MASC 2™

Multidimensional Anxiety Scale for Children 2nd Edition–Parent

John S. March, M.D., MPH

Assessment Report

Youth's Name/ID:	**Jennifer L**
Youth's Age:	10 years
Youth's Gender:	Female
Youth's Birth Date:	April 25, 2002
Youth's Grade:	4
Parent's Name/ID:	Mrs. L
Parent's Relationship to Youth:	mom
Administration Date:	October 10, 2012
Assessor's Name:	Dr. H.W.
Data Entered By:	ML
Normative Option:	Gender Specific norms

This Assessment Report is intended for use by qualified assessors only, and is not to be shown or presented to the respondent or any other unqualified individuals.

P.O. Box 950, North Tonawanda, NY 14120-0950
3770 Victoria Park Ave., Toronto, ON M2H 3M6

ver. 1.0

Introduction

The Multidimensional Anxiety Scale for Children 2nd Edition–Parent (MASC 2™–P) is a comprehensive assessment of anxiety dimensions in children and adolescents aged 8 to 19 years as observed by parents. The MASC 2–P indexes the range and severity of anxiety symptoms, and can be a useful adjunct to the diagnosis of anxiety disorders. When combined with other valid sources of information, the MASC 2–P can aid in the early identification of anxiety-prone youth, as well as in monitoring treatment effects. This report provides descriptive information about scale scores, and outlines which scores may be indicative of anxiety symptoms by comparing that individual's scores to a norm group. Additional interpretive information is found in the *Multidimensional Anxiety Scale for Children 2nd Edition Manual* (published by MHS).

This report is an interpretive aid and should not be provided to the parents, teachers, or youth, or used as the sole basis for clinical diagnosis or intervention. Administrators are cautioned against drawing unsupported interpretations. To obtain a comprehensive view of the individual, information from this report should be combined with information gathered from other psychometric measures, interviews, observations, and available records. This report is based on an algorithm that produces the most common interpretations of the obtained scores. Administrators should review the parent's responses to specific items to ensure that these interpretations apply.

Response Style Analysis

The following section provides the parent's score on the **Inconsistency Index**.

Raw Score	Guideline
3	The Inconsistency Index score does not indicate inconsistent response style.

T-score Guidelines

The guidelines in the following table apply to all T-scores presented in this report.

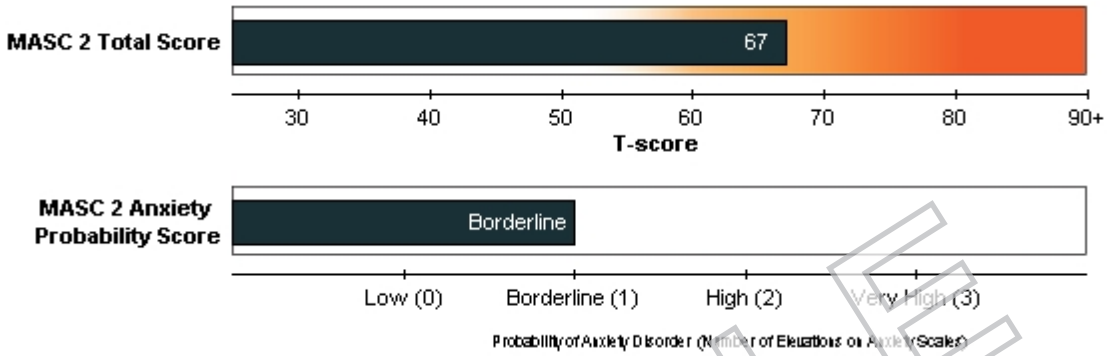
T-score	Guideline
70+	Very Elevated
65–69	Elevated
60–64	Slightly Elevated
55–59	High Average
40–54	Average
<40	Low

