BASC™3

Behavior Assessment System for Children, Third Edition

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

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Child Information		Test Information	
ID:		Test Date:	03/04/2025
Name:	Elias Lewis	Rater Name:	John H. Lewis
Gender:	Male	Rater Gender:	Male
Birth Date:	08/31/2008	Relationship:	Father
Age:	16:6	Administration Language:	English
Grade:			
School:			

Norm Group 1: General Combined
Norm Group 2: General Gender-Specific
Norm Group 3: Clinical Gender-Specific
Norm Group 4: ADHD Combined

[1.16 / RE1 / QG1]

Pearson

COMMENTS AND CONCERNS

Rater General Comments

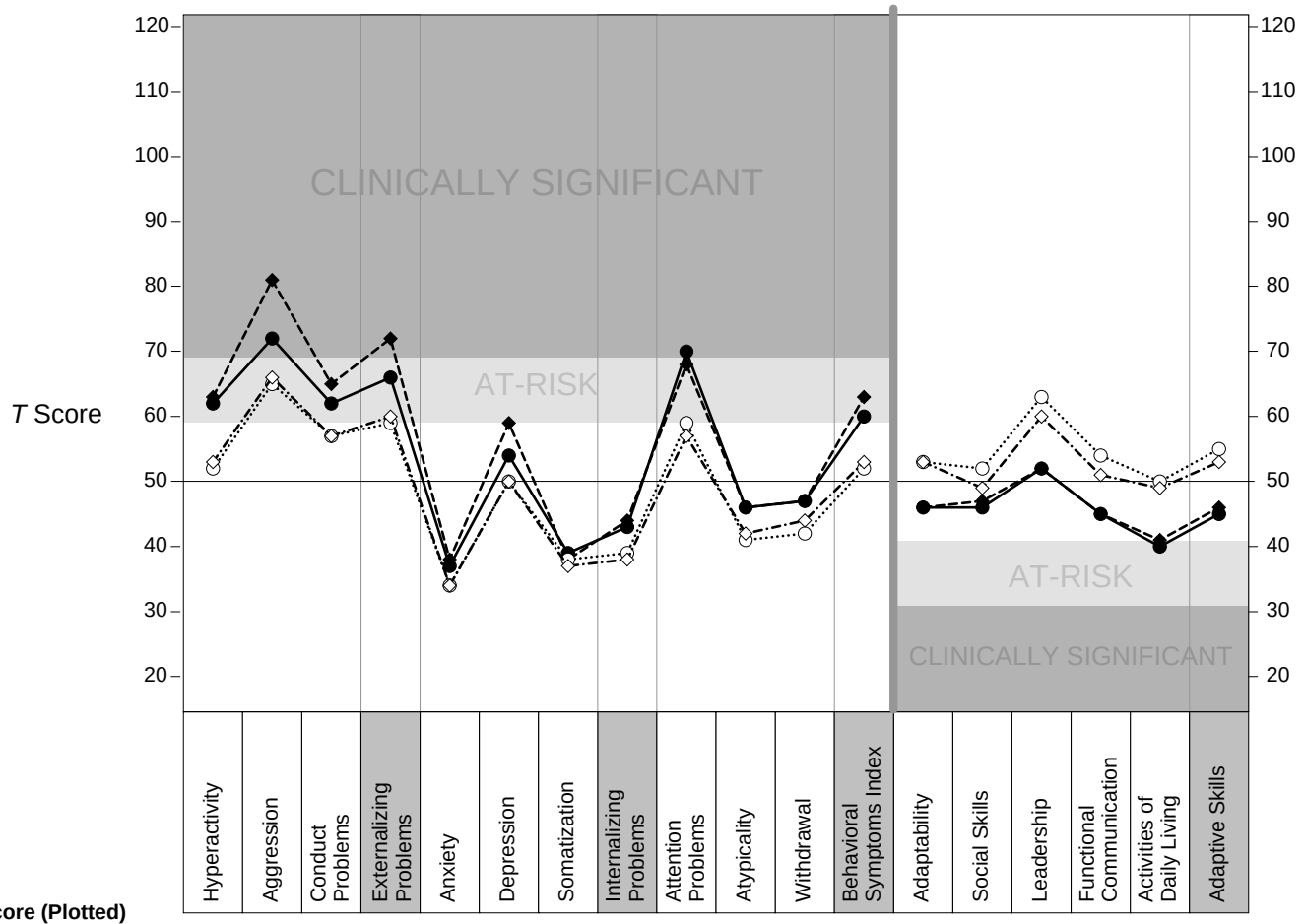
What are the behavioral and/or emotional strengths of this child?
He is a strong leader, very confident, and "outward." He can adapt to situations quickly and is ambitious to succeed, although he is not clear how. He listens to his father's discipline even when he doesn't like it and is generally respectful most of the time. He is friendly to new people and respectful at appropriate times when meeting new adults.

Please list any specific behavioral and/or emotional concerns you have about this child.
He likes the power associated with gang culture. He seems to look to his exterior for his self-worth. i.e., he has to act like he is super rich and likes brand clothes. That is who he thinks he is. I feel it all comes from a deep sense of insecurity that I can figure out with him. He is a handsome, smart, cool kid who feels like he isn't enough.

VALIDITY INDEX SUMMARY

F Index	Response Pattern	Consistency
Acceptable Raw Score: 0	Acceptable Raw Score: 117	Caution Raw Score: 11

CLINICAL AND ADAPTIVE *T*-SCORE PROFILE



***T* Score (Plotted)**																		
● General Combined	62	72	62	66	37	54	39	43	70	46	47	60	46	46	52	45	40	45
◆ Gen. Gender-Spec.	63	81	65	72	38	59	38	44	68	46	47	63	46	47	52	45	41	46
❍ Clin. Gender-Spec.	52	65	57	59	34	50	38	39	59	41	42	52	53	52	63	54	50	55
◊ ADHD Combined	53	66	57	60	34	50	37	38	57	42	44	53	53	49	60	51	49	53
Percentile																		
General Combined	88	96	90	93	3	78	4	21	97	46	47	87	35	32	53	28	16	31
Gen. Gender-Spec.	89	99	92	96	7	84	7	31	96	49	48	90	32	36	57	30	20	31
Clin. Gender-Spec.	65	90	80	82	2	57	4	10	81	18	25	63	63	57	89	65	50	70
ADHD Combined	65	91	79	84	2	55	3	9	75	19	31	65	61	46	84	55	45	61

CLINICAL AND ADAPTIVE SCORE TABLE: General Combined Norm Group

Composite Score Summary

	Raw Score	*T* Score	Percentile Rank	95% Confidence Interval
Externalizing Problems	196	66	93	62-70
Internalizing Problems	130	43	21	39-47
Behavioral Symptoms Index	351	60	87	57-63
Adaptive Skills	229	45	31	42-48

Composite Comparisons	Difference	Significance Level	Frequency of Difference
Externalizing Problems vs. Internalizing Problems	23	0.01	1% or less

Mean *T* score of the BSI	**59**
Mean *T* score of the Adaptive Skills Composite	**46**

Scale Score Summary

	Raw Score	*T* Score	Percentile Rank	95% Confidence Interval	Ipsative Comparison		
					Difference	Significance Level	Frequency of Difference
Hyperactivity	9	62	88	55-69	3	NS	
Aggression	13	72	96	66-78	13	0.05	5% or less
Conduct Problems	12	62	90	56-68	3	NS	
Anxiety	2	37	3	30-44	-22	0.05	2% or less
Depression	9	54	78	49-59	-5	NS	
Somatization	0	39	4	33-45	-20	0.05	2% or less
Atypicality	2	46	46	40-52	-13	0.05	2% or less
Withdrawal	4	47	47	40-54	-12	0.05	10% or less
Attention Problems	19	70	97	63-77	11	0.05	10% or less
Adaptability	14	46	35	39-53	0	NS	
Social Skills	18	46	32	40-52	0	NS	
Leadership	15	52	53	45-59	6	NS	
Activities of Daily Living	11	40	16	32-48	-6	NS	
Functional Communication	22	45	28	38-52	-1	NS	

Note: All classifications of test scores are subject to the application of the standard error of measurement (*SEM*) when making classification decisions. Individual clinicians are advised to consider all case-related information to determine if a particular classification is appropriate. See the BASC-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 Elias by John falls within the **Acceptable** range and does not indicate the presence of negative response distortion.

