BASC™3

Behavior Assessment System for Children, Third Edition

Behavior Assessment System for Children, Third Edition (BASC™-3)
BASC-3 Parent Rating Scales - Child
Interpretive Summary Report with Intervention Recommendations

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

	Child Information
ID:	12345
Name:	Sample Examinee
Gender:	Female
Birth Date:	06/01/2005
Age:	10:1
Grade:	5th
School:	Riverview School

	Test Information
Test Date:	07/17/2015
Rater Name:	Anne Sample
Rater Gender:	Female
Relationship:	Mother
Administration Language:	English

Norm Group 1: General Combined

PsychCorp

[1.1 / RE1 / QG1]

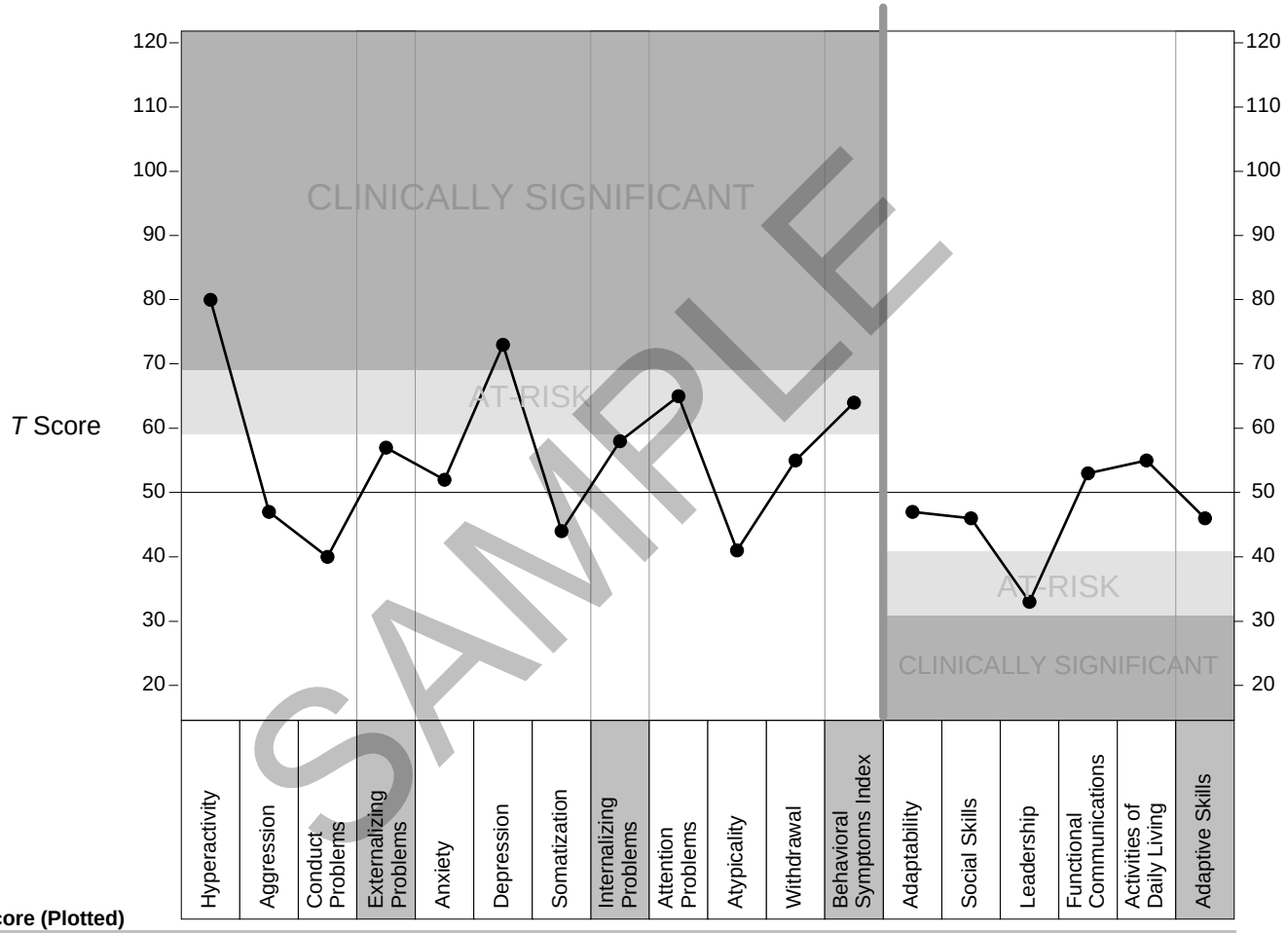
COMMENTS AND CONCERNS

No comments or concerns were provided.

VALIDITY INDEX SUMMARY

F Index	Response Pattern	Consistency
Acceptable	Acceptable	Acceptable
Raw Score: 0	Raw Score: 130	Raw Score: 10

CLINICAL AND ADAPTIVE *T*-SCORE PROFILE



***T* Score (Plotted)**	Hyperactivity	Aggression	Conduct Problems	Externalizing Problems	Anxiety	Depression	Somatization	Internalizing Problems	Attention Problems	Atypicality	Withdrawal	Behavioral Symptoms Index	Adaptability	Social Skills	Leadership	Functional Communications	Activities of Daily Living	Adaptive Skills
● General Combined	80	47	40	57	52	73	44	58	65	41	55	64	47	46	33	53	55	46

Percentile																		
General Combined	99	48	8	80	66	97	33	81	91	13	78	90	38	32	6	58	65	34

CLINICAL AND ADAPTIVE SCORE TABLE: General Combined Norm Group

Composite Score Summary

	Raw Score	*T* Score	Percentile Rank	90% Confidence Interval
Externalizing Problems	167	57	80	53-61
Internalizing Problems	169	58	81	54-62
Behavioral Symptoms Index	361	64	90	60-68
Adaptive Skills	234	46	34	43-49

