Behavior Assessment System for Children, Third Edition

Behavior Assessment System for Children, Third Edition (BASC™-3)
BASC-3 Self-Report of Personality - Child
Interpretive Summary Report with Intervention Recommendations

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Child Information		Test Information	
ID:		Test Date:	01/21/2021
Name:	Simone Lorge	Rater Name:	Self
Gender:	Female		
Birth Date:	12/31/2010		
Age:	10:0	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
Norm Group 5: ADHD Gender-Specific

PsychCorp

[1.7 / RE1 / QG1]

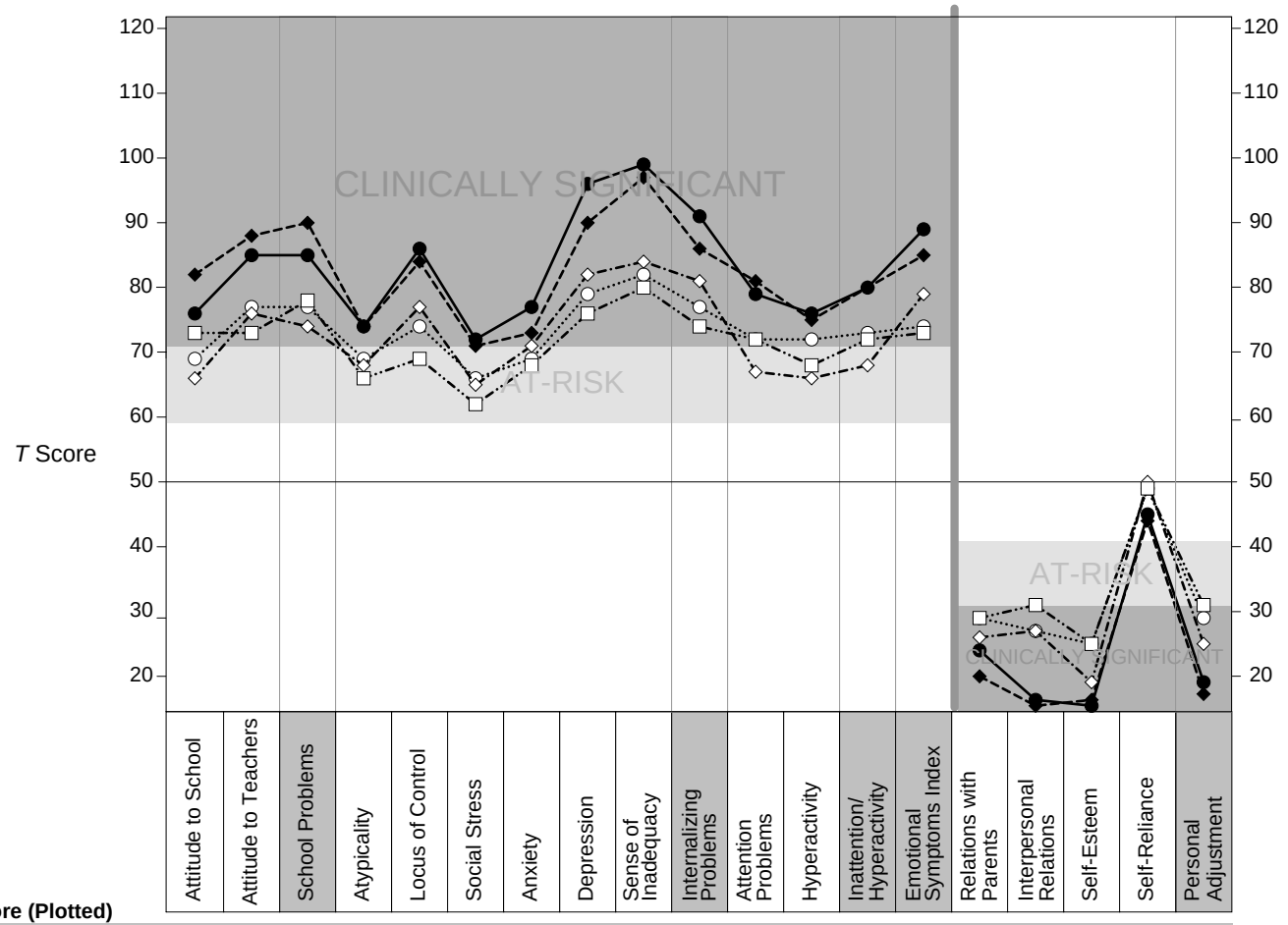
COMMENTS AND CONCERNS

No comments or concerns were provided.

VALIDITY INDEX SUMMARY

F Index	Response Pattern	Consistency	*L* Index	*V* Index
Caution	Acceptable	Acceptable	Acceptable	Acceptable
Raw Score: 3	Raw Score: 89	Raw Score: 8	Raw Score: 0	Raw Score: 0

CLINICAL AND ADAPTIVE *T*-SCORE PROFILE



T Score (Plotted)	Attitude to School	Attitude to Teachers	School Problems	Atypicality	Locus of Control	Social Stress	Anxiety	Depression	Sense of Inadequacy	Internalizing Problems	Attention Problems	Hyperactivity	Inattention/ Hyperactivity	Emotional Symptoms Index	Relations with Parents	Interpersonal Relations	Self-Esteem	Self-Reliance	Personal Adjustment
● General Combined	76	85	85	74	86	72	77	96	99	91	79	76	80	89	24	16	15	45	19
◆ Gen. Gender-Spec.	82	88	90	74	84	71	73	90	97	86	81	75	80	85	20	14	16	44	17
❍ Clin. Gender-Spec.	69	77	77	69	74	66	69	79	82	77	72	72	73	74	29	27	25	49	29
◊ ADHD Combined	66	76	74	68	77	65	71	82	84	81	67	66	68	79	26	27	19	50	25
❑ ADHD Gender-Spec.	73	73	78	66	69	62	68	76	80	74	72	68	72	73	29	31	25	49	31

Percentile																			
General Combined	98	99	99	97	99	97	99	99	99	99	99	98	99	99	2	1	1	31	1
Gen. Gender-Spec.	99	99	99	97	99	96	97	99	99	99	99	98	99	99	1	1	1	25	1
Clin. Gender-Spec.	93	99	99	95	98	92	95	99	99	99	98	99	99	98	3	4	1	42	3
ADHD Combined	92	98	98	95	99	91	97	99	99	99	97	93	96	99	1	3	1	51	2
ADHD Gender-Spec.	96	97	99	93	95	85	94	98	99	98	98	96	98	97	1	6	3	45	5

CLINICAL AND ADAPTIVE SCORE TABLE: General Combined Norm Group

Composite Score Summary

	Raw Score	*T* Score	Percentile Rank	95% Confidence Interval
School Problems	161	85	99	78-92
Internalizing Problems	504	91	99	87-95
Inattention/Hyperactivity	155	80	99	73-87
Emotional Symptoms Index	484	89	99	85-93
Personal Adjustment	100	19	1	14-24

