BASC-2™

BASC-2 Teacher Rating Scales - Child
Behavior Assessment System for Children, Second Edition
Clinical Report

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	Child Information		**Test Information**
ID:	123456789	Test Date:	12/11/2009
Name:	Timmy Testcase	Rater:	Mrs Math
Gender:	Male	Position:	
Birth Date:	02/06/1998	Time Known Child:	
Age:	11		
Grade:			
School:			

Norm Group 1: General - Combined Sex

The Behavior Assessment System for Children, Second Edition (BASC-2) is an integrated system designed to facilitate the differential diagnosis and classification of a variety of emotional and behavioral disorders of children and to aid in the design of treatment plans. This computer-generated report should not be the sole basis for making important diagnostic or treatment decisions.

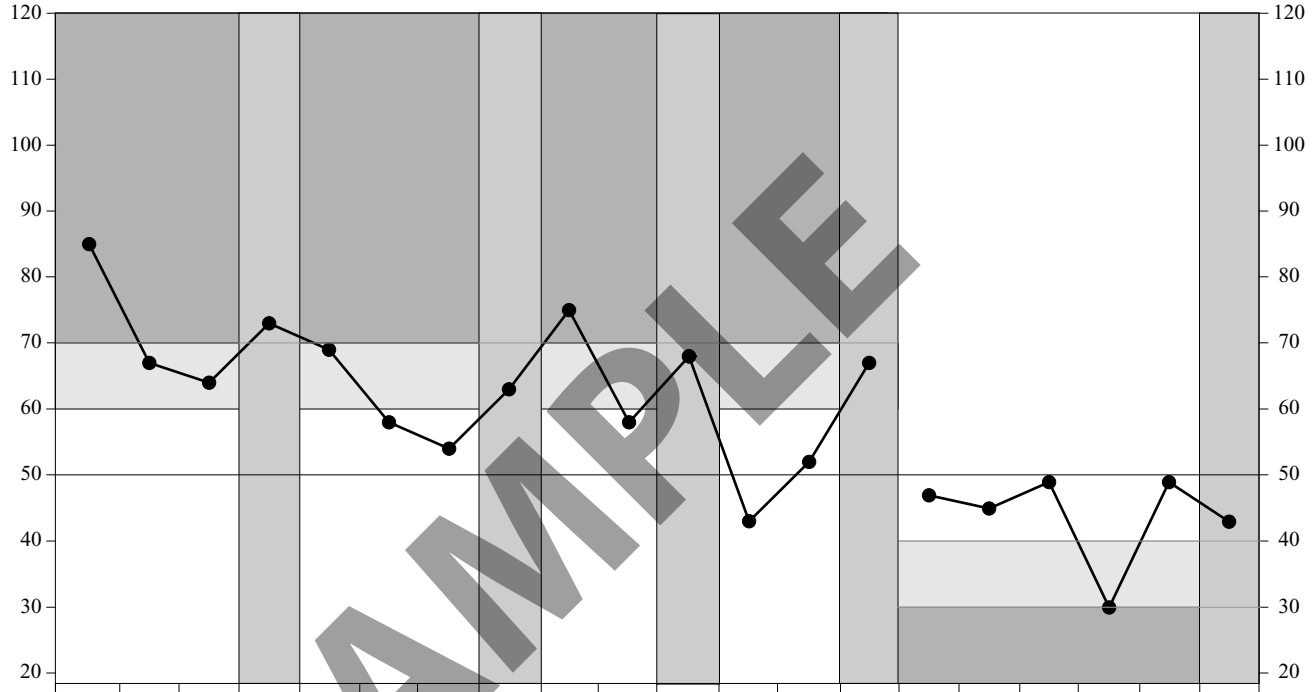
PEARSON

PsychCorp

VALIDITY INDEX SUMMARY

F Index	Response Pattern	Consistency
Acceptable	Acceptable	Acceptable
Raw Score: 0	Raw Score: 104	Raw Score: 4

T-SCORE PROFILE



	Hyperactivity	Aggression	Conduct Problems	Externalizing Problems	Anxiety	Depression	Somatization	Internalizing Problems	Attention Problems	Learning Problems	School Problems	Atypicality	Withdrawal	Behavioral Symptoms Index	Adaptability	Social Skills	Leadership	Study Skills	Functional Communication	Adaptive Skills
T Score (Plotted)																				
● Gen.-Comb. Sex	85	67	64	73	69	58	54	63	75	58	68	43	52	67	47	45	49	30	49	43
Percentile																				
Gen.-Comb. Sex	99	93	90	97	95	84	77	90	99	80	95	20	67	94	36	33	48	3	40	24

TRS SCORE SUMMARY: General - Combined Sex Norm Group

Composite Score Summary

	Raw Score	*T* Score	Percentile Rank	90% Confidence Interval
Externalizing Problems	216	73	97	70-76
Internalizing Problems	181	63	90	58-68
School Problems	133	68	95	64-72
Behavioral Symptoms Index	380	67	94	64-70
Adaptive Skills	220	43	24	40-46

Composite Comparisons	Difference	Significance Level	Frequency of Difference
Externalizing Problems vs. Internalizing Problems	10	0.01	greater than 25%
Internalizing Problems vs. School Problems	-5	NS	
Externalizing Problems vs. School Problems	5	NS	

Mean *T* score of the BSI	**63**
Mean *T* score of the Adaptive Skills Composite	**44**

Scale Score Summary

	Raw Score	*T* Score	Percentile Rank	90% Confidence Interval	Ipsative Comparison		
					Difference	Significance Level	Frequency of Difference
Hyperactivity	28	85	99	81-89	22	0.05	1% or less
Aggression	11	67	93	63-71	4	NS	
Conduct Problems	9	64	90	59-69	1	NS	
Anxiety	9	69	95	62-76	6	NS	
Depression	6	58	84	52-64	-5	NS	
Somatization	3	54	77	47-61	-9	NS	
Attention Problems	21	75	99	71-79	12	0.05	5% or less
Learning Problems	9	58	80	52-64	-5	NS	
Atypicality	0	43	20	36-50	-20	0.05	1% or less
Withdrawal	5	52	67	46-58	-11	0.05	10% or less
Adaptability	14	47	36	41-53	3	NS	
Social Skills	10	45	33	40-50	1	NS	
Leadership	8	49	48	43-55	5	NS	
Study Skills	2	30	3	25-35	-14	0.05	1% or less
Functional Communication	21	49	40	44-54	5	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-2 Manual for additional information on SEMs and confidence intervals.

CLINICAL VALIDITY SUMMARY

The BASC-2 F Index is a classically derived infrequency scale, designed to assess the possibility that a rater has depicted a child's behavior in an inordinately negative fashion. The F Index consists of items that represent maladaptive behaviors to which the rater answered "almost always" and adaptive behaviors to which the rater responded "never."

The F Index produced from the ratings of Timmy by the teacher falls within the **Acceptable** range and does not indicate the presence of negative response distortion.

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

The Consistency Index produced from the ratings of Timmy by the teacher falls within the **Acceptable** range, and indicates the rater consistently answered items when completing the rating form.

SCALE SUMMARY

This report is based on Mrs Math's rating of Timmy's behavior using the BASC-2 Teacher 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 73, with a 90 percent confidence-interval range of 70-76 and a percentile rank of 97. Timmy's T score on this composite scale falls in the Clinically Significant classification range.

Timmy's T score on Hyperactivity is 85 and has a percentile rank of 99. This T score falls in the Clinically Significant classification range, and usually warrants follow-up. Timmy's teacher reports that Timmy engages in an unusually high number of behaviors that are adversely affecting other children in the classroom. These behaviors are reported to be disruptive and indicate that Timmy is having a problem maintaining his self-control.

Timmy's T score on Aggression is 67 and has a percentile rank of 93. This T score falls in the At-Risk classification range, and follow-up may be necessary. Timmy's teacher reports that Timmy sometimes displays aggressive behaviors, such as being argumentative, defiant, and/or threatening to others. Because aggressive behaviors in children often are present with other externalizing behaviors and with diminished social relations, even moderately elevated Aggression scores such as this may warrant intervention.

Timmy's T score on Conduct Problems is 64 and has a percentile rank of 90. This T score falls in the At-Risk classification range, and follow-up may be necessary. Timmy's teacher reports that Timmy sometimes engages in rule-breaking behavior, such as cheating, deception, and/or stealing.

Internalizing Problems
The Internalizing Problems composite scale T score is 63, with a 90 percent confidence-interval range of 58-68 and a percentile rank of 90. Timmy's T score on this composite scale falls in the At-Risk classification range.

Timmy's T score on Anxiety 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. Timmy's teacher reports that Timmy sometimes displays behaviors stemming from worry, nervousness, and/or fear.

Timmy's T score on Depression is 58 and has a percentile rank of 84. Timmy's teacher reports that Timmy displays depressive behaviors no more often than others his age.

Timmy's T score on Somatization is 54 and has a percentile rank of 77. Timmy's teacher reports that Timmy complains of health-related problems to about the same degree as others his age.

School Problems
The School Problems composite scale T score is 68, with a 90 percent confidence-interval range of 64-72 and a percentile rank of 95. Timmy's T score on this composite scale falls in the At-Risk classification range.

Timmy's T score on Attention Problems is 75 and has a percentile rank of 99. This T score falls in the Clinically Significant classification range, and usually warrants follow-up. Timmy's teacher reports that Timmy has significant difficulty maintaining necessary levels of attention at school. The problems experienced by Timmy are probably interfering with academic performance and functioning in other areas.