Composite Comparisons	Difference	Significance Level	Frequency of Difference
Externalizing Problems vs. Internalizing Problems	-1	NS	

Mean *T* score of the BSI	**60**
Mean *T* score of the Adaptive Skills Composite	**47**

Scale Score Summary

	Raw Score	*T* Score	Percentile Rank	90% Confidence Interval	Ipsative Comparison		
					Difference	Significance Level	Frequency of Difference
Hyperactivity	22	80	99	73-87	20	0.05	1% or less
Aggression	2	47	48	39-55	-13	0.05	5% or less
Conduct Problems	1	40	8	34-46	-20	0.05	2% or less
Anxiety	13	52	66	46-58	-8	NS	
Depression	17	73	97	67-79	13	0.05	5% or less
Somatization	3	44	33	38-50	-16	0.05	15% or less
Atypicality	0	41	13	35-47	-19	0.05	1% or less
Withdrawal	7	55	78	49-61	-5	NS	
Attention Problems	13	65	91	60-70	5	NS	
Adaptability	14	47	38	41-53	0	NS	
Social Skills	19	46	32	41-51	-1	NS	
Leadership	5	33	6	27-39	-14	0.05	1% or less
Activities of Daily Living	20	55	65	48-62	8	NS	
Functional Communication	28	53	58	47-59	6	NS	

Note: All classifications of test scores are subject to the application of the standard error of measurement (*SEM*) when making classification decisions. Individual clinicians are advised to consider all case-related information to determine if a particular classification is appropriate. See the BASC-3 Manual for additional information on *SEM*s and confidence intervals.

CLINICAL VALIDITY INDEX NARRATIVES

The BASC-3 *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 score produced from the ratings of Sample by Anne 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 score produced from the ratings of Sample by Anne falls within the **Acceptable** range and indicates the rater consistently answered items when completing the rating form.

VALIDITY INDEX ITEM LISTS

Validity Index ratings for *F* Index, Response Pattern Index, and Consistency Index are all Acceptable.

F Index

The *F* Index rating is Acceptable.

Response Pattern Index

The Response Pattern Index rating is Acceptable.

Consistency Index

The Consistency Index rating is Acceptable.

CLINICAL AND ADAPTIVE SCALE NARRATIVES

This report is based on Anne Sample's rating of Sample's behavior using the BASC-3 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 57, with a 90% confidence interval range of 53-61 and a percentile rank of 80.

Sample's *T* score on Hyperactivity is 80 and has a percentile rank of 99. This *T* score falls in the Clinically Significant classification range and usually warrants follow-up. Sample's mother reports that Sample engages in many disruptive, impulsive, and uncontrolled behaviors.

Sample's *T* score on Aggression is 47 and has a percentile rank of 48. Sample's mother reports that Sample tends not to act aggressively any more often than others of her age.

Sample's *T* score on Conduct Problems is 40 and has a percentile rank of 8. Sample's mother reports that Sample demonstrates rule-breaking behavior no more often than others her age.

Internalizing Problems

The Internalizing Problems composite scale *T* score is 58, with a 90% confidence interval range of 54-62 and a percentile rank of 81.

Sample's *T* score on Anxiety is 52 and has a percentile rank of 66. Sample's mother reports that Sample displays anxiety-based behaviors no more often than others her age.

Sample's *T* score on Depression is 73 and has a percentile rank of 97. This *T* score falls in the Clinically Significant classification range and follow-up may be necessary. Sample's mother reports that Sample is withdrawn, pessimistic, and/or sad. Scores in this range usually warrant assessment of vegetative symptoms (e.g., weight loss or gain, fatigue). Suicidal tendencies should also be explored.

Sample's *T* score on Somatization is 44 and has a percentile rank of 33. Sample's mother reports that Sample complains of health-related problems to about the same degree as others her age.

Behavioral Symptoms Index

The Behavioral Symptoms Index (BSI) composite scale *T* score is 64, with a 90% confidence interval range of 60-68 and a percentile rank of 90. Sample'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.

Sample's *T* score on Atypicality is 41 and has a percentile rank of 13. Sample's mother reports that Sample generally displays clear, logical thought patterns and she is generally aware of her surroundings.

Sample's *T* score on Withdrawal is 55 and has a percentile rank of 78. Sample's mother reports that Sample does not avoid social situations and appears to be capable of developing and maintaining friendships with others.

Sample's *T* score on Attention Problems is 65 and has a percentile rank of 91. This *T* score falls in the At-Risk classification range and follow-up may be necessary. Sample's mother reports that Sample has difficulty maintaining necessary levels of attention at school. The problems experienced by Sample might disrupt academic performance and functioning in other areas.

Adaptive Skills

The Adaptive Skills composite scale *T* score is 46, with a 90% confidence interval range of 43-49 and a percentile rank of 34.

Sample's *T* score on Adaptability is 47 and has a percentile rank of 38. Sample's mother reports that Sample is able to adapt as well as most others her age to a variety of situations.

Sample's *T* score on Social Skills is 46 and has a percentile rank of 32. Sample's mother reports that Sample possesses sufficient social skills and generally does not experience debilitating or abnormal social difficulties.

Sample's *T* score on Leadership is 33 and has a percentile rank of 6. This *T* score falls in the At-Risk classification range and follow-up may be necessary. Sample's mother reports that Sample sometimes has difficulty making decisions, lacks creativity, and/or has trouble getting others to work together effectively.

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

Sample's *T* score on Functional Communication is 53 and has a percentile rank of 58. Sample's mother reports that Sample generally exhibits adequate expressive and receptive communication skills and that Sample is usually able to seek out and find new information when needed.