Composite Comparisons	Difference	Significance Level	Frequency of Difference
School Problems vs. Internalizing Problems	-6	NS	
Internalizing Problems vs. Inattention/Hyperactivity	11	0.05	25% or less
School Problems vs. Inattention/Hyperactivity	5	NS	

Mean *T* score of the ESI	**81**
Inverted Mean *T* score of the ESI	**19**

Scale Score Summary

	Raw Score	*T* Score	Percentile Rank	95% Confidence Interval	Ipsative Comparison		
					Difference	Significance Level	Frequency of Difference
Attitude to School	17	76	98	68-84	-5	NS	
Attitude to Teachers	17	85	99	77-93	4	NS	
Atypicality	20	74	97	67-81	-7	NS	
Locus of Control	18	86	99	76-96	5	NS	
Social Stress	16	72	97	64-80	-9	NS	
Anxiety	25	77	99	69-85	-4	NS	
Depression	24	96	99	88-104	15	0.05	1% or less
Sense of Inadequacy	23	99	99	89-109	18	0.05	1% or less
Attention Problems	21	79	99	70-88	-2	NS	
Hyperactivity	19	76	98	68-84	-5	NS	
Relations with Parents	10	24	2	17-31	5	NS	
Interpersonal Relations	5	16	1	7-25	-3	NS	
Self-Esteem	4	15	1	6-24	-4	NS	
Self-Reliance	12	45	31	35-55	26	0.05	2% or less

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 SEMs and confidence intervals.

CLINICAL VALIDITY INDEX NARRATIVES

The *V* Index consists of nonsensical or extremely improbable items that typically are only marked by examinees due to carelessness, a failure to understand the questions, or a failure to cooperate with the assessment process.

Simone obtained a *V* Index score that falls within the **Acceptable** range, providing some indication that she understood the items and responded to them in accordance with the instructions provided on the test form.

The Consistency Index identifies situations when the examinee has given inconsistent responses to items that are typically answered in a similar way, based on comparisons made to examinees from the general population. The Consistency Index was designed to identify ratings that might not be easily interpretable due to these response discrepancies.

Simone's Consistency Index score falls within the **Acceptable** range, providing some support that she understood the rating form items and was attentive when providing responses to each item.

The BASC-3 *F* Index is a classically derived infrequency scale, designed to assess the possibility that a respondent depicted himself or herself in an inordinately negative fashion. The *F* Index consists of items that represent maladaptive behaviors to which the respondent answered "almost always" or "true" and adaptive behaviors to which the respondent answered "never" or "false." An elevated *F* Index score typically indicates the presence of extraordinarily high levels of maladaptive behavior or emotional distress, or may indicate that the respondent is presenting his or her problems as being more severe than they actually are. Sometimes, the *F* Index is referred to as a "fake-bad" scale since it might be perceived as an attempt to present a negatively distorted view of a person's behavior or emotions. It is important to note that an elevated *F* Index score does not invalidate the results of the assessment; rather, it can serve as a moderator for the interpretation of the overall results obtained on the rating scale.

To discern the correct interpretation of obtained scores in the presence of an elevated *F* Index score, it is necessary to have a good understanding of the referral issue, the child's history, and the current context of the child's life. Comparisons with data taken from other settings as well as other test results will also be useful in determining the best interpretation of the *F* Index as well as the other obtained scores. Simone's SRP responses have produced an *F* Index score that falls within the **Caution** range. This indicates a negative overall view of Simone's thoughts, feelings, and behavior. Typically, a review of the individual items on the *F* Index scale and responses to these items is useful for making an appropriate determination as to the interpretation of the BASC-3 scale scores. Caution should be used when interpreting BASC-3 scale scores; careful corroboration of these ratings based on additional sources of information (e.g., history, clinical interview, other data sources) is recommended.

The SRP *L* Index is designed to detect a response set that may be characterized as one of social desirability or "faking good." In general, it is composed of items that represent behaviors that children engage in at least some of the time. Simone's responses to the *L* Index items resulted in a score within the **Acceptable** range, indicating that she may not have attempted to present herself in a positive light.

VALIDITY INDEX ITEM LISTS

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

F Index

33. I like who I am. (False)
64. I am good at schoolwork. (Never)
110. I get along with my teacher. (Never)

Response Pattern Index

The Response Pattern Index rating is Acceptable.

Consistency Index

The Consistency Index rating is Acceptable.

L Index

The *L* Index rating is Acceptable.

V Index

The *V* Index rating is Acceptable.

CLINICAL AND ADAPTIVE SCALE NARRATIVES

This report is based on Simone's rating of herself using the BASC-3 Self-Report of Personality 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.

School Problems

The School Problems composite scale *T* score is 85, with a 95% confidence interval range of 78-92 and a percentile rank of 99. Simone's *T* score on this composite scale falls in the Clinically Significant classification range.

Simone's *T* score on Attitude to School is 76 and has a percentile rank of 98. This *T* score falls in the Clinically Significant classification range and usually warrants follow-up. Simone reports that she dislikes school intensely and often wishes to be elsewhere.

Simone's *T* score on Attitude to Teachers is 85 and has a percentile rank of 99. This *T* score falls in the Clinically Significant classification range and usually warrants follow-up. Simone generally considers her teacher(s) to be unfair, uncaring, and/or overly demanding.

Internalizing Problems

The Internalizing Problems composite scale *T* score is 91, with a 95% confidence interval range of 87-95 and a percentile rank of 99. Simone's *T* score on this composite scale falls in the Clinically Significant classification range.

Simone's *T* score on Atypicality is 74 and has a percentile rank of 97. This *T* score falls in the Clinically Significant classification range and usually warrants follow-up. Simone reports having a number of unusual thoughts and perceptions.

Simone's *T* score on Locus of Control is 86 and has a percentile rank of 99. This *T* score falls in the Clinically Significant classification range and usually warrants follow-up. Simone reports having little control over events occurring in her life and reports being blamed for things that she did not do.

Simone's *T* score on Social Stress is 72 and has a percentile rank of 97. This *T* score falls in the Clinically Significant classification range and usually warrants follow-up. Simone reports having difficulty establishing and maintaining close relationships with others and reports being isolated and lonely.

Simone's *T* score on Anxiety is 77 and has a percentile rank of 99. This *T* score falls in the Clinically Significant classification range and usually warrants follow-up. Simone reports excessive worrying, nervousness, and/or an inability to relax.

Simone's *T* score on Depression is 96 and has a percentile rank of 99. This *T* score falls in the Clinically Significant classification range and usually warrants follow-up. Simone reports generally feeling sad, being misunderstood, and/or feeling that life is getting worse and worse. Scores in this range may warrant assessment of vegetative symptoms (e.g., weight loss or gain, fatigue). Suicidal tendencies should also be explored.

