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Evaluation and Diagnosis of Emotional and Behavioral Disorders in the Schools Under the BASC-3 Model: Getting it right and getting to interventions that work!

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Conflict of Interest Notice

I am the author of the BASC-3, the assessment scale and other intervention materials that will be emphasized in today's training. While I view my comments and opinions as expressed to be accurate, you should judge the facts and materials for yourself and make an independent decision regarding your choice of diagnostic and related techniques.

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What we hope to do today.

- This training will focus on development and application of a model of assessment of emotional and behavioral disorders in a school setting with an emphasis on not just eligibility, but developing a comprehensive diagnosis and understanding of the student. Following a review of application of the BASC-3 to determining ED eligibility, differential diagnosis that leads to a process of identification of evidence-based interventions tailored to student needs will be emphasized. While the BASC-3 will be emphasized as model for such assessments and advanced interpretive methods for BASC-3 reviewed, the basic approach applies to most assessment devices. Diagnosis of ADHD will be used as a model but other disorders will be discussed as well. Actuarial approaches will be emphasized but the need to integrate these approaches to individual children will also be stressed and approaches to involving parents in the process will be discussed as time permits.

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First Order of Business…Are EBDs real, or just "made up" disorders?

- Psychopathology in history and literature extends back to at least ancient Greece in the western world but is present in most cultural histories worldwide.
- Seen as due to demonic possession in earliest records.
- Later seen as a curse from a God, blasphemers, "witches," estimates are 100s of thousands executed between 1500-1800 alone.
- 1800s EBDs were often thought of as disorders of moral development –a notion that remained with us until the late 1950s and harbored by some yet today.
- Concept as illness or disorder has been with us in the medical and psychological literature for over 150 years.

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Emotional and Behavioral Disorders Are Real

- Codified in DSMs since inception.
- Recognized in Federal legislation.
- As the neurosciences progress, we are more and more discovering the neurobiological links to psychopathology.
- Some are actual illnesses and some are just brain malfunctions that are structural, chemical, or both, but are a result of faulty brain function.
- A small number may represent learned behaviors—but all of our systems interact in a model of reciprocal determinism to produce behavior.
- It is rarely "bad parenting" and never so for most disorders.
- EBDs predate and were not invented by "big pharma."
- EBDs can be accurately, objectively identified and successfully treated.
- Still, our society has a tendency unduly to pathologize normal variations in behavior and seek excuses, so we must get it right, and differentiate disorders from normal behavioral variations.

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Let's Look at ADHD as an Ex….Is ADHD real, or a "made up" disorder?

- In 1865, Heinrich Hoffman in Germany wrote the story of "Fidgety Phil," which remains a good description of children with ADHD though he neglected to name it.
- In 1902, Drs. Still and Tredgold described 43 children in their clinical practice with serious problems with sustained attention and impulse control with a boy:girl ratio of 3:1.
- Dr. Still believed this was a disorder of moral development –a notion that remained with us until the late 1950s and harbored by some yet today.
- ADHD has been with us in the medical literature for over 150 years.

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ADHD is Real

- **ADHD is a neurobiological disorder**
- **Imaging studies have shown it to be a disorder of self-regulation due to hypoactivity of key communication circuitry in and between the frontal regions of the brain and the meso-limbic and posterior portions of the brain (key dopamine, serotonin, and noradrenaline pathways especially).**
- **It is associated with hypodensity of the prefrontal region on average in ADHD individuals.**
- **We have characterized it as "like having a Ferrari brain with bicycle brakes." (C. R. Reynolds, K. Vannest, & J. Harrison, 2012. *The energetic brain: Understanding and managing ADHD*. NY: John Wiley and Sons)**
- **ADHD was known, under various names, long before there were drugs and big pharma to treat it.**
- **It also need not be limiting and can be managed effectively at all ages.**
- **But, it has many mimics and we have to use comprehensive diagnostic procedures to get it right.**

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The American Academy of Pediatrics Report on Diagnosis of ADHD

In 2000, the American Academy of Pediatrics (AAP) released a report on diagnosis of ADHD (AAP Committee on Quality Improvement, 2000). Noting that ADHD is a common problem and becoming increasingly a controversial one, the AAP (2000) recommended broad diagnostic work that is largely behaviorally based.

In 2019 AAP reiterated these Guidelines with minimal changes but did note that psychosocial/behavioral interventions should be the first line of treatment followed by medication: https://publications.aap.org/pediatrics/article/144/4/e20192528/81590/Clinical-Practice-Guideline-for-the-Diagnosis

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AAP recommended in 2000 and Reaffirmed in 2019 that…

- The assessment of ADHD should include information obtained directly from parents or caregivers, as well as a classroom teacher or other school professional, regarding the core symptoms of ADHD in various settings, the age of onset, duration of symptoms and degree of functional impairment.
- Evaluation of a child with ADHD should also include assessment for co-existing conditions: learning and language problems, aggression, disruptive behavior, depression or anxiety. Many children diagnosed with ADHD also have a **co-existing condition.**

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Broad-band assessment is necessary for accurate diagnosis

In making these recommendations in 2000 and in their reaffirmation on 2019, the AAP appears to recognize the need, as we do and as others have long noted (e.g., Goldstein, 1999), for a broad-based assessment of the behavior and affect of children suspected of having ADHD.

Why is this important?

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It is important because…

- Narrow-band scales tend to over-diagnose.
- Mimics are common.
- Comorbidities are common.
- Behaviors may be specific to a single setting—information from home, school, and community are crucial to triangulate as are data from a clinical interview.
- Pervasiveness of the presentation is important to diagnosis and to intervention.
- Secondary and other comorbidities should influence choices and sequences of treatments.

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These recommendations apply not just to ADHD and other DSM diagnoses

- Where should the student with ADHD or another DSM Dx be classified and served?? ED? OHI? SpEd or 504?
- Dictated by the student's behavior and needs—decide one student at a time.
- Comprehensive assessment is needed.
- The criteria for categorization of a student as emotionally disturbed under IDEIA requires that we look broadly at children, the context of their behavior, and its acuteness/chronicity—its history. OHI and other IDEIA definitions have comprehensive requirements as well.

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Emotional disturbance

- The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance:
  - An inability to learn that cannot be explained by intellectual, sensory, or health factors;
  - An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
  - Inappropriate types of behavior or feelings under normal circumstances;
  - A general pervasive mood of unhappiness or depression;
  - A tendency to develop physical symptoms or fears associated with personal or school problems;
- The term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.

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What is the BASC-3 Model and How Does It Fit IDEIA and the DSM??