BASC-3 PRS-C INTERVENTION RECOMMENDATIONS

Note. Information contained in the Intervention Summary section of this report is based on the BASC-3 Behavior Intervention Guide, authored by Kimberly J. Vannest, Cecil R. Reynolds, and Randy W. Kamphaus.

Primary Improvement Areas	Secondary Improvement Areas	Adaptive Skill Strengths
- Hyperactivity - Depression	- Leadership - Attention Problems	- None

Sample's scores on Hyperactivity and Depression fall in the clinically significant range and probably should be considered among the first behavioral issues to resolve. Her score on Attention Problems is also elevated and may warrant targeted interventions and/or further monitoring to ensure it doesn't worsen.

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

Sample's BASC-3 profile indicates significant problems with Hyperactivity, Depression, and Attention Problems. Based on Anne Sample's ratings, Sample is experiencing problems with the following behaviors:

Hyperactivity

- fiddling with things
- interrupting others
- disrupting others
- having poor self-control
- acting without thinking
- being overly active
- not waiting for turn

Depression

- getting easily upset
- changing moods quickly
- complaining about not being liked
- being sad
- being pessimistic
- being lonely

Attention Problems

- paying attention
- listening well
- staying focused

Primary Improvement Area: Hyperactivity

Hyperactivity problems are considered to be one of Sample's most significant behavioral and emotional areas to address. The *DSM-5*™ lists symptoms such as fidgeting and squirming, leaving a seat unexpectedly, running or climbing inappropriately, failing to stay quiet, having difficulty waiting for a turn, or frequently interrupting and intruding socially. 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:

- Contingency Management
- Daily Behavior Report Cards (DBRC)
- Functional Behavioral Assessment
- Multimodal Interventions
- Parent Training
- Self-Management
- Task Modification

Detailed summaries of the Contingency Management and Self-Management intervention strategies are provided below. See the BASC-3 Behavior Intervention Guide for more information about these strategies and 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 that maintain hyperactive and impulsive behavior. Contingency management involves shaping the child's existing behavior and providing opportunities for the new, desired behavior to become internalized. Contingency management programs for hyperactivity include the individual or combined use of behavioral intervention strategies such as token economies; point systems; verbal praise; response cost; timeout from peers, reinforcers, attention, or privileges; varying amounts and frequency of teacher attention; verbal reprimands; and removal of praise. The goal of contingency management is to decrease the child's activity levels that negatively impact learning by reshaping the environment to reinforce or eliminate behaviors.

The essential elements of Contingency Management include the following:

1. Define the behavioral objectives clearly in operationally defined terms.
2. Identify pre-established and taught routines for earning and losing reinforcers.
3. Provide appropriate levels and types of reinforcers to shape behavior.
4. Deliver contingencies consistently at fixed or random intervals.
5. Implement response-cost contingencies as needed.

The procedural steps for incorporating contingency management strategies into the treatment of hyperactivity are summarized below. See the BASC-3 Behavior Intervention Guide for a detailed discussion of this topic.

PREP

- Select a behavior to target. There may be several that are problematic, but only choose one to start.
- Define the child's behavior in operational terms.
- Identify who will record baseline data on the frequency (i.e., how often) and/or severity (i.e., how much) of the hyperactivity. Use this information as a sample of functioning (e.g., length of time child remains seated, amount of time child waits before blurting out an answer) before the intervention to permit evaluation of the degree of post-intervention improvement.
- Consider the child's preference for reinforcers. For example, if the child enjoys computer games, computer time can be earned or lost. Reinforcement surveys can help to determine reinforcers that are appropriate and meaningful to the child.

IMPLEMENT

- Use the baseline data to set behavioral goals. Common goals include increasing the amount of time spent on task or decreasing the amount of off-task behavior during a specific interval. Modest increases in the amount of time spent on task, such as 20%, are more appropriate than large increases, such as 100%. If age appropriate, review the goals with the child or have the child participate in goal setting.
- Review the rules for providing reinforcers and ensure that the child understands them by asking him or her to repeat them back or to demonstrate when contingencies will occur and for what.
- Use a 1:1 ratio of behavior to reinforcement (i.e., every time the child performs the appropriate behavior, he or she is reinforced for it) when teaching new skills. If the behavior is a performance problem and not a skill problem, then it may be sufficient to reinforce less frequently (e.g., one out of three times the child performs the appropriate behavior). Intermittent intervals may also work, such as providing a non-scheduled ratio of reinforcement to behavior.

  * Consider using tokens or points that can be cashed in for reinforcers at the end of a specified time period as a modification to the intervention if necessary. Token systems are typically more effective once basic behavioral goals have been met, and the tokens can be used to maintain the behavior.
- Use an electronic or paper visual aid to track behavior. This will assist the child in understanding progress and which specific behaviors are being targeted.
- Provide the reinforcer to the child when he or she meets the goal. Do not provide the reinforcer if the goal is not met. Previously earned reinforcers, such as tokens, may be taken away when a goal is not met.

EVALUATE

- Collect and examine data during the use of contingency management. You should expect to see large changes in behavior in a few days. If you do not, reconsider the implementation. Ensure reinforcement opportunities are consistent and not missed. If it seems that reinforcement opportunities have been inconsistent or missed, revisit the implement phase.
- Remain aware of the potential for satiation or boredom with a reinforcer, such as filling up on candy or getting tired of listening to music.

  * After consistent effects are established, thin and fade the schedule of reinforcement to become more unpredictable and more irregular over time to avoid creating dependency on rewards to obtain appropriate behavior.

Hyperactivity Intervention Option 2: Self-Management

Self-management strategies for hyperactivity are techniques that children can use to monitor their own activity level, record the results, and compare this level to a predetermined acceptable level of activity. Self-management in this context involves a combination of three behavioral techniques: self-monitoring, self-monitoring plus reinforcement, and self-reinforcement. The goal of self-management training is to increase the child's awareness of his or her own level of activity in order to produce an automatic response without relying on external reinforcement or prompting.