Simone's *T* score on Sense of Inadequacy is 99 and has a percentile rank of 99. This *T* score falls in the Clinically Significant classification range and usually warrants follow-up. Simone reports being dissatisfied with her ability to perform a variety of tasks even when putting forth substantial effort.

Inattention/Hyperactivity

The Inattention/Hyperactivity composite scale *T* score is 80, with a 95% confidence interval range of 73-87 and a percentile rank of 99. Simone's *T* score on this composite scale falls in the Clinically Significant classification

range.

Simone's *T* score on Attention Problems is 79 and has a percentile rank of 99. This *T* score falls in the Clinically Significant classification range and usually warrants follow-up. Simone reports having significant difficulty maintaining necessary levels of attention. These problems are probably interfering with academic performance and functioning in other areas.

Simone's *T* score on Hyperactivity is 76 and has a percentile rank of 98. This *T* score falls in the Clinically Significant classification range and usually warrants follow-up. Simone reports frequently engaging in restless and disruptive behaviors.

Emotional Symptoms Index

The Emotional Symptoms Index composite scale *T* score is 89, with a 95% confidence interval range of 85-93 and a percentile rank of 99. Simone's *T* score on this composite scale falls in the Clinically Significant classification range.

Personal Adjustment

The Personal Adjustment composite scale *T* score is 19, with a 95% confidence interval range of 14-24 and a percentile rank of 1. Simone's *T* score on this composite scale falls in the Clinically Significant classification range.

Simone's *T* score on Relations With Parents is 24 and has a percentile rank of 2. This *T* score falls in the Clinically Significant classification range and usually warrants follow-up. Simone reports having a poor relationship with her parents. She may report having little trust in her parents and she may feel incidental to family life and decision making.

Simone's *T* score on Interpersonal Relations is 16 and has a percentile rank of 1. This *T* score falls in the Clinically Significant classification range and usually warrants follow-up. Simone reports having substantial difficulty establishing and maintaining relationships with others.

Simone's *T* score on Self-Esteem is 15 and has a percentile rank of 1. This *T* score falls in the Clinically Significant classification range and usually warrants follow-up. Simone reports a negative self-image, both in terms of personal and physical attributes.

Simone's *T* score on Self-Reliance is 45 and has a percentile rank of 31. Simone reports having about as much confidence as others her age in her ability to make decisions, solve problems, and/or be dependable.

BASC-3 SRP-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
- Sense of Inadequacy - Depression - Locus of Control - Attitude to Teachers (Academic Problems) - Self-Esteem - Interpersonal Relations (Social Skills) - Attention Problems - Anxiety - Hyperactivity - Attitude to School (Academic Problems) - Relations with Parents - Atypicality - Social Stress	- None	- None

Simone's scores on Depression and Attitude to Teachers (Academic Problems) fall in the clinically significant range and probably should be considered among the first behavioral issues to resolve.

Note that Simone has scores on Sense of Inadequacy, Locus of Control, Self-Esteem, Attention Problems, Anxiety, Hyperactivity, Attitude to School (Academic Problems), Relations with Parents, Atypicality, and Social Stress that are areas of concern. Interventions for these areas are not provided in this report. However, these areas may require additional follow up.

Simone's BASC-3 profile indicates significant problems with Depression, Attitude to Teachers (Academic Problems), and Interpersonal Relations (Social Skills). Based on her ratings, Simone is experiencing problems with the following behaviors:

Depression

- having things go right
- having too many problems
- feeling depressed
- feeling things are getting worse
- feeling understood
- feeling sad
- being listened to

Attitude to Teachers

- being understood by teachers
- being trusted by teachers
- being liked by teachers
- being treated fairly by teachers
- liking teachers

Interpersonal Relations

- getting along with others
- being liked by others
- being around others

Primary Improvement Area: Depression

Depression-related symptoms and behaviors are considered one of Simone'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.

<u>Depression Intervention Option 1: Relaxation Training</u>

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.

Primary Improvement: Attitude to Teachers (Academic Problems)

Academic problems are considered a significant problem for Simone. On the Self-Report of Personality, academic problems are assessed indirectly through the Attitude to School and Attitude to Teachers scales.

Academic problems are defined as the presence of academic difficulties particularly in understanding or completing homework. Learning problems can encompass a variety of academic domains, including reading, writing, spelling, and mathematics. Learning difficulties can cause problems beyond the classroom. The pervasive nature of academic problems--their influence on numerous content areas and academic skills--often makes dealing with academic problems challenging for both teacher and student alike and requires diligence and a long-term approach to intervention strategies to achieve successful remediation. These challenges are especially difficult for students with emotional and behavioral disorders, whose academic failures may also be due to problems with acquiring and processing information. These learning problems are significant contributors to increased risk of earning lower grades, being retained, and dropping out of school. Therefore, academic intervention is as important as the typical social and behavioral interventions.

Interventions for academic problems may be teacher directed or student directed. Student-directed interventions are techniques that students can use to store, retrieve, and generalize information for academic task completion and to manage their own behavior and learning. These self-mediated strategies are not instinctive and must be explicitly taught before independent use can be expected. Several intervention strategies have been shown to effectively remediate academic problems, including:

- Advance Organizers
- Cognitive Organizers
- Instructional Strategies: Structure
  - Scaffolding
  - Procedural Prompting
  - Instructional Sequencing
  - Scripted Lessons
- Instructional Strategies: Time
  - Rate and Pacing
  - Pausing
  - Allocated and Engaged Times

- Instructional Strategies: Responding
- Mnemonics
- Peer Tutoring
- Classwide Peer Tutoring
- Self-Monitoring
- Self-Instruction
- Reprocessing Strategies
  - Summarization
  - Paraphrasing
  - Cover, Copy, and Compare
  - Self-Questioning
- Task-Selection Strategies

Detailed summaries of the instructional strategies and self-monitoring are provided below. See the BASC-3 Behavior Intervention Guide for additional detail about these strategies, along with the other intervention strategies listed above.

Academic Problems Intervention Option 1: Instructional Strategies

Instructional strategies may alter structure, time, and/or student responding to assist students with academic problems. These changes create optimal learning environments and provide opportunities for improved student learning. The structure of instruction may be modified by scaffolding, procedural prompts, instructional sequencing, and/or scripted lessons. The timing aspects of instruction that may be modified include the rate and pacing of instruction, pauses during instruction, and amounts of allocated and engaged time within a lesson. Responding strategies affect the frequency and types of responses and verbal exchanges between the students and teacher to provide correction or confirmation.

Different strategies in altering structure, time, and responding aspects of instructional strategies are summarized below. See the BASC-3 Behavior Intervention Guide for a detailed discussions of this topic.

