometimes)

Atypicality
  11. Does strange things. (Sometimes)
23. Babbles to self. (Sometimes)
43. Acts confused. (Sometimes)
55. Repeats one thought over and over. (Sometimes)
75. Seems out of touch with reality. (Never)
87. Acts as if other children are not there. (Never)
96. Seems unaware of others. (Never)
107. Hears sounds that are not there. (Never)
119. Stares blankly. (Sometimes)
128. Says things that make no sense. (Sometimes)
139. Sees things that are not there. (Never)
151. Shows feelings that do not fit the situation. (Sometimes)
160. Acts strangely. (Never)

Conduct Problems
  15. Disobeys. (Almost always)
29. Steals. (Never)
47. Breaks the rules. (Sometimes)
61. Lies to get out of trouble. (Sometimes)
79. Deceives others. (Never)
93. Sneaks around. (Sometimes)
111. Lies. (Sometimes)
125. Breaks the rules just to see what will happen. (Often)
157. Gets into trouble. (Often)

Depression
  10. Is easily upset. (Sometimes)
18. Complains about being teased. (Sometimes)
28. Cries easily. (Sometimes)
42. Says, “Nobody understands me.”. (Never)
50. Complains about not having friends. (Never)
60. Says, “Nobody likes me.”. (Never)
74. Is negative about things. (Often)
82. Says, “I don't have any friends.”. (Never)
92. Says, “I want to die” or “I wish I were dead.”. (Sometimes)
106. Says, “I hate myself.”. (Never)
114. Is sad. (Often)
124. Seems lonely. (Sometimes)
138. Says, “I want to kill myself.” (Never)
156. Changes moods quickly. (Often)

Hyperactivity
   6. Cannot wait to take turn. (Almost always)
   20. Is unable to slow down. (Sometimes)
   38. Disrupts other children’s activities. (Often)
   52. Acts out of control. (Sometimes)
   70. Fiddles with things while at meals. (Sometimes)
   84. Is overly active. (Sometimes)
   102. Interrupts others when they are speaking. (Often)
   116. Acts without thinking. (Sometimes)
   134. Interrupts parents when they are talking on the phone. (Almost always)
   148. Has poor self-control. (Often)

Somatization
   30. Expresses fear of getting sick. (Sometimes)
   54. Complains of pain. (Sometimes)
   59. Has stomach problems. (Never)
   62. Says, “I think I’m sick.”. (Never)
   86. Has headaches. (Never)
   91. Complains about health. (Sometimes)
   94. Gets sick. (Sometimes)
   118. Has fevers. (Never)
   123. Is afraid of getting sick. (Sometimes)
   126. Complains of being sick when nothing is wrong. (Sometimes)
   150. Vomits. (Never)
   158. Complains of shortness of breath. (Never)

Withdrawal
   16. Makes friends easily. (Often)
   21. Refuses to join group activities. (Never)
   25. Will change direction to avoid having to greet someone. (Sometimes)
   48. Avoids competing with other children. (Sometimes)
   53. Is chosen last by other children for games. (Never)
   57. Is shy with other children. (Sometimes)
   80. Quickly joins group activities. (Sometimes)
   89. Shows fear of strangers. (Sometimes)
   112. Avoids other children. (Never)
   121. Has trouble making new friends. (Never)
   144. Prefers to be alone. (Sometimes)
   153. Is shy with adults. (Often)
ITEMS BY SCALE - ADAPTIVE SCALES

Activities of Daily Living
3. Has trouble following regular routines. (Sometimes)
35. Acts in a safe manner. (Often)
39. Organizes chores or other tasks well. (Almost always)
67. Sets realistic goals. (Often)
71. Volunteers to help clean up around the house. (Sometimes)
99. Attends to issues of personal safety. (Almost always)
103. Has trouble fastening buttons on clothing. (Never)
131. Needs to be reminded to brush teeth. (Sometimes)

Adaptability
1. Shares toys or possessions with other children. (Sometimes)
14. Recovers quickly after a setback. (Sometimes)
33. Is easily soothed when angry. (Sometimes)
46. Adjusts well to changes in routine. (Often)
65. Adjusts well to new teachers. (Often)
78. Adjusts well to changes in family plans. (Often)
110. Is a “good sport.”. (Almost always)
142. Is stubborn. (Sometimes)