The Consistency Index identifies situations when the rater has given inconsistent responses to items that are typically answered in a similar way, based on comparisons made to raters from the general population. The Consistency Index was designed to identify ratings that might not be easily interpretable due to these response discrepancies. It can be elevated for a variety of reasons, including a lack of effort or attention when completing the ratings, a rater changing their perspective regarding the child's behavior when completing the rating form, a rater having difficulty understanding the items due to a low reading ability or language comprehension problems, or different raters completing different parts of the form (e.g., the child's math teacher completing one part of the form and a science teacher completing the other part of the form). All of these scenarios are highly likely to result in an elevated Consistency Index score, alerting the clinician to a high probability that the obtained ratings across BASC-3 scales might not be sufficiently reliable to interpret. Frequently, a brief interview with the person providing the ratings can provide valuable insights into the reasons for an elevated Consistency Index.

John's ratings of Elias have produced a Consistency Index score that falls within the **Caution** range. This may indicate that John experienced some difficulty when completing the rating form. Caution may be warranted when interpreting the BASC-3 scale scores. A review of the individual item pairs contributing to the Consistency Index will be useful in determining if the obtained response differences can be reasonably explained or if they are likely the result of some other undesirable factor.

VALIDITY INDEX ITEM LISTS

A summary of the ratings and items contributing to the validity indexes with cautionary ratings are presented below.

F Index

The *F* Index rating is Acceptable.

Response Pattern Index

The Response Pattern Index rating is Acceptable.

Consistency Index

69. Bullies others. (Sometimes)
138. Hurts others on purpose. (Never)

98. Is in trouble with the police. (Sometimes)
162. Uses illegal drugs. (Never)

87. Is easily distracted. (Often)
123. Has trouble concentrating. (Almost always)

106. Tries to help others be their best. (Sometimes)
147. Encourages others to do their best. (Often)

43. Listens to directions. (Often)
79. Listens carefully. (Sometimes)

26. Loses control when angry. (Never)
63. Gets angry easily. (Sometimes)

93. Is cruel to others. (Sometimes)
160. Puts others down. (Often)

3. Is easily upset. (Sometimes)
48. Overreacts to stressful situations. (Never)

23. Talks over others. (Sometimes)
172. Interrupts others when they are speaking. (Almost always)

53. Acts out of control. (Never)
164. Is overly aggressive. (Sometimes)

CLINICAL AND ADAPTIVE SCALE NARRATIVES

This report is based on John H. Lewis's rating of Elias'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 66, with a 95% confidence interval range of 62-70 and a percentile rank of 93. Elias's *T* score on this composite scale falls in the At-Risk classification range.

Elias's *T* score on Hyperactivity 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. Elias's father reports Elias displays a moderately high number of disruptive, impulsive, and uncontrolled behaviors. Such behaviors are probably not considered severe but may warrant further follow-up, particularly if other scales are elevated.

Elias's *T* score on Aggression is 72 and has a percentile rank of 96. This *T* score falls in the Clinically Significant classification range and usually warrants follow-up. Elias's father reports Elias displays a high number of aggressive behaviors and may be reported as being argumentative, defiant, and/or threatening to others.

Elias's *T* score on Conduct Problems is 62 and has a percentile rank of 90. This *T* score falls in the At-Risk classification range and follow-up may be necessary. Elias's father reports Elias sometimes engages in rule-breaking behavior such as cheating, deception, and/or stealing.

Internalizing Problems

The Internalizing Problems composite scale *T* score is 43, with a 95% confidence interval range of 39-47 and a percentile rank of 21.

Elias's *T* score on Anxiety is 37 and has a percentile rank of 3. Elias's father reports Elias displays relatively few anxiety-based behaviors compared to others of the same age.

Elias's *T* score on Depression is 54 and has a percentile rank of 78. Elias's father reports Elias displays depressive behaviors no more often than others of the same age.

Elias's *T* score on Somatization is 39 and has a percentile rank of 4. Elias's father reports Elias complains of health-related problems less frequently than others of the same age.

Behavioral Symptoms Index

The Behavioral Symptoms Index (BSI) composite scale *T* score is 60, with a 95% confidence interval range of 57-63 and a percentile rank of 87. Elias'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.

Elias's *T* score on Atypicality is 46 and has a percentile rank of 46. Elias's father reports Elias generally displays clear, logical thought patterns and a general awareness of his surroundings.

Elias's *T* score on Withdrawal is 47 and has a percentile rank of 47. Elias's father reports Elias does not avoid social situations and appears to be capable of developing and maintaining friendships with others.

Elias's *T* score on Attention Problems is 70 and has a percentile rank of 97. This *T* score falls in the Clinically Significant classification range and usually warrants follow-up. Elias's father reports Elias has significant difficulty maintaining necessary levels of attention. The problems experienced by Elias are probably interfering with

academic performance and functioning in other areas.

Adaptive Skills

The Adaptive Skills composite scale *T* score is 45, with a 95% confidence interval range of 42-48 and a percentile rank of 31.

Elias's *T* score on Adaptability is 46 and has a percentile rank of 35. Elias's father reports Elias is able to adapt as well as most others of the same age to a variety of situations.

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

Elias's *T* score on Leadership is 52 and has a percentile rank of 53. Elias's father reports Elias, when compared to others of the same 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.

Elias's *T* score on Activities of Daily Living is 40 and has a percentile rank of 16. This *T* score falls in the At-Risk classification range and follow-up may be necessary. Elias's father reports Elias has difficulty performing simple daily tasks in a safe and efficient manner.

Elias's *T* score on Functional Communication is 45 and has a percentile rank of 28. Elias's father reports Elias generally exhibits adequate expressive and receptive communication skills and Elias is usually able to seek out and find new information when needed.

BASC-3 PRS-A 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
- Aggression - Attention Problems	- Conduct Problems - Hyperactivity - Activities of Daily Living	- None

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

Note that Elias has scores on Hyperactivity and Activities of Daily Living that are areas of concern. Interventions for these areas are not provided in this report. However, these areas may require additional follow up.

Elias's BASC-3 profile indicates significant problems with Aggression, Attention Problems, and Conduct Problems. Based on John H. Lewis's ratings, Elias is experiencing problems with the following behaviors:

Aggression

- being flexible
- speaking kindly to others
- getting back at others

Attention Problems

- paying attention
- listening well
- staying focused
- missing deadlines

Conduct Problems

- using foul language
- breaking rules

Primary Improvement Area: Aggression

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

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

- Bully Prevention
- Child-Centered Play Therapy

- Classroom Social Dynamics
- Cognitive Restructuring
- Counseling Groups
- Good Behavior Game (GBG)
- Incremental Theory Training
- Mindfulness Training
- Peer-Mediated Conflict Resolution and Negotiation
- Problem-Solving Training
- Replacement Behavior Training
- Social Skills Training
- Verbal Mediation

Detailed summaries of the Problem-Solving Training and Replacement Behavior Training 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.

Aggression Intervention Option 1: Problem-Solving Training

Problem-solving training for aggression teaches children a sequential and deliberate process for handling potentially negative situations that arise during the course of social interactions. A goal of this strategy is to help the child to develop a new skill set and to engage in different thinking and new behaviors to reduce aggression and other problem behaviors.

The essential elements of Problem-Solving Training include the following:
1. Help the child recognize that a problem exists.
2. Define the problem accurately (e.g., whose problem is it and why).
3. Generate possible solutions.
4. Evaluate each solution for its pros and cons.
5. Design, implement, and evaluate the use of the solution.

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

PREP
- Identify one or two examples of triggers that lead to aggression.
- Review one or two examples of school-related aggression on record to initiate discussion. Use these examples if children have difficulty understanding any of the implementation steps.

IMPLEMENT
- Ask each child to identify one school-related aggression problem. Each child can also record an aggression problem on an index card to be collected. Review each child's card, and choose one of the cards to present to the group. Write the selected problem on the whiteboard (ensuring the child's identity is not disclosed). If the children hesitate, provide prepared examples. Phase out prepared examples in subsequent sessions.
- Ask the children to define the problem thoroughly. Lead the children through identifying different perspectives and reinforcers of the problematic behavior.