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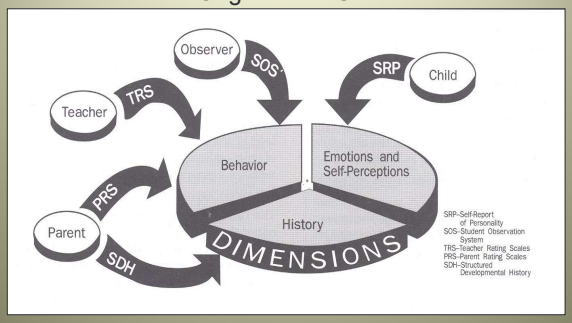
What is the BASC-3?

A Multidimensional, Multimethod approach to assessing child and adolescent EBDs.

The Original BASC Model



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BASC-3 Diagnostic Components

All Are Available via Paper and Q-Global/Digital

All Forms Except TRS, SRP-I, and SRP-COL are Available in English and Spanish

- **SDH: The Structured-Developmental History**
  All ages
- **SOS: Student Observation System**
  All ages
- **SRP: Self-report of Personality**
  SRP-I Ages 6-7 | **SRP-C** Ages 8-11 | **SRP-A** Ages 12-21 | **SRP-COL** Ages 18-25
- **PRS: Parent Rating Scales**
  PRS-P Ages 2-5 | **PRS-C** Ages 6-11 | **PRS-A** Ages 12-21
- **TRS: Teacher Rating Scales**
  TRS-P Ages 2-5 | **TRS-C** Ages 6-11 | **TRS-A** Ages 12-21
- **PRQ: Parenting Relationship Questionnaire**
  Ages 2-18

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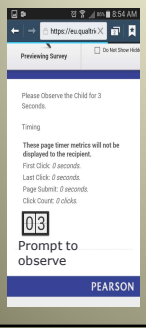
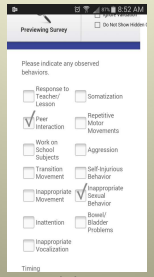
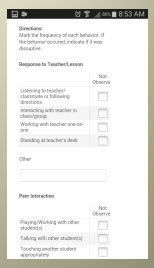
Student Observation System – Digital and Paper

Digital for Smartphone or Tablet





Record observations



Complete Part A

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Student Observation System – Digital and Paper

- Digital administration occurs through Q-global
  - Promotes consistency with BASC-3 components
  - Enables users to have all BASC-3 results in the same place
  - Users do not have to find, purchase, or install any apps; administrations begin by simply opening a web address
  - Is the replacement for the BASC-2 POP; BASC-3 SOS does not offer ability for customization of forms
- Paper is still offered, and can be entered into Q-global if desired

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SOS Scales

Adaptive Scales

- Response to teacher
- Work on school subjects
- Peer interaction
- Transition movement

Behavior Problem Scales

- Inappropriate movement
- Inattention
- Inappropriate vocalization
- Somatization
- Repetitive motor movements
- Aggression
- Self-injurious behavior
- Inappropriate sexual behavior
- Bowel/bladder problems

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Can BASC-3 Be Used to Determine EBDs?

- Yes, if you follow our model.
- BASC-3 is not a "single instrument."
- BA<u>System</u>C-3 is a comprehensive <u>system</u> that is multi-method and multi-dimensional making use of many instruments and methods.
- Historical questionnaire/structured interviews, observational scales, behavior rating scales for home and school, self-reports, parenting questionnaires, monitoring scales.
- Assists in clinical interviewing.

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Applying the BASC-3 Model to Assessment of EBDs

Eligibility for School Services and Differential Diagnosis

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Choosing the Right Norms for Diagnosing EBDs: Conflicting Recommendations in the Literature

- BASC-3 Offers
  - Same Sex Normative Tables (male, female)
  - Combined Gender Normative Tables (male + female)
  - ADHD and General Clinical Norm Groups

  All are presented by age level

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What are norms?

- Commonly misunderstood and misapplied.
- Norms are simply reference groups (and I wish we would rename them as such in our official nomenclature—"standardization sample" is an even worse characterization!).
- Different reference groups answer different questions.

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Choosing Norms: Asking Qs

- General National Norms-Does Rob have problems with depression relative to other children his age?
- Sex-based Norms-how does Michelle's hyperactivity compare to that of other girls?
- Clinical Norms-How severe is Natalie's psychoticism in comparison to other children diagnosed with mental health disorders of childhood, including EBDs?
- ADHD Norms-How severe are Kent's symptoms of depression in comparison to other children diagnosed with ADHD

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Why do we need norms?

- Its a matter of scaling.

  Interval versus ratio scaling (and nominal and ordinal).
- It is a matter of relativity.
- It is a matter of frequency.
- In clinical assessment, ultimately it is a matter of "normality," as much as we may dislike the term.
- Norms are especially crucial for eligibility.

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Gender Differences on Measures of Behavior, Feelings, and Affect Abound Across Age and Reporter.

They are present on rating scales, self-reports, and behavioral observations.

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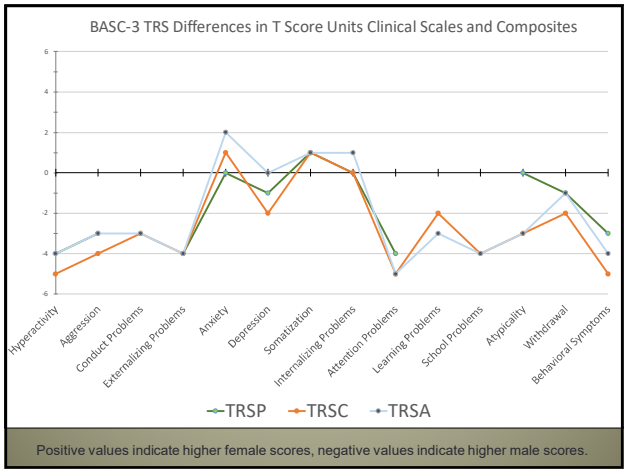

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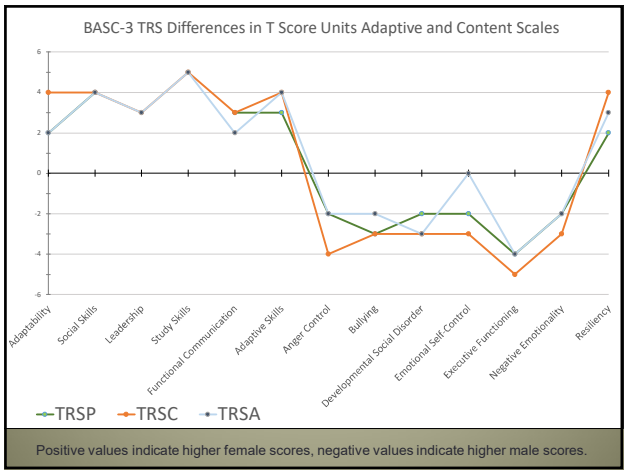