Interpreting MASC 2 Scores

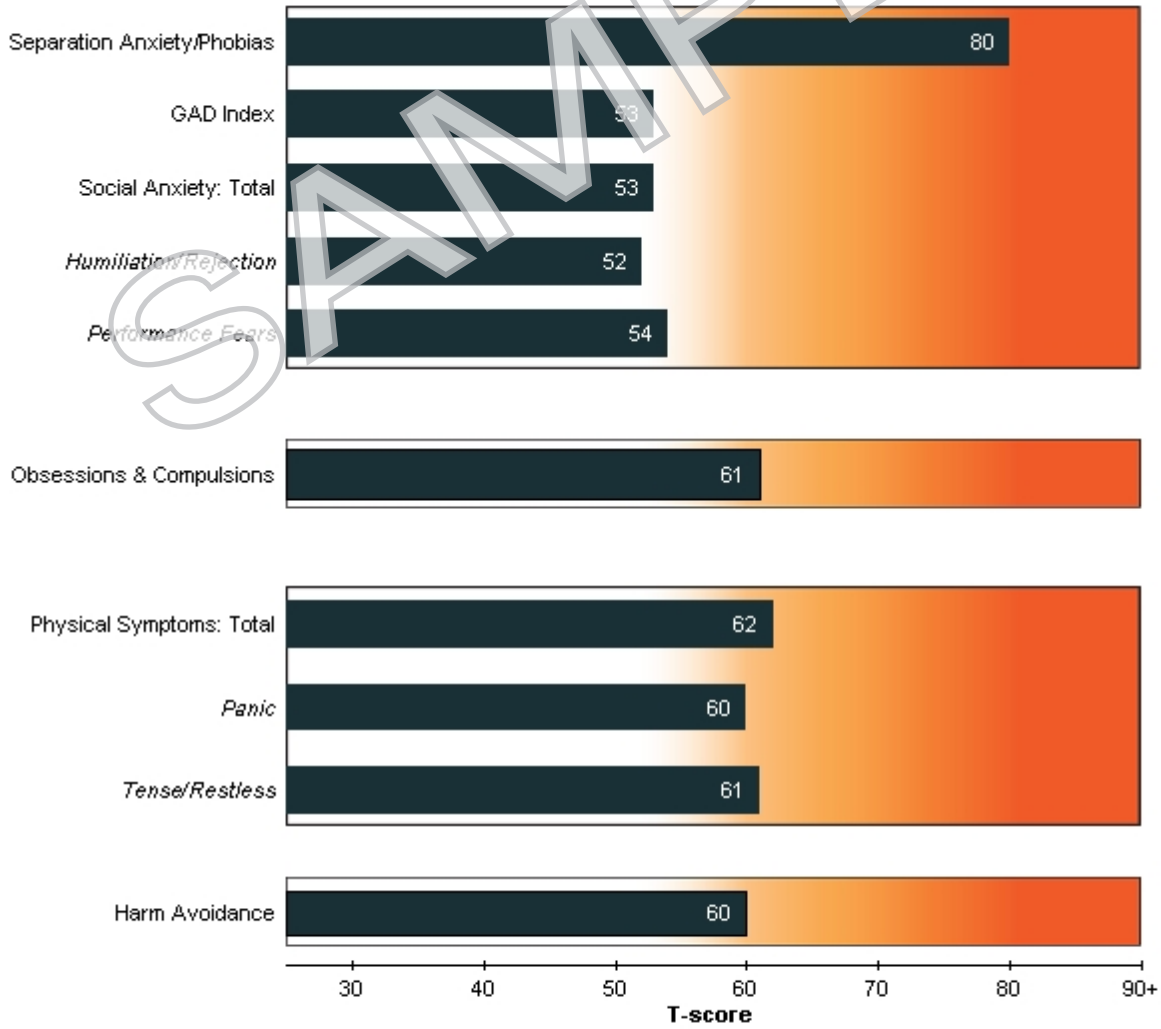
Responses on the MASC 2 are combined to create 11 T-scores: MASC 2 Total Score, Separation Anxiety/Phobias, Generalized Anxiety Disorder (GAD) Index, Social Anxiety (Total, Humiliation/Rejection, Performance Fears), Obsessions & Compulsions, Physical Symptoms (Total, Tense/Restless, Panic), and Harm Avoidance. Higher T-scores indicate more severe and/or a greater number of symptoms. The MASC 2 Anxiety Probability score estimates the likelihood that a youth has one or more anxiety disorders based on the number of Anxiety Scales (i.e., Separation Anxiety/Phobias, GAD Index, Social Anxiety: Total) that are classified as at least Slightly Elevated (i.e., T-score ≥ 60).

Overview of MASC 2 Scores

The following graphs display results from the parent's assessment of Jennifer L and provide information about how Jennifer L compares to the normative group. Higher T-scores indicate more severe and/or a greater number of symptoms. For the MASC 2 Anxiety Probability score, a higher score indicates a greater chance that the youth has at least one anxiety disorder. Please refer to the *MASC 2 Technical Manual* for more information about interpreting these results.