- Ask the children to generate at least three alternative acceptable solutions. Encourage all legitimate attempts at solutions, regardless of how unrealistic they might be. These can be written on a board for the group to discuss in an open forum.
- Evaluate each potential solution. Elicit evaluative discussion of these solutions and if each meets the needs of all parties involved. Cross out solutions the children decide are ineffective. List the costs and benefits of each solution. Ask the children to choose the best solution.
- Practice the plan. Ask the children to generate ideas for doing this. These could include role-play of the situation or simply talking about ways a child could practice.
- Incorporate the plan into an actual situation. Discuss situations in which the newly learned skill can be practiced, and encourage preparation to discuss its effectiveness at the next meeting.
- Teach the children to generalize these steps to other problems by using the acronym ICE (i.e., Identify the problem, Create alternatives, and Evaluate options).
- Create an evaluation plan for any problem behaviors and determine appropriate reinforcers. Choose a reinforcer that is desirable and use a 1:1 ratio for any new appropriate behavior (i.e., reinforce each instance of the target behavior).

EVALUATE

- Check for comprehension by asking the children to demonstrate the process independently.
- Ask the children to report back on their ICE results after a plan has been implemented.
- Ask the children to identify particular places or times where they might want to use ICE for problem solving.
- Ask the children to rate the program.
- Monitor incidences of aggression to evaluate the effects of problem solving.

Aggression Intervention Option 2: Replacement Behavior Training

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

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

The essential elements of Replacement Behavior Training include the following:

1. Administer a functional behavioral assessment (FBA; see Chapters 4 and 10 of the BASC-3 Behavior Intervention Guide) to create an operational definition of the aggressive behavior and to identify the setting events, antecedents, and consequences contributing to or resulting from the aggressive behavior. Identify the function of the behavior (e.g., to escape or avoid, tangible reward, stimulation).
2. Identify and teach the child to engage in a socially acceptable replacement behavior that is as easy for the child as the problem behavior and that will result in the same outcome (e.g., to escape or avoid, tangible reward, stimulation).
3. Identify potential functionally equivalent reinforcers, prompt for and reinforce the replacement behavior, and ignore inappropriate behaviors.
4. Evaluate and revise as needed.

The procedural steps for incorporating replacement behavior training into the treatment of an individual child with aggression problems are summarized below. See the BASC-3 Behavior Intervention Guide for a detailed

discussion of this topic.

PREP

- Determine if the child will be an active participant in the intervention based upon the child's cognitive and developmental readiness and the specifics of the intervention.
- Identify the target behavior and operationally define it.
- Identify who will be responsible for data collection for the FBA.
- Administer an FBA to identify the setting events, antecedents, and consequences contributing to or resulting from the aggressive behavior.
- Offer a hypothesis in the FBA about the function of the behavior (e.g., to escape or avoid, tangible reward, stimulation).
- Introduce the antecedent to test the hypothesis.
- Select a replacement behavior that serves the same function as the aggressive behavior.
- Identify potential reinforcers to increase the use of the replacement behavior.
- Identify who will teach and monitor replacement behavior use and reinforcement.

IMPLEMENT

- Introduce the concept of replacement behavior training to the child.
- Teach the appropriate behavior that will be used to replace the problem behavior if the desired approach is to be more directive and use a direct-instruction model.
- If needed, remind the child to use the replacement behavior when the situation arises by using prompts or an agreed upon signal the child can use to communicate a need.
- Reinforce the use of the replacement behavior. Thank the child and honor the signal when used appropriately so the child learns that this behavior leads to needs being met. If the child uses an inappropriate behavior, ignore the behavior and prompt the child to use the signal; then move on quickly. This type of response ensures the class is not drawn off task. If the teaching and training is in a small group, practice sessions may include an action plan to use when a child forgets.
- Fade the use of prompts and reinforcement gradually as the replacement behavior supplants the inappropriate behavior.

EVALUATE

- Monitor the use of the replacement behavior.
- Monitor natural reinforcers or the use of periodic or unscheduled reinforcement.
- Consider tracking or having the child or another involved adult track the decrease in the inappropriate behavior and/or the increase in the replacement behavior. If charted or recorded, discuss in subsequent check-in meetings.
- Consider booster training sessions or additional reinforcement if the new appropriate behavior is not maintained.

Primary Improvement Area: Attention Problems

Attention problems are considered to be one of Elias'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.

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, 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.

Secondary Improvement Area: Conduct Problems

Conduct problems are considered one of Elias's most significant behavioral and emotional problems. In general, children with conduct disorder usually exhibit a repetitive and persistent pattern of behaviors in which the basic rights of others or major age-appropriate societal norms or rules are violated. Dealing with children 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 with elevated 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:

- Anger Management Skills Training
- Independent Group-Oriented Contingency Management
- Interdependent Group-Oriented Contingency Management
- Moral Motivation Training
- Multimodal Interventions
- Multisystemic Therapy
- Parent Training
- Problem-Solving Training
- Social Skills Training

Detailed summaries of the Social Skills Training and Parent Training 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.

Conduct Problems Intervention Option 1: Social Skills Training

Social skills training is a cognitive-behavioral approach that involves teaching children the prosocial skills to facilitate successful functioning in their typical environments. Social skills training is necessary for children 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 children with elevated risks through instruction in the use of prosocial skills as an alternative to maladaptive behaviors. The essential elements of Social Skills Training include the following:
1. Determine any social skills deficits.
2. Demonstrate appropriate social skills via explanations and explicit modeling.
3. Apply learned social skills in contrived scenarios.

4. Provide feedback and reinforcement for appropriate responses.
5. Apply learned social skills in an actual situation.

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

PREP

- Organize the schedule of meetings.
- Form small groups of children who have similar problems.
- Establish performance goals.
- Set boundaries, consequences, and rules for participation.
- Determine common social skills or social competency deficits that may be responsible for triggering the child's conduct problems and prioritize them for intervention. These determinations are made from assessments; recommendations from teachers, parents, and caregivers; and child self-disclosures or self-assessment.

IMPLEMENT

- Introduce only one specific social skill for each session (e.g., "Today we will talk about listening effectively and seven steps that will help us do that.")
- Use visual representations of each step associated with the social skill being taught. Write the steps on notecards or paper. Ask the children to recite the steps. Model the correct behavior associated with each step.
- Establish performance goals, such as, "I want to spend more time talking to my mom, and less time arguing about what I've done wrong," or "I want to stop disobeying my teachers."
- Engage the children in a discussion (e.g., brainstorming) centered on recent events that required use of the new skill. For example, "When was a time you wished you could talk to your mom instead of arguing?"
- Introduce and model the new skill. For example, make eye contact, take a deep breath, and say, "I understand what you are saying," rather than arguing.
- Encourage the children to role-play the skill while others coach them. For example, set up a scenario where you role-play the mother and try to get the child to start arguing. The child uses the new social skill of "make eye contact, breathe deeply, and verbalize calmly." Practice just the one skill taught during each session.
- Facilitate the retention of learned behaviors at the next meeting by reviewing skills that were taught during previous intervention sessions. Ask the children about opportunities to use the skill, review progress, or make modifications when things did not go as planned. For example, the child says, "I looked at my mom, took deep breaths, and said, 'I understand what you are saying,' but she kept arguing and thought I was making fun of her, so I started arguing back!"
- Maintain skill acquisition by holding periodic refresher sessions.
- Encourage children to use journals to record or keep track of skills used and the subsequent outcome. Journals can be optional or assigned as homework to record daily personal experiences with the newly learned social skills. As available and if appropriate, encourage them to read journal entries aloud for the group depending on child and counselor preference.

EVALUATE

- Distribute copies of the skill steps to teachers and parents and ask them to monitor and record use of the skill. Monitor these records if available.
- Schedule routine observations such as weekly classroom walk-throughs or monthly classroom observations to monitor social skills as time permits.

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 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 children with elevated risk by increasing the use of effective parenting skills and positive disciplinary techniques.