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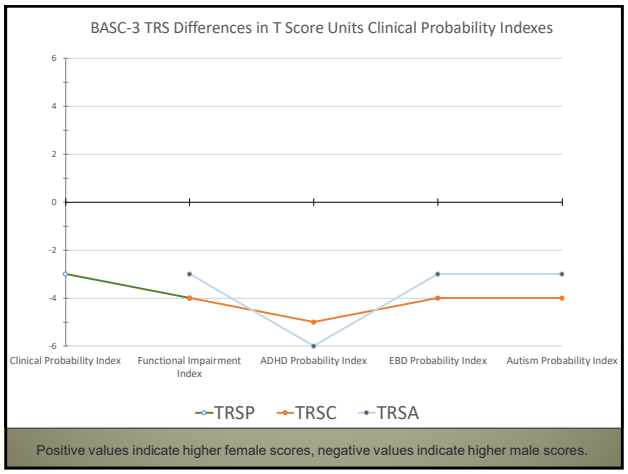

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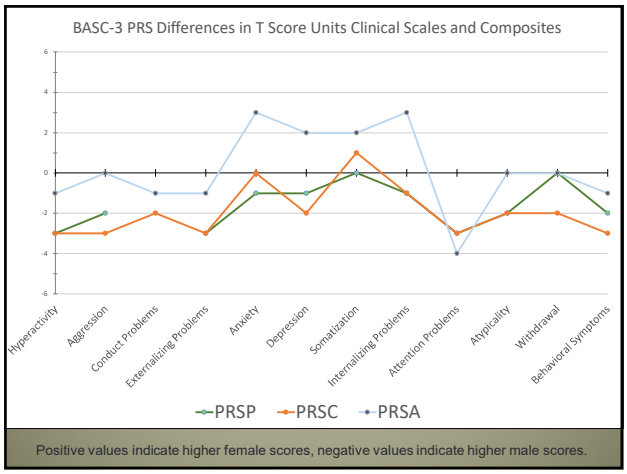

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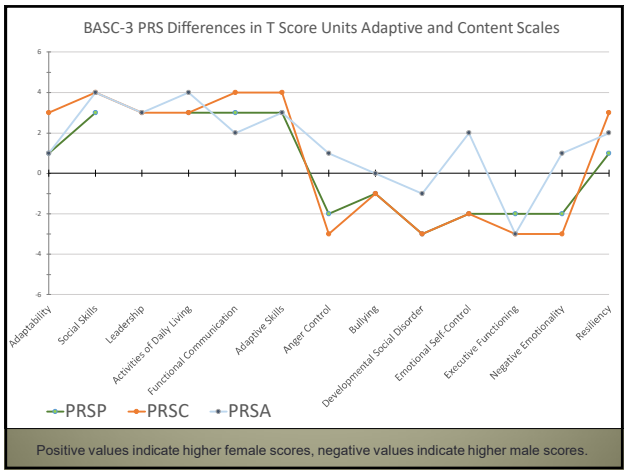

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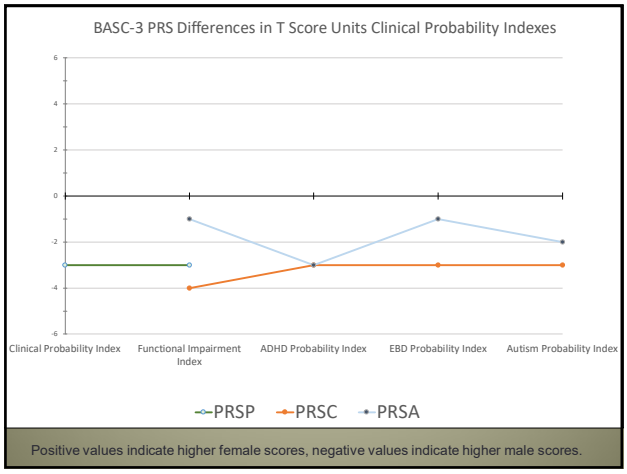

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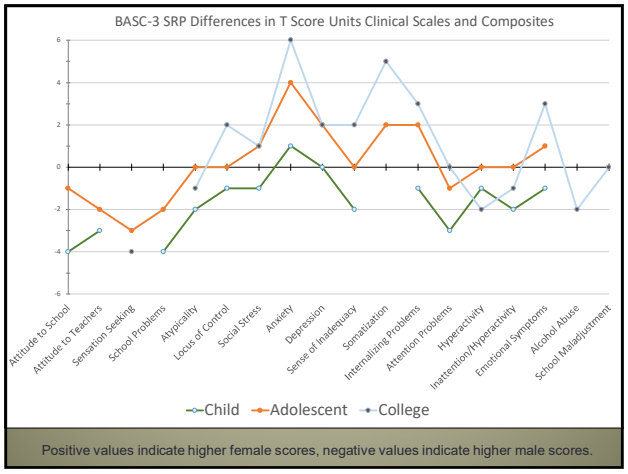

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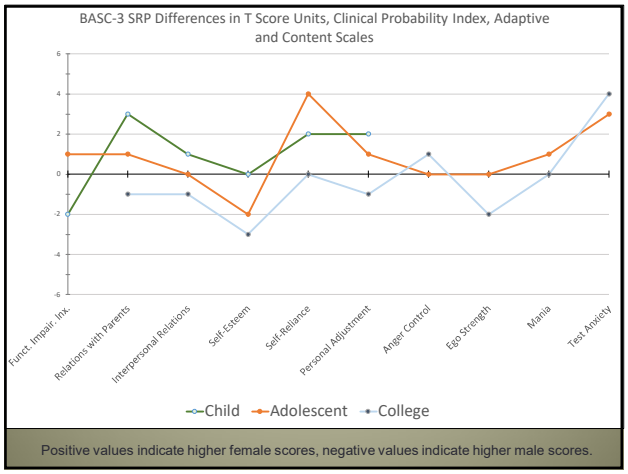

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Homogeneous Gender Norms Equate Males and Females on All Variables

- Does this reflect reality?
- Are boys and girls really different in how they think, feel, and behave?
- Yes. Use combined gender norms to preserve differences.
- No—the differences are artifacts of measurement bias. Use homogenous gender norms to remove all observed differences, thereby equating boys and girls on all variables.

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What happens when we equate boys and girls? Exs.