Timmy's T score on Learning Problems is 58 and has a percentile rank of 80. Timmy's teacher reports that Timmy does not have unusual difficulty comprehending and completing schoolwork.

Behavioral Symptoms Index
The Behavioral Symptoms Index (BSI) composite scale T score is 67, with a 90 percent confidence-interval range of 64-70 and a percentile rank of 94. Timmy's T score on this composite scale falls in the At-Risk classification range. Scale summary information for Hyperactivity, Aggression, Depression, and Attention Problems (scales included in the BSI) has been provided above. Scale summary information for the remaining BSI scales is given next.

Timmy's T score on Atypicality is 43 and has a percentile rank of 20. Timmy's teacher reports that Timmy generally displays clear, logical thought patterns and he is generally aware of his surroundings.

Timmy's T score on Withdrawal is 52 and has a percentile rank of 67. Timmy's teacher reports that Timmy does not avoid social situations and appears to be capable of developing and maintaining friendships with others.

Adaptive Skills
The Adaptive Skills composite scale T score is 43, with a 90 percent confidence-interval range of 40-46 and a percentile rank of 24.

Timmy's T score on Adaptability is 47 and has a percentile rank of 36. Timmy's teacher reports that Timmy is able to adapt as well as most others his age to a variety of situations.

Timmy's T score on Social Skills is 45 and has a percentile rank of 33. Timmy's teacher reports that Timmy possesses sufficient social skills and generally does not experience debilitating or abnormal social difficulties.

Timmy's T score on Leadership is 49 and has a percentile rank of 48. Timmy's teacher reports that, when compared to others his age, Timmy demonstrates a typical level of creativity, ability to work under pressure, and/or an ability to bring others together to complete a work assignment.

Timmy's T score on Study Skills is 30 and has a percentile rank of 3. This T score falls in the Clinically Significant classification range, and usually warrants follow-up. Timmy's teacher reports that Timmy demonstrates weak study skills, is poorly organized, and has difficulty turning in assignments on time.

Timmy's T score on Functional Communication is 49 and has a percentile rank of 40. Timmy's teacher reports that Timmy generally exhibits adequate expressive and receptive communication skills, and that Timmy is usually able to seek out and find new information when needed.

BASC-2 TRS-C INTERVENTION SUMMARY

Note. Information contained in the Intervention Summary section of this report is based on the *BASC-2 Intervention Guide*, authored by Kimberly J. Vannest, Cecil R. Reynolds, and Randy W. Kamphaus.

Primary Improvement Areas	Secondary Improvement Areas	Adaptive Skill Strengths
ı Hyperactivity ı Attention Problems ı Study Skills (Academic Problems)	ı Anxiety ı Aggression ı Conduct Problems	ı None

Timmy's scores on Hyperactivity, Attention Problems, and Study Skills (Academic Problems) fall in the clinically significant range, and probably should be considered among the first behavioral issues to resolve.

Note that Timmy has scores on Anxiety, Aggression, and Conduct Problems that are areas of concern. Interventions for these areas are not provided in this report. However, these areas may require additional follow up.

Timmy's BASC-2 profile indicates significant problems with Hyperactivity, Attention Problems, and Study Skills (Academic Problems). Based on Mrs Math's ratings, Timmy is experiencing problems with the following behaviors:

Hyperactivity

- leaving seat
- disrupting others
- being overly active
- acting without thinking
- interrupting others
- having poor self-control
- not waiting for turn
- seeking attention

Attention Problems

- staying focused
- paying attention
- listening well

Study Skills

- studying well
- reading
- staying organized
- completing homework
- making up assignments

Primary Improvement Area: Hyperactivity

Hyperactivity problems are considered to be one of Timmy 's most significant behavioral and emotional areas to address. Hyperactivity is characterized as overactivity or excessive task-irrelevant physical (i.e., motor) movement. Children and adolescents with hyperactivity often make noises at inappropriate times, leave their assigned seats without permission, and talk during times designated for silence in the classroom. Hyperactivity problems can occur alone or can co-occur with attention problems and are usually exhibited by children in both home and school settings.

There are a variety of interventions that have been shown to reduce, or have shown promise for reducing, hyperactive behavior, including:

- Functional Assessment
- Contingency Management
- Parent Training
- Self-Management of Hyperactivity
- Task Modification
- Multimodal Interventions

Detailed summaries of the Contingency Management and Self-Management intervention strategies are provided below. See the *BASC-2 Intervention Guide* for additional detail about these strategies, along with the other intervention strategies listed above.

Hyperactivity Intervention Option 1: Contingency Management

In contingency management for hyperactivity, behavioral interventions are used to modify consequent events (i.e., events that occur after the behavior) that are often maintained through the reinforcement of overactive and impulsive behavior. The goal of contingency management is to decrease activity levels that negatively impact learning by shaping the child's existing behavior and providing opportunities for the new, desired behavior to become internalized. The procedural steps for incorporating contingency management strategies into the treatment of hyperactivity are summarized below. See the *BASC-2 Intervention Guide* for a detailed discussion of this topic.

Procedural steps for the application of contingency management

1. Define the behavior in operational terms.
2. Determine the behavioral goals.

3. Determine the reinforcers.
4. Explain the system to the child.
5. Implement the chosen reinforcement strategy (e.g., token system).
6. Adjust the reinforcement as needed.

Considerations When Implementing a Contingency Management Intervention Strategy

For Teaching. Teachers are generally adept at procedures that involve classwide prompting or acknowledgement and may need only minimal coaching to be more effective with students with hyperactivity. Some issues that typically frustrate teachers include the modification of systems, the immediacy of reinforcer use, the consistency in application, and the setting of goals that will encourage and change student behavior. Teachers must modify the structure of token economy systems when the student loses more points than he or she earns, or students will not maintain an interest or be able to access the reinforcer. Reinforcement must be immediate for students with hyperactivity; contingencies that are hours, days, or weeks away are unlikely to be effective. Behavioral interventions for students with hyperactivity require long-term consistency, and once a student engages in appropriate behaviors, fading may occur but monitoring should also occur so that the intervention can be reapplied when necessary. Goal setting or criteria setting for access to reinforcers is as critical as immediate access. If a student is engaging in hyperactive behaviors 90% of the time, a goal of 0% is unrealistic. Goals need to be seen as gradual, and intermediate steps toward reaching a long-term solution are important for reducing hyperactivity. Goals should also be specific when possible, targeting the relevant behaviors that fit under the class of hyperactivity. For example, fidgeting and running around a classroom may have a differential impact on the setting and need to be addressed separately, even if both actions are part of hyperactivity.

For Culture and Language Differences. Home-school communication and the use of contingency management techniques in both settings will improve the application of any intervention. At minimum, attempt to provide communication in the primary language of the parent, and, if necessary, use an adult translator or bilingual staff person to articulate the program of intervention and describe how contingencies could be managed at home.

For Age and Developmental Level. Contingency and reinforcement choices should include the child or adolescent's preferences and should be age and developmentally appropriate.

Research Studies Supporting Use of Contingency Management Intervention Strategies

The following studies support the use of contingency management intervention strategies for dealing with hyperactivity problems. Detailed annotations of these studies are included in the *BASC-2 Intervention Guide.*

Ayllon, T., Layman, D., & Kandel, H. J. (1975). A behavioral-educational alternative to drug control of hyperactive children. *Journal of Applied Behavior Analysis, 8,* 137-146.

Ayllon, T., & Roberts, M. D. (1974). Eliminating discipline problems by strengthening academic performance. *Journal of Applied Behavior Analysis, 7,* 71-76.

DuPaul, G. J., Guevremont, D. C., & Barkley, R. A. (1992). Behavioral treatment of attention-deficit hyperactivity disorder in the classroom: The use of the Attention Training System. *Behavior Modification, 16,* 204-225.

Fabiano, G. A., & Pelham, W. E., Jr. (2003). Improving the effectiveness of behavioral classroom interventions for attention-deficit/hyperactivity disorder: A case study. *Journal of Emotional and Behavioral Disorders, 11,* 124-130.

McGoey, K. E., & DuPaul, G. J. (2000). Token reinforcement and response cost procedures: Reducing the disruptive behavior of preschool children with attention-deficit/hyperactivity disorder. *School Psychology Quarterly, 15* (3), 330-343.

Reitman, D., Hupp, S. D. A., O'Callaghan, P. M., Gulley, V., & Northup, J. (2001). The influence of a token economy and methylphenidate on attentive and disruptive behavior during sports with ADHD-diagnosed children. *Behavior Modification, 25* (2), 305-323.

Hyperactivity Intervention Option 2: Self-Management

Self-management as an intervention for hyperactivity is a process in which children monitor their own activity level, record the results, and compare this level to a predetermined, acceptable level of activity. The goal of self-management is for the child to become aware of his or her own level of activity in order to produce an automatic response without relying on external reinforcement or prompting. A child's ability to produce this automatic response through internalized controls can decrease his or her situation-specific, inappropriate overactivity. The procedural steps for incorporating self-management strategies into the treatment of hyperactivity are summarized below. See the *BASC-2 Intervention Guide* for a detailed discussion of this topic.