The essential elements of Parent Training include the following:

1. Teach or coach parents to understand coercive parent-child interactions and their cycle.
2. Teach appropriate skill sets through modeling, including:
   a. effective reinforcement strategies and different types of reinforcers (e.g., verbal praise, social reinforcers, tangible reinforcers, and activity reinforcers);
   b. observation skills;
   c. play skills;
   d. response-cost techniques;
   e. timeout procedures;
   f. punishment and extinction;
   g. relationship enhancement skills (e.g., partner support, communication, and problem solving);
   h. token economy and reward charts;
   i. contingency contracts;
   j. mood management;
   k. self-determination;
   l. relaxation techniques;
   m. stress reduction techniques;
   n. anger management techniques; and
   o. self-monitoring and self-reward.

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

PREP

- Determine if group or individual parent training will work for the trainer and the setting.
- Conduct an intake assessment with the family. Include an evaluation of the family climate to determine the needs of the family and any barriers to success, a broad overview of the goals of the intervention, the relevance of the information to be presented, and the responsibilities of the parents in the process.
- Identify skill deficits and formulate the goals and objectives that can be achieved by implementing family and parent management techniques.
- Determine the logistics of the intervention's implementation, including format, location, and the time of the intervention.
- Find a mutually satisfactory time for meeting, and determine the appropriate number of training sessions that might be needed. Consider creating a partnership contract to agree on the number of times to meet and the techniques to learn.

IMPLEMENT

- Teach a specific parenting technique, using descriptions and examples to demonstrate relevance to the individual.

- Verbally describe the technique.
- Discuss parental concerns about using the technique, and provide evidence of its effectiveness so that families know what to expect.
- Model the technique. 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, role-play examples with several parents so everyone who attends is involved and contributes.
- Bring the child into the session and briefly explain the technique for individual family sessions in the home. Have the parents role-play the technique with the child. Provide feedback after the performance, highlighting positive statements regarding the parents' implementation.
- Encourage independent implementation by requesting the use of the technique a specific number of times by the next session.
- Request that the parents document the effects, including any problems encountered, and note any questions they have.
- Begin each session by reviewing the effective parenting technique discussed in the previous session, reviewing the homework assignment, and answering specific parental questions.

EVALUATE

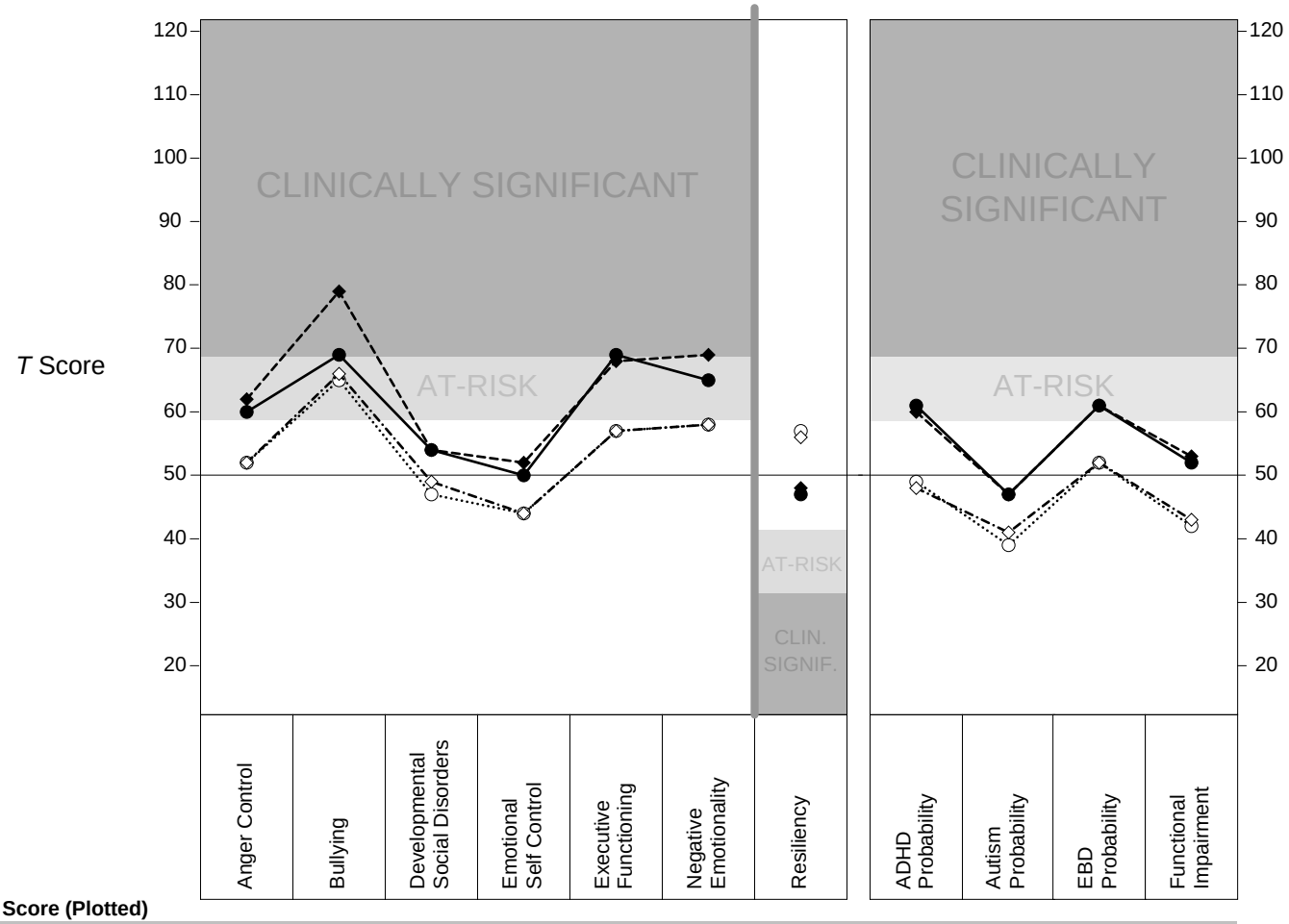
- Monitor both parent training and the parent's application of the training to determine the effects of the training topics.
- Continue parent training at the rate and duration needed to sustain effectiveness.

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 be 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 Elias. 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	60	69	54	50	69	65	47	61	47	61	52
◆ Gen. Gender-Spec.	62	79	54	52	68	69	48	60	47	61	53
❍ Clin. Gender-Spec.	52	65	47	44	57	58	57	49	39	52	42
◊ ADHD Combined	52	66	49	44	57	58	56	48	41	52	43

Percentile											
General Combined	86	95	70	56	96	92	38	85	43	86	65
Gen. Gender-Spec.	89	97	72	68	95	95	39	83	43	87	66
Clin. Gender-Spec.	66	91	42	31	76	80	78	45	14	65	22
ADHD Combined	64	91	51	28	77	78	72	41	19	63	26

CONTENT SCALE SCORE TABLE: General Combined Norm Group

	Raw Score	*T* Score	Percentile Rank	95% Confidence Interval
Anger Control	9	60	86	53-67
Bullying	12	69	95	64-74
Developmental Social Disorders	16	54	70	47-61
Emotional Self-Control	8	50	56	44-56
Executive Functioning	42	69	96	63-75
Negative Emotionality	12	65	92	58-72
Resiliency	23	47	38	41-53

Content Scale Narratives

Elias's *T* score on Anger Control 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. Elias's father reports Elias has a tendency to become irritable quickly and has difficulty maintaining self-control when faced with adversity.

Elias's *T* score on Bullying is 69 and has a percentile rank of 95. This *T* score falls in the At-Risk classification range and follow-up may be necessary. Elias's father reports Elias has a tendency to be disruptive, intrusive, and/or threatening toward other students.

Elias's *T* score on Developmental Social Disorders is 54 and has a percentile rank of 70. Elias's father reports Elias has social and communication skills that are typical of others of the same age.

Elias's *T* score on Emotional Self-Control is 50 and has a percentile rank of 56. Elias's father reports Elias is able to control his reactions to environmental changes about as well as others of the same age.

Elias's *T* score on Executive Functioning is 69 and has a percentile rank of 96. This *T* score falls in the At-Risk classification range and follow-up may be necessary. Elias's father reports Elias sometimes has difficulty controlling and maintaining his behavior and mood.