- Girls and anxiety disorders?
- Boys and externalizing disorders?
- Are boys less adversely affected and girls more adversely affected by a common set of symptoms of inattention?
- What if judges used homogeneous gender norms for sentencing considerations?

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Use of Homogenous Gender Norms Will Deny Identification and Treatment of Disorders Across Gender for Groups with Higher Prevalence Rates and Yield Unnecessary Diagnoses and Treatment on Those with Lower Prevalence Rates

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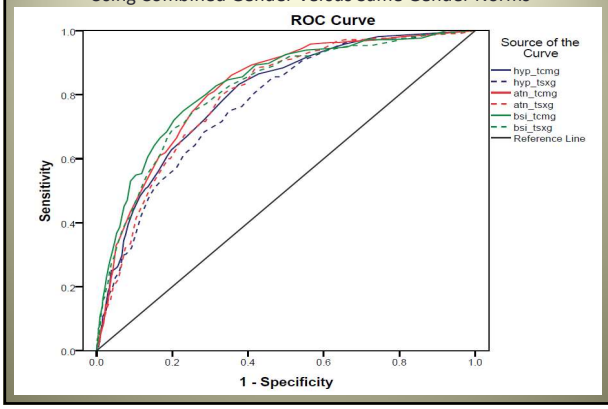
Homogenous Gender Norms Lessen Diagnostic Accuracy: ROC Curves for ADHD

39

ADHD: Diagnostic Accuracy of Teacher Ratings for Ages 6 yrs-11 yrs Using Combined Gender Versus Same Gender Norms



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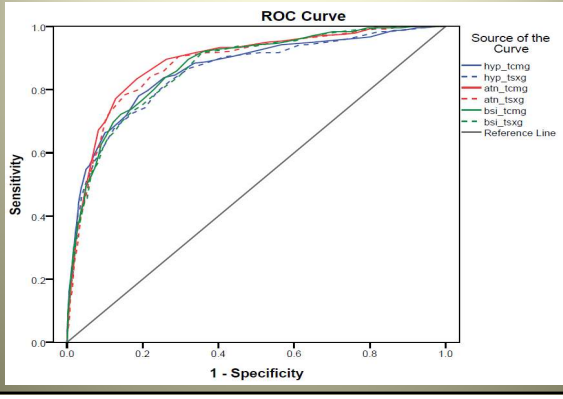
ADHD: Diagnostic Accuracy of Parent Ratings for Ages 6 yrs-11 yrs Using Combined Gender Versus Same Gender Norms



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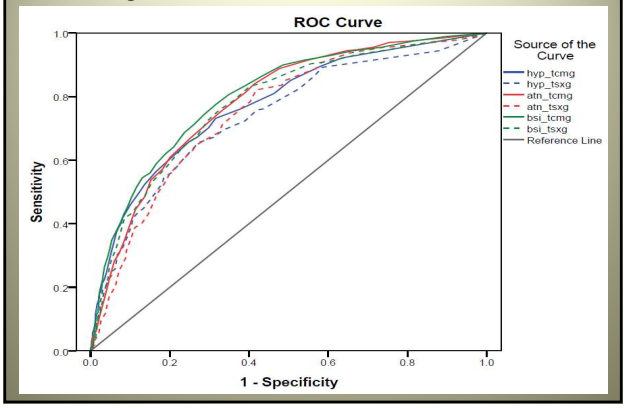
ADHD: Diagnostic Accuracy of Teacher Ratings for Ages 12 yrs-18 yrs Using Combined Gender Versus Same Gender Norms



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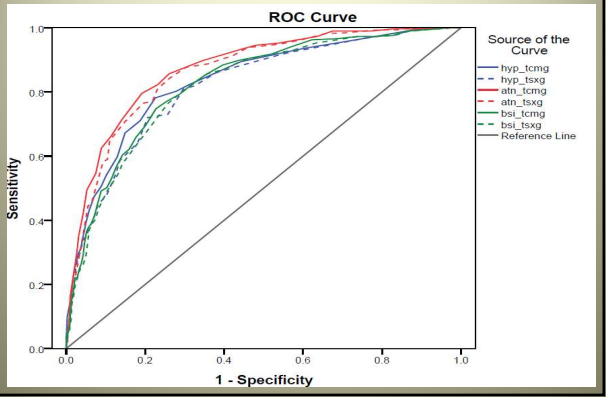
ADHD: Diagnostic Accuracy of Parent Ratings for Ages 12 yrs-18 yrs Using Combined Gender Versus Same Gender Norms



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ROC Curve Summary

- In some cases the differences are small, but in every case at both age groups displayed, and across both parents and teachers as raters, combined gender norms were more accurate at the sweet spot of sensitivity and specificity.
- For really extreme cases, it does not matter which norm set we use, as the ROC Curves merge, but these are the cases where we have the fewest and least difficult diagnostic problems.

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Combined or Same Sex Norms?

- Combined gender norms preserve known and documented differences on key behavioral and emotional constructs, e. g., anxiety, hyperactivity.
- Combined gender norms preserve known and accepted differences in prevalence rates of disorders known to differ as a function of gender.
- Combined gender norms are likewise the most appropriate reference group for nonbinary groups.
- Combined gender norms are more accurate overall in the diagnostic process with the exception of the most extreme cases—in really extreme cases, choice of norms is irrelevant, but these are not the cases that worry us.

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BASC-3 and IDEIA Emotional Disturbance: Eligibility, not Dx

- The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance:
  - An inability to learn that cannot be explained by intellectual, sensory, or health factors;
  - An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
  - Inappropriate types of behavior or feelings under normal circumstances;
  - A general pervasive mood of unhappiness or depression;
  - A tendency to develop physical symptoms or fears associated with personal or school problems;
- The term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.

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Eligibility is the Key to Services

- But, tells us us little about treatment.
- Still, we must assess and evaluate eligibility.
- First let's look at how BASC-3 helps with the eligibility decision and then we will turn to the question of differential diagnosis and differentiated services.

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Breaking Down the IDEIA Definition and Linking to BASC-3 Model

- The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance:
- History—the SDH, clinical interview, review of records.
- Impairment—Adaptive Scales especially helpful, but specific behavioral scales as well for each IDEIA criterion.
- Functional Impairment Index
- Adaptive scales often inform least restrictive placement decisions.

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BASC-3 Emotional Disturbance Qualification Scales: EDQS

- New content scales that provide a prima facie match to the 5 qualifying criteria of the Federal IDEIA definition of ED.
- Provide a social maladjustment indicator.
- All are expert derived scales based upon a content-level matching of BASC-3 clinical, adaptive, and content scales to the Federal criteria.
- Each scale is a rescaled composite score of other BASC-3 scales.
- Separate-gender and combined-gender norms are available for the EDQS.