Procedural steps for the application of self-management of hyperactivity

1. Teach self-monitoring procedures to the child.
    a. Identify the problem behavior and the new behavior to replace it.
    b. Model the replacement behavior, and indicate the level (i.e., the frequency and/or intensity) at which it should occur.
    c. Role-play the expected level and behavior with the child.
    d. Ask the child and the person modeling the behavior (e.g., teacher) to record either a plus (+), indicating appropriate activity level, or a minus (-), indicating overactivity.
    e. Compare both sets of ratings.
    f. Provide reinforcement for accurate child recordings.
    g. Continue this process until the child masters self-recording (i.e., typically with 90% accuracy).
2. Determine if the replacement behavior is happening in the desired setting.
3. As needed, prompt the child to monitor activity (e.g., a beep on a tape recorder).
4. Ask the child to self-record the occurrence of the replacement behavior.

5. Graph the occurrence of the replacement behavior in order to demonstrate success or failure of the targeted behavior and activity level.
6. Provide consistent feedback and appropriate reinforcement.

Considerations When Implementing a Self-Management Intervention Strategy

For Teaching. When teaching children to self-manage, it is important to thoughtfully consider the goal of the intervention. If the objective is to reduce fidgety behaviors, the intervention and outcome will be different than improving a class of behaviors, such as listening or assignment completion. For example, targeting fidgety behaviors may result in solely monitoring and recording the tapping of a foot or pencil, which may not produce the same results that monitoring on-task behavior or task completion might. However, reducing fidgety behaviors may be the primary goal in other situations. For example, if a student's behavior interrupts the other students' class work or creates a negative relationship with the teacher, it may be best to focus on reducing those behaviors, even if the student's overall academic performance is not targeted and, therefore, does not improve.

Research Studies Supporting Use of Self-Management Intervention Strategies

The following studies support the use of self-management intervention strategies for dealing with hyperactivity problems. Detailed annotations of these studies are included in the *BASC-2 Intervention Guide.*

Christie, D. J., Hiss, M., & Lozanoff, B. (1984). Modification of inattentive classroom behavior: Hyperactive children's use of self-recording with teacher guidance. *Behavior Modification, 8* (3), 391-406.

Horn, W. F., Chatoor, I., & Conners, C. K. (1983). Additive effects of Dexedrine and self-control training. *Behavior Modification, 7,* (3), 383-402.

Kern, L., Ringdahl, J. E., Hilt, A., & Sterling-Turner, H. E. (2001). Linking self-management procedures to functional analysis results. *Behavioral Disorders, 26* (3), 214-226.

Varni, J. W., & Henker, B. (1979). A self-regulation approach to the treatment of three hyperactive boys. *Child Behavior Therapy, 1* (2), 171-192.

Primary Improvement Area: Attention Problems

Attention problems are considered to be one of Timmy 's most significant behavioral and emotional areas to address. Attention problems are defined as chronic and severe inconsistencies in the ability to maintain and regulate focus to tasks for more than short periods of time, and are characterized by distractibility, an inability to concentrate, an inability to maintain attention to tasks for long periods of time, disorganization, failure to complete tasks, and a lack of study skills. Children and adolescents with attention problems exhibit an inability to control and direct attention to the demands of a task and are frequently distracted by irrelevant stimuli even in a relatively quiet classroom environment or by internal distractions.

The interventions presented below are behaviorally based, and involve strategies that include learning new behaviors and learning how to monitor existing behavior periodically. These interventions include:

- Contingency Management
- Daily Behavior Report Cards
- Modified Task Presentation
- Self-Management of Attention
- Classwide Peer Tutoring
- Computer-Assisted Instruction
- Multimodal Interventions

Detailed summaries of the Daily Behavior Report Card and Modified Task Presentation intervention strategies are provided below. See the *BASC-2 Intervention Guide* for additional detail about these strategies, along with the other intervention strategies listed above.

Attention Problems Intervention Option 1: Daily Behavior Report Cards

Daily behavior report cards (DBRCs) are used to record a child's behavior each day. The goal in implementing a DBRC strategy is to change behavior by providing systematic feedback on performance and progress to students and parents, followed by appropriate reinforcement. The result is increased attention (or decreased inattention) during specific tasks and conditions. The procedural steps for incorporating DBRC strategies into the treatment of attention problems are summarized below. See the *BASC-2 Intervention Guide* for a detailed discussion of this topic.

Procedural steps for application of daily behavior report cards to improve attention

1. Identify the target behaviors for improving attention. Include other adults who will help, such as behavioral consultants, teachers, or parents. Decide who will participate in rating.
2. Ask the rater to assign a letter grade (A, B, C, or D) to the child's performance for each day. Each target behavior is rated each day. Use letter grades (instead of frequency of behavior, for example) are preferable because they are usually more meaningful to students and families. Explain the behavioral "anchors" (i.e., typical behavior for earning each grade) to avoid drift among raters or differences in personal tolerance levels. For example, attending during 10 out of 20 minutes of class time may earn a "C," 15 minutes may earn a "B," and 17 minutes of attention or more might earn an "A."
3. Give feedback to the student using a check-in/check-out daily system (where the child "checks in" to receive the day's goals and "checks out" to receive his or her grade), a home-note correspondence system, or a teacher conference with graphing/charting.
4. Reward the student, either at home or school, for meeting performance goals. This may or may not be needed depending on the child.

Considerations When Implementing a Daily Behavior Report Card Intervention Strategy

Consideration should be given to who does the rating and who hands out the praise and reinforcement for any child. Effectiveness of the contingency is indicative of whether or not the interaction with the

adult is a positive or negative (i.e., punitive) one. DBRCs are not meant as a channel for communicating punishment or for reporting daily bad behavior; they are ideally used to provide objective and frequent feedback to the student and to communicate progress to the family.

For Culture and Language Differences. The DBRC is only as effective as the reinforcement or contingency attached to it, and the communication with families can be a component of that reinforcer or contingency. Therefore, effective communication with the family may necessitate use of the home language or extra consideration may need to be given to accurately explain the purpose and process of the DBRC.

For Age and Developmental Level. Age may also be a consideration with younger children responding quickly to teacher attention and feedback, while adolescents may need consideration for the potential embarrassment of getting daily grades on behavior that would indicate to peers that the child had a problem.

Research Studies Supporting Use of Daily Behavior Report Card Intervention Strategies

The following studies support the use of DBRC intervention strategies for dealing with attention problems. Detailed annotations of these studies are included in the *BASC-2 Intervention Guide*.

Drew, B. M., Evans, J. H., Bostow, D. E., Geiger, G., & Drash, P. W. (1982). Increasing assignment completion and accuracy using a daily report card procedure. *Psychology in the Schools, 19* (4), 540-547.

Fabiano, G. A., & Pelham, W. E., Jr. (2003). Improving the effectiveness of behavioral classroom interventions for attention-deficit/hyperactivity disorder: A case study. *Journal of Emotional and Behavioral Disorders, 11* (2), 124-130.

Karraker, R. J. (1972). Increasing academic performance through home-managed contingency programs. *Journal of School Psychology, 10* (2), 173-179.

Kelley, M. L., & McCain, A. P. (1995). Promoting academic performance in inattentive children: The relative efficacy of school-home notes with and without response cost. *Behavior Modification, 19* (3), 357-375.

McCain, A. P., & Kelley, M. L. (1993). Managing the classroom behavior of an ADHD preschooler: The efficacy of a school-home note intervention. *Child & Family Behavior Therapy, 15* (3), 33-44.

Attention Problems Intervention Option 2: Modified Task Presentation

Modified task presentation strategies refer to a collection of specific options that can be used to increase the interest level of an activity, which will increase the amount of time the child attends to learning the task or activity. Based on information obtained through a functional assessment, tasks are altered using antecedent instructional modifications. A number of modification strategies have been recommended by researchers, including:

- Offering a choice of instructional activities
- Providing guided notes and instruction in attending to relevant information
- Using high-interest activities and hands-on demonstrations
- Modifying in-class assignments and responses
- Modifying homework
- Highlighting relevant material or key information with colors, symbols, or font changes
- Providing increased opportunities to respond
- Varying the pace of instruction

A summary of each of these strategies is provided below. See the *BASC-2 Intervention Guide* for a more detailed discussion of each strategy.

Offering a Choice of Instructional Activities. Encouraging students to engage in active decision-making and exercise control over making choices can help increase their level of attention. Using this approach, students are allowed to choose activities, materials, or a task sequence within a set of instructional material outlined by the teacher. This approach is most successful when the choices offered for student selection are relevant to the curriculum or learning objectives, so consideration should be given to ensure that learning goals are not compromised.

Providing Guided Notes and Instruction in Attending to Relevant Information. In this strategy, the teacher provides "guided notes" to help the student follow along during lectures and class presentations. Guided notes contain some information about the lecture or presentation, but spaces are left for students to fill in the most relevant and important ideas.

Using High-Interest Activities and Hands-on Demonstrations. Activities and tasks that are novel and interesting to students can increase work productivity. Teachers can begin lessons with high-interest activities that require participation and facilitate attention.

Modifying In-Class Assignments and Responses. There are many ways assignments can be modified to accommodate students who struggle with attention problems, including: allowing students to use a computer or tape recorder when completing written assignments, dividing longer assignments into multiple shorter ones, reducing the number and types of items, allowing oral responses, and giving written directions of expectations for completing the assignment. However, keep in mind that modifications are not a permanent solution for many students. While modifications and supports are in place, interventions to increase attention on a long-term basis must also be implemented.

Modifying Homework. Homework requires good attention skills on many levels. Homework can be modified very successfully in a number of ways, including decreasing the amount of it given, giving extended time for its completion, teaching and using routine procedures (e.g., homework planners), providing assistance through one-on-one or group tutoring or via the telephone or internet, and allowing it to be completed at school instead of at home.