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

Elias's *T* score on Resiliency is 47 and has a percentile rank of 38. Elias's father reports Elias is able to overcome stress and adversity about as well as others of the same age.

EXECUTIVE FUNCTIONING INDEX SUMMARY

Overall Executive Functioning Index	Problem Solving Index	Attentional Control Index	Behavioral Control Index	Emotional Control Index
Elevated Raw Score: 51	Elevated Raw Score: 20	Elevated Raw Score: 19	Elevated Raw Score: 9	Not Elevated Raw Score: 3

EXECUTIVE FUNCTIONING INDEX NARRATIVES

Elias's Overall Executive Functioning Index score is 51. This score falls in the Elevated classification range and follow-up may be necessary. John reports Elias has some difficulty in one or more areas of executive functioning. Summary information for problem solving, attentional control, behavioral control, and emotional control is provided below.

Elias's Problem Solving Index score is 20. This score falls in the Elevated classification range and follow-up may be necessary. John reports Elias may experience problems with planning, making decisions, and organizational skills.

Elias's Attentional Control Index score is 19. This score falls in the Elevated classification range and follow-up may be necessary. John reports Elias sometimes has trouble concentrating, following directions, and may have a tendency to make careless mistakes.

Elias's Behavioral Control Index score is 9. This score falls in the Elevated classification range and follow-up may be necessary. John reports Elias sometimes has difficulty maintaining self-control and has difficulty regulating impulsive behaviors.

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

EMOTIONAL DISTURBANCE QUALIFICATION SCALES (EDQs) SUMMARY

The EDQ scales were developed to reflect clinical and adaptive scale combinations that are grouped specifically to align with the constructs of emotional disturbance (ED) represented in the federal Individuals with Disabilities Education Improvement Act (IDEIA; 2004) disability definition[1]. These constructs serve as the minimum criteria used to determine a student's eligibility for special education and related services under the classification of ED. Because of the breadth of assessment provided by the BASC-3, examiners are advised to consider other BASC-3 clinical, adaptive, and content scales, the history of the behaviors they measure, and the duration of any behavioral or emotional problems when making special education and related services eligibility recommendations.

Emotional Disturbance Qualification Composites (EDQCs)	Raw Score	*T* Score	Percentile Rank	95% Confidence Interval	Clinical Indicator
EDQC 1: Unsatisfactory Interpersonal Relationships	337	58	80	55-61	Acceptable
EDQC 2: Inappropriate Behavior/Feelings	353	50	63	47-53	Acceptable
EDQC 3: Unhappiness or Depression	119	60	87	56-64	At-Risk
EDQC 4: Physical Symptoms or Fears	76	37	1	32-42	Acceptable
EDQC 5[2]: Schizophrenia and Related Disorders of Thought	287	59	82	56-62	Acceptable
				Social Maladjustment Indicator	Absent

[1] The EDQs covers 5 of the 6 Emotional Disturbance criteria as defined by IDEIA (2004). The first criteria – "An inability to learn that cannot be explained by intellectual, sensory, or health factors" – is not covered by the BASC-3.

[2] Although elevated scores on the EDQC 5 should raise concerns of schizophrenia or another thought disorder as a possibility, it also correlates highly to autism spectrum disorder (ASD) and when elevated should prompt a more thorough evaluation to rule out ASD as the most likely diagnosis, especially if the actuarially derived Autism Index is also elevated.

EMOTIONAL DISTURBANCE QUALIFICATION SCALES (EDQs) NARRATIVES

EDQC 1: Unsatisfactory Interpersonal Relationships
Elias's *T* score on the Unsatisfactory Interpersonal Relationships Composite is 58 and has a percentile rank of 80. John reports Elias maintains satisfactory interpersonal relationships with others compared to same-age peers.

EDQC 2: Inappropriate Behavior/Feelings
Elias's *T* score on the Inappropriate Behavior/Feelings Composite is 50 and has a percentile rank of 63. John reports Elias displays appropriate types of behaviors and feelings under normal circumstances that are comparable to same-age peers.

EDQC 3: Unhappiness or Depression
Elias's *T* score on the Unhappiness or Depression Composite is 60 and has a percentile rank of 87. This *T* score falls in the At-Risk classification range and follow-up assessment or intervention may be necessary. John reports Elias shows some signs of pervasive unhappiness or depressive mood moderately more often than same-age peers.

EDQC 4: Physical Symptoms or Fears
Elias's *T* score on the Physical Symptoms or Fears Composite is 37 and has a percentile rank of 1. John reports Elias displays physical symptoms or fears associated with personal or school problems about as often as same-age peers.

EDQC 5: Schizophrenia and Related Disorders of Thought
Elias's *T* score on the Schizophrenia and Related Disorders of Thought Composite is 59 and has a percentile rank of 82. John reports Elias displays developmentally appropriate thinking patterns, perceptions, and communication skills. Elias shows no signs of schizophrenia or related disorders when compared to same-age peers.

Social Maladjustment Indicator
Based on John's responses, there is no indication Elias presents with social maladjustment at this time. However, the need for follow-up assessment or intervention should occur based on the laws and regulations in the appropriate jurisdiction.

CLINICAL INDEX SCORE TABLE: General Combined Norm Group

	Raw Score	*T* Score	Percentile Rank	95% Confidence Interval
ADHD Probability Index	15	61	85	54-68
Autism Probability Index	12	47	43	40-54
EBD Probability Index	21	61	86	55-67
Functional Impairment Index	37	52	65	47-57

CLINICAL SUMMARY

The BASC-3 items endorsed by Elias's parent/guardian resulted in clinically significant Aggression and Attention Problems scale scores. Children with this profile may exhibit inattention, distractibility, and verbal and physical aggression serving several functions, which could include obtaining control over others, retaliating in response to perceived provocation, or escaping an adverse situation. Given this profile, possible diagnostic considerations might include oppositional defiant disorder (ODD). Attention-deficit/hyperactivity disorder (ADHD) is also a possibility, as children with aggression may exhibit attentional problems that are overlooked as a result of other disruptive behaviors. Thus, careful attention to these issues, even when they are not the presenting complaint, can be helpful for making an accurate diagnosis. In addition to a clinically significant Attention Problems scale score, Elias exhibits a clinically significant Aggression scale score and an at-risk Conduct Problems scale score. 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, that 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 to do 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.

Elias's profile is characterized by a clinically significant Attention Problems scale score in addition to an at-risk 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.

Children who experience difficulties with hyperactivity, aggression, conduct problems, and attention problems present a unique challenge to parents. They may require frequent redirection, more consistent parenting practices, and stronger reinforcements and consequences in order to manage their behavior. They may also defy parent requests, engage parents in frequent arguments or acts of aggression, 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., 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 John on the PRS-A rating form. Each section first presents a list of symptoms of the disorder, along with PRS-A items that correspond to these symptoms. Then related *DSM-5* criteria and codes are presented. While information from PRS-A 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-A 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-A Items and John H. Lewis's Responses*
__	Does not pay close attention to details, or makes careless mistakes	
X	Has difficulty sustaining attention	1. Pays attention. (Sometimes) 27. Has a short attention span. (Almost always)
X	Does not seem to listen when spoken to	43. Listens to directions. (Often) 79. Listens carefully. (Sometimes) 119. Pays attention when being spoken to. (Often)
__	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	
X	Is easily distracted	87. Is easily distracted. (Often)
__	Is often forgetful	

	Symptoms for ADHD: Hyperactivity/Impulsivity	*Relevant BASC-3 PRS-A Items and John H. Lewis's Responses*
__	Fidgets or squirms excessively	
__	Leaves seat inappropriately	
__	Feels restless	
__	Has difficulty engaging in activities quietly	
__	Acts as if "driven by a motor"	53. Acts out of control. (Never) 130. Has poor self-control. (Never)
__	Talks excessively	
X	Blurts out answers	10. Acts without thinking. (Often)
__	Has trouble waiting his turn	14. Cannot wait to take turn. (Sometimes)
X	Interrupts others' conversations or activities	107. Interrupts parents when they are talking on the phone. (Sometimes) 114. Disrupts other adolescents' activities. (Sometimes) 172. Interrupts others when they are speaking. (Almost always)

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.