The essential elements of Self-Management Training include the following:

1. Teach the child to monitor his or her own activity level.
2. Teach the child to record his or her own activity level.
3. Teach the child to check against self-determined goals.
4. Teach the child to reinforce him- or herself.

The procedural steps for incorporating self-management strategies into the treatment of hyperactivity are summarized below. See the BASC-3 Behavior Intervention Guide for a detailed discussion of this topic.

PREP

- Determine the specific area for self-management of hyperactivity (e.g., impulsivity control, hyperactive behavior).
- Determine the cuing method for the self-management (e.g., audio cue tape, wrist counter, teacher signal).
- Identify the paper self-recording form.
- Identify a goal.
- Determine a reinforcer.
- Gain commitment for participation from the child.
- Determine if an adult will provide simultaneous monitoring and recording for accuracy checks later. (If so, be sure to demonstrate to both the child and adult during the IMPLEMENT step.)

IMPLEMENT

- Teach self-monitoring procedures to the child including any new replacement behaviors (e.g., relaxation, deep breathing).
- Model the replacement behavior and indicate the level (i.e., the frequency and/or intensity) at which it should occur. Consider role-playing the expected level and behavior with the child as a check for understanding.
- Explain what cuing is and how it will work. Discuss and determine how often the cue will be heard or seen (e.g., every 30 seconds for 10 minutes, or every 1 minute for 20 minutes during a certain class or instructional time).
- Demonstrate how the child will record his or her attention to task when the cue is heard. The cues or prompts can be audio recorded or generated by a watch with intermittent beeps; intervals from 15 seconds up to 2 minutes can be used, depending on the child. At the sound of each cue, the child records his or her activity level by placing a check mark on the self-monitoring sheet.
- Ask the child to demonstrate the techniques and check for his or her understanding.
- Start the cuing and prompt if necessary to remind the child to record.
- Monitor activity levels and the replacement behavior. Provide a basic level of reinforcement for participation even if goals are not met, and provide a higher level of reinforcement when goals are met.

EVALUATE

- If an adult was monitoring the child at the same time, ask the child and adult to compare their recording forms.
  * Place scores on a single graph to facilitate the comparison.
  * Discuss if the scores are dramatically different allowing for some degree of error is acceptable and expected.
  * Highly praise and encourage perfectly matched scores as a goal depending on the number of intervals.
- Encourage the child to self-reinforce the behavior both for displaying appropriate activity levels and consistently and accurately recording the replacement behavior. Reinforcement is phased out as naturally occurring reinforcement takes place (e.g., better grades, better skills, less discipline in classrooms).

Primary Improvement Area: Depression

Depression-related symptoms and behaviors are considered one of Sample's most significant behavioral and emotional problems. The Depression scale on the BASC-3 rating scales indicates feelings of unhappiness, sadness, and stress that may result in an inability to carry out everyday activities. Depression is a condition

resulting from a combination of distorted cognitions; a lack of positive reinforcement for rational cognitions and behaviors; and an abundance of negative reinforcement for dysfunctional emotions, thinking, and behaviors. Cognitive theory attributes depression to negative or depression-producing thoughts or schemas. Negative events experienced by a person are linked to internal attributes, resulting in negative thinking that is used to interpret new events, which can ultimately lead to depression. Behavioral theory, on the other hand, considers depression to be a result of stressful events that lead to a disruption of adaptive behavior or stem from a lack of positive reinforcement and an excess of negative consequences.

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

- Cognitive-Behavioral Therapy (which typically includes one or more of the strategies below)
  - Psychoeducation
  - Problem-Solving Skills Training
  - Cognitive Restructuring
  - Pleasant-Activity Planning
  - Relaxation Training
  - Self-Management Training
  - Family Involvement
- Interpersonal Psychotherapy

A detailed summary of Relaxation Training and Problem-Solving Skills Training intervention is provided below. See the BASC-3 Behavior Intervention Guide for additional details about these interventions, along with the other intervention strategies listed above.

Depression Intervention Option 1: Relaxation Training

Relaxation training teaches children to relax by monitoring muscle tension created by stressful situations and events. Tension-related physical discomfort can exacerbate common depressive symptoms and cause a child to feel even worse about him- or herself and the situation. Improvements in the child's physical well-being can influence his or her thoughts and emotions and lead to a reduction in depressive symptomatology.

The goal of relaxation training is to help the child learn to use physiological changes in his or her body to relieve depressive symptoms.

The essential elements of Relaxation Training include the following:

1. Identify emotional triggers and their corresponding physical symptoms.
2. Teach the child the selected relaxation techniques.

The procedural steps for incorporating Relaxation Training into the treatment of depression are summarized below. See the BASC-3 Behavior Intervention Guide for a detailed discussion of this topic.

PREP

- Identify a specific symptom of the child's depression, along with the effect it has on the child (e.g., crying, headaches).

IMPLEMENT

- Teach the child to use a relaxation technique.
- Ask the child to imagine a situation that causes the undesired symptoms.

- Practice the technique with the child until he or she is able to perform the steps independently. Discuss how the technique can help the child feel calmer in the imagined situation. Model the steps for the child as needed.

EVALUATE

- Check in with the child periodically to assess whether the relaxation technique is being used correctly and at the appropriate times.
- Provide refresher training as necessary.

Depression Intervention Option 2: Problem-Solving Skills Training

Problem solving enables a child to identify negative thinking that occurs in a specific situation, recognize how those thoughts can lead to depression, and replace those thoughts and subsequent feelings with healthier ones.

The goal of problem-solving skills training is to help a child to view situational depression (caused by a lack of positive reinforcement) as a dilemma to be resolved rather than as a hopeless situation or an incurable disease.