Highlighting Relevant Material or Key Information with Colors, Symbols, or Font Changes. Providing cues so that students can easily attend to the most relevant material in large or complex tasks or lessons helps students with attention problems to filter out unnecessary stimuli and prevents them from

attending to the wrong information. Possible cues include using highlighters and using larger or different fonts or graphics. Increasing intratask stimulation by adding novelty through color can increase important task features. Teachers may also do this with the class as a group by leading students through exercises where main ideas are highlighted in one color, vocabulary words in another color, etc.

Providing Increased Opportunities to Respond. In this strategy, students are given increased opportunities to respond to academic material using varied response methods (e.g., written responses, the class answering in unison, individual student answer cards, etc.) This increased opportunity to respond increases engagement and attention and improves academic performance as a secondary benefit.

Varying the Pace of Instruction. Briskly paced instruction increases levels of on-task behavior because rapid pacing is thought to require more attending effort. Teachers can increase the pacing of their instruction either by increasing their rate of presenting material or by decreasing the length of instructional pauses.

Considerations When Implementing Modified Task Presentation Intervention Strategies

For Teaching. Instructional interventions require a certain degree of match between teacher disposition and skill. A teacher may be less willing to make changes because he or she is committed to a particular style or teaching method based on personal values and beliefs about education. A teacher may also view attention problems as lack of effort rather than a valid learning problem. He or she may feel threatened, or appear insensitive, when instructional changes are suggested for students who are already demanding, and who are a fraction of the children they must serve. A well-intentioned teacher, on the other hand, may simply not have enough time or computer (or other) resources to adapt his or her lesson plans. Always keep the complicated relationship between teachers and students in mind. Teachers and students often have reciprocal behaviors that may reinforce or punish the type of teaching used in the classroom. Rely on the experience of the classroom teacher and his or her appraisal of the situation, and anticipate the level of control and choice teachers will expect when recommending changes in instructional behaviors.

Because there are many different types of instructional modification interventions for attention, they have the largest likelihood of success when implemented after a functional assessment. Such an assessment can help to uncover the antecedents and consequences, describe the topography of the attention problems, and reveal the environmental and setting events for the attention problems. For example, using guided notes won't help a student who is out of his or her seat for the majority of the lecture. Likewise, a student who struggles to bring back completed homework will not find high-interest, novel or engaging classroom activities helpful in learning the specific attention skill needed to improve his or her grades.

Research Studies Supporting Use of Modified Task Presentation Intervention Strategies

The following studies support the use of modified task presentation intervention strategies for dealing with attention problems. Detailed annotations of these studies are included in the *BASC-2 Intervention Guide*.

Abikoff, H., Courtney, M. E., Szeibel, P. J., & Koplewicz, H. S. (1996). The effects of auditory stimulation on the arithmetic performance of children with ADHD and nondisabled children. *Journal of Learning Disabilities, 29* (3), 238-246.

Belfiore, P. J., Grskovic, J. A., Murphy, A. M., & Zentall, S. S. (1996). The effects of antecedent color on reading for students with learning disabilities and co-occurring attention-deficit/hyperactivity disorder. *Journal of Learning Disabilities, 29* (4), 432-438.

Clarke, S., Dunlap, G., Foster-Johnson, L., Childs, K. E., Wilson, D., White, R., et al. (1995). Improving the conduct of students with behavioral disorders by incorporating student interests into curricular activities. *Behavioral Disorders, 20* (4), 221-237.

Dunlap, G., dePerczel, M., Clarke, S., Wilson, D., Wright, S., White, R., et al. (1994). Choice making to promote adaptive behavior for students with emotional and behavioral challenges. *Journal of Applied Behavior Analysis, 27* (3), 505-518.

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Zentall, S. S. (1985). Stimulus-control factors in search performance of hyperactive children. *Journal of Learning Disabilities, 18* (8), 480-485.

Zentall, S. S. (1989). Attentional cuing in spelling tasks for hyperactive and comparison regular classroom children. *The Journal of Special Education, 23* (1), 83-93.

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Zentall, S. S., & Kruczek, T. (1988). The attraction of color for active attention-problem children. *Exceptional Children, 54* (4), 357-362.

Primary Improvement Area: Study Skills (Academic Problems)

Academic problems are considered a significant problem for Timmy. On the Teacher Rating Scales, academic problems are identified by the Learning Problems and Study Skills scales. 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 retention, dropping out of school, and earning lower grades. Therefore, academic intervention is as important as the typical social and behavioral interventions.

A variety of interventions have been shown to be effective in remediating academic problems, and have been categorized as teacher-mediated, peer-mediated, or self-mediated. Teacher-mediated interventions focus on the teacher as the primary behavioral change agent, while peer-mediated interventions emphasize peers helping peers. Self-mediated interventions are used independently by the student for the self-regulation of learning. Within each category, interventions have been classified based on their underlying principles. The interventions offered for the academic problems category include:

- Teacher-Mediated Interventions
  - Advance Organizers
  - Presentation Strategies
  - Task-Selection Strategies
- Peer-Mediated Interventions
  - Peer Tutoring
  - Classwide Peer Tutoring
- Self-Mediated Interventions
  - Cognitive Organizers
  - Mnemonics
  - Self-Monitoring
  - Self-Instruction

- Reprocessing Strategies

Detailed summaries of the Peer Tutoring and Classwide Peer Tutoring intervention strategies from the Peer-Mediated intervention section are provided below. See the *BASC-2 Intervention Guide* for additional detail about these strategies, along with the other intervention strategies listed above.

Academic Problems Intervention Option 1: Peer Tutoring

Peer tutoring consists of students assisting other students in learning through teaching. It includes goals that are both academic and social in nature, and it provides an opportunity for students to participate in semi-social activities with structured relationships. Peer tutoring can take many forms. Students can be paired with others who are on different academic levels or the same academic level, or pairings can be made between students of different ages. As with most academic interventions, considerable attention should be given to the preparation and planning stages to ensure a well-structured program.

The procedural steps for incorporating peer tutoring strategy into the treatment of academic problems are summarized below. See the *BASC-2 Intervention Guide* for a detailed discussion of this topic.

Procedural steps for the application of peer tutoring

1. Define the tutoring context, such as when tutoring will occur, its duration, and the general rules that will apply to the tutoring sessions.
2. Define the objectives of the tutoring program for the students. Objectives can be written academic or social goals, and can be individual or group based, but should include both tutor and tutee learning.
3. Choose the subject or content area that will be taught during the tutoring program.
4. Notify parents that peer tutoring is going to be implemented in the class. This notice should include information about the purpose of peer tutoring, the role of the students involved, the date tutoring will begin, the skills that will be practiced or taught, and the contact information for further questions.
5. Write a lesson plan for the tutors. This plan should be scripted for reading and following directions, including the examples and the correction procedures.
6. Select and match participants. Assign a tutor to one or two students for a specific period of time. The period of time should be long enough for the tutor and tutee to become comfortable with each other and for the instruction to complete a sequence.
7. Train the tutors. In the first tutoring session, the teacher models being the tutor. That is, the teacher actually does the tutoring during this lesson. While modeling, the teacher assesses the tutors' understanding of the process.
8. Monitor the tutoring process. During subsequent sessions, the teacher observes peer-tutoring sessions for student focus, understanding of the process, and student progress.
9. Evaluate the program by determining if the initial objectives have been met.
10. Provide feedback to students and other interested persons (e.g., parents, school administrators) about how the program went.

Considerations When Implementing a Peer Tutoring Intervention Strategy

For Teaching. Peer tutoring requires a commitment of time in order to pair students, write scripts, prepare materials, and teach procedures, but the outcomes are worth the initial investment. Students receive much larger slices of instructional time and engaged time as well as additional opportunities to respond and receive corrective feedback. Also, the peer-tutoring structure allows the teacher to become the instructional leader or facilitator, monitoring a classroom of students who are teaching and learning in pairs, and permits the teacher to provide more one-on-one instruction. In addition to these advantages, materials can be reused and modifications on pairings or rotation of pairs of students can be made in an ongoing manner.

For Culture and Language Differences. Peer tutoring has a distinct literature on its effectiveness for second-language learners. Use in rural and urban schools shows evidence of effectiveness in a variety of classroom settings, making peer tutoring a strong intervention for classroom use.

For Age and Developmental Level. Peer tutoring and cross-age tutoring both appear to work well with early grades. Naturally, the instructor should consider the developmental level of the students, the types of tasks assigned, and the training elements involved, all of which might make peer tutoring instruction less feasible for very young children.

Research Studies Supporting Use of Peer Tutoring Intervention Strategies

The following studies support the use of peer tutoring intervention strategies for dealing with academic problems. Detailed annotations of these studies are included in the *BASC-2 Intervention Guide*.

Franca, V. M., & Kerr, M. M. (1990). Peer tutoring among behaviorally disordered students: Academic and social benefits to tutor and tutee. *Education and Treatment of Children, 13* (2), 109-128.

Maher, C. A. (1982). Behavioral effects of using conduct problem adolescents as cross-age tutors. *Psychology in the Schools, 19* (3), 360-364.

Scruggs, T. E., Mastropieri, M. A., & Richter, L. (1985). Peer tutoring with behaviorally disordered students: Social and academic benefits. *Behavioral Disorders, 10* (4), 283-294.