MASC 2 Scales



Detailed Scores

The following tables summarize the results of the parent's assessment of Jennifer L and provide information about how Jennifer L compares to the normative group. Higher T-scores indicate more severe and/or a greater number of symptoms. For the MASC 2 Anxiety Probability score, a higher score indicates a greater chance that the youth has at least one anxiety disorder. Please refer to the *MASC 2 Technical Manual* for more information about interpreting these results.

MASC 2 Total Score

Scale	Raw Score	T-score	Guideline
MASC 2 Total Score	70	67	Elevated

MASC 2 Anxiety Probability Score

Number of Elevations on Anxiety Scales	Probability	Guideline
1	Borderline	There is a borderline probability that the youth has one or more anxiety disorders.

MASC 2 Scales

Scale		Raw Score	T-score	Guideline
Anxiety Scales	**Separation Anxiety/Phobias**	22	80	Very Elevated
	GAD Index	10	53	Average
	Social Anxiety: Total	12	53	Average
	Humiliation/Rejection	7	52	Average
	Performance Fears	5	54	Average
Obsessions & Compulsions		7	61	Slightly Elevated
Physical Symptoms	**Physical Symptoms: Total**	8	62	Slightly Elevated
	Panic	4	60	Slightly Elevated
	Tense/Restless	4	61	Slightly Elevated
Harm Avoidance		21	60	Slightly Elevated

Summary: Score Interpretation

The following section summarizes the parent's assessment of Jennifer L on the Multidimensional Anxiety Scale for Children 2nd Edition–Parent (MASC 2–P). Scores for each scale/subscale are reported in this section, and include the obtained T-score. Higher scores indicate greater problems. Interpretive guidelines are also provided. For scales/subscales with T-scores of 60 or higher (i.e., Slightly Elevated or higher), this section also flags item-level elevations (if any) to provide more information about the specific symptoms Jennifer L is experiencing. For scales/subscales with T-scores lower than 60 (i.e., High Average or lower), item-level information can be found in the *Item Responses by Scale* section of this report.

Response Style Analysis

The **Inconsistency Index** score (raw score = 3) does not indicate an inconsistent response style.

MASC 2 Total Score

The **MASC 2 Total Score** indicates the parent's assessment of Jennifer L and the extent to which Jennifer L is experiencing signs and symptoms of anxiety. Ratings on this scale yielded a T-score of 67, which falls within the Elevated score range. This result, according to her parent's ratings, indicates that overall, Jennifer L is likely experiencing an elevated number of anxiety symptoms. An examination of all scale scores will identify the anxiety dimension(s) that are likely to be most problematic for Jennifer L.

MASC 2 Anxiety Probability Score

The **MASC 2 Anxiety Probability Score** estimates the likelihood that the youth is experiencing one or more anxiety disorders. Based on the profile of elevations on the Anxiety Scales (i.e., Separation Anxiety/Phobias, GAD Index, and Social Anxiety), Jennifer L has a **Borderline** probability of having one or more anxiety disorders. Since the MASC 2 does not make formal diagnoses but instead indicates the probability of one or more diagnoses, other clinically relevant information should also be carefully considered in the assessment process.

MASC 2 Scales

MASC 2 Anxiety Scales

The **Separation Anxiety/Phobias** scale score reflects the parent's assessment of Jennifer L, and the extent to which Jennifer L is anxious about being alone or scared of certain places or things. Ratings on this scale yielded a T-score of 80, which falls within the Very Elevated score range. Specifically, Jennifer L is scared or fearful of:

- Being away from her parents/family
- Not being near mom or dad
- Going away to camp
- Being in the dark
- Sleeping alone
- Riding in a car/bus
- Bad weather, the dark, animals or bugs

The **GAD Index** score reflects the parent's assessment of Jennifer L, and the extent to which Jennifer L may be experiencing symptoms similar to youth diagnosed with Generalized Anxiety Disorder, including elevated worry about future events and associated physical symptoms. Ratings on this scale yielded a T-score of 53, which falls within the Average score range. No Generalized Anxiety problems are indicated.