Structure
The structure of instruction refers to the formation or development of the content and the organization of its delivery. Well-designed curriculum has an implicit structure, and good instruction presents that structure explicitly to students. Common structure methods used include the following:

1. Scaffold
2. Procedural prompt
3. Instructional sequence
4. Scripted lessons

Scaffolding is the generic term for the instructional support provided by the teacher until the student is able to transition into independent thinking and learning. Scaffolds can be aids to developing and applying cognitive strategies. Scaffolded instruction provides an instructional bridge between existing student knowledge and new content.

Procedural prompts are visual, verbal, or auditory prompts to help students organize and remember new information. There are two main steps to follow when applying procedural prompts. First, determine if the challenge to learning is related to memory (organization) or thinking (application). Second, ask questions that create opportunities for chunking (remembering concepts together), linking (connecting items sequentially or by relation to each other), retrieval (accessing the information more efficiently), or schema (connecting newly learned

material with previously learned material).

Instructional sequencing refers to the order in which information is presented to a student, as well as how a student structures his or her learning. During instruction, information to be learned should be incorporated into the context of previously learned information. When presenting information, provide clear and explicit expectations for student performance. Information should be presented using examples and nonexamples, and should be explicitly linked or connected to previously learned information. Throughout the lesson, students should be given ample opportunities to respond to questions. They also should receive consistent reinforcement for correct responses and frequent feedback loops to correct and shape incorrect responses. Information that is learned should then be reviewed and practiced. In order to promote retention of the learned information, provide opportunities to demonstrate that information has been learned.

Scripted lessons are a variant of the instructional sequencing concept. Teachers write scripts for lesson plans, including how the information will be presented, the desired responses by students, and the routines that will be used for learning the material. Prompts for teacher and students are included in the scripts. Although scripted lessons can take a variety of forms, they generally follow the same steps as instructional sequencing.

Time
Time is the component of instructional strategies that refers to how much, how quickly, and how smoothly instruction is presented. There are three major components of time:

1. Rate and pacing
2. Pausing
3. Allocated and engaged time

Rate and pacing refer to the speed and regularity of the presentation and of practicing new material. The speed of a lesson can determine the amount of material covered, the amount of practice in which students engage, and the interest level of the students. A good fit between the time needed for learner processing and the pace needed for effective instruction is required to optimize learning time.

Pausing is the delay in time between instructional prompts and expected student responses. It can help to maintain a brisk rate of instruction and provide a rhythm in which students intently listen to the instruction and process the information prior to responding. Pausing can also be used to increase exposure to material through repetition. Providing an instructional prompt following portions of instruction in a lesson can provide students with the opportunity to consider the answer and create memory through active repetition of new knowledge.

Allocated time refers to the time dedicated to instruction and learning. Engaged time is the component of allocated time that reflects the time a student spends learning tasks. It is suggested that teachers maximize their instructional time to reflect a minimum of 50% active instruction, 35% active monitoring, and 15% or less organizing and managing. The level of student engagement in learning tasks can be monitored and increased individually through a variety of self-monitoring techniques or the use of reinforcers contingent on levels of on-task behavior.

Responding
Responding provides opportunities for students to participate by answering questions, restating instruction, or asking questions about content. The teacher provides feedback via correction or confirmation. The types and frequency of student responses and teacher feedback are fairly easy to assess and relatively pliable. With minimal training, a teacher can dramatically increase both the opportunities for student response and the immediacy and frequency of specific praise or corrective feedback provided during a lesson.

Academic Problems Intervention Option 2: Self-Monitoring

Self-monitoring requires a person to record information about his or her personal performance on a task to improve self-regulation of behavior. Self-monitoring consists of several components, including awareness, observation, monitoring, and documentation. Self-monitoring places control of behavioral change in the student's sphere of influence and deemphasizes external control agents. The goal of self-monitoring is to improve a

student's skills needed for self-regulation of behavior.

The essential elements of Self-Monitoring include the following:

1. Identify the problem.
2. Identify the replacement behavior.
3. Monitor and record behavior.
4. Prompt for student self-evaluation.
5. Ensure self-rewarding or reinforcing occurs.

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

PREP

- Identify a behavior for change (either to increase or decrease). This may be done in conjunction with the student or identified by the teacher or other involved adult.
- Explain the behavior to the student, articulating a definition to the extent necessary (e.g., explaining what "off task" means, discussing that homework is on time if it is turned in at the beginning of class).
- Review baseline data with the student in a non-threatening, non-accusatory way.
- Emphasize the benefits of improving academic performance.

IMPLEMENT

- Set a reasonable and achievable goal and identify the reward for achieving this goal.
- Choose an appropriate recording form or method for tracking the selected behavior or charting the academic data. Forms and methods employed may include using a tone or stopwatch, checklist, frequency counts, tally sheets, event recording, time sampling, narrative diary, wrist counters, graphs, charts, or tangible item counters. The method for recording can be as simple as making tally marks on a piece of paper at each instance of the behavior or as complex as writing a descriptive account of the behavior. Appropriate intervals for recording can be as short as one minute for behavior that may occur more frequently (e.g., off-task behavior during class) or once per class period for a less frequent behavior (e.g., checking for homework completion at the beginning of each class).
- Have the student practice the technique with teacher prompting and self-monitoring and self-recording.
- Compare notes on the frequency of the behavior and provide reinforcement to the student for accurate self-recording. In some situations positive feedback alone is a sufficient reinforcer; in others, tangible rewards are needed initially.
- Fade the use of self-monitoring supports gradually after goal mastery.

EVALUATE

- Assess on an ongoing basis the student's ability to self-monitor.
- Consider the intrusiveness of any cueing.

Primary Improvement: Interpersonal Relations (Social Skills)

Social skills problems are considered to be one of Simone's most significant behavioral and emotional areas to address. Social skills are learned, situation-specific behaviors (both verbal and nonverbal) that are demonstrated in particular social contexts. Deficits in social skills interfere with social, emotional, and academic functioning and are frequently observed in children with emotional and behavioral disorders. Social skills training is a cognitive-behavioral approach to teaching prosocial concepts needed for children to function successfully in multiple social environments. The goal of social skills training is to help the child develop skills that will enable him

or her to engage in appropriate interactions with others by remediating the behavioral challenges associated with his or her social skills deficits.

The essential elements of Social Skills Training include the following:

1. Identify the target social skills to develop.
2. Teach the skills and talk about why each is useful or important.
3. Model the skills through active demonstration.
4. Help the child practice the skills in a controlled environment while receiving feedback.
5. Assist the child in generalizing the skills by practicing them in new environments.

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

PREP

- Determine whether the training is an intervention or if it is preventative.

  * If it is an intervention, assess the child's social skills and determine the specific skill(s) the child needs to master. Instruction should be tailored to a child's specific needs, not based on a set list or a fixed curriculum. For example, if the child throws tantrums to get desired objects, the therapist should specifically teach the skill of asking for objects.