Academic Problems Intervention Option 2: Classwide Peer Tutoring

Classwide peer tutoring is a form of peer tutoring in which students in the same class help one another during the lesson. Like peer tutoring, classwide peer tutoring focuses on improving the academic performance of students. However, whereas peer tutoring can be implemented in a variety of settings, classwide peer tutoring is designed for classroom settings and can be used to facilitate large-group instruction. Classwide peer tutoring is based on the principles of maximizing engagement time of students, providing frequent opportunities for practice, increasing rates of student response and feedback loops, and minimizing errors in learning and off-task behavior. Classwide peer tutoring also incorporates an element of progress monitoring by recording performance over time.

The procedural steps for incorporating classwide peer tutoring into the treatment of academic problems are summarized below. See the *BASC-2 Intervention Guide* for a detailed discussion of this topic.

Procedural steps for the application of classwide peer tutoring

1. Create and prepare the tutor-tutee folders with appropriate materials for the lesson.
2. Review the tutor-tutee rules with the students.
3. Create two large teams within a class that are equal in terms of the students' skill levels.
4. Assign tutor-tutee pairs (these will rotate within the larger team).
5. Monitor the scoring used by the students.
6. Switch roles after 5 minutes (with the tutor becoming the tutee and vice versa).
7. Record points on a class chart.

Considerations When Implementing a Classwide Peer Tutoring Intervention Strategy

For Teaching. Classwide peer tutoring has many of the same preliminary issues as peer tutoring, such as preparation time and considerations for student abilities, curriculum levels, and pairings. It also has implementation issues, such as the need for close monitoring of student engagement and classroom behavior during tutoring. However, classwide peer tutoring also includes competition among teams. The effects of competition can sometimes include covert behaviors such as cheating or undermining of peer relationships (e.g., "I don't want Joe on my team; he brings our scores down."). The rotation of pairs ensures some degree of equality for all individuals, and team points are awarded. Matching the teams so that each team has a similarly distributed group of student scores ensures greater equality as well. Another possible solution is to concentrate on point levels rather than a win/lose system of reinforcement. Additionally, the use of a raffle for any team members that beat a previous score or achieve above a certain level can be an effective deterrent for the drawbacks to competitiveness. Strong monitoring of the tutoring process is important, as is the distribution of points for appropriate behavior, so that verbal encouragement is worth as much as an accurate answer.

Research Studies Supporting Use of Classwide Peer Tutoring Intervention Strategies

The following studies support the use of classwide peer tutoring intervention strategies for dealing with academic problems. Detailed annotations of these studies are included in the *BASC-2 Intervention Guide.*

Chun, C. C., & Winter, S. (1999). Classwide peer tutoring with or without reinforcement: Effects on academic responding, content coverage, achievement, intrinsic interest and reported project experiences. *Educational Psychology, 19* (2), 191-205.

Fuchs, D., Fuchs L. S., & Burish, P. (2000). Peer-assisted learning strategies: An evidence-based practice to promote reading achievement. *Learning Disabilities Research and Practice, 15* (2), 85-91.

Fuchs, D., Fuchs, L, S., Mathes, P. G., & Simmons, D. C. (1997). Peer-assisted learning strategies: Making classrooms more responsive to diversity. *American Educational Research Journal, 34* (1), 174-206.

Fuchs, L. S., & Fuchs, D. (1995). Acquisition and transfer effects of classwide peer-assisted learning strategies in mathematics for students with varying learning histories. *School Psychology Review, 24* (4), 604-621.

Greenwood, C. R., & Delquadri, J. (1995). Classwide peer tutoring and the prevention of school failure. *Preventing School Failure, 39* (4), 21-25.

Maheady, L., Harper, G. F., & Sacca, K. (1998). A classwide peer tutoring system in a secondary, resource room program for the mildly handicapped. *Journal of Research and Development in Education, 21* (3), 76-83.

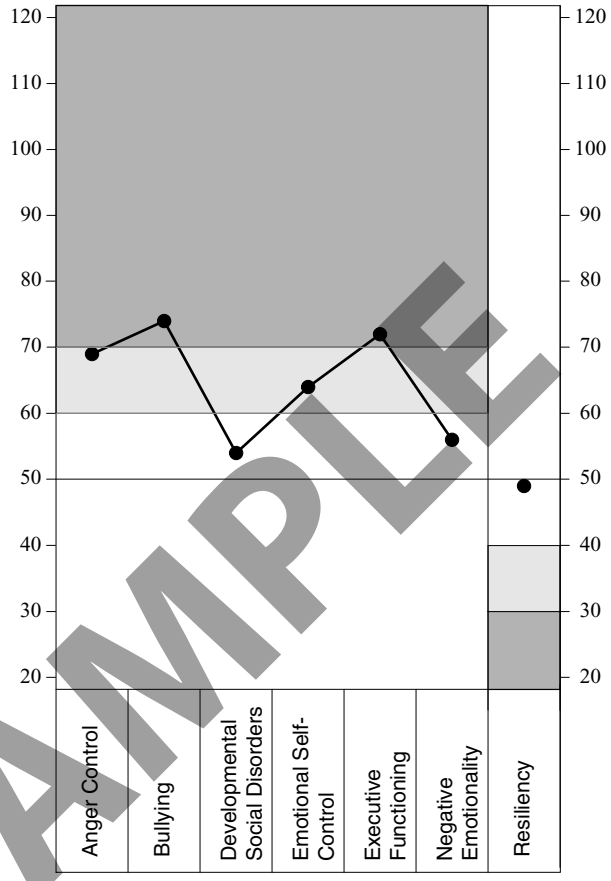
Concluding Recommendations

When using any intervention, it is important to monitor the effectiveness of the interventions you are trying. For intervention areas that include the Aggression, Attention Problems, Hyperactivity, and Conduct Problems scales, you may choose to use the BASC-2 Progress Monitor Externalizing and ADHD Problems form. For interventions that include the Anxiety scales, you may choose to use the BASC-2 Progress Monitor Internalizing Problems forms.

Regardless of the method used to monitor progress, it is important to document the effectiveness of the interventions you have tried with Timmy. The *BASC-2 Intervention Guide Documentation Checklist* is designed to facilitate the recording of the steps that have been taken to remediate or manage a child's behavioral or emotional problems. It also includes a section to record the fidelity of the intervention approaches that have been used, a factor that is critical to the success of any intervention program.

CONTENT SCALES

The information provided below is based on content scales that have been theoretically and empirically developed. This information is considered to be secondary to the clinical, adaptive, and composite scale information provided previously. An elevated content scale score may warrant additional follow-up.



T Score (Plotted)	Anger Control	Bullying	Developmental Social Disorders	Emotional Self-Control	Executive Functioning	Negative Emotionality	Resiliency
● Gen.-Comb. Sex	69	74	54	64	72	56	49

Percentile							
Gen.-Comb. Sex	95	97	68	90	96	76	45

Summary: General - Combined Sex Norm Group

	Raw Score	*T* Score	Percentile Rank	90% Confidence Interval
Anger Control	16	69	95	62-76
Bullying	19	74	97	69-79
Developmental Social Disorders	16	54	68	49-59
Emotional Self-Control	8	64	90	57-71
Executive Functioning	12	72	96	66-78
Negative Emotionality	4	56	76	48-64
Resiliency	23	49	45	44-54

Content Scales

Timmy's T score on Anger Control 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. Timmy's teacher reports that Timmy has a tendency to become irritable quickly and has difficulty maintaining his self-control when faced with adversity.

Timmy's T score on Bullying is 74 and has a percentile rank of 97. This T score falls in the Clinically Significant classification range, and usually warrants follow-up. Timmy's teacher reports that Timmy has a tendency to be disruptive, intrusive, and/or threatening toward other students.

Timmy's T score on Developmental Social Disorders is 54 and has a percentile rank of 68. Timmy's teacher reports that Timmy has social and communication skills that are typical of others his age.

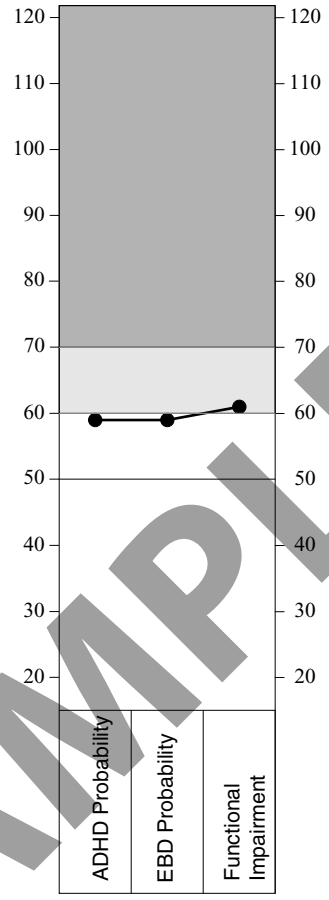
Timmy's T score on Emotional Self-Control is 64 and has a percentile rank of 90. This T score falls in the At-Risk classification range, and follow-up may be necessary. Timmy's teacher reports that Timmy can become easily upset, frustrated, and/or angered in response to environmental changes.

Timmy's T score on Executive Functioning is 72 and has a percentile rank of 96. This T score falls in the Clinically Significant classification range, and usually warrants follow-up. Timmy's teacher reports that Timmy has difficulty controlling and maintaining his behavior and mood.

Timmy's T score on Negative Emotionality is 56 and has a percentile rank of 76. Timmy's teacher reports that Timmy reacts to changes in everyday activities or routines in a manner that is typical of others his age.

Timmy's T score on Resiliency is 49 and has a percentile rank of 45. Timmy's teacher reports that Timmy is able to overcome stress and adversity about as well as do others his age.