The **Social Anxiety: Total** scale comprises the following subscales: Humiliation/Rejection, which reflects anticipation of embarrassment, and Performance Fears, which reflects anticipatory anxiety about being "on stage" in a public or interpersonal context. Ratings on this scale yielded a T-score of 53, which falls within the Average score range. Although the youth did not receive an elevated score on the Social Anxiety: Total scale (according to her parent's ratings), an examination of the Humiliation/Rejection and Performance Fears subscale scores is recommended.

The **Humiliation/Rejection** subscale score reflects the parent's assessment of Jennifer L, and the extent to which Jennifer L may be anxious about being humiliated, embarrassed, or rejected by others in social settings. Ratings on this subscale yielded a T-score of 52, which falls within the Average score range. No Humiliation/Rejection problems are indicated.

The **Performance Fears** subscale score indicates the parent's assessment of Jennifer L and the extent to which Jennifer L may be feeling anxious about performing (e.g., public speaking, answering a teacher's question in class) in public settings. Ratings on this subscale yielded a T-score of 54, which falls within the Average score range. No Performance Fears problems are indicated.

Obsessions and Compulsions

The **Obsessions & Compulsions** scale score reflects the parent's assessment of Jennifer L, and the extent to which Jennifer L may be experiencing obsessive thoughts and/or engaging in compulsive behaviors that are consistent with a diagnosis of Obsessive-Compulsive Disorder. Ratings on this scale yielded a T-score of 61, which falls within the Slightly Elevated score range. Specifically, Jennifer L tends to experience:

- Thought intrusion
- Fear of contamination
- Excessive checking

Physical Symptoms

The **Physical Symptoms: Total** scale comprises the following subscales: Panic and Tense/Restless. Although physical symptoms alone are not predictive of anxiety disorders at the diagnostic level, they are often targets for treatment. Ratings on this scale yielded a T-score of 62, which falls within the Slightly Elevated score range. Examine the Physical Symptoms subscales (Panic and Tense/Restless) to identify the dimension(s) that may be most problematic for Jennifer L.

The **Panic** subscale score indicates the parent's assessment of Jennifer L, and the extent to which Jennifer L may be experiencing panic symptoms. If these panic symptoms are unprovoked, then a formal diagnosis of panic disorder should be considered. Ratings on this subscale yielded a T-score of 60, which falls within the Slightly Elevated score range. Specifically, she is likely to:

- Have trouble breathing
- Feel dizzy
- Have sweaty or cold hands

The **Tense/Restless** subscale score indicates the parent's assessment of Jennifer L, and the extent to which Jennifer L may be feeling tense, shaky, jumpy, restless, or on edge. Ratings on this subscale yielded a T-score of 61, which falls within the Slightly Elevated score range. Specifically, Jennifer L tends to:

- Be shaky or jittery

Harm Avoidance

The **Harm Avoidance** scale score reflects the parent's assessment of Jennifer L, and the extent to which Jennifer L attempts to avoid negative outcomes, wrongdoings, and/or dangers (e.g., experiential avoidance). Although harm avoidant behaviors alone are not predictive of anxiety disorders at the diagnostic level, they often are important targets for exposure based treatments. Ratings on this scale yielded a T-score of 60, which falls within the Slightly Elevated score range. Specifically, Jennifer L tends to:

- Check for potential danger
- Stay away from upsetting things

Intervention Suggestions

The MASC 2 provides an easy way to identify anxiety and Obsessive-Compulsive Disorder (OCD) symptoms and to develop a treatment plan that includes syndromal and item-level targets. This section presents intervention suggestions for Jennifer L based on scale score elevations (i.e., T-scores ≥ 60) for the Total Score, the Anxiety scales (i.e., Separation Anxiety/Phobias, GAD Index, Social Anxiety: Total), the Obsessions & Compulsions scale, the Physical Symptoms: Total scale, and/or the Harm Avoidance scale.