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The BASC–3 EDQS Composites

EDQC and Corresponding IDEIA Criteria

EDQC 1	EDQC 2	EDQC 3	EDQC 4	EDQC 5
IDEIA ED Criteria (B)	IDEIA ED Criteria (C):	IDEIA ED Criteria (D):	IDEIA ED Criteria (E):	IDEIA ED Criteria (ii):
An inability to build or maintain satisfactory interpersonal relationships with peers and teachers	Inappropriate types of behavior or feelings under normal circumstances	A general pervasive mood of unhappiness or depression	A tendency to develop physical symptoms or fears associated with personal or school problems	The term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance

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	1	2	3	4	5
TRS–C TRS–A PRS–C PRS–A	•Aggression •Conduct Problems •Leadership *(Reverse scored)* •Social Skills *(Reverse scored)* •Withdrawal •Developmental Social Disorders	•Anxiety •Atypicality •Depression •Withdrawal •Developmental Social Disorders •Emotional Self-Control •Negative Emotionality	•Depression •Negative Emotionality	•Anxiety •Somatization	•Atypicality •Withdrawal •Attention Problems •Functional Communication *(Reverse scored)* •Executive Functioning
SRP–C	•Attitude to Teachers •Interpersonal Relations *(Reverse scored)* •Social Stress	•Anxiety •Attitude to School •Atypicality •Depression •Self-Esteem *(Reverse scored)* •Sense of Inadequacy •Social Stress	•Depression •Self-Esteem *(Reverse scored)* •Sense of Inadequacy	•Anxiety •Social Stress	•Attention Problems •Atypicality •Interpersonal Relations *(Reverse scored)* •Locus of Control
SRP–A	•Attitude to Teachers •Interpersonal Relations *(Reverse scored)* •Social Stress	•Anxiety •Attitude to School •Atypicality •Depression •Self-Esteem *(Reverse scored)* •Sense of Inadequacy •Social Stress •Mania	•Depression •Self-Esteem *(Reverse scored)* •Sense of Inadequacy	•Anxiety •Social Stress •Somatization •Test Anxiety	•Attention Problems •Atypicality •Interpersonal Relations *(Reverse scored)* •Locus of Control

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The BASC-3 EDQS SM Indicator

- **Only offered for the TRS and PRS forms.**
- **Identifies cases that may warrant further investigation by the clinician.**
- **The term "social maladjustment" (SM) has not been operationally defined by Federal IDEIA legislation.**
- **Its interpretation and use varies widely across the field. In some states and local districts, DSM disorders such as conduct disorder (CD) and oppositional defiant disorder (ODD) are considered exclusively to indicate the presence of SM—some states do not.**
- **The proper interpretation and use of the SM classification and its definition remain controversial in the absence of clear federal guidance and an operational definition. The new BASC–3 EDQS and SM indicators are not intended to supersede local policies but rather to provide aggregated, normative data based on a prima facie match to the federal definition of emotional disturbance**
- **The SM indicator is offered as a suggestion that further assessment procedures may be warranted depending on guidelines set forth by state and local jurisdictions.**
- **It is important to note, however, that many students who are SM are also ED, and being socially maladjusted does not rule out ED. The comorbidity rate between SM and certain forms of ED is high.**
- **The EDQS SM algorithm emphasizes detection of SM in the absence of other prima facie indications of ED, and it is unusual for an examinee to obtain positive results on an EDQS and on the SM indicator (although it is possible).**

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Social Maladjustment Profiles on the PRS/TRS

- Aggression
- Hyperactivity — All ≥ T of 60
- Conduct Pxs

Concurrent With

- Anxiety
- Depression — Both < 60
- Adaptive Composite <45

Also consider Sensation Seeking on the SRP. Often ≥ 60 in SM.

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Please remember, the presence of social maladjustment does not grant any form of immunity from Emotional Disturbance as defined in IDEIA

- ▶ Yes—you can have SM and ED
- ▶ Yes—you can have a substance abuse Dx and ED
- ▶ Yes—you can have most any diagnosis and ED. There are no known immunizing disorders.

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BASC-3 EDQS

- Only available via computer-scoring. No hand scoring option is available.
- Available to all computer scoring options at no added cost.
- Automatically included with other content scales unless deselected in the report menu options.

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Differentiating Between the Emotional and Behavioral Disorder Index (EBD Index) and the EDQS

- The EBD Index and the EDQS were created using radically different methods and thus are complementary, providing quite different types of information. Because of the differences in the derivation of the EBD Index and the EDQS, they will not always agree, although they will more often than not.
- The EBD Index is actuarially derived with no regard for item content. It is based on the ability of items to differentiate statistically students in special education with pre-existing classifications of ED and non-referred students. The EBD Index reflects how closely BASC–3 item scores match those of students who were identified as ED. The sample used to derive the EBD Index represents students who are actually being classified and placed in special education.
- We perceive a national referral bias that favors teacher referrals of students who tend to be more aggressive display more externalizing problems. The EBD Index subsequently correlates highly with externalizing disorders and is less sensitive to students with internalizing disorders.
- In sharp contrast, the five composites of the EDQS are solely content-derived scales based on expert opinion and consensus to match the content of the BASC–3 scales to the criteria of the Federal definition as it is written into the laws and regulations that govern disability determination as ED.

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EDQS Reporting Example From Computer Score Reports: 1 TRS-C Age 8

Emotional Disturbance Qualification Composites (EDQCs)	Raw Score	*T* Score	Percentile Rank	90% Confidence Interval	Clinical Indicator
EDQC 1: Unsatisfactory Interpersonal Relationships	461	83	99	81-85	Clinically Significant
EDQC 2: Inappropriate Behavior/Feelings	434	65	91	63-67	At-Risk
EDQC 3: Unhappiness or Depression	106	53	74	49-57	Acceptable
EDQC 4: Physical Symptoms or Fears	132	70	95	65-75	Clinically Significant
EDQC 5[a]: Schizophrenia and Related Disorders of Thought	349	73	97	70-76	Clinically Significant
				Social Maladjustment Indicator	Present

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Sample Narrative for Ex. 1

- **EDQC 1: Unsatisfactory Interpersonal Relationships**

John's *T* score on the Unsatisfactory Interpersonal Relationships Composite is 83 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. Teacher reports that John has significant difficulty establishing and/or maintaining interpersonal relationships with others compared to same-age peers.