CLINICAL INDEXES



T Score (Plotted)			
● Gen.-Comb. Sex	59	59	61

Percentile			
Gen.-Comb. Sex	78	83	84

Clinical Summary

The BASC-2 items endorsed by Timmy's teacher resulted in clinically significant Hyperactivity and Attention Problems scales, a pattern that occurred in 1.5% of the standardization sample. Children with this profile may exhibit inattention, distractibility, hyperactivity, and impulsivity. Given this profile, possible diagnostic considerations might include attention-deficit/hyperactivity disorder (ADHD). Problems with hyperactivity and inattention are likely to occur across multiple settings (e.g., school, home, etc.) and be worse it situations requiring sustained mental effort. Furthermore, difficulties concentrating and behavioral agitation are features of several mental and physical disorders; thus, thorough history taking and clinical interviewing may be helpful in distinguishing between ADHD-related behaviors from symptoms associated with other disorders. In addition to clinically significant Hyperactivity and Attention Problems scales, Timmy exhibits at-risk Conduct Problems and Aggression scales. This suggests that oppositional defiant disorder (ODD) and conduct disorder (CD) are additional diagnostic possibilities.

A number of considerations could be useful in differentiating between behavioral disorders. ADHD is characterized by increased levels of inattention, behavioral activity, and impulsivity that often disturb others and result in rule violations; similarly, the core features of ODD include frequent defiance and rule violations. In both cases, these behaviors will be relatively mild in severity compared to CD, which is characterized by more serious forms of misbehavior such as physical violence, truancy, or theft, which deviate from societal standards and represent violations of others' rights. Children with ADHD may exhibit oppositionality secondary to problems with attention and hyperactivity (e.g., refusing homework because it is difficult to sit still and stay on track), but they are unlikely to exhibit the same level of purposeful defiance, vindictiveness, and deliberate annoyance of others seen in children with ODD. Understanding the functions and causes of these behaviors, perhaps through methods such as thorough history taking and detailed clinical interviewing, can be helpful in distinguishing whether they are more characteristic of ADHD or ODD. Neither ODD nor CD requires symptoms of inattention or hyperactivity to make a diagnosis; thus, it is possible to have an additional diagnosis of ADHD in the context of either ODD or CD when the criteria for both have been met. However, because all of the features of ODD are also characteristic of CD, a CD diagnosis takes precedence over ODD.

Timmy's profile is characterized by a clinically significant Attention Problems scale score in addition to a clinically significant Hyperactivity scale score. In making diagnostic considerations regarding the possibility of ADHD, such a profile is probably more consistent with a diagnosis of ADHD - combined type, as opposed to primary hyperactive/impulsive or inattentive type.

Timmy also exhibited an elevation on BASC-2 internalizing scale of Anxiety, a pattern that occurred in 22.2% of the BASC-2 standardization sample with clinically significant Hyperactivity and Attention Problems scales. This profile indicates that he is experiencing increased levels of internal distress characterized by anxiety and additional diagnostic considerations are likely to include anxiety disorders (e.g., generalized anxiety disorder, panic disorder, obsessive compulsive disorder, etc.). Children with these problems may exhibit inattention and restlessness, which can appear behaviorally similar to ADHD. Furthermore, it may be the case that emotional distress is causing Timmy to act out, or that negative feedback related to his behavioral issues is resulting in these internalizing problems Thus, further investigation is warranted in order to clarify the complex relationship between his various behavioral and mood symptoms.

If it is believed that Timmy is exhibiting comorbid mood and behavioral problems, the following considerations may be helpful. With respect to ADHD, it is useful to note that symptoms of hyperactivity or inattention are typically present before age 7 in ADHD, whereas the onset of these behaviors may occur later in mood disorders. Furthermore, children with ADHD are likely to exhibit these symptoms in situations that require sustained effort but motivated by highly reinforcing activities. In anxiety, children may exhibit problems with inattention and restlessness only in anxiety-provoking situations (e.g., social setting, testing, etc.), whereas in ADHD the symptoms are likely to occur across settings. ADHD can be diagnosed with mood difficulties if criteria for both diagnoses are met. In these cases, it is important to note that restlessness and inattention are typically rated positively for mood disorders only in cases where they are significantly worse during periods of mood disturbance relative to what is accounted for by ADHD alone.

DSM-IV-TR™ Diagnostic Considerations

Listed below are DSM-IV-TR Diagnostic Considerations based on the ratings obtained from the teacher on the TRS-C rating form. Each section presents a list of symptoms as described in the DSM-IV-TR, along with TRS-C items that correspond to these symptoms. While this information will likely be helpful for making a diagnosis, clinicians are strongly encouraged to use additional information that is gathered outside of the BASC-2 TRS-C form (e.g., observations of behavior, clinical interviews) when making a formal diagnosis. Adapted with permission from the Diagnostic and Statistical Manual of Mental Disorders, Text Revision, Fourth Edition (American Psychiatric Association, 2000).

Attention-Deficit/Hyperactivity Disorder 314.0x

Symptoms for ADHD: Inattention

		Relevant BASC-2 TRS-C Items and Mrs Math's Responses
X	Has difficulty sustaining attention	5. Item Content Omitted (True) 33. Item Content Omitted (True)
X	Seems not to be listening when spoken to	44.Item Content Omitted (True) 72.Item Content Omitted (True) 128. Item Content Omitted (True)
X	Has trouble organizing activities/tasks	91. Item Content Omitted (True)
X	Is easily distracted	61. Item Content Omitted (True) 100. Item Content Omitted (True)
__	Is often forgetful	
__	Does not play close attention to details	
__	Makes careless mistakes	
__	Fails to finish tasks (not due to defiance or failure to understand)	
__	Dislikes/avoids tasks that involve sustained mental effort	
__	Loses needed materials	

ITEMS NOT SHOWN

Special Note:
The content of the test items is included in the actual reports. To protect the integrity of the test, the item content does not appear in this sample report.

Symptoms for ADHD: Hyperactivity/Impulsivity

		Relevant BASC-2 TRS-C Items and Mrs Math's Responses
X	Leaves seat inappropriately	10. Item Content Omitted (True)
X	Acts as if "driven by a motor"	26. Item Content Omitted (True)
X	Blurts out answers	46. Item Content Omitted (True)
X	Has trouble waiting his/her turn	74. Item Content Omitted (True)
X	Interrupts others' conversations or activities	18. Item Content Omitted (True)
		38. Item Content Omitted (True)
		54. Item Content Omitted (True)
		102. Item Content Omitted (True)
__	Runs around or climbs excessively/inappropriately	
__	Has difficulty engaging in activities quietly	
__	Talks excessively	

Special Note:
The content of the test items is included in the actual reports. To protect the integrity of the test, the item content does not appear in this sample report.

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

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

7. Do symptoms occur solely during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder? [NO]	Yes	No

Note. The qualifying answer pertaining to the diagnostic criteria for ADHD is indicated in square brackets[ ].

ADHD Diagnostic Summary (Mark answers as appropriate.)

Was a diagnosis of ADHD made? Yes No Date:_____

If yes, indicate code based on type:

— 314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type (if criteria for BOTH inattention and hyperactivity/impulsivity were met over the past six months)

— 314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type (if ONLY criteria for inattention were met over the past six months)

— 314.01 Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type (if ONLY criteria for hyperactivity/impulsivity were met over the past six months)

__ In Partial Remission (check if the individual's current symptoms no longer meet full criteria)

Conduct Disorder 312.8x

Symptoms for Conduct Disorder

		Relevant BASC-2 TRS-C Items and Mrs Math's Responses
X	Bullies, intimidates, or threatens others	24. Item Content Omitted (True) 64. Item Content Omitted (True)
__	Has inflicted physical harm on people	120. Item Content Omitted (True)
__	Lies to obtain things or favors or to avoid obligations	98. Item Content Omitted (True) 112.Item Content Omitted (True)
X	Has committed theft of money or items of nontrivial value without confronting a victim	56. Item Content Omitted (True)
__	Starts physical fights	
__	Has used a weapon that can seriously injure others (e.g., knife, bat, broken bottle, gun)	
__	Has inflicted physical harm on animals	
__	Has committed theft while confronting a victim (e.g., mugging, armed robbery)	
__	Has forced someone to participate in a sexual act against their will	
__	Has deliberately set a fire to intentionally cause serious damage	
__	Has deliberately destroyed others' property (by means other than fire)	
__	Has broken into someone else's car, house, or other building	
__	Stays out past parent-imposed curfew (beginning before age 13)	
__	Has run away from home overnight at least twice (or once for a lengthy period)	
__	Often skips school (beginning before age 13)	

ITEMS NOT SHOWN

Special Note:
The content of the test items is included in the actual reports. To protect the integrity of the test, the item content does not appear in this sample report.

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

Has the individual exhibited three or more of the behaviors listed above in the past 12 months, with at least one behavior present in the past six months? [YES]	Yes	No
Do symptoms significantly impair academic, social, or occupational functioning? [YES]	Yes	No
Has Antisocial Personality Disorder been ruled out (age 18 and older)? [YES]	Yes	No

Note. The qualifying answer pertaining to the diagnostic criteria for Conduct Disorder is indicated in square brackets[ ].