Using the MASC 2 to Understand the Clinical Picture

This section provides general intervention suggestions for children and adolescents with elevated MASC 2 anxiety score(s). Children and adolescents who experience difficulty with anxiety usually have both symptoms (something the youth experiences, such as worry) and signs (something that is visible, like restlessness). Symptoms and signs extend across three key domains: cognitive, emotional, and behavioral. The cognitive domain represents anxious thoughts and worries (such as “I am afraid to raise my hand in class”); the emotional domain represents fearful feelings (such as fear manifested in physical sensations); and the behavioral domain, including avoidance of anxiety producing stimuli represents the physical effects of anxiety (such as sweating or shakiness), reactive behaviors (such as distractibility associated with anxiety), or maladaptive ways of coping (such as experiential avoidance or family accommodation). Not surprisingly, thoughts, feelings, behaviors and physical symptoms are strongly linked as follows:

- Cognitive domain: When a youth encounters an anxiety-provoking stimulus, it is first cognitively appraised as fearful—usually when one overestimates the risk (cognitive threat appraisal). The youth then feels anxious and behaves in ways that reflect anxious thinking. For example, a youth who is anxious about getting called on in class because his/her fear of rejection and humiliation might try to keep a low profile to avoid the situation.
- Emotional domain: A youth finds himself/herself in a context which is linked to the feeling of fear (emotional threat appraisal). This feeling then drives anxious cognitions and behaviors. For example, a youth who is already fearful in class may experience heart racing that leads to thoughts reflecting social anxiety, and so keeps a low profile.
- Behavioral domain: Behavior powerfully governs both emotional responses and thought. For example, a youth who is already avoidant of settings in which he/she might have to speak up becomes increasingly fearful and avoidant in the classroom.
- By virtue of their unpleasantness, physical symptoms of anxiety are powerful problem maintaining factors since they elicit avoidant behaviors and so negatively reinforce those same symptoms. For example, a socially anxious youth feels nauseated and worries about getting called on in class, and so tries to avoid getting noticed in part because of the fear of throwing up.

As noted, these symptoms and signs do not take place in a vacuum but rather are conditioned by the youth’s environment. When a youth anticipates and responds to his/her environment, the environment then responds back in a way that typically maintains the youth's anxiety by encouraging experiential avoidance (avoiding things that make the youth anxious), which is a key feature of anxiety that is captured on the MASC 2 Harm Avoidance scale. Families, peers, and teachers may also accommodate the youth’s anxiety. Accommodation (e.g., providing reassurance, participating in avoidant behaviors, doing tasks for the youth that he/she is capable of doing, or tolerating delays) is done to decrease the youth’s distress which helps in the short term, but unintentionally reinforces avoidance and maintains anxiety in the long run. With either experiential avoidance or accommodation, the anxiety disorder is maintained by negative reinforcement, which is defined as the removal of a negative affect or behavior in a way that perpetuates the signs and symptoms of anxiety. As a result, half to two-thirds of families with children diagnosed with anxiety report hardship with siblings, marital discord, and/or school problems related to the youth’s anxiety disorder. In addition, these signs and symptoms influence the youth’s relationship with himself/herself and other people. Examination of the MASC 2 anxiety domains and elevated items provides an overview of the individual youth's level of anxiety and also how the youth and his or her environment cope with anxiety.

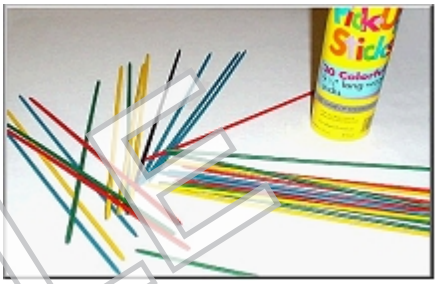
The Special Case of OCD

Many youth with OCD will also experience anxiety disorders, and a smaller number of youth with anxiety disorders also will have OCD. Obsessions are persistent and intrusive thoughts, images, or impulses that

also cause the youth significant anxiety or distress. Examples include thoughts about contamination, order or symmetry, or harm to others. Compulsions are repetitive behaviors or mental acts that are performed in order to prevent or reduce anxiety and distress. Common examples include hand washing, checking, and counting. Similar to anxiety disorders, symptoms of OCD are established and maintained through negative reinforcement. For example, a youth tries to avoid the triggers that provoke OCD; however, if he/she is unable to do so, the youth performs the accompanying rituals as quickly as possible to get rid of the dysphoric feelings and thoughts that define OCD. Families, peers, and teachers frequently accommodate to the youth's obsessions and compulsions. Accommodation (e.g., providing reassurance, participating in rituals or avoidant behaviors, or doing tasks for the youth that he/she is capable of doing) is done to decrease short term distress and improve functional outcomes. Accommodation, however, prevents the youth from realizing that the stimuli behind his/her obsessions and compulsions are not real or threatening. Consequently, intrusive thoughts, avoidance, and other reinforced behaviors are maintained.