  * If it is preventative, the organizational or leadership team should identify target social skills for instruction and either all children or small groups of at-risk children should learn similar sets of critical social skills to prevent problems.

- Determine the format of instruction. The target social skills can be taught to a group or to individuals, and the skills can be taught in either a clinical or natural environment.

  * A natural environment is the ideal training scenario for generalization; however, training sessions are not always possible in school settings due to environmental constraints (e.g., lack of personnel, lack of adequate training, competing demands of classroom settings).

  * Groups can have children with similar social skills deficits (homogeneous grouping) or children with different deficits (heterogeneous grouping). When working with a homogeneous group, be sure to provide enough supervision and structure to prevent modeling of inappropriate behaviors.

- Schedule consistent times for social skills training keeping in mind that high training intensity (both frequency of meetings and overall program duration) is desirable.

  * If the skill is taught to an individual child in his or her natural environment, select a time based on the child's current schedule (e.g., getting along with others might be taught during recess).

  * If the skill is taught in a pull-out group session, select a specific time during the day that does not interfere with academic instruction. Determine the behavioral expectations for the group and post them in a highly visible area.

IMPLEMENT

- Explain the purpose of the training and define the concept of social skills for the children.
- Teach the children the steps to master the selected skills, focusing on one skill per lesson.

  * Begin with a visual representation (written or pictorial, depending on the children's abilities) of the steps required for performing the skill, and then ask the children to write down the steps on notecards or paper to help them remember the steps.

  * Instruct the children to verbalize the steps of a social skill using choral responding (i.e., reciting them aloud and in unison) if desired, and verbally reinforce children as they recite the steps.

- Demonstrate appropriate use of the skill by modeling it with another adult or with other children.
- Ask the children to provide examples of appropriate times to use this skill and situations in the recent past when this skill could have been useful.

- Ask the children to reenact some of the situations described and encourage them to incorporate the newly learned social skill. Assign other children to be monitors of the process so that they feel included even though they are not role-playing the situation.

    * Provide feedback and reinforcement during the role-play to both the actors and the children who are monitoring the use of the steps.

    * Elicit feedback after the role-play from all children, including the actors, on how effectively the skill was used.
- Provide relevant adults (e.g., teachers, parents, tutors, classroom volunteers) with a copy of the steps of the skill. Ask the adults to model the skill, encourage the child to apply the new skill, and reinforce all efforts.
- At the beginning of the next session, review the steps for the skill taught in the previous session.
- Provide reinforcement to the children for situational use of the skill to increase the likelihood of skill maintenance and generalization, which are vital to all skills training programs.

EVALUATE

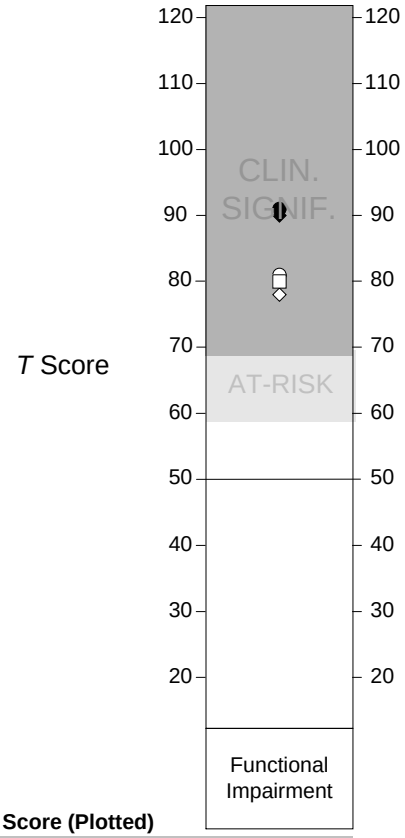
- Ask children who can write to record all social situations in which they use the skill in a journal. Children who cannot write can report daily to parents or to a teacher who can record their experiences.
- Monitor and continually assess the children's use of the skill (either through direct observation or by reviewing their journals) to identify any skills that need to be re-taught or reinforced.
- Hold periodic refresher courses on the skills taught in order to maintain skill acquisition.

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 Simone. 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	91
◆ Gen. Gender-Spec.	90
❍ Clin. Gender-Spec.	81
◊ ADHD Combined	78
❑ ADHD Gender-Spec.	80

Percentile	
General Combined	99
Gen. Gender-Spec.	99
Clin. Gender-Spec.	99
ADHD Combined	99
ADHD Gender-Spec.	99

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	173	68	94	56-80	At-Risk
EDQC 2: Inappropriate Behavior/Feelings	579	92	99	88-96	Clinically Significant
EDQC 3: Unhappiness or Depression	280	101	99	95-107	Clinically Significant
EDQC 4: Physical Symptoms or Fears	149	77	98	71-83	Clinically Significant
EDQC 5[2]: Schizophrenia and Related Disorders of Thought	255	77	99	68-86	Clinically Significant

[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
Simone's *T* score on the Unsatisfactory Interpersonal Relationships Composite is 68 and has a percentile rank of 94. This *T* score falls in the At-Risk classification range and follow-up assessment or intervention may be necessary. Simone reports some difficulty establishing and/or maintaining interpersonal relationships with others compared to same-age peers.

EDQC 2: Inappropriate Behavior/Feelings
Simone's *T* score on the Inappropriate Behavior/Feelings Composite is 92 and has a percentile rank of 99. This *T* score falls in the Clinically Significant classification range and usually warrants follow-up assessment or intervention. Simone displays behaviors or feelings that are significantly inappropriate under normal circumstances much more often than same-age peers.

EDQC 3: Unhappiness or Depression
Simone's *T* score on the Unhappiness or Depression Composite is 101 and has a percentile rank of 99. This *T* score falls in the Clinically Significant classification range and usually warrants follow-up assessment or intervention. Simone displays significant signs of pervasive unhappiness or depressive mood much more often than same-age peers.

EDQC 4: Physical Symptoms or Fears
Simone's *T* score on the Physical Symptoms or Fears Composite is 77 and has a percentile rank of 98. This *T* score falls in the Clinically Significant classification range and usually warrants follow-up assessment or intervention. Simone displays physical symptoms or fears associated with personal or school problems much more often than same-age peers.

EDQC 5: Schizophrenia and Related Disorders of Thought
Simone's *T* score on the Schizophrenia and Related Disorders of Thought Composite is 77 and has a percentile rank of 99. This *T* score falls in the Clinically Significant classification range and usually warrants follow-up assessment or intervention. Simone displays significantly elevated levels of atypical or withdrawn behavior and may struggle with functional communication compared to same-age peers.