The essential elements of Problem-Solving Training include the following:

1. Define the problem (e.g., thinking patterns, loss of appetite, decreased interest, agitation) as actionable.
2. Generate potential actions or solutions.
3. Evaluate these options.
4. Select the option that is the best fit and try it out.
5. Evaluate and revise as desired.

The procedural steps for incorporating problem-solving skills training into the treatment of depression are summarized below. See the BASC-3 Behavior Intervention Guide for a detailed discussion of this topic.

PREP

- Identify acceptable times and locations to meet privately with the child or the child and parent(s) as appropriate.
- Prepare to gather information from outside sources about the types of challenges and problems the child is facing if the child is not forthcoming or has limited self-awareness.

IMPLEMENT

- Discuss with the child the likely causes of his or her depression and the resulting symptoms.
- Reframe these in the context of problems to be solved rather than an illness to be treated.
- Brainstorm with the child to generate solutions to the problem.

  * For example, a child may begin to experience feelings of loneliness after quitting the swim team. Solutions to this problem might include rejoining the team or joining a similar or more interesting social group.

  * Divorce, death, and other incidents involving bereavement and loss of control require solutions that focus on the child's feelings, thoughts, or behaviors rather than the event itself. The event itself cannot be changed, but the feelings, thoughts, and behaviors that result from the event may be actionable.
- Together, evaluate the pros and cons of each solution and choose the best option to try.
- Be aware of and sensitive to the desires, strengths, and needs of the child during solution generation and selection. Start with simple solutions to avoid overwhelming the child.
- Work out a gradual approach with the child as you would for a homework assignment, outlining the steps needed and setting a target date for completion.

EVALUATE

- Monitor the child's progress. Consider revising the plan as necessary. Provide plenty of encouragement both for attempts and for successes.

Secondary Improvement Area: Attention Problems

Attention problems are considered to be one of Sample'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 with attention problems exhibit an inability to control and direct attention to the demands of a task and are frequently distracted by internal distractions and irrelevant stimuli, even in a relatively quiet classroom environment.

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:

- Classwide Peer Tutoring
- Computer-Assisted Instruction
- Contingency Management
- Daily Behavior Report Cards
- Modified-Task Presentation Strategies
- Multimodal Interventions
- Parent Training
- Self-Management

Detailed summaries of the Daily Behavior Report Cards and Modified Task-Presentation intervention strategies are provided below. See the BASC-3 Behavior Intervention Guide for more information about these strategies and 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 DBRCs strategy is to change behavior by providing systematic feedback on performance and progress to children and parents, followed by appropriate reinforcement. The result is increased attention (or decreased inattention) during specific tasks and conditions.

The essential elements of DBRCs include the following:

1. Define the target behaviors.
2. Monitor and record behaviors daily.
3. Provide reinforcement for exhibiting the target behaviors.
4. Communicate results to children and parents.

The procedural steps for incorporating DBRCs into the treatment of attention problems are summarized below. See the BASC-3 Behavior Intervention Guide for a detailed discussion of this topic.

PREP

- Identify the target behaviors for improving attention.
- Identify the rater of the target behavior.

- Identify if the DBRC will be used for communication, monitoring, or performance feedback, and if it will involve contingencies. Contingencies may be delivered at school during feedback sessions and at home for performance at school.
- Create and explain the rating system to raters. For example, assign a letter grade to the child's performance for each day. Each target behavior is rated daily. Letter grades (instead of frequency of behavior, for example) are preferable because they are usually more meaningful to children and parents.
- Explain the behavioral anchors (i.e., typical behavior for earning each grade) to avoid variance 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 or more might earn an "A."

IMPLEMENT

- Ask the rater to begin ratings on a specific day and during a specific time period.
- Show ratings to the child in feedback sessions and provide brief, encouraging feedback.
- Consider graphing or charting progress, depending on the age, developmental level, and interest of the child.
- Consider using the ratings as part of a checking in and checking out system. The child may check in at the beginning of the day to get a pep talk and receive reminders of goals or targets, and then check out at the end of the day to review performance and discuss goals or targets for the next day.
- Reward the child either at home or school for meeting performance goals. This step may or may not be needed for some children.

EVALUATE

- Compare the ratings from before the intervention with the ratings during the intervention to determine if the change occurring is large enough to be useful for the school setting.

  * Changes in behavior should be moderate to large when the intervention is used throughout the day.
- Ensure reinforcement has been used consistently if the change is not moderate to large. Reassess reinforcer quality and feedback quality. Consider graphing or charting performance goals if those visual aids are not currently in place.

<u>Attention Problems Intervention Option 2: Modified Task-Presentation</u>

Modified task-presentation strategies refer to a collection of specific options that can be used to increase the interest level of an activity, with the goal of increasing the amount of time the child attends to learning the task or activity. Based on information obtained through a functional behavioral assessment, tasks are altered using antecedent instructional modifications.

A number of modification strategies have been recommended by researchers, including:

1. Offering a choice of instructional activities
2. Providing guided notes and instruction in attending to relevant information
3. Using high-interest activities and hands-on demonstrations
4. Modifying in-class assignments and responses
5. Modifying homework
6. Highlighting relevant material or key information with colors, symbols, or font changes

The procedural steps for incorporating modified task-presentation strategies into the treatment of attention problems are summarized below. See the BASC-3 Behavior Intervention Guide for a detailed discussion of this topic.

PREP

- Use assessment or observation data to determine which strategies best fit the person delivering the content, the needs of the child, and the content of the lesson.
- Identify the differences in when, where, and how the typical group instruction or tasks vary from those for a targeted or individual group, or if the strategy will be a menu-like choice selection for all children.
- Prepare materials if necessary, and plan the modification if it involves changing presentation style or a modification to the environment (e.g., music).

IMPLEMENT

- Present the task using the modified strategy.