Functional Communication
34. Provides own telephone number when asked. (Almost always)
66. Speaks in short phrases that are hard to understand. (Sometimes)
76. Answers telephone properly. (Often)
81. Is unclear when presenting ideas. (Never)
98. Has difficulty explaining rules of games to others. (Never)
108. Is able to describe feelings accurately. (Sometimes)
113. Tracks down information when needed. (Often)
122. Responds appropriately when asked a question. (Almost always)
130. Is clear when telling about personal experiences. (Almost always)
140. Accurately takes down messages. (Sometimes)
145. Has trouble getting information when needed. (Sometimes)
154. Communicates clearly. (Often)

Leadership
4. Gives good suggestions for solving problems. (Never)
19. Joins clubs or social groups. (Sometimes)
36. Is a “self-starter.”. (Often)
51. Is good at getting people to work together. (Almost always)
68. Is creative. (Sometimes)
83. Is usually chosen as a leader. (Almost always)
100. Will speak up if the situation calls for it. (Sometimes)
132. Makes decisions easily. (Often)

Social Skills
31. Congratulates others when good things happen to them. (Often)
63. Encourages others to do their best. (Often)
85. Offers help to other children. (Sometimes)
95. Compliments others. (Often)
117. Tries to bring out the best in other people. (Sometimes)
127. Volunteers to help with things. (Sometimes)
149. Shows interest in others' ideas. (Often)
159. Says, “please” and “thank you.”. (Sometimes)

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. Has a short attention span. (Sometimes)
26. Hits other children. (Never)
56. Argues when denied own way. (Often)
58. Threatens to hurt others. (Never)
65. Adjusts well to new teachers. (Often)
92. Says, “I want to die” or “I wish I were dead.”. (Sometimes)
142. Is stubborn. (Sometimes)

Bullying
1. Shares toys or possessions with other children. (Sometimes)
6. Cannot wait to take turn. (Almost always)
8. Teases others. (Never)
24. Bullies others. (Never)
26. Hits other children. (Never)
38. Disrupts other children’s activities. (Often)
47. Breaks the rules. (Sometimes)
52. Acts out of control. (Sometimes)
58. Threatens to hurt others. (Never)
136. Is cruel to others. (Never)

Developmental Social Disorders
9. Has a short attention span. (Sometimes)
16. Makes friends easily. (Often)
39. Organizes chores or other tasks well. (Almost always)
46. Adjusts well to changes in routine. (Often)
53. Is chosen last by other children for games. (Never)
53. Encourages others to do their best. (Often)
55. Seeks out touch with reality. (Never)
89. Acts as if other children are not there. (Never)
93. Compliments others. (Often)
121. Has trouble making new friends. (Never)
149. Shows interest in others' ideas. (Often)
151. Shows feelings that do not fit the situation. (Sometimes)
154. Communicates clearly. (Often)
160. Acts strangely. (Never)

**Emotional Self-Control**
10. Is easily upset. (Sometimes)
52. Acts out of control. (Sometimes)
90. Loses temper too easily. (Sometimes)
148. Has poor self-control. (Often)
151. Shows feelings that do not fit the situation. (Sometimes)
156. Changes moods quickly. (Often)

**Executive Functioning**
6. Cannot wait to take turn. (Almost always)
10. Is easily upset. (Sometimes)
26. Hits other children. (Never)
36. Is a “self-starter.” (Often)
56. Argues when denied own way. (Often)
73. Is easily distracted. (Often)
78. Adjusts well to changes in family plans. (Often)
102. Interrupts others when they are speaking. (Often)
116. Acts without thinking. (Sometimes)
156. Changes moods quickly. (Often)

**Negative Emotionality**
10. Is easily upset. (Sometimes)
56. Argues when denied own way. (Often)
110. Is a “good sport.” (Almost always)
142. Is stubborn. (Sometimes)
156. Changes moods quickly. (Often)

**Resiliency**
7. Is easily annoyed by others. (Sometimes)
10. Is easily upset. (Sometimes)
14. Recovers quickly after a setback. (Sometimes)
16. Makes friends easily. (Often)
33. Is easily soothed when angry. (Sometimes)
46. Adjusts well to changes in routine. (Often)
67. Sets realistic goals. (Often)
68. Is creative. (Sometimes)
74. Is negative about things. (Often)
78. Adjusts well to changes in family plans. (Often)
121. Has trouble making new friends. (Never)