- **EDQC 2: Inappropriate Behavior/Feelings**

John's *T* score on the Inappropriate Behavior/Feelings Composite is 65 and has a percentile rank of 91. This *T* score falls in the At-Risk classification range and follow-up assessment or intervention may be necessary. Teacher reports that John displays some inappropriate behaviors or feelings under normal circumstances more often than same-age peers.

- **EDQC 3: Unhappiness or Depression**

John's *T* score on the Unhappiness or Depression Composite is 53 and has a percentile rank of 74. Teacher reports that John displays no signs of pervasive unhappiness or depressive mood when compared to same-age peers.

- **EDQC 4: Physical Symptoms or Fears**

John's *T* score on the Physical Symptoms or Fears Composite is 70 and has a percentile rank of 95. This *T* score falls in the Clinically Significant classification range and usually warrants follow-up assessment or intervention. Teacher reports that John 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**

John's *T* score on the Schizophrenia and Related Disorders of Thought Composite is 73 and has a percentile rank of 97. This *T* score falls in the Clinically Significant classification range and usually warrants follow-up assessment or intervention. Teacher reports that John displays significantly elevated levels of atypical or withdrawn behavior and may struggle with functional communication compared to same-age peers.

- **Social Maladjustment Indicator**

Teacher's responses suggest that John exhibits behaviors that are inconsistent with societal norms much more often than same-age peers. Teacher's responses suggest that social maladjustment may be present and follow-up assessment or intervention should occur based on the laws and regulations in the appropriate jurisdiction. Examiners should be aware that the presence of social maladjustment does not rule out emotional disturbance and that social maladjustment and various forms of emotional disturbance are often comorbid.

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BASC-3 EDQS Ex. 2 SRP-A Age 15

Emotional Disturbance Qualification Composites (EDQCs)	Raw Score	*T* Score	Percentile Rank	90% Confidence Interval	Clinical Indicator
EDQC 1: Unsatisfactory Interpersonal Relationships	240	86	99	82-90	Clinically Significant
EDQC 2: Inappropriate Behavior/Feelings	548	73	97	70-76	Clinically Significant
EDQC 3: Unhappiness or Depression	197	68	93	64-72	At-Risk
EDQC 4: Physical Symptoms or Fears	260	68	94	64-72	At-Risk
EDQC 5[a]: Schizophrenia and Related Disorders of Thought	273	74	97	70-78	Clinically Significant

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EDQS Ex. 2 Narratives

- **EDQC 1: Unsatisfactory Interpersonal Relationships**

Lucy's *T* score on the Unsatisfactory Interpersonal Relationships Composite is 86 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. Lucy has significant difficulty establishing and/or maintaining interpersonal relationships with others compared to same-age peers.

- **EDQC 2: Inappropriate Behavior/Feelings**

Lucy's *T* score on the Inappropriate Behavior/Feelings Composite is 73 and has a percentile rank of 97. This *T* score falls in the Clinically Significant classification range and usually warrants follow-up assessment or intervention. Lucy displays behaviors or feelings that are significantly inappropriate under normal circumstances much more often than same-age peers.

- **EDQC 3: Unhappiness or Depression**

Lucy's *T* score on the Unhappiness or Depression Composite is 68 and has a percentile rank of 93. This *T* score falls in the At-Risk classification range and follow-up assessment or intervention may be necessary. Lucy shows some signs of pervasive unhappiness or depressive mood moderately more often than same-age peers.

- **EDQC 4: Physical Symptoms or Fears**

Lucy's *T* score on the Physical Symptoms or Fears 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. Lucy displays physical symptoms or fears associated with personal or school problems moderately more often than same-age peers.

- **EDQC 5: Schizophrenia and Related Disorders of Thought**

Lucy's *T* score on the Schizophrenia and Related Disorders of Thought Composite is 74 and has a percentile rank of 97. This *T* score falls in the Clinically Significant classification range and usually warrants follow-up assessment or intervention. Lucy displays significantly elevated levels of atypical or withdrawn behavior and may struggle with functional communication compared to same-age peers.

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BASC-3 EDQS Ex. 3 PRS-C Age 8

Emotional Disturbance Qualification Composites (EDQCs)	Raw Score	T Score	Percentile Rank	90% Confidence Interval	Clinical Indicator
EDQC 1: Unsatisfactory Interpersonal Relationships	387	70	96	67-73	Clinically Significant
EDQC 2: Inappropriate Behavior/Feelings	367	53	69	50-56	Acceptable
EDQC 3: Unhappiness or Depression	94	47	45	42-52	Acceptable
EDQC 4: Physical Symptoms or Fears	145	76	98	71-81	Clinically Significant
EDQC 5*: Schizophrenia and Related Disorders of Thought	230	45	36	42-48	Acceptable
				Social Maladjustment Indicator	Absent

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EDQS Ex. 3 Narratives

EDQC 1: Unsatisfactory Interpersonal Relationships
John's *T* score on the Unsatisfactory Interpersonal Relationships Composite is 70 and has a percentile rank of 96. This *T* score falls in the Clinically Significant classification range and usually warrants follow-up assessment or intervention. Mother reports that John has significant difficulty establishing and/or maintaining interpersonal relationships with others compared to same-age peers.

EDQC 2: Inappropriate Behavior/Feelings
John's *T* score on the Inappropriate Behavior/Feelings Composite is 53 and has a percentile rank of 69. Mother reports that John displays appropriate types of behaviors and feelings under normal circumstances that are comparable to same-age peers.

EDQC 3: Unhappiness or Depression
John's *T* score on the Unhappiness or Depression Composite is 47 and has a percentile rank of 45. Mother reports that John displays no signs of pervasive unhappiness or depressive mood when compared to same-age peers.

EDQC 4: Physical Symptoms or Fears
John's *T* score on the Physical Symptoms or Fears Composite is 76 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. Mother reports that John 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
John's *T* score on the Schizophrenia and Related Disorders of Thought Composite is 45 and has a percentile rank of 36. Mother reports that John displays developmentally appropriate thinking patterns, perceptions, and communication skills. John shows no signs of schizophrenia or related disorders when compared to same-age peers.