EVALUATE

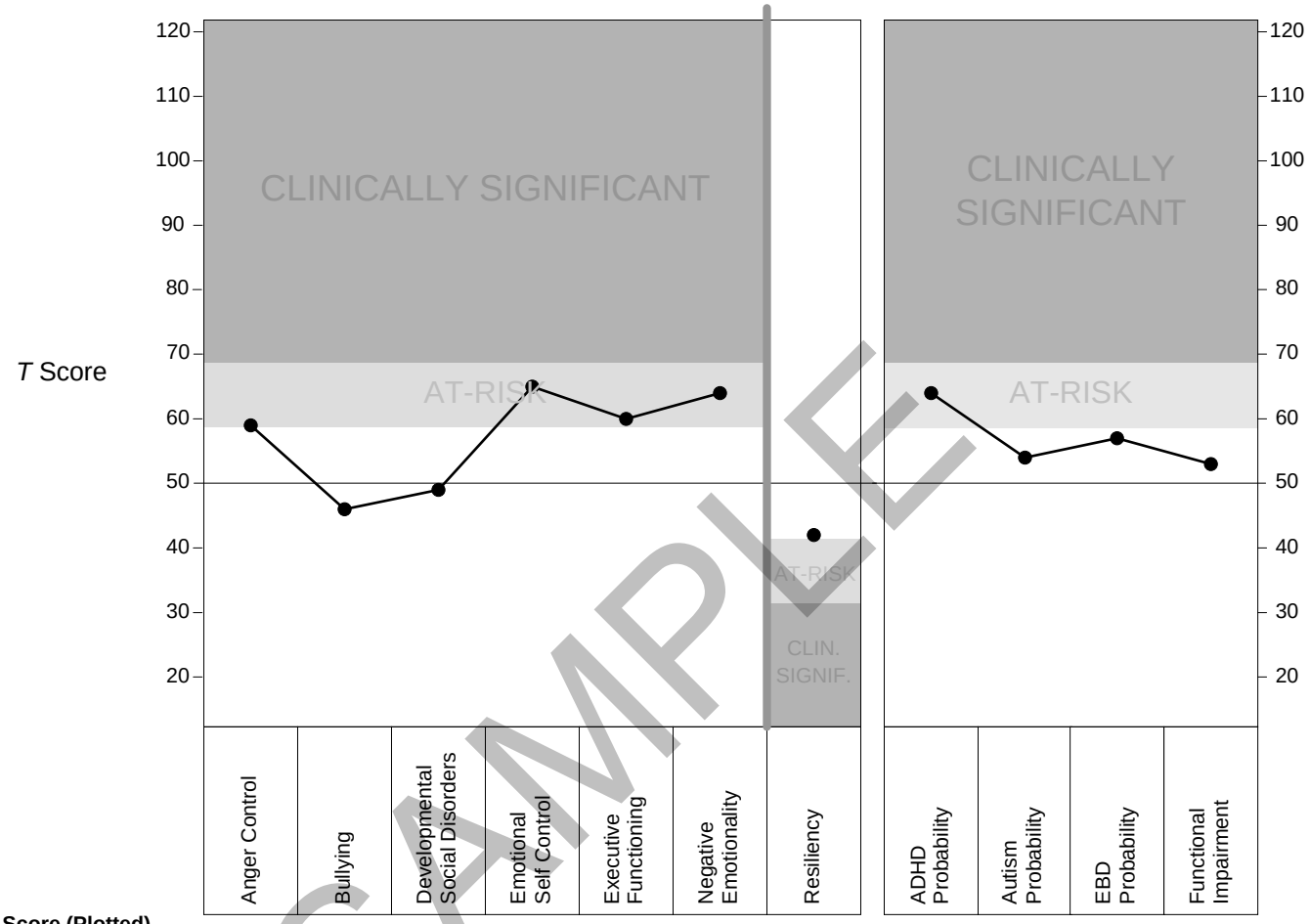
- Engage in direct observation of the child's attention problems and class performance as a whole.
- Determine which modifications seem to have the greatest positive impact and which are ineffective using observational data. Continue use of those modifications that are effective, and discontinue those that are not.

Concluding Recommendations

When using any intervention, it is important to monitor the effectiveness of the interventions you are trying. The BASC-3 Flex Monitor is an Internet-based tool that can used to monitor and track the impact of intervention strategies. Monitoring forms can be selected from a list of existing forms, or forms can be customized to meet the specific needs of each implementation. Forms can be completed online or printed for completion. Additional information about the BASC-3 Flex Monitor can be found at www.pearsonclinical.com.

Regardless of the method used to monitor progress, it is important to document the effectiveness of the interventions you have tried with Sample. The BASC-3 Behavior 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 problem(s). It also includes a section to record the fidelity of the intervention approach that has been used, a factor that is critical to the success of any intervention program.

CONTENT SCALE AND INDEX *T*-SCORE PROFILE



***T* Score (Plotted)**											
● General Combined	59	46	49	65	60	64	42	64	54	57	53
Percentile											
General Combined	81	42	54	92	83	91	22	91	75	78	67

CONTENT SCALE SCORE TABLE: General Combined Norm Group

	Raw Score	*T* Score	Percentile Rank	90% Confidence Interval
Anger Control	9	59	81	52-66
Bullying	1	46	42	40-52
Developmental Social Disorders	10	49	54	43-55
Emotional Self-Control	14	65	92	59-71
Executive Functioning	30	60	83	55-65
Negative Emotionality	9	64	91	57-71
Resiliency	12	42	22	36-48

Content Scale Narratives

Sample's *T* score on Anger Control is 59 and has a percentile rank of 81. Sample's mother reports that Sample regulates her affect and self-control under adverse conditions as well as others her age.

Sample's *T* score on Bullying is 46 and has a percentile rank of 42. Sample's mother reports that Sample does not tend to act in a threatening or intrusive manner.