The Rationale for Cognitive-Behavior Therapy

When considered together, the signs and symptoms identified on the MASC 2 at the item level are like a pile of pickup sticks. Each color stick represents a specific anxiety syndrome like separation anxiety or OCD. Each stick then represents a symptom or sign in relationship to all the others in the pile. Some sticks are highly correlated and sit in close proximity; others are less closely related and occur in decreased proximity.



The clinician's task is to identify the sticks, note their relationship to each other, and pick them up in the proper order. In relation to cognitive-behavior therapy, the clinician works with the youth to identify specific targets by placing them on an exposure hierarchy (rated from most easily to resist, to most difficult) so that they can be approached rather than avoided. It is also important to understand target dependencies. For example, a youth with both separation and social anxiety may need to address public speaking anxiety symptoms before going away to camp, so he/she can ask for help, if necessary.

It is easy to see how anxiety becomes established and maintained through negative reinforcement (i.e. experiential avoidance or accommodation). Unfortunately, doing so prevents the youth from realizing that the stimulus and anxiety themselves are not threatening. Consequently, anxious thoughts/feelings, avoidance, and other reinforced behaviors are maintained. Successful treatment should therefore include exposure to the feared stimulus in the absence of anxiety reducing behaviors (e.g., reassurance seeking or behavioral avoidance) until the anxiety has diminished. As a result of successive exposure trials, the relationship is broken between the stimulus, the anxious response, and accompanying problem-maintaining behaviors. Symptoms are reduced, and distress and dysfunction are minimized. Although exposure, as a behavioral intervention, is the key to success in treating anxious children and adolescents, cognitive interventions are also helpful in confronting exaggerated probabilities of harm (e.g., something bad will happen), costs (e.g., death) and over responsibility (e.g., it's my fault since I didn't do anything to prevent it). Struggling with unruly fears by trying to suppress them may worsen the problem by increasing avoidance of anxious thoughts and feelings thus making them more powerful and aversive. Mindfulness or acceptance strategies (allowing situations to be present without a lot of reactivity) can be very helpful in minimizing negative affectivity and in successfully completing an exposure task.

When OCD is present, exposure-based interventions take the form of exposure to OCD triggers and obsessions while at the same time blocking rituals (response prevention) until the obsessions and compulsions have diminished—a process termed exposure and response prevention. As a result of successive Enhanced Relapse Prevention (ERP) trials, the relationship is broken between the stimulus, the undesired response, and accompanying problem-maintaining behaviors. Symptoms are reduced, and distress and dysfunction are minimized. Although ERP, as a behavioral intervention, is the key to success in treating children and adolescents with obsessions and compulsions, cognitive interventions also can be helpful in confronting exaggerated probabilities of harm (e.g., my failure to check the toaster will cause a house fire), costs (e.g., the house will burn down and my family will be killed), and over responsibility (e.g., I'm responsible because I didn't check the toaster). As with anxiety disorders, mindfulness or acceptance strategies (allowing situations to be present without a lot of reactivity) can be very helpful in minimizing negative affectivity and in successfully completing an exposure task.

In summary, the MASC 2 identifies broad clusters of anxiety and/or obsessive-compulsive symptoms, narrows the focus to specific signs and symptoms that are troubling the youth and family, and provides a strong foundation for treatment planning using cognitive-behavioral approaches.

For a broad overview of childhood-onset mental disorders:

Kendall, P., & Comer, J. (2010). *Childhood Disorders (2nd edition)*, London: Psychology Press.

Kendal, P., & Hedtke, K. (2006). *Cognitive-Behavioral Therapy for Anxious Children: Therapist Manual, Third Edition.* Temple University, Philadelphia: Workbook Publishers.

Chorpita, B. (2007). *Modular Cognitive-Behavioral Therapy for Childhood Anxiety Disorders (Guides to Individualized Evidence-Based Treatment).* New York: Guilford Press.

Because many anxious children also have difficulties with depression and disruptive behavioral, a modular multi-component approach may be useful:

Chorpita, B., & Weisz, J. (2009). *MATCH-ADTC: Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems.* Satellite Beach, FL: PracticeWise Publications.

The following books may be helpful in providing information on treating youth with Obsessive-Compulsive Disorder.