CLINICAL INDEX SCORE TABLE: General Combined Norm Group

	Raw Score	*T* Score	Percentile Rank	95% Confidence Interval
Functional Impairment Index	48	91	99	83-99

CLINICAL INDEX NARRATIVES

Simone endorsed BASC-3 items that resulted in clinically significant Depression and Anxiety scale scores, a pattern that occurred in 1.6% of the BASC-3 standardization sample. Individuals with this pattern of elevations typically endorse sadness, hopelessness, worry, and nervousness. Internal states of distress may manifest in a wide range of behaviors such as poor concentration, hyperactivity, irritability, or aggression, which may be more readily apparent to parents and teachers. Thus, when interpreting parent or teacher reports of these behaviors, it may be useful to consider Simone's endorsement of internalizing difficulties. Given Simone's profile, diagnostic considerations will likely include depressive disorders (e.g., major depressive disorder, bipolar disorder) and anxiety disorders (e.g., generalized anxiety disorder, panic disorder, obsessive-compulsive disorder).

Anxiety and depression frequently co-occur and share a number of common features. In fact, for children and adolescents, it is possible to meet diagnostic criteria for major depressive disorder based solely on symptoms that are shared with generalized anxiety disorder, including irritability, sleep disturbances, fatigue, restlessness, and difficulties concentrating (although the opposite is not true, because generalized anxiety disorder also requires that these symptoms be caused by significant anxiety and worry). Thus, careful attention should be paid to whether these symptoms are primarily driven by anxiety, mood disturbance, or in some cases, both. Detailed history-taking and a thorough clinical interview will be helpful in this regard, and concurrent diagnoses should be given in cases where an individual meets criteria for both a depressive and anxiety disorder.

Simone also exhibited elevations on the BASC-3 scales of Hyperactivity and Attention Problems, a pattern that occurred in 70.8% of the BASC-3 standardization sample with clinically significant Depression and Anxiety scale scores. This suggests that Simone is endorsing inattention, forgetfulness, hyperactivity, and impulsivity, as well as a recognition that others notice these behaviors. In addition, it indicates that diagnostic considerations might include attention-deficit/hyperactivity disorder (ADHD). However, it should be noted that mood problems may result in attention problems and restlessness, which can appear behaviorally similar to ADHD. Furthermore, it may be the case that emotional distress is causing Simone to act out, or that negative feedback related to her behavioral issues is resulting in depressed or anxious mood. An important clinical goal will likely be clarifying the relationship between Simone's mood and behavioral symptoms. Understanding the onset, course, and function of these symptoms, through thorough clinical interviews and history-taking, will likely be helpful in determining whether behavior or mood is the primary concern for Simone.

ADHD and mood disorders frequently co-occur. In differentiating between ADHD and mood disorders, it is helpful 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, individuals with ADHD are more likely to exhibit restlessness in situations that are not highly motivating or reinforcing. Conversely, individuals with depression are more likely to exhibit poor motivation and behavioral agitation even while engaged in pleasurable activities. In cases of anxiety, individuals may exhibit problems with inattention and restlessness only in anxiety-provoking situations (e.g., social setting, testing), whereas in ADHD the symptoms are likely to occur across settings. ADHD can be diagnosed with mood disorders 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.

Simone's BASC-3 profile is also characterized by an elevated Social Stress scale score, which suggests that her social interactions may be characterized by tension, pressure, and a lack of social coping resources, which are common issues in individuals with internalizing problems. Furthermore, children and adolescents with behavioral difficulties may perceive social interactions as stressful, as their behaviors may result in conflict or rejection. Additional assessment of Simone's social functioning through clinical interviewing and history-taking might be helpful in clarifying how this domain could be utilized as part of her treatment plan. It may be important to note that Simone's profile is characterized by elevated Depression, Anxiety, and Social Stress scale scores, which is sometimes referred to as the "SAD" triad. Individuals with this profile may be experiencing significant emotional distress characterized by depressed mood and tension, as well as poor social support. When all of the SAD scales are elevated, a decompensation process may be looming, and additional investigation would likely be helpful in determining what immediate interventions to implement.

Simone's endorsements on the BASC-3 SRP resulted in an elevated Locus of Control scale score. Elevations on this scale indicate the belief of being controlled by external forces (e.g., authority figures such as parents or teachers). High scores on this scale may represent a "Why bother?" attitude, as well as a tendency to blame others for mistakes or believe that rewards will not be fairly distributed even in cases of appropriate behavior. Individuals with external control beliefs may exhibit depression or anxiety due to viewing the world as less safe and secure, which is consistent with Simone's endorsement of mood issues. Furthermore, these beliefs are common in individuals who are experiencing anxiety associated with a traumatic event. External control beliefs may also be evident in individuals with behavioral control problems, as they are likely to be engaged in more conflict with parents and teachers. This is consistent with Simone's report of problems with attention and hyperactivity. Thus, further assessment of this area, through clinical interviewing and history-taking, may be useful in understanding any potential mood or behavioral problems and guiding intervention planning.

Simone's BASC-3 profile is also characterized by an elevated Sense of Inadequacy scale score. Elevations of this scale may suggest low achievement expectations, a lack of perseverance, and a perception of being unsuccessful. These types of negative beliefs are sometimes associated with depression and anxiety (even in individuals who appear self-assured), which is consistent with Simone's endorsement of mood issues. Difficulties in this domain may also be associated with inattention and hyperactivity, as children and adolescents with these behaviors may struggle in academic and social settings. Further investigation of this area, as well as how Simone's functioning in this domain interacts with any behavioral or mood issues, will likely be helpful in making diagnostic considerations and planning interventions.

Simone's pattern of endorsements on the BASC-3 resulted in a clinically significant Interpersonal Relations scale score. Low scores on this scale may indicate difficulties with social skills. Individuals who endorse problems in this area are typically interested in developing relationships, but they are unsuccessful and they may blame themselves for these failures. For individuals with internalizing symptoms, these interpersonal problems may result from poor motivation or social anxiety, and they may help maintain the negative self-perceptions and attributional biases characteristic of mood disorders. Thus, further investigation of Simone's interpersonal functioning, as well as how it interacts with any reported clinical symptoms, will likely be useful in forming diagnostic conclusions and treatment plans.

Simone's pattern of endorsements on the BASC-3 resulted in a clinically significant Self-Esteem scale score. This may indicate dissatisfaction with one's self and feelings of shyness and/or insecurity. Simone's profile is characterized by elevated Depression and Anxiety scale scores, suggesting that these domains could be assessed in conjunction with her low self-esteem. Critical self-evaluation, worries about performance, and negative attributions are common in depression and anxiety and may be contributing to Simone's low self-esteem scale score. In addition, children and adolescents who exhibit problems with attention and hyperactivity may struggle with academics or peer relationships, and they may also receive more negative feedback compared to peers, all of which can negatively impact self-esteem. Thus, further investigation of this domain is likely warranted, especially because it may be a good target for behavioral and cognitive interventions.