Disruptive Mood Dysregulation Disorder

List of Symptoms

	Symptoms for Disruptive Mood Dysregulation Disorder	*Relevant BASC-3 PRS-A Items and John H. Lewis's Responses*
	Area 1: Severe, Recurrent Temper Outbursts	
__	Has verbally or physically aggressive temper outbursts	26. Loses control when angry. (Never) 37. Throws or breaks things when angry. (Never) 48. Overreacts to stressful situations. (Never)
	Area 2: Mood Between Temper Outbursts	
X	Persistently irritable or angry mood between temper outbursts	32. Is easily stressed. (Never) 140. Is irritable. (Often)

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.

Oppositional Defiant Disorder

List of Symptoms

	Symptoms for Oppositional Defiant Disorder	*Relevant BASC-3 PRS-A Items and John H. Lewis's Responses*
	Angry/Irritable Mood	
__	Loses temper	
__	Is easily annoyed by others	
__	Is resentful/angry	
	Argumentative/Defiant Behavior	
X	Argues with authority figures	115. Argues when denied own way. (Often)
__	Defies rules or refuses to comply with requests from authority figures	122. Lies to get out of trouble. (Sometimes)
X	Deliberately annoys others	28. Teases others. (Almost always)
__	Blames other people for his/her own misbehavior or mistakes	
	Vindictiveness	
X	Has been vindictive/spiteful at least twice within the past 6 months	146. Gets back at others. (Often)

DSM-5 Codes and Diagnostic Criteria

Oppositional Defiant Disorder 313.81 (F91.3)

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

Conduct Disorder

List of Symptoms

Aggression to People and Animals	*Relevant BASC-3 PRS-A Items and John H. Lewis's Responses*
__ Bullies, intimidates, or threatens others	66. Threatens to hurt others. (Sometimes) 69. Bullies others. (Sometimes)
__ Starts physical fights	
__ Has used a weapon that can seriously injure others (e.g., knife, bat, broken bottle, gun)	
__ Has inflicted physical harm on people	93. Is cruel to others. (Sometimes) 103. Hits other adolescents. (Sometimes)
__ Has inflicted physical harm on animals	59. Is cruel to animals. (Never)
__ Has committed theft while confronting a victim (e.g., mugging, armed robbery)	
__ Has forced someone to participate in a sexual act against their will	
Destruction of Property	
__ Has deliberately set a fire to cause serious damage	118. Sets fires. (Never)
__ Has deliberately destroyed others' property (by means other than fire)	
Deceitfulness or Theft	
__ Has broken into someone else's car, house, or other building	
__ Lies to obtain things or favors or to avoid obligations	22. Lies. (Sometimes) 85. Deceives others. (Sometimes) 122. Lies to get out of trouble. (Sometimes)
__ Has committed theft of money or items of nontrivial value without confronting a victim	52. Steals. (Never)

Serious Violations of Rules	*Relevant BASC-3 PRS-A Items and John H. Lewis's Responses*
__ Stays out at night despite parental prohibitions (beginning before age 13)	
__ Has run away from home overnight at least twice (or once for a lengthy period)	155. Runs away from home overnight. (Never)
__ Often skips school (beginning before age 13)	

DSM-5 Codes and Diagnostic Criteria

Conduct Disorder 312.8x (F91.x)

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

DSM-5™ DIAGNOSTIC CONSIDERATIONS

The BASC-3 PRS-A contains items related to a number of *DSM-5* criteria for the diagnosis of disorders. Listed below are ALL items related to *DSM-5* criteria regardless of their responses. While information from PRS-A 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-A form (e.g., observations of behavior, clinical interviews) when making a formal diagnosis.

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

Related BASC-3 items:

1. Pays attention. (Sometimes)
10. Acts without thinking. (Often)
14. Cannot wait to take turn. (Sometimes)
27. Has a short attention span. (Almost always)
43. Listens to directions. (Often)
53. Acts out of control. (Never)
79. Listens carefully. (Sometimes)
87. Is easily distracted. (Often)
107. Interrupts parents when they are talking on the phone. (Sometimes)
114. Disrupts other adolescents' activities. (Sometimes)
119. Pays attention when being spoken to. (Often)
130. Has poor self-control. (Never)
172. Interrupts others when they are speaking. (Almost always)

Conduct Disorder 312.8x (F91.x)

Related BASC-3 items:

22. Lies. (Sometimes)
52. Steals. (Never)
59. Is cruel to animals. (Never)
66. Threatens to hurt others. (Sometimes)
69. Bullies others. (Sometimes)
85. Deceives others. (Sometimes)
93. Is cruel to others. (Sometimes)
103. Hits other adolescents. (Sometimes)
118. Sets fires. (Never)
122. Lies to get out of trouble. (Sometimes)
155. Runs away from home overnight. (Never)

Oppositional Defiant Disorder 313.81 (F91.3)

Related BASC-3 items:

28. Teases others. (Almost always)
115. Argues when denied own way. (Often)
122. Lies to get out of trouble. (Sometimes)
146. Gets back at others. (Often)

Disruptive Mood Dysregulation Disorder 296.99 (F34.8)

Related BASC-3 items:

26. Loses control when angry. (Never)
32. Is easily stressed. (Never)
37. Throws or breaks things when angry. (Never)
48. Overreacts to stressful situations. (Never)
140. Is irritable. (Often)

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.

General Behavior Issues

28. Teases others. (Almost always)
76. Uses foul language. (Almost always)

61. Breaks the rules. (Often)

14. Cannot wait to take turn. (Sometimes)
22. Lies. (Sometimes)
66. Threatens to hurt others. (Sometimes)
69. Bullies others. (Sometimes)
103. Hits other adolescents. (Sometimes)

Academic Behavior Issues

114. Disrupts other adolescents' activities. (Sometimes)

Adaptive/Social Behavior Issues

172. Interrupts others when they are speaking. (Almost always)

151. Acts in a safe manner. (Sometimes)

CRITICAL ITEMS

Bolded items may be of particular interest.

12. Is a picky eater. (Never)
24. Avoids exercise or other physical activity. (Never)
26. Loses control when angry. (Never)
35. Says, "I hate myself." (Never)
49. Eats things that are not food. (Never)
50. Says, "I want to die" or "I wish I were dead." (Never)
56. Smokes or chews tobacco. (Never)
59. Is cruel to animals. (Never)
65. Falls down or trips over things easily. (Never)
66. Threatens to hurt others. (Sometimes)
69. Bullies others. (Sometimes)
93. Is cruel to others. (Sometimes)
96. Sleeps with parents. (Never)
97. Confuses real with make-believe. (Never)
100. Picks on others who are different from his or her self. (Never)
103. Hits other adolescents. (Sometimes)
117. Says, "I want to kill myself." (Never)
118. Sets fires. (Never)
125. Throws up after eating. (Never)
134. Has seizures. (Never)
138. Hurts others on purpose. (Never)
152. Has panic attacks. (Never)
155. Runs away from home overnight. (Never)
162. Uses illegal drugs. (Never)

ITEMS BY SCALE - CLINICAL SCALES

Aggression

28. Teases others. (Almost always)
37. Throws or breaks things when angry. (Never)
55. Manipulates others. (Sometimes)
66. Threatens to hurt others. (Sometimes)
69. Bullies others. (Sometimes)
93. Is cruel to others. (Sometimes)
103. Hits other adolescents. (Sometimes)
115. Argues when denied own way. (Often)
146. Gets back at others. (Often)
164. Is overly aggressive. (Sometimes)

Anxiety

4. Worries. (Never)
20. Is fearful. (Never)
32. Is easily stressed. (Never)
92. Is nervous. (Never)
99. Worries about what teachers think. (Never)
104. Says, "I'm not very good at this." (Never)
120. Worries about making mistakes. (Often)
135. Worries about things that cannot be changed. (Never)
141. Appears tense. (Never)
152. Has panic attacks. (Never)
153. Says, "I'm afraid I will make a mistake." (Never)
163. Says, "I get nervous during tests" or "Tests make me nervous." (Never)
166. Has trouble making decisions. (Never)