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

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BASC-3 EDQS: Summary and Cautions

- The BASC–3 EDQS reflect new combinations of BASC–3 scales grouped to align with the constructs of ED as represented in IDEIA.
- These constructs serve as the minimum criteria that are used to determine a student's eligibility for special education under these Federal rules. The EDQS are useful when conducting comprehensive psychoeducational evaluations for special education eligibility. These are expert scales designed to match the criteria put forth in the federal definition. They do not answer the Q of why the students behave as they do.
- Some who meet the criteria for ED based on behavior may be better categorized under a different disability when their behaviors are better accounted for by the other disability. Good examples of this are examinees who have ADHD and/or ASD.
- Nearly all students with ADHD will have inappropriate behavior under normal circumstances. Sometimes this will be caused by an emotional disturbance; however, in many cases these behaviors are better accounted for by the presence of ADHD. Examinees with ASD will almost always be unable to build and maintain appropriate relationships with peers and teachers.
- When seeking the most appropriate school placement for an examinee with ASD whose ED indicators are elevated, it is important to discern whether the qualifying behaviors are in addition to ASD or caused directly by the ASD. This determination is best accomplished via a detailed history and clinical interview in the context of a comprehensive evaluation.
- Although students with intellectual disability have a higher prevalence rate of mental health disorders than those with normal intellectual development, some students may exhibit immature behaviors consistent with their developmental level but give the appearance of ED. Examiners should investigate the source of the ED symptoms because they may be an indication of comorbid ED or may be accounted for better by developmental level.
- Making the classification and/or diagnosis that best accounts for the observed behaviors is a common task in the field and is consistent with most diagnostic guidance in documents such as the *DSM-5*.

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THE BASC-3 EDQS

The BASC–3 EMOTIONAL DISTURBANCE QUALIFICATION SCALES (EDQS) SUPPLEMENTAL INFORMATION GUIDE is available to all BASC-3 customers free of charge on the Pearson Clinical Assessment web site. It is only 6 pages long but contains critical information relating to accurate interpretation of the EDQS. Please do read it before using these scales to make decisions about students.

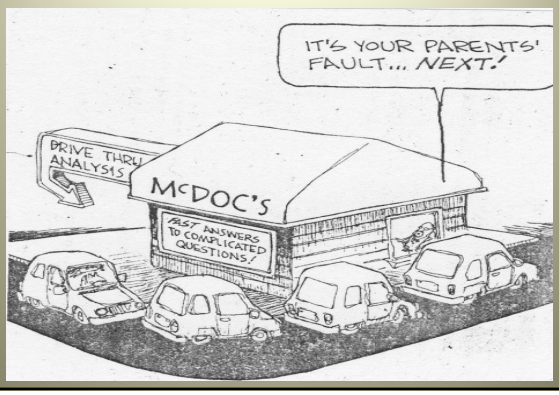
64

Qualification Means Access BUT Differential Diagnosis is Crucial to Treatment Success

- Treatment of child and adolescent emotional and behavioral disorders should never be "one-size" fits all.
- The evidence-based research literature argues strongly in favor of matching treatments to specific diagnoses and dimensions of behavior if we are to be effective in treatment.
- Students with EBDs deserve treatment—not just management.
- A declaration of eligibility (i. e., Randy is ED) is insufficient to guide Rx.

65

One size fits all does not work



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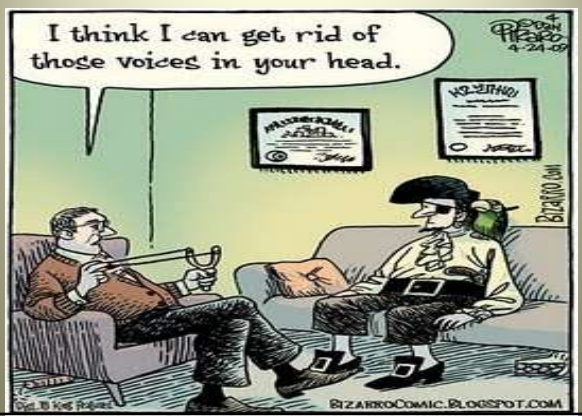
We must match the Rx to the Dx



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The BASC-3 Model Provides the Guidance and the BASC-3 Materials the Wherewithal to Make Accurate Diagnoses of EBDs

- History and Context (SDH).
- Current behavior in multiple settings (PRS/TRS).
- Assessed via multiple methods (e. g., SRP, PRS/TRS, SOS).
- Evaluation of feelings, emotions, and self-perceptions (SRP) and Parenting (PRQ).
- Links to evidence-based interventions and monitoring forms (e. g., BIG, Flex Monitor, Treatment Fidelity).

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Do not interpret test data blindly

69

Sorry, Bugs and Rorschachs Just Seem to go Together

70

History and Context are Crucial

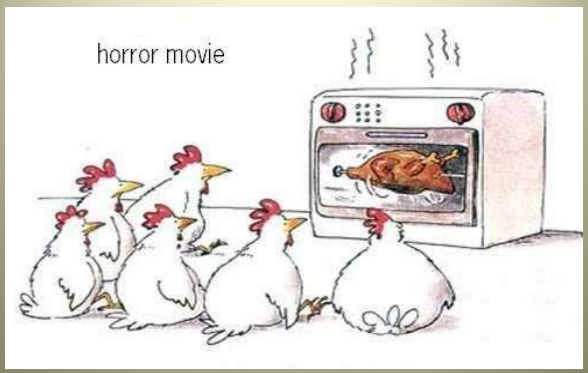
Berg, Franzen, and Wedding (1987) suggest that

"A careful history is the most powerful weapon in the arsenal of every clinician, whether generalist or specialist. Brain-behavior relations are extremely complex and involve many different moderator variables, such as age, level of premorbid functioning, and amount of education. Without knowledge of values for these moderator variables, it is virtually impossible to interpret even specialized, sophisticated test results." (p.47)

Berg, R., Franzen, M., & Wedding, D. (1987). Screening for brain impairment: A manual for mental health practice. New York: Springer.

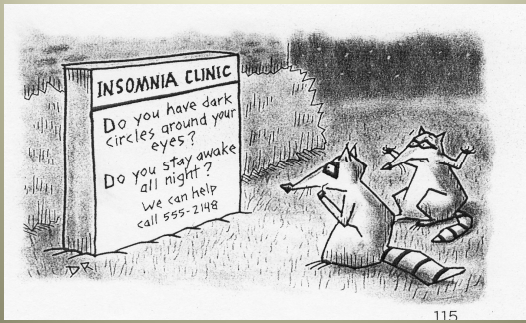
71

Context is Always Important



72

Know who you are evaluating: Remember, "Symptoms" do not mean the same thing for everyone.



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Symptoms Common to 3 Disorders

Symptoms		
Affective	Physical	Cognitive
Emotional lability	Accident proneness	Attention problems
Quick temper	Restlessness	Memory deficit
Hyperirritability	Overactivity	Learning problems
Exaggerated startle responses	Sleep problems	
Decreased self-esteem	Enuresis	

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Attention Deficit Hyperactivity Disorder, Overanxious Disorder of Childhood, and Post-Traumatic Stress Disorder

Symptoms		
Affective	Physical	Cognitive
Emotional lability	Accident proneness	Attention problems
Quick temper	Restlessness	Memory deficit
Hyperirritability	Overactivity	Learning problems
Exaggerated startle responses	Sleep problems	
Decreased self-esteem	Enuresis	

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Now, let's examine some specific applications for differential diagnosis, leading off with ADHD as a detailed example followed by a briefer look at several other of the more common disorders you will encounter and some less frequent ones.