Sample's *T* score on Developmental Social Disorders is 49 and has a percentile rank of 54. Sample's mother reports that Sample has social and communication skills that are typical of others her age.

Sample's *T* score on Emotional Self-Control is 65 and has a percentile rank of 92. This *T* score falls in the At-Risk classification range and follow-up may be necessary. Sample's mother reports that Sample can become easily upset, frustrated, and/or angered in response to environmental changes.

Sample's *T* score on Executive Functioning is 60 and has a percentile rank of 83. This *T* score falls in the At-Risk classification range and follow-up may be necessary. Sample's mother reports that Sample sometimes has difficulty controlling and maintaining her behavior and mood.

Sample's *T* score on Negative Emotionality 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. Sample's mother reports that Sample has a tendency to react negatively when faced with changes in everyday activities or routines.

Sample's *T* score on Resiliency is 42 and has a percentile rank of 22. Sample's mother reports that Sample is able to overcome stress and adversity about as well as others her age.

EXECUTIVE FUNCTIONING INDEX SUMMARY

Overall Executive Functioning Index	Problem Solving Index	Attentional Control Index	Behavioral Control Index	Emotional Control Index
Not Elevated	Not Elevated	Elevated	Elevated	Not Elevated
Raw Score: 38	Raw Score: 11	Raw Score: 13	Raw Score: 11	Raw Score: 3

EXECUTIVE FUNCTIONING INDEX NARRATIVES

Sample's Overall Executive Functioning Index score is 38. This score falls in the Not Elevated classification range. Summary information for problem solving, attentional control, behavioral control, and emotional control is provided below.

Sample's Problem Solving Index score is 11. This score falls in the Not Elevated classification range.

Sample's Attentional Control Index score is 13. This score falls in the Elevated classification range and follow-up may be necessary. Anne reports that Sample sometimes has trouble concentrating, following directions, and may have a tendency to make careless mistakes.

Sample's Behavioral Control Index score is 11. This score falls in the Elevated classification range and follow-up may be necessary. Anne reports that Sample sometimes has difficulty maintaining her self-control and has difficulty regulating impulsive behaviors.

Sample's Emotional Control Index score is 3. This score falls in the Not Elevated classification range.

CLINICAL PROBABILITY INDEX

The BASC-3 items endorsed by Sample's parent/guardian resulted in a clinically significant Hyperactivity scale score, a pattern that occurred in 4.7% of the standardization sample. Children with this profile may exhibit problems with behavioral regulation and may 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) and to be worse in situations requiring sustained mental effort.

Sample'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 presentation, as opposed to predominantly hyperactive/impulsive or inattentive presentation.

Sample also exhibited an elevation on the BASC-3 internalizing scale of Depression, a pattern that occurred in 64.7% of the BASC-3 standardization sample with a clinically significant Hyperactivity scale score. This profile indicates that she is experiencing increased levels of internal distress characterized by depressed mood, and additional diagnostic considerations are likely to include depressive disorders (e.g., major depressive disorder, bipolar disorder). Children with these problems may exhibit inattention and restlessness, which can appear behaviorally similar to ADHD. Furthermore, it may be the case that emotional distress is causing Sample to act out, or that negative feedback related to her behavioral issues is resulting in these internalizing problems. Thus, further investigation is warranted in order to clarify the complex relationship between her various behavioral and mood symptoms.

If it is believed that Sample is exhibiting comorbid mood and behavioral problems, the following considerations may be helpful. With respect to ADHD, it is useful to note that symptoms of hyperactivity or inattention are typically present before age 7 in ADHD, whereas the onset of these behaviors may occur later in mood disorders. Furthermore, children with ADHD are likely to exhibit these symptoms in situations that require sustained effort but are motivated by highly reinforcing activities. Conversely, individuals with depression may be more likely to exhibit poor motivation and behavioral agitation even while engaged with pleasurable activities. ADHD can be diagnosed with mood difficulties if criteria for both diagnoses are met. In these cases, it is important to note that restlessness and inattention are typically rated positively for mood disorders only in cases where they are significantly worse during periods of mood disturbance relative to what is accounted for by ADHD alone.

Children who experience difficulties with hyperactivity and attention problems present a unique challenge to parents. They may require frequent redirection, more consistent parenting practices, and stronger reinforcements/consequences in order to manage their behavior. 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., using the BASC-3 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) might help the therapist prioritize treatment goals.

DSM-5™ DIAGNOSTIC CRITERIA

Listed below are *DSM-5* Diagnostic Criteria based on the ratings obtained from Anne on the PRS-C rating form. Each section first presents a list of symptoms of the disorder, along with PRS-C items that correspond to these symptoms. Then related *DSM-5* criteria and codes are presented. While information from PRS-C items will likely be helpful for making a diagnosis, clinicians are strongly encouraged to use additional information that is gathered outside of the BASC-3 PRS-C form (e.g., observations of behavior, clinical interviews) when making a formal diagnosis. Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (Copyright © 2013).

Attention-Deficit/Hyperactivity Disorder (ADHD)

List of Symptoms

Symptoms for ADHD: Inattention	*Relevant BASC-3 PRS-C Items and Anne Sample's Responses*
__ Does not pay close attention to details, or makes careless mistakes	*Note: Item Responses omitted from this sample for copyright protection.*
X Has difficulty sustaining attention	
X Does not seem to listen when spoken to	
__ Does not follow through on instructions and fails to finish tasks	
__ Has trouble organizing activities/tasks	
__ Dislikes/avoids tasks that involve sustained mental effort	
__ Loses necessary materials	
__ Is easily distracted	
__ Is often forgetful	

Symptoms for ADHD: Hyperactivity/Impulsivity	*Relevant BASC-3 PRS-C Items and Anne Sample's Responses*
X Fidgets or squirms excessively	
__ Leaves seat inappropriately	*Note: Item Responses omitted from this sample for copyright protection.*
X Feels restless	
__ Has difficulty engaging in activities quietly	
X Acts as if "driven by a motor"	
__ Talks excessively	
X Blurts out answers	
X Has trouble waiting her turn	
X Interrupts others' conversations or activities	

DSM-5 Codes and Diagnostic Criteria

Attention-Deficit/Hyperactivity Disorder (ADHD) 314.0x (F90.x)

See the Q-global Resource Library for a reprint of the *DSM-5* Diagnostic Criteria for ADHD.