DSM-5™ DIAGNOSTIC CRITERIA

Listed below are *DSM-5* Diagnostic Criteria based on the ratings obtained from on the SRP-C rating form. Each section first presents a list of symptoms of the disorder, along with SRP-C items that correspond to these symptoms. Then related *DSM-5* criteria and codes are presented. While information from SRP-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 SRP-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 SRP-C Items and's Responses*
__	Does not pay close attention to details, or makes careless mistakes	
X	Has difficulty sustaining attention	12. I think that I have a short attention span. (True) 28. I have attention problems. (True) 40. People tell me I should pay more attention (True) 53. I have trouble paying attention to the teacher. (Almost always) 103. I have trouble paying attention to what I am doing. (Almost always) 122. I get into trouble for not paying attention. (Almost always)
X	Does not seem to listen when spoken to	132. I listen when people are talking to me. (Sometimes)
__	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 SRP-C Items and's Responses*
X	Fidgets or squirms excessively	51. I have trouble sitting still. (Almost always) 75. I have trouble standing still in lines. (Almost always) 106. People tell me to be still. (Often)
__	Leaves seat inappropriately	
__	Feels restless	
X	Has difficulty engaging in activities quietly	89. People tell me that I am too noisy. (Often)
__	Acts as if "driven by a motor"	
__	Talks excessively	
__	Blurts out answers	115. I talk without waiting for others to say something. (Sometimes)
__	Has trouble waiting her turn	
X	Interrupts others' conversations or activities	86. I talk while other people are talking. (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.

Generalized Anxiety Disorder

List of Symptoms

	Area 1: Presence of Significant Worry/Anxiety	*Relevant BASC-3 SRP-C Items and's Responses*
X	Difficult to control, excessive anxiety and worry about a number of events/activities	27. I often worry about something bad happening to me. (True) 83. I worry but I don't know why. (Almost always) 91. I worry about what is going to happen. (Almost always) 136. I worry when I go to bed at night. (Often)
	Area 2: Symptoms Associated With Worry/Anxiety	
X	Feels restless, keyed up, or on edge	49. I get nervous. (Almost always) 85. I get nervous when things do not go the right way for me. (Sometimes)
__	Tires easily	
__	Has trouble concentrating or mind goes blank	
__	Is irritable	
__	Experiences muscle tension	
__	Has trouble sleeping	

DSM-5 Codes and Diagnostic Criteria

Generalized Anxiety Disorder 300.02 (F41.1)

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

Major Depressive Disorder

List of Symptoms

	Symptoms for Major Depressive Episode	*Relevant BASC-3 SRP-C Items and's Responses*
X	Depressed (or irritable in children/adolescents) mood most of the day, almost every day	62. I feel sad. (Often) 81. I feel depressed. (Often) 94. I feel like my life is getting worse and worse. (Almost always)
__	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	3. I feel good about myself. (False) 26. I wish I were different. (True) 33. I like who I am. (False) 38. I don't seem to do anything right. (True)
__	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.

DSM-5™ DIAGNOSTIC CONSIDERATIONS

The BASC-3 SRP-C 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 SRP-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 SRP-C 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:

12. I think that I have a short attention span. (True)
28. I have attention problems. (True)
40. People tell me I should pay more attention (True)
51. I have trouble sitting still. (Almost always)
53. I have trouble paying attention to the teacher. (Almost always)
75. I have trouble standing still in lines. (Almost always)
86. I talk while other people are talking. (Almost always)
89. People tell me that I am too noisy. (Often)
103. I have trouble paying attention to what I am doing. (Almost always)
106. People tell me to be still. (Often)
115. I talk without waiting for others to say something. (Sometimes)
122. I get into trouble for not paying attention. (Almost always)
132. I listen when people are talking to me. (Sometimes)

Generalized Anxiety Disorder 300.02 (F41.1)

Related BASC-3 items:

27. I often worry about something bad happening to me. (True)
49. I get nervous. (Almost always)
83. I worry but I don't know why. (Almost always)
85. I get nervous when things do not go the right way for me. (Sometimes)
91. I worry about what is going to happen. (Almost always)
136. I worry when I go to bed at night. (Often)

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

Related BASC-3 items:

3. I feel good about myself. (False)
26. I wish I were different. (True)
33. I like who I am. (False)
38. I don't seem to do anything right. (True)
62. I feel sad. (Often)
81. I feel depressed. (Often)
94. I feel like my life is getting worse and worse. (Almost always)

CRITICAL ITEMS

Bolded items may be of particular interest.

8. I never seem to get anything right. (True)
14. Nobody ever listens to me. (True)
34. Sometimes I want to hurt myself. (True)
57. Other kids hate to be with me. (Often)
62. I feel sad. (Often)
70. I hate school. (Almost always)
94. I feel like my life is getting worse and worse. (Almost always)
98. I feel safe at school. (Almost always)
102. I have trouble controlling my thoughts. (Almost always)
116. I hear voices in my head that no one else can hear. (Sometimes)
127. Other people make fun of me. (Sometimes)
129. No one understands me. (Almost always)

ITEMS BY SCALE - CLINICAL SCALES

Attitude to School

5. I don't like thinking about school. (True)
16. I don't care about school. (True)
21. I can't wait for school to be over. (True)
70. I hate school. (Almost always)
77. My school feels good to me. (Sometimes)
98. I feel safe at school. (Almost always)
119. I feel like I want to quit school. (Almost always)
131. School is boring. (Almost always)

Attitude to Teachers

9. My teacher understands me. (False)
47. My teacher is proud of me. (Never)
67. I like my teacher. (Sometimes)
80. My teacher trusts me. (Sometimes)
97. My teacher gets mad at me for no good reason. (Often)
110. I get along with my teacher. (Never)
134. Teachers are unfair. (Almost always)

Atypicality

13. Sometimes, when alone, I hear my name. (True)
34. Sometimes I want to hurt myself. (True)
46. Even when alone, I feel like someone is watching me. (Sometimes)
61. I feel like people are out to get me. (Almost always)
69. I see things that others cannot see. (Sometimes)
79. People think I'm strange. (Almost always)
88. I see weird things. (Sometimes)
92. I hear things that others cannot hear. (Almost always)
102. I have trouble controlling my thoughts. (Almost always)
116. I hear voices in my head that no one else can hear. (Sometimes)

Locus of Control

20. I can't seem to control what happens to me. (True)
31. My parents blame too many of their problems on me. (False)
37. I never get my way. (True)
42. Things go wrong for me, even when I try hard. (True)
96. I am blamed for things I don't do. (Almost always)
111. I get blamed for things I can't help. (Almost always)
130. People get mad at me, even when I don't do anything wrong. (Almost always)
133. My parents expect too much from me. (Almost always)