Attention Problems

1. Pays attention. (Sometimes)
9. Is organized. (Never)
27. Has a short attention span. (Almost always)
43. Listens to directions. (Often)
79. Listens carefully. (Sometimes)
87. Is easily distracted. (Often)
95. Misses deadlines. (Often)
119. Pays attention when being spoken to. (Often)
123. Has trouble concentrating. (Almost always)

Atypicality

11. Has strange ideas. (Never)
25. Seems odd. (Never)
39. Seems out of touch with reality. (Never)
84. Stares blankly. (Never)
97. Confuses real with make-believe. (Never)
108. Acts strangely. (Never)
116. Says things that make no sense. (Never)
139. Is suspicious of others. (Often)
145. Babbles to self. (Never)
150. Seems unaware of others. (Never)
169. Does weird things. (Never)

Conduct Problems

5. Gets into trouble. (Sometimes)
22. Lies. (Sometimes)
40. Disobeys. (Sometimes)
52. Steals. (Never)
56. Smokes or chews tobacco. (Never)
61. Breaks the rules. (Often)
68. Breaks the rules just to see what will happen. (Never)
76. Uses foul language. (Almost always)
85. Deceives others. (Sometimes)
98. Is in trouble with the police. (Sometimes)
122. Lies to get out of trouble. (Sometimes)
138. Hurts others on purpose. (Never)
157. Sneaks around. (Sometimes)
162. Uses illegal drugs. (Never)

Depression

3. Is easily upset. (Sometimes)
19. Is sad. (Sometimes)
35. Says, "I hate myself." (Never)
41. Changes moods quickly. (Almost always)
50. Says, "I want to die" or "I wish I were dead." (Never)
77. Says, "I don't have any friends." (Never)
89. Cries easily. (Never)
94. Seems lonely. (Sometimes)
102. Is negative about things. (Sometimes)
110. Says, "I can't do anything right." (Never)
117. Says, "I want to kill myself." (Never)
121. Says, "Nobody likes me." (Never)
140. Is irritable. (Often)

Hyperactivity

10. Acts without thinking. (Often)
14. Cannot wait to take turn. (Sometimes)
23. Talks over others. (Sometimes)
53. Acts out of control. (Never)
107. Interrupts parents when they are talking on the phone. (Sometimes)
114. Disrupts other adolescents' activities. (Sometimes)
130. Has poor self-control. (Never)
172. Interrupts others when they are speaking. (Almost always)

Somatization

6. Complains of being sick when nothing is wrong. (Never)
18. Says, "I think I'm sick." (Never)
31. Gets sick. (Never)
42. Complains about health. (Never)
47. Complains of pain. (Never)
58. Expresses fear of getting sick. (Never)
71. Complains of stomach pain. (Never)
88. Has headaches. (Never)
111. Complains of physical problems. (Never)
154. Is afraid of getting sick. (Never)

Withdrawal

33. Isolates self from others. (Sometimes)
46. Is shy with other adolescents. (Never)
83. Quickly joins group activities. (Often)
113. Has trouble making new friends. (Never)
127. Avoids other adolescents. (Never)
144. Prefers to play alone. (Often)
149. Avoids making friends. (Never)
165. Makes friends easily. (Almost always)

ITEMS BY SCALE - ADAPTIVE SCALES

Activities of Daily Living

21. Makes healthy food choices. (Often)
36. Sets realistic goals. (Never)
45. Is careless with belongings. (Sometimes)
60. Needs to be reminded to brush teeth. (Never)
80. Is able to keep to a schedule. (Sometimes)
86. Cleans up after self. (Never)
143. Organizes chores or other tasks well. (Often)
151. Acts in a safe manner. (Sometimes)

Adaptability

7. Is easy to please. (Often)
54. Handles winning and losing well. (Sometimes)
72. Recovers quickly after a setback. (Often)
82. Accepts things as they are. (Often)
124. Adjusts well to changes in routine. (Often)
129. Adjusts well to changes in family plans. (Often)
137. Adjusts well to new teachers. (Sometimes)
156. Adjusts well to changes in plans. (Often)

Functional Communication

8. Likes to talk about his or her day. (Never)
34. Accurately takes down messages. (Sometimes)
62. Has difficulty explaining rules of games to others. (Never)
70. Communicates clearly. (Often)
78. Has trouble getting information when needed. (Sometimes)
81. Responds appropriately when asked a question. (Often)
90. Is unclear when presenting ideas. (Never)
101. Starts conversations. (Often)
105. Is effective when presenting information to a group. (Often)
133. Tracks down information when needed. (Often)
142. Is able to describe feelings accurately. (Sometimes)
158. Is clear when telling about personal experiences. (Often)

Leadership

17. Is a "self-starter." (Never)
29. Is usually chosen as a leader. (Almost always)
57. Is good at getting people to work together. (Often)
67. Works well under pressure. (Often)
132. Gives good suggestions for solving problems. (Often)
136. Makes decisions easily. (Often)
148. Is highly motivated to succeed. (Sometimes)
171. Prefers to be a leader. (Almost always)

Social Skills

2. Makes positive comments about others. (Sometimes)
13. Says, "please" and "thank you." (Often)
51. Shows interest in others' ideas. (Often)
73. Compliments others. (Often)
91. Makes others feel welcome. (Often)
106. Tries to help others be their best. (Sometimes)
128. Accepts people who are different from his or her self. (Often)
131. Offers help to other adolescents. (Often)
147. Encourages others to do their best. (Often)
170. Congratulates others when good things happen to them. (Often)

ITEMS BY SCALE - CONTENT SCALES

Anger Control

26. Loses control when angry. (Never)
37. Throws or breaks things when angry. (Never)
41. Changes moods quickly. (Almost always)
63. Gets angry easily. (Sometimes)
66. Threatens to hurt others. (Sometimes)
115. Argues when denied own way. (Often)
130. Has poor self-control. (Never)
140. Is irritable. (Often)

Bullying

28. Teases others. (Almost always)
55. Manipulates others. (Sometimes)
66. Threatens to hurt others. (Sometimes)
69. Bullies others. (Sometimes)
85. Deceives others. (Sometimes)
93. Is cruel to others. (Sometimes)
100. Picks on others who are different from his or her self. (Never)
138. Hurts others on purpose. (Never)
146. Gets back at others. (Often)
160. Puts others down. (Often)
167. Tells lies about others. (Never)

Developmental Social Disorders

30. Engages in repetitive movements. (Sometimes)
33. Isolates self from others. (Sometimes)
38. Avoids eye contact. (Sometimes)
51. Shows interest in others' ideas. (Often)
70. Communicates clearly. (Often)
81. Responds appropriately when asked a question. (Often)
97. Confuses real with make-believe. (Never)
108. Acts strangely. (Never)
113. Has trouble making new friends. (Never)
124. Adjusts well to changes in routine. (Often)
129. Adjusts well to changes in family plans. (Often)
142. Is able to describe feelings accurately. (Sometimes)
144. Prefers to play alone. (Often)
145. Babbles to self. (Never)
150. Seems unaware of others. (Never)
156. Adjusts well to changes in plans. (Often)
158. Is clear when telling about personal experiences. (Often)
159. Shows basic emotions clearly. (Sometimes)

Emotional Self Control

3. Is easily upset. (Sometimes)
20. Is fearful. (Never)
32. Is easily stressed. (Never)
41. Changes moods quickly. (Almost always)
44. Is overly emotional. (Never)
48. Overreacts to stressful situations. (Never)
53. Acts out of control. (Never)
54. Handles winning and losing well. (Sometimes)
89. Cries easily. (Never)
130. Has poor self-control. (Never)
140. Is irritable. (Often)
141. Appears tense. (Never)

Executive Functioning

1. Pays attention. (Sometimes)
9. Is organized. (Never)
10. Acts without thinking. (Often)
14. Cannot wait to take turn. (Sometimes)
15. Plans well. (Never)
27. Has a short attention span. (Almost always)
36. Sets realistic goals. (Never)
53. Acts out of control. (Never)
54. Handles winning and losing well. (Sometimes)
64. Takes a step-by-step approach to work. (Never)
72. Recovers quickly after a setback. (Often)
75. Breaks large problems into smaller steps. (Never)
87. Is easily distracted. (Often)
107. Interrupts parents when they are talking on the phone. (Sometimes)
112. Plans ahead. (Never)
115. Argues when denied own way. (Often)
123. Has trouble concentrating. (Almost always)
130. Has poor self-control. (Never)