March, J., & Benton, C. (2007). *Talking Back to OCD.* New York: Guilford Press.

March, J., & Mulle, K. (1998). *OCD in Children and Adolescents: A Cognitive-Behavioral Treatment Manual.* New York: Guilford Press.

For Administrator: This section of the report may be given to parents (caregivers) or to a third party upon parental consent.

Multidimensional Anxiety Scale for Children 2nd Edition Feedback Handout for Parent Ratings

Youth's Name/ID:	Jennifer L
Youth's Age:	10 years
Date of Assessment:	October 10, 2012
Assessor's Name:	Dr. H. W.

This feedback handout explains the child's score, based on the parent's ratings of this child on the Multidimensional Anxiety Scale for Children 2nd Edition–Parent Form (MASC 2–P).

What is the MASC 2–P?
The MASC 2–P is a set of rating scales that is used to gather information from parents about how their child is feeling. It mostly measures the feelings or thoughts that make their child nervous or anxious, according to the parent's observations. The MASC 2–P is based on a test that was developed by Dr. John S. March, an expert in childhood anxiety disorders. Research has shown that the MASC 2–P is reliable and valid.

Why do parents complete the MASC 2–P?
Information from parents (or guardians) about their child's feelings and behaviors is extremely important. Parents can describe their child's symptoms and feelings in different situations, including in the home and the community. The most common reason for using the MASC 2–P is to better understand why the child may be feeling nervous or anxious, so that a plan can be made to help the child feel better. This information can also be used to see if the child's treatment is helping. The MASC 2–P is sometimes used as a routine checkup, even if there is no reason to think that the child is having a problem with anxiety. If you are not sure why you were asked to take the MASC 2–P, please ask the assessor listed at the top of this form.

How does the MASC 2–P work?
The parent read 50 statements that describe how the child has been thinking, feeling, or acting recently. The parent's ratings were then grouped together to see which kind of situations or things the child is most nervous about. The parent's choices were compared to those expected for other 10-year-old females. These results show if the child is having more anxious feelings or thoughts than her peers.

Results from the MASC 2–P
The following section lists the areas covered by the MASC 2–P. It also shows whether the parent observed average levels of anxiety, or if the parent's ratings of Jennifer L were higher than usual. If the parent's results of Jennifer L are different from the standard results, a description is given to help understand the difficulties that Jennifer L may be having. Jennifer L may not show *all* of the problems in an area; she may have only *some* of the problems. Also, please remember that a parent's high scores do not necessarily mean that Jennifer L has a serious problem or requires treatment. MASC 2–P results must be considered with other information (for example, interviews or other test results, and observations of the child) and be confirmed by a qualified clinician, before the decision is made that a problem exists.

Overall Anxiety Symptoms
Based on the parent's rating, Jennifer L may be feeling more anxious about various situations and things than other people her age.

Probability of having an Anxiety Problem
The parent's rating indicates that Jennifer L has a Borderline chance of having a problem with anxiety.

Anxiety Related to Being Alone
The parent's rating of Jennifer L was higher than average. Jennifer L may be feeling anxious about being alone or away from her parents, particularly in unfamiliar situations or places.

Generalized Anxiety
The parent's rating of Jennifer L was average. Jennifer L is not experiencing many symptoms of generalized anxiety, signs of which include worrying, being restless, and feeling sick.

Anxiety about Being Humiliated or Rejected
The parent's rating of Jennifer L was average. Jennifer L is not overly anxious about other people making fun of her and/or thinking negatively about her.

Anxiety Related to Performing Publicly
The parent's rating of Jennifer L was average. Jennifer L is not overly shy and/or worried about performing or doing things in front of other people.

Intrusive Thoughts and Compulsive Behaviors
The parent's rating of Jennifer L was higher than average. Jennifer L may be experiencing intrusive thoughts and compulsive behaviors.

Panic
The parent's rating of Jennifer L was higher than average. Jennifer L may be experiencing panic symptoms, which include: shortness of breath, dizziness, chest pains, racing heart, stomach sickness, sweaty or cold hands, and feelings of strangeness.

Feelings of Tension/Restlessness
The parent's rating of Jennifer L was higher than average. Jennifer L may be tense, restless, jumpy, and shaky.

Harm Avoidance Behaviors
The parent's rating of Jennifer L was higher than average. Jennifer L may be engaging in more harm avoidance behaviors compared to other people her age.