ITEMS BY SCALE - CLINICAL INDEXES

ADHD Probability
6. Cannot wait to take turn. (Almost always)
9. Has a short attention span. (Sometimes)
20. Is unable to slow down. (Sometimes)
39. Organizes chores or other tasks well. (Almost always)
55. Repeats one thought over and over. (Sometimes)
66. Speaks in short phrases that are hard to understand. (Sometimes)
70. Fiddles with things while at meals. (Sometimes)
73. Is easily distracted. (Often)
81. Is unclear when presenting ideas. (Never)
84. Is overly active. (Sometimes)
102. Interrupts others when they are speaking. (Often)
154. Communicates clearly. (Often)

EBD Probability
1. Shares toys or possessions with other children. (Sometimes)
14. Recovers quickly after a setback. (Sometimes)
16. Makes friends easily. (Often)
21. Refuses to join group activities. (Never)
26. Hits other children. (Never)
31. Congratulates others when good things happen to them. (Often)
35. Acts in a safe manner. (Often)
36. Is a “self-starter.”. (Often)
52. Acts out of control. (Sometimes)
65. Adjusts well to new teachers. (Often)
78. Adjusts well to changes in family plans. (Often)
80. Quickly joins group activities. (Sometimes)
85. Offers help to other children. (Sometimes)
90. Loses temper too easily. (Sometimes)
104. Calls other children names. (Never)
114. Is sad. (Often)
117. Tries to bring out the best in other people. (Sometimes)
121. Has trouble making new friends. (Never)
138. Says, “I want to kill myself.”. (Never)
149. Shows interest in others’ ideas. (Often)
157. Gets into trouble. (Often)
Functional Impairment

3. Has trouble following regular routines. (Sometimes)
5. Worries. (Sometimes)
6. Cannot wait to take turn. (Almost always)
9. Has a short attention span. (Sometimes)
10. Is easily upset. (Sometimes)
16. Makes friends easily. (Often)
17. Pays attention. (Never)
21. Refuses to join group activities. (Never)
25. Will change direction to avoid having to greet someone. (Sometimes)
28. Cries easily. (Sometimes)
31. Congratulates others when good things happen to them. (Often)
33. Is easily soothed when angry. (Sometimes)
34. Provides own telephone number when asked. (Almost always)
35. Acts in a safe manner. (Often)
39. Organizes chores or other tasks well. (Almost always)
43. Acts confused. (Sometimes)
48. Avoids competing with other children. (Sometimes)
57. Is shy with other children. (Sometimes)
66. Speaks in short phrases that are hard to understand. (Sometimes)
67. Sets realistic goals. (Often)
71. Volunteers to help clean up around the house. (Sometimes)
75. Seems out of touch with reality. (Never)
76. Answers telephone properly. (Often)
77. Worries about things that cannot be changed. (Sometimes)
79. Deceives others. (Never)
80. Quickly joins group activities. (Sometimes)
81. Is unclear when presenting ideas. (Never)
85. Offers help to other children. (Sometimes)
89. Shows fear of strangers. (Sometimes)
90. Loses temper too easily. (Sometimes)
91. Complains about health. (Sometimes)
94. Gets sick. (Sometimes)
98. Has difficulty explaining rules of games to others. (Never)
99. Attends to issues of personal safety. (Almost always)
100. Will speak up if the situation calls for it. (Sometimes)
103. Has trouble fastening buttons on clothing. (Never)
108. Is able to describe feelings accurately. (Sometimes)
112. Avoids other children. (Never)
113. Tracks down information when needed. (Often)
121. Has trouble making new friends. (Never)
122. Responds appropriately when asked a question. (Almost always)
124. Seems lonely. (Sometimes)
128. Says things that make no sense. (Sometimes)
130. Is clear when telling about personal experiences. (Almost always)
131. Needs to be reminded to brush teeth. (Sometimes)
132. Makes decisions easily. (Often)
140. Accurately takes down messages. (Sometimes)
144. Prefers to be alone. (Sometimes)
145. Has trouble getting information when needed. (Sometimes)
148. Has poor self-control. (Often)
153. Is shy with adults. (Often)
154. Communicates clearly. (Often)
156. Changes moods quickly. (Often)
157. Gets into trouble. (Often)

**End of Report**

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ITEM RESPONSES

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: 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
151: 2  152: 1  153: 3  154: 3  155: 1  156: 3  157: 3  158: 1  159: 2  160: 1