Conduct Disorder Diagnostic Summary (Mark answers as appropriate.)

l Was a diagnosis of Conduct Disorder made? Yes No Date:_____

If yes, indicate code based on type:

— 312.81 Conduct Disorder, Childhood-Onset Type (at least one characteristic behavior prior to age 10)

— 312.82 Conduct Disorder, Adolescent-Onset Type (no characteristic behaviors observed prior to age 10)

__ 312.89 Conduct Disorder, Unspecified Onset (age of onset unknown)

__ Severity

— Mild (minimum criteria present to make the diagnosis AND behaviors cause only minimal harm to others)

— Moderate (number and harmfulness of problem behaviors in between "mild" and "severe" labels)

— Severe (many more problem behaviors present than needed to make the diagnosis OR behaviors cause significant harm to others)

Generalized Anxiety Disorder 300.02

Symptoms for Generalized Anxiety Disorder

		Relevant BASC-2 TRS-C Items and Mrs Math's Responses
__	Irritable	114. Item Content Omitted (True)
X	Excessive anxiety and worry about a number of events	11. Item Content Omitted (True) 53. Item Content Omitted (True) 81.Item Content Omitted (True) 137. Item Content Omitted (True)
X	Feels restless, keyed up, or on edge	39. Item Content Omitted (True) 109. Item Content Omitted (True)
__	Tires easily	
__	Has trouble concentrating or mind goes blank	
__	Experiences muscle tension	
__	Has trouble sleeping	

Special Note:
The content of the test items is included in the actual reports. To protect the integrity of the test, the item content does not appear in this sample report.

Considerations for Diagnosis of Generalized Anxiety Disorder (Mark answers as appropriate.)

Is the individual experiencing excessive anxiety/worry (defined as more days than not for at least six months)? [YES]	Yes	No
Has the individual experienced one or more of the symptoms listed above in conjunction with anxiety (at least one symptom present for more days than not for the past six months)? [YES]	Yes	No
Does the individual have difficulty controlling the anxiety/worry? [YES]	Yes	No
Do symptoms cause significant distress or impairment in social functioning, occupational functioning, or other important areas? [YES]	Yes	No
Have Panic Disorder, Social Phobia, Obsessive-Compulsive Disorder, Separation Anxiety Disorder, Anorexia Nervosa, Somatization Disorder, Hypochondriasis, and Posttraumatic Stress Disorder been ruled out? [YES]	Yes	No
Are symptoms due to effects of drugs, medication, or a medical condition? [NO]	Yes	No

Do symptoms occur solely during a Mood Disorder, Psychotic Disorder, or Pervasive Developmental Disorder? [NO]	Yes	No

Note. The qualifying answer pertaining to the diagnostic criteria for Generalized Anxiety Disorder is indicated in square brackets[ ].

Generalized Anxiety Disorder Diagnostic Summary (Mark answers as appropriate.)

l Was a diagnosis of Generalized Anxiety Disorder made? Yes No Date:_____

Oppositional Defiant Disorder 313.81

Symptoms for Oppositional Defiant Disorder

		Relevant BASC-2 TRS-C Items and Mrs Math's Responses
X	Loses temper	13. Item Content Omitted (True) 36.Item Content Omitted (True)
__	Argues	8. Item Content Omitted (True)
__	Defies rules or refuses to comply with requests	52. Item Content Omitted (True)
__	Deliberately annoys others	92. Item Content Omitted (True) 108.Item Content Omitted (True) 136. Item Content Omitted (True)
__	Is easily annoyed by others	114. Item Content Omitted (True)
__	Is vindictive/spiteful	80. Item Content Omitted (True)
__	Blames other people for his/her own misbehavior or mistakes	
__	Is resentful/angry	

ITEMS NOT SHOWN

Special Note:
The content of the test items is included in the actual reports. To protect the integrity of the test, the item content does not appear in this sample report.

Considerations for Diagnosis of Oppositional Defiant Disorder (Mark answers as appropriate.)

Has the individual shown a pattern of hostile, defiant behavior for at least six months, during which four or more of the symptoms listed above have been present? [YES] (Note. Only count a symptom if the individual displays the given behavior more frequently than others of a similar age and developmental level.)	Yes	No
Do the symptoms significantly impair social, academic, or occupational functioning? [YES]	Yes	No
Have Conduct Disorder and (for individuals age 18 or older) Antisocial Personality Disorder been ruled out? [YES]	Yes	No
Do the symptoms occur solely during the course of a Psychotic or Mood Disorder? [NO]	Yes	No

Note. The qualifying answer pertaining to the diagnostic criteria for Oppositional Defiant Disorder is indicated in square brackets[ ].

Oppositional Defiant Disorder Diagnostic Summary (Mark answers as appropriate.)

| Was a diagnosis of Oppositional Defiant Disorder made? Yes No Date:_____

TARGET BEHAVIORS FOR INTERVENTION

The behaviors listed below were identified by the rater as being particularly problematic. These behaviors may be appropriate targets for intervention or treatment. It can be useful to readminister the BASC-2 in the future to determine progress toward meeting the associated behavioral objectives.

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General Behavior Issues

38. Disrupts other children's activities. (Almost always)
18. Bothers other children when they are working. (Often)
24. Threatens to hurt others. (Often)
74. Item Content Omitted (True)
102. Item Content Omitted (True)
14. Item Content Omitted (True)
36. Item Content Omitted (True)
56. Item Content Omitted (True)
64. Item Content Omitted (True)
70. Item Content Omitted (True)
92. Item Content Omitted (True)
108. Item Content Omitted (True)
112. Item Content Omitted (True)
120. Item Content Omitted (True)
136. Item Content Omitted (True)

Adaptive/Social Behavior Issues

54. Interrupts others when they are speaking. (Almost always)
7. Item Content Omitted (True)
19. Item Content Omitted (True)
84. Item Content Omitted (True)

CRITICAL ITEMS

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

16. Eats too much. (Never)
21. Eats things that are not food. (Never)
23. Sees things that are not there. (Never)
24. Threatens to hurt others. (Often)
37. Item Content Omitted (True)
64. Item Content Omitted (True)
97. Item Content Omitted (True)
99. Item Content Omitted (True)
107. Item Content Omitted (True)
114. Item Content Omitted (True)
118. Item Content Omitted (True)
120. Item Content Omitted (True)
125. Item Content Omitted (True)
127. Item Content Omitted (True)
130. Item Content Omitted (True)
135. Item Content Omitted (True)

Special Note:
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ITEMS BY SCALE - CLINICAL SCALES

Special Note:
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Aggression

8. Argues when denied own way. (Sometimes)
24. Threatens to hurt others. (Often)
36. Item Content Omitted (True)
52. Item Content Omitted (True)
64. Item Content Omitted (True)
80. Item Content Omitted (True)
92. Item Content Omitted (True)
108. Item Content Omitted (True)
120. Item Content Omitted (True)
136. Item Content Omitted (True)

Anxiety

11. Worries about things that cannot be changed. (Sometimes)
25. Says, “I get nervous during tests” or “Tests make me nervous.”. (Sometimes)
39. Item Content Omitted (True)
53. Item Content Omitted (True)
81. Item Content Omitted (True)
109. Item Content Omitted (True)
137. Item Content Omitted (True)

Attention Problems

5. Has a short attention span. (Almost always)
33. Pays attention. (Never)
44. Item Content Omitted (True)
61. Item Content Omitted (True)
72. Item Content Omitted (True)
100. Item Content Omitted (True)
128. Item Content Omitted (True)

Atypicality

23. Sees things that are not there. (Never)
51. Seems out of touch with reality. (Never)
65. Item Content Omitted (True)
67. Item Content Omitted (True)
79. Item Content Omitted (True)
93. Item Content Omitted (True)
95. Item Content Omitted (True)
107. Item Content Omitted (True)
121. Item Content Omitted (True)
123. Item Content Omitted (True)

Special Note:
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Conduct Problems

14. Breaks the rules. (Sometimes)
28. Disobeys. (Sometimes)
42. Item Content Omitted (True)
56. Item Content Omitted (True)
70. Item Content Omitted (True)
84. Item Content Omitted (True)
98. Item Content Omitted (True)
112. Item Content Omitted (True)
126. Item Content Omitted (True)

Depression

9. Says, “I hate myself.”. (Never)
12. Seems lonely. (Sometimes)
37. Item Content Omitted (True)
40. Item Content Omitted (True)
49. Item Content Omitted (True)
68. Item Content Omitted (True)
77. Item Content Omitted (True)
96. Item Content Omitted (True)
105. Item Content Omitted (True)
124. Item Content Omitted (True)
133. Item Content Omitted (True)

Hyperactivity

10. Has trouble staying seated. (Almost always)
18. Bothers other children when they are working. (Often)
26. Item Content Omitted (True)
38. Item Content Omitted (True)
46. Item Content Omitted (True)
54. Item Content Omitted (True)
66. Item Content Omitted (True)
74. Item Content Omitted (True)
94. Item Content Omitted (True)
102. Item Content Omitted (True)
122. Item Content Omitted (True)

Special Note:
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Learning Problems

20. Does not complete tests. (Often)
48. Has poor handwriting or printing. (Sometimes)
76. Item Content Omitted (True)
82. Item Content Omitted (True)
104. Item Content Omitted (True)
110. Item Content Omitted (True)
132. Item Content Omitted (True)
138. Item Content Omitted (True)

Somatization

6. Complains about health. (Sometimes)
27. Has headaches. (Sometimes)
34. Item Content Omitted (True)
55. Item Content Omitted (True)
62. Item Content Omitted (True)
83. Item Content Omitted (True)
90. Item Content Omitted (True)
111. Item Content Omitted (True)
139. Item Content Omitted (True)

Withdrawal

7. Refuses to join group activities. (Sometimes)
19. Refuses to talk. (Sometimes)
35. Item Content Omitted (True)
47. Item Content Omitted (True)
63. Item Content Omitted (True)
75. Item Content Omitted (True)
103. Item Content Omitted (True)
131. Item Content Omitted (True)

ITEMS BY SCALE - ADAPTIVE SCALES

Special Note:
The content of the test items is included in the actual reports. To protect the integrity of the test, the item content does not appear in this sample report.