Social Stress

4. My friends have more fun than I do. (True)
44. I am left out of things. (Almost always)
52. I am bothered by teasing from others. (Sometimes)
59. People say bad things to me. (Sometimes)
87. People act as if they don't hear me. (Sometimes)
99. I am lonely. (Almost always)
109. Other people seem to ignore me. (Sometimes)

112. I feel out of place around people. (Often)
121. Other people find things wrong with me. (Often)

Anxiety

27. I often worry about something bad happening to me. (True)
49. I get nervous. (Almost always)
65. I feel stressed. (Almost always)
76. Little things bother me. (Almost always)
83. I worry but I don't know why. (Almost always)
85. I get nervous when things do not go the right way for me. (Sometimes)
91. I worry about what is going to happen. (Almost always)
104. I am afraid I might do something bad. (Sometimes)
118. I am bothered by thoughts about death. (Almost always)
125. I am afraid of a lot of things. (Sometimes)
136. I worry when I go to bed at night. (Often)

Depression

7. I have too many problems. (True)
14. Nobody ever listens to me. (True)
25. Nothing ever goes right for me. (True)
38. I don't seem to do anything right. (True)
55. I feel lonely. (Almost always)
62. I feel sad. (Often)
81. I feel depressed. (Often)
94. I feel like my life is getting worse and worse. (Almost always)
114. I feel like I have no friends. (Almost always)
129. No one understands me. (Almost always)

Sense of Inadequacy

8. I never seem to get anything right. (True)
54. When I take tests, I can't think. (Almost always)
63. I want to do better, but I can't. (Almost always)
68. I am disappointed with my grades. (Almost always)
78. It is hard for me to keep my mind on schoolwork. (Almost always)
90. People tell me to try harder. (Almost always)
108. Even when I try hard, I fail. (Almost always)
124. I fail at things. (Almost always)

Attention Problems

12. I think that I have a short attention span. (True)
28. I have attention problems. (True)
40. People tell me I should pay more attention (True)
53. I have trouble paying attention to the teacher. (Almost always)
73. I forget to do things. (Often)
103. I have trouble paying attention to what I am doing. (Almost always)
113. I am a good listener. (Sometimes)
122. I get into trouble for not paying attention. (Almost always)
132. I listen when people are talking to me. (Sometimes)

Hyperactivity

1. I often do things without thinking. (True)
51. I have trouble sitting still. (Almost always)
71. People tell me to slow down. (Almost always)
75. I have trouble standing still in lines. (Almost always)
86. I talk while other people are talking. (Almost always)
89. People tell me that I am too noisy. (Often)
106. People tell me to be still. (Often)
115. I talk without waiting for others to say something. (Sometimes)

ITEMS BY SCALE - ADAPTIVE SCALES

Relations with Parents

45. My parents are easy to talk to. (Sometimes)
50. I like my parents. (Often)
56. My parents trust me. (Never)
60. My parents are proud of me. (Never)
74. I like going places with my parents. (Often)
82. My mother and father help me if I ask them to. (Sometimes)
105. My parents like to be with me. (Sometimes)
120. My parents listen to what I say. (Sometimes)
135. I am proud of my parents. (Sometimes)
137. My mother and father like my friends. (Sometimes)

Interpersonal Relations

10. My classmates don't like me. (True)
18. Other children don't like to be with me. (True)
35. I have a hard time making friends. (True)
43. I get along well with others. (Sometimes)
57. Other kids hate to be with me. (Often)
66. I feel that nobody likes me. (Almost always)
95. I am liked by others. (Sometimes)
127. Other people make fun of me. (Sometimes)

Self-Esteem

3. I feel good about myself. (False)
26. I wish I were different. (True)
33. I like who I am. (False)
48. I get upset about my looks. (Often)
84. I like the way I look. (Sometimes)
101. I'm happy with who I am. (Sometimes)
123. My looks bother me. (Often)

Self-Reliance

23. If I have a problem, I can usually work it out. (False)
58. I am a dependable friend. (Almost always)
64. I am good at schoolwork. (Never)
72. I am someone you can count on. (Almost always)
93. I am dependable. (Almost always)
117. I can solve difficult problems by myself. (Often)
128. I am good at making decisions. (Sometimes)

ITEMS BY SCALE - CLINICAL INDEXES

Functional Impairment

1. I often do things without thinking. (True)
18. Other children don't like to be with me. (True)
20. I can't seem to control what happens to me. (True)
28. I have attention problems. (True)
40. People tell me I should pay more attention (True)
49. I get nervous. (Almost always)
51. I have trouble sitting still. (Almost always)
53. I have trouble paying attention to the teacher. (Almost always)
54. When I take tests, I can't think. (Almost always)
62. I feel sad. (Often)
66. I feel that nobody likes me. (Almost always)
68. I am disappointed with my grades. (Almost always)
86. I talk while other people are talking. (Almost always)
89. People tell me that I am too noisy. (Often)
93. I am dependable. (Almost always)
99. I am lonely. (Almost always)
103. I have trouble paying attention to what I am doing. (Almost always)
116. I hear voices in my head that no one else can hear. (Sometimes)
119. I feel like I want to quit school. (Almost always)
124. I fail at things. (Almost always)

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

1: 1	2: 2	3: 2	4: 1	5: 1	6: 2	7: 1	8: 1	9: 2	10: 1
11: 1	12: 1	13: 1	14: 1	15: 2	16: 1	17: 2	18: 1	19: 2	20: 1
21: 1	22: 2	23: 2	24: 2	25: 1	26: 1	27: 1	28: 1	29: 2	30: 2
31: 2	32: 2	33: 2	34: 1	35: 1	36: 2	37: 1	38: 1	39: 1	40: 1
41: 2	42: 1	43: 2	44: 4	45: 2	46: 2	47: 1	48: 3	49: 4	50: 3
51: 4	52: 2	53: 4	54: 4	55: 4	56: 1	57: 3	58: 4	59: 2	60: 1
61: 4	62: 3	63: 4	64: 1	65: 4	66: 4	67: 2	68: 4	69: 2	70: 4
71: 4	72: 4	73: 3	74: 3	75: 4	76: 4	77: 2	78: 4	79: 4	80: 2
81: 3	82: 2	83: 4	84: 2	85: 2	86: 4	87: 2	88: 2	89: 3	90: 4
91: 4	92: 4	93: 4	94: 4	95: 2	96: 4	97: 3	98: 4	99: 4	100: 3
101: 2	102: 4	103: 4	104: 2	105: 2	106: 3	107: 4	108: 4	109: 2	110: 1
111: 4	112: 3	113: 2	114: 4	115: 2	116: 2	117: 3	118: 4	119: 4	120: 2
121: 3	122: 4	123: 3	124: 4	125: 2	126: 1	127: 2	128: 2	129: 4	130: 4
131: 4	132: 2	133: 4	134: 4	135: 2	136: 3	137: 2			