133. Tracks down information when needed. (Often)
136. Makes decisions easily. (Often)
168. Evaluates own ideas. (Sometimes)
173. Finds ways to solve problems. (Often)

Negative Emotionality

3. Is easily upset. (Sometimes)
16. Finds fault with everything. (Often)
35. Says, "I hate myself." (Never)
50. Says, "I want to die" or "I wish I were dead." (Never)
74. Reacts negatively. (Sometimes)
76. Uses foul language. (Almost always)
102. Is negative about things. (Sometimes)
115. Argues when denied own way. (Often)
140. Is irritable. (Often)

Resiliency

17. Is a "self-starter." (Never)
54. Handles winning and losing well. (Sometimes)
57. Is good at getting people to work together. (Often)
67. Works well under pressure. (Often)
72. Recovers quickly after a setback. (Often)
109. Has good coping skills. (Sometimes)
124. Adjusts well to changes in routine. (Often)
126. Overcomes problems. (Often)
132. Gives good suggestions for solving problems. (Often)
133. Tracks down information when needed. (Often)
156. Adjusts well to changes in plans. (Often)
161. Is resilient. (Almost always)
173. Finds ways to solve problems. (Often)

ITEMS BY SCALE - CLINICAL INDEXES

ADHD Probability

43. Listens to directions. (Often)
67. Works well under pressure. (Often)
79. Listens carefully. (Sometimes)
87. Is easily distracted. (Often)
123. Has trouble concentrating. (Almost always)
124. Adjusts well to changes in routine. (Often)
136. Makes decisions easily. (Often)
143. Organizes chores or other tasks well. (Often)
172. Interrupts others when they are speaking. (Almost always)

Autism Probability

25. Seems odd. (Never)
30. Engages in repetitive movements. (Sometimes)
38. Avoids eye contact. (Sometimes)
46. Is shy with other adolescents. (Never)
51. Shows interest in others' ideas. (Often)

57. Is good at getting people to work together. (Often)
70. Communicates clearly. (Often)
73. Compliments others. (Often)
81. Responds appropriately when asked a question. (Often)
101. Starts conversations. (Often)
108. Acts strangely. (Never)
113. Has trouble making new friends. (Never)
124. Adjusts well to changes in routine. (Often)
131. Offers help to other adolescents. (Often)
144. Prefers to play alone. (Often)
145. Babbles to self. (Never)
165. Makes friends easily. (Almost always)
171. Prefers to be a leader. (Almost always)

EBD Probability

2. Makes positive comments about others. (Sometimes)
5. Gets into trouble. (Sometimes)
13. Says, "please" and "thank you." (Often)
15. Plans well. (Never)
26. Loses control when angry. (Never)
37. Throws or breaks things when angry. (Never)
41. Changes moods quickly. (Almost always)
44. Is overly emotional. (Never)
53. Acts out of control. (Never)
63. Gets angry easily. (Sometimes)
66. Threatens to hurt others. (Sometimes)
69. Bullies others. (Sometimes)
85. Deceives others. (Sometimes)
102. Is negative about things. (Sometimes)
115. Argues when denied own way. (Often)
122. Lies to get out of trouble. (Sometimes)
128. Accepts people who are different from his or her self. (Often)
130. Has poor self-control. (Never)
164. Is overly aggressive. (Sometimes)
170. Congratulates others when good things happen to them. (Often)

Functional Impairment

1. Pays attention. (Sometimes)
3. Is easily upset. (Sometimes)
4. Worries. (Never)
5. Gets into trouble. (Sometimes)
10. Acts without thinking. (Often)
21. Makes healthy food choices. (Often)
27. Has a short attention span. (Almost always)
32. Is easily stressed. (Never)
34. Accurately takes down messages. (Sometimes)
36. Sets realistic goals. (Never)
39. Seems out of touch with reality. (Never)
41. Changes moods quickly. (Almost always)
42. Complains about health. (Never)
46. Is shy with other adolescents. (Never)
60. Needs to be reminded to brush teeth. (Never)
62. Has difficulty explaining rules of games to others. (Never)

70. Communicates clearly. (Often)
74. Reacts negatively. (Sometimes)
78. Has trouble getting information when needed. (Sometimes)
80. Is able to keep to a schedule. (Sometimes)
83. Quickly joins group activities. (Often)
85. Deceives others. (Sometimes)
89. Cries easily. (Never)
90. Is unclear when presenting ideas. (Never)
94. Seems lonely. (Sometimes)
105. Is effective when presenting information to a group. (Often)
113. Has trouble making new friends. (Never)
116. Says things that make no sense. (Never)
127. Avoids other adolescents. (Never)
130. Has poor self-control. (Never)
131. Offers help to other adolescents. (Often)
133. Tracks down information when needed. (Often)
135. Worries about things that cannot be changed. (Never)
136. Makes decisions easily. (Often)
142. Is able to describe feelings accurately. (Sometimes)
143. Organizes chores or other tasks well. (Often)
151. Acts in a safe manner. (Sometimes)
158. Is clear when telling about personal experiences. (Often)
163. Says, "I get nervous during tests" or "Tests make me nervous." (Never)
165. Makes friends easily. (Almost always)
170. Congratulates others when good things happen to them. (Often)

ITEMS BY SCALE - EXECUTIVE FUNCTIONING INDEX

Problem Solving Index

15. Plans well. (Never)
36. Sets realistic goals. (Never)
64. Takes a step-by-step approach to work. (Never)
75. Breaks large problems into smaller steps. (Never)
112. Plans ahead. (Never)
133. Tracks down information when needed. (Often)
136. Makes decisions easily. (Often)
168. Evaluates own ideas. (Sometimes)
173. Finds ways to solve problems. (Often)

Attentional Control Index

1. Pays attention. (Sometimes)
9. Is organized. (Never)
27. Has a short attention span. (Almost always)
43. Listens to directions. (Often)
79. Listens carefully. (Sometimes)
87. Is easily distracted. (Often)
95. Misses deadlines. (Often)
119. Pays attention when being spoken to. (Often)
123. Has trouble concentrating. (Almost always)

Behavioral Control Index

10. Acts without thinking. (Often)
14. Cannot wait to take turn. (Sometimes)
53. Acts out of control. (Never)
107. Interrupts parents when they are talking on the phone. (Sometimes)
115. Argues when denied own way. (Often)
130. Has poor self-control. (Never)
172. Interrupts others when they are speaking. (Almost always)

Emotional Control Index

44. Is overly emotional. (Never)
48. Overreacts to stressful situations. (Never)
54. Handles winning and losing well. (Sometimes)
63. Gets angry easily. (Sometimes)

Overall Executive Functioning Index

1. Pays attention. (Sometimes)
9. Is organized. (Never)
10. Acts without thinking. (Often)
14. Cannot wait to take turn. (Sometimes)
15. Plans well. (Never)
27. Has a short attention span. (Almost always)
36. Sets realistic goals. (Never)
43. Listens to directions. (Often)
44. Is overly emotional. (Never)
48. Overreacts to stressful situations. (Never)
53. Acts out of control. (Never)
54. Handles winning and losing well. (Sometimes)
63. Gets angry easily. (Sometimes)
64. Takes a step-by-step approach to work. (Never)
75. Breaks large problems into smaller steps. (Never)
79. Listens carefully. (Sometimes)
87. Is easily distracted. (Often)
95. Misses deadlines. (Often)
107. Interrupts parents when they are talking on the phone. (Sometimes)
112. Plans ahead. (Never)
115. Argues when denied own way. (Often)
119. Pays attention when being spoken to. (Often)
123. Has trouble concentrating. (Almost always)
130. Has poor self-control. (Never)
133. Tracks down information when needed. (Often)
136. Makes decisions easily. (Often)
168. Evaluates own ideas. (Sometimes)
172. Interrupts others when they are speaking. (Almost always)
173. Finds ways to solve problems. (Often)

The Behavior Assessment System for Children, Third Edition (BASC-3) 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.

End of Report

ITEM RESPONSES

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