Adaptability

1. Adjusts well to new teachers. (Often)
13. Is easily soothed when angry. (Sometimes)
29. Item Content Omitted (True)
41. Item Content Omitted (True)
57. Item Content Omitted (True)
69. Item Content Omitted (True)
85. Item Content Omitted (True)
113. Item Content Omitted (True)

Functional Communication

3. Responds appropriately when asked a question. (Almost always)
22. Communicates clearly. (Often)
31. Item Content Omitted (True)
50. Item Content Omitted (True)
59. Item Content Omitted (True)
78. Item Content Omitted (True)
87. Item Content Omitted (True)
106. Item Content Omitted (True)
115. Item Content Omitted (True)
134. Item Content Omitted (True)

Leadership

2. Is creative. (Often)
30. Works well under pressure. (Sometimes)
58. Item Content Omitted (True)
86. Item Content Omitted (True)
89. Item Content Omitted (True)
117. Item Content Omitted (True)

Social Skills

4. Says, “please” and “thank you.”. (Sometimes)
15. Encourages others to do their best. (Often)
32. Item Content Omitted (True)
43. Item Content Omitted (True)
60. Item Content Omitted (True)
71. Item Content Omitted (True)
88. Item Content Omitted (True)
116. Item Content Omitted (True)

Study Skills

17. Analyzes the nature of a problem before starting to solve it. (Never)
45. Reads assigned chapters. (Never)
73. Item Content Omitted (True)
91. Item Content Omitted (True)
101. Item Content Omitted (True)
119. Item Content Omitted (True)
129. Item Content Omitted (True)

Special Note:
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ITEMS BY SCALE - CONTENT SCALES

Anger Control

1. Adjusts well to new teachers. (Often)
5. Has a short attention span. (Almost always)
8. Item Content Omitted (True)
19. Item Content Omitted (True)
24. Item Content Omitted (True)
30. Item Content Omitted (True)
37. Item Content Omitted (True)
69. Item Content Omitted (True)
74. Item Content Omitted (True)
113. Item Content Omitted (True)
120. Item Content Omitted (True)

Bullying

14. Breaks the rules. (Sometimes)
18. Bothers other children when they are working. (Often)
24. Item Content Omitted (True)
38. Item Content Omitted (True)
64. Item Content Omitted (True)
69. Item Content Omitted (True)
74. Item Content Omitted (True)
84. Item Content Omitted (True)
94. Item Content Omitted (True)
102. Item Content Omitted (True)
120. Item Content Omitted (True)
136. Item Content Omitted (True)

Developmental Social Disorders

5. Has a short attention span. (Almost always)
15. Encourages others to do their best. (Often)
22. Item Content Omitted (True)
35. Item Content Omitted (True)

47. Item Content Omitted (True)
51. Item Content Omitted (True)
57. Item Content Omitted (True)
60. Item Content Omitted (True)
88. Item Content Omitted (True)
91. Item Content Omitted (True)
103. Item Content Omitted (True)
116. Item Content Omitted (True)
121. Item Content Omitted (True)
131. Item Content Omitted (True)

Special Note:
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Emotional Self-Control

29. Gets upset when plans are changed. (Sometimes)
36. Loses temper too easily. (Sometimes)
49. Item Content Omitted (True)
66. Item Content Omitted (True)
94. Item Content Omitted (True)
113. Item Content Omitted (True)

Executive Functioning

8. Argues when denied own way. (Sometimes)
46. Acts without thinking. (Often)
49. Item Content Omitted (True)
54. Item Content Omitted (True)
61. Item Content Omitted (True)
74. Item Content Omitted (True)
120. Item Content Omitted (True)

Negative Emotionality

8. Argues when denied own way. (Sometimes)
29. Gets upset when plans are changed. (Sometimes)
41. Item Content Omitted (True)
49. Item Content Omitted (True)

Resiliency

2. Is creative. (Often)
13. Is easily soothed when angry. (Sometimes)
17. Item Content Omitted (True)
30. Item Content Omitted (True)
35. Item Content Omitted (True)
49. Item Content Omitted (True)
57. Item Content Omitted (True)
77. Item Content Omitted (True)
85. Item Content Omitted (True)
113. Item Content Omitted (True)

114. Item Content Omitted (True)
131. Item Content Omitted (True)

ITEMS BY SCALE - CLINICAL INDEXES

ITEMS NOT SHOWN

Special Note:
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ADHD Probability

3. Responds appropriately when asked a question. (Almost always)
5. Has a short attention span. (Almost always)
50. Item Content Omitted (True)
57. Item Content Omitted (True)
58. Item Content Omitted (True)
61. Item Content Omitted (True)
63. Item Content Omitted (True)
72. Item Content Omitted (True)
73. Item Content Omitted (True)
78. Item Content Omitted (True)
79. Item Content Omitted (True)
82. Item Content Omitted (True)
85. Item Content Omitted (True)
86. Item Content Omitted (True)
89. Item Content Omitted (True)
91. Item Content Omitted (True)
100. Item Content Omitted (True)
106. Item Content Omitted (True)
117. Item Content Omitted (True)
128. Item Content Omitted (True)

EBD Probability

7. Refuses to join group activities. (Sometimes)
8. Argues when denied own way. (Sometimes)
13. Item Content Omitted (True)
17. Item Content Omitted (True)
28. Item Content Omitted (True)
29. Item Content Omitted (True)
30. Item Content Omitted (True)
36. Item Content Omitted (True)
49. Item Content Omitted (True)
65. Item Content Omitted (True)
67. Item Content Omitted (True)
77. Item Content Omitted (True)
94. Item Content Omitted (True)
105. Item Content Omitted (True)
112. Item Content Omitted (True)

121. Item Content Omitted (True)
131. Item Content Omitted (True)

Functional Impairment

3. Responds appropriately when asked a question. (Almost always)
5. Has a short attention span. (Almost always)
6. Item Content Omitted (True)
7. Item Content Omitted (True)
11. Item Content Omitted (True)
12. Item Content Omitted (True)
13. Item Content Omitted (True)
18. Item Content Omitted (True)
19. Item Content Omitted (True)
20. Item Content Omitted (True)
22. Item Content Omitted (True)
25. Item Content Omitted (True)
29. Item Content Omitted (True)
31. Item Content Omitted (True)
32. Item Content Omitted (True)
33. Item Content Omitted (True)
35. Item Content Omitted (True)
36. Item Content Omitted (True)
46. Item Content Omitted (True)
47. Item Content Omitted (True)
48. Item Content Omitted (True)
49. Item Content Omitted (True)
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58. Item Content Omitted (True)
59. Item Content Omitted (True)
63. Item Content Omitted (True)
66. Item Content Omitted (True)
71. Item Content Omitted (True)
73. Item Content Omitted (True)
74. Item Content Omitted (True)
75. Item Content Omitted (True)
76. Item Content Omitted (True)
78. Item Content Omitted (True)
79. Item Content Omitted (True)
82. Item Content Omitted (True)
87. Item Content Omitted (True)
91. Item Content Omitted (True)
96. Item Content Omitted (True)
98. Item Content Omitted (True)
104. Item Content Omitted (True)

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106. Item Content Omitted (True)
110. Item Content Omitted (True)
113. Item Content Omitted (True)
115. Item Content Omitted (True)
123. Item Content Omitted (True)
126. Item Content Omitted (True)
131. Item Content Omitted (True)
132. Item Content Omitted (True)
134. Item Content Omitted (True)
137. Item Content Omitted (True)
138. Item Content Omitted (True)
139. Item Content Omitted (True)

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End of Report

ITEM RESPONSES

1: 3	2: 3	3: 4	4: 2	5: 4	6: 2	7: 2	8: 2	9: 1	10: 4
11: 2	12: 2	13: 2	14: 2	15: 3	16: 1	17: 1	18: 3	19: 2	20: 3
21: 1	22: 3	23: 1	24: 3	25: 2	26: 4	27: 2	28: 2	29: 2	30: 2
31: 3	32: 2	33: 1	34: 1	35: 3	36: 2	37: 2	38: 4	39: 3	40: 1
41: 2	42: 2	43: 2	44: 1	45: 1	46: 3	47: 1	48: 2	49: 1	50: 2
51: 1	52: 2	53: 3	54: 4	55: 1	56: 2	57: 3	58: 2	59: 2	60: 2
61: 4	62: 1	63: 3	64: 2	65: 1	66: 4	67: 1	68: 2	69: 3	70: 2
71: 3	72: 1	73: 1	74: 3	75: 2	76: 3	77: 2	78: 3	79: 1	80: 2
81: 2	82: 1	83: 1	84: 2	85: 3	86: 2	87: 2	88: 2	89: 2	90: 1
91: 1	92: 2	93: 1	94: 3	95: 1	96: 1	97: 1	98: 2	99: 1	100: 4
101: 2	102: 3	103: 1	104: 3	105: 1	106: 3	107: 1	108: 2	109: 2	110: 1
111: 2	112: 2	113: 3	114: 1	115: 3	116: 2	117: 3	118: 2	119: 1	120: 2
121: 1	122: 4	123: 1	124: 2	125: 2	126: 2	127: 1	128: 1	129: 2	130: 1
131: 1	132: 3	133: 2	134: 3	135: 1	136: 2	137: 2	138: 1	139: 1	