Major Depressive Disorder

List of Symptoms

	Symptoms for Major Depressive Episode	*Relevant BASC-3 PRS-C Items and Anne Sample's Responses*
X	Depressed (or irritable in children/adolescents) mood most of the day, almost every day	*Note: Item Responses omitted from this sample for copyright protection.*
__	Greatly decreased interest or pleasure in all, or almost all, activities most of the day, almost every day	
__	Significant weight gain/loss (change of more than 5% of body weight in a month) without dieting, or increase/decrease in appetite almost every day (*Note.* For children, failure to make expected weight gains)	
__	Insomnia or excessive sleep almost every day	
__	Observable psychomotor agitation/retardation almost every day	
__	Fatigue/loss of energy almost every day	
X	Feelings of worthlessness or excessive/inappropriate guilt almost every day	
__	Difficulty thinking, concentrating, or making decisions almost every day	
__	Recurrent thoughts about death or suicide, a suicide attempt, or a specific suicide plan	

DSM-5 Codes and Diagnostic Criteria

Major Depressive Disorder 296.xx (F32.x and F33.x)

See the Q-global Resource Library for a reprint of the *DSM-5* Diagnostic Criteria for Major Depressive Disorder.

Disruptive Mood Dysregulation Disorder

List of Symptoms

Symptoms for Disruptive Mood Dysregulation Disorder	*Relevant BASC-3 PRS-C Items and Anne Sample's Responses*
Area 1: Severe, Recurrent Temper Outbursts	
__ Has verbally or physically aggressive temper outbursts	*Note: Item Responses omitted from this sample for copyright protection.*
Area 2: Mood Between Temper Outbursts	
X Persistently irritable or angry mood between temper outbursts	

DSM-5 Codes and Diagnostic Criteria

Disruptive Mood Dysregulation Disorder 296.99 (F34.8)

See the Q-global Resource Library for a reprint of the *DSM-5* Diagnostic Criteria for Disruptive Mood Dysregulation Disorder.

Persistent Depressive Disorder

List of Symptoms

Area 1: Depressed Mood	*Relevant BASC-3 PRS-C Items and Anne Sample's Responses*
X Depressed mood	

Note: Item Responses omitted from this sample for copyright protection.

Area 2: Symptoms Associated With Depressed Mood	
__ Overeating or decreased appetite	
__ Insomnia or excessive sleep	
__ Fatigue or decreased energy	
X Poor self-esteem	
X Difficulty making decisions or concentrating	
__ Feeling hopeless	

DSM-5 Codes and Diagnostic Criteria

Persistent Depressive Disorder 300.4 (F34.1)

See the Q-global Resource Library for a reprint of the *DSM-5* Diagnostic Criteria for Persistent Depressive Disorder.

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-3 in the future to determine progress toward meeting the associated behavioral objectives.

Note: Item Responses omitted from this sample for copyright protection.

CRITICAL ITEMS

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

Note: Item Responses (Critical Items and Items by Scale) omitted from this sample for copyright protection.

ITEM RESPONSES

1: 2	2: 3	3: 1	4: 2	5: 4	6: 2	7: 1	8: 2	9: 2	10: 1
11: 3	12: 1	13: 1	14: 4	15: 1	16: 2	17: 1	18: 2	19: 1	20: 2
21: 2	22: 3	23: 2	24: 3	25: 2	26: 2	27: 3	28: 2	29: 1	30: 1
31: 2	32: 3	33: 4	34: 2	35: 1	36: 1	37: 3	38: 2	39: 1	40: 3
41: 1	42: 3	43: 1	44: 2	45: 2	46: 3	47: 3	48: 1	49: 1	50: 2
51: 1	52: 1	53: 2	54: 2	55: 1	56: 4	57: 2	58: 1	59: 1	60: 3
61: 4	62: 1	63: 1	64: 1	65: 2	66: 1	67: 2	68: 1	69: 2	70: 1
71: 2	72: 1	73: 3	74: 1	75: 1	76: 4	77: 3	78: 1	79: 2	80: 3
81: 1	82: 1	83: 1	84: 2	85: 2	86: 3	87: 1	88: 1	89: 1	90: 4
91: 2	92: 3	93: 3	94: 1	95: 2	96: 1	97: 3	98: 1	99: 3	100: 3
101: 1	102: 2	103: 3	104: 2	105: 1	106: 1	107: 2	108: 1	109: 3	110: 3
111: 1	112: 2	113: 2	114: 3	115: 1	116: 3	117: 1	118: 1	119: 3	120: 2
121: 2	122: 1	123: 1	124: 1	125: 1	126: 1	127: 3	128: 2	129: 1	130: 3
131: 1	132: 1	133: 2	134: 4	135: 3	136: 1	137: 3	138: 2	139: 1	140: 1
141: 1	142: 3	143: 2	144: 1	145: 1	146: 1	147: 2	148: 2	149: 3	150: 1
151: 3	152: 1	153: 4	154: 2	155: 1	156: 1	157: 1	158: 1	159: 3	160: 2
161: 1	162: 1	163: 1	164: 1	165: 4	166: 3	167: 1	168: 2	169: 3	170: 2
171: 1	172: 3	173: 2	174: 3	175: 3					