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Know the DSM Criteria

DSM 5 Criteria For ADHD

A. A persistent pattern of inattention and/or hyperactivity that interferes with functioning or development that is characterized by (1) and/or (2).

(1) **Inattention**: Six (or more) of the following Sxs have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities;[9 classes of inattentive activity are then listed]

(2) **Hyperactivity and Impulsivity**: Six (or more) of the following Sxs have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities;[9 classes of inattentive activity are then listed]

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Inattention Exs.

- Fails to give attention to details…
- Makes careless mistakes
- Difficulty sustaining attention
- Does not seem to listen when spoken to directly
- Does not follow through on instructions
- Difficulty organizing tasks
- Loses things
- Forgetful in everyday tasks
- Easily distracted by extraneous stimuli

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Hyperactivity and Impulsivity Exs.

- Fidgets and/or squirms often.
- Leaves seat when being seated is expected.
- Runs about and/or climbs on things.
- Unable to play or be in leisure activities quietly
- Talks excessively.
- On the go or acts as if "driven by a motor."
- Difficulty waiting turns.
- Interrupts and intrudes on others.

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Add'l Required Criteria for Dx

- At least 2 Sxs of Inattention, Hyperactivity, or Impulsivity present prior to age 12.
- At least 2 Sxs are present in more than one setting.
- Clear evidence the Sxs interfere with social, academic, or occupational functioning.
- The Sxs do not appear during a psychotic disorder only and are not better explained by another mental disorder (e. g., anxiety, a mood disorder, substance abuse, personality disorder,…) [These rule outs are crucial to correct Dx.]

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Common Associated Features of ADHD

- Mild delays in learning, language, social, and motor development.
- Work performance is impaired.
- Poor performance on tests of attention, memory, and executive function.
- When co-morbid with a mood disorder, conduct disorder, or substance use disorder, suicide risk is elevated.

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Use the BASC-3 Q-Global Report Features

- **Validity Indexes**
- **Clinical and Adaptive Scales**
- **Content Scales**
- **Clinical Probability Indexes**
- **Executive Functioning Indexes**
- **Validity Index Item Lists**
- **Clinical And Adaptive Scale Narratives**
- **Content Scale Narratives**
- **Target Behaviors For Intervention**
- **Critical Items**
- **DSM-5 Diagnostic Considerations**
- **Items By Scale**
- **Item Responses**

Advanced Clinical Section

- **Validity Index Narratives**
- **Clinical Summary**
- **DSM-5 Diagnostic Criteria**

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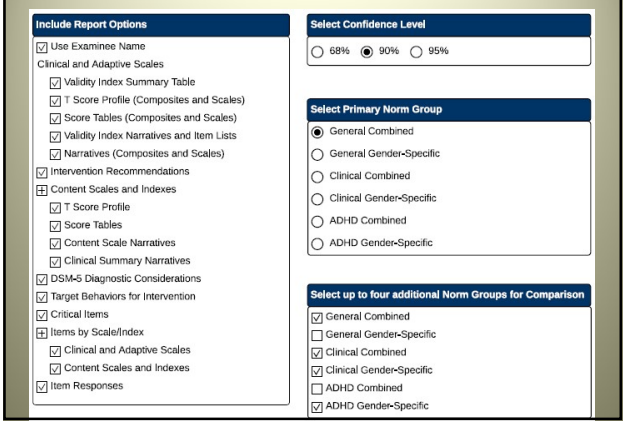
Report Options for BASC-3 Q-Global



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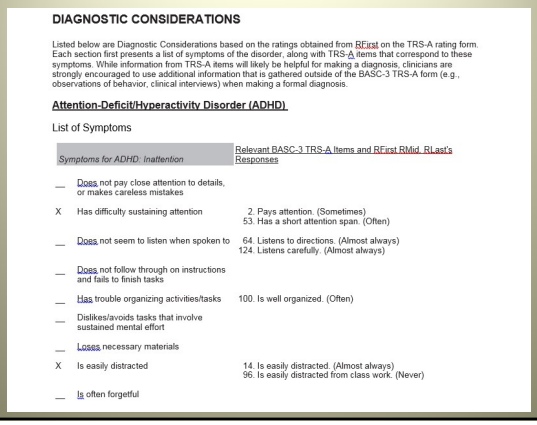
Sample Diagnostic Criteria Section BASC-3 Q-Global



DIAGNOSTIC CONSIDERATIONS

Listed below are Diagnostic Considerations based on the ratings obtained from RFirst on the TRS-A rating form. Each section first presents a list of symptoms of the disorder, along with TRS-A items that correspond to these symptoms. While information from TRS-A items will likely be helpful for making a diagnosis, clinicians are strongly encouraged to use additional information that is gathered outside of the BASC-3 TRS-A form (e.g., observations of behavior, clinical interviews) when making a formal diagnosis.

Attention-Deficit/Hyperactivity Disorder (ADHD)

List of Symptoms

	Symptoms for ADHD: Inattention	Relevant BASC-3 TRS-A Items and RFirst RMid, RLast's Responses
__	Does not pay close attention to details, or makes careless mistakes	
X	Has difficulty sustaining attention	2. Pays attention. (Sometimes) 53. Has a short attention span. (Often)
__	Does not seem to listen when spoken to	64. Listens to directions. (Almost always) 124. Listens carefully. (Almost always)
__	Does not follow through on instructions and fails to finish tasks	
__	Has trouble organizing activities/tasks	100. Is well organized. (Often)
__	Dislikes/avoids tasks that involve sustained mental effort	
__	Loses necessary materials	
X	Is easily distracted	14. Is easily distracted. (Almost always) 96. Is easily distracted from class work. (Never)
__	Is often forgetful	

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Clinical Probability Indexes From BASC-3 Include ADHD

Index	Teacher Rating Scale			Parent Rating Scale		
	P 2-5	C 6-11	A 12-21	P 2-5	C 6-11	A 12-21
ADHD Probability		*	*		*	*
Emotional Behavior Disorder Probability		*	*		*	*
Autism Probability		*	*		*	*
Functional Impairment	*	*	*	*	*	*
General Clinical Probability	*			*		

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BASC-3 ADHD Probability Index

Children who present with elevated scores on this index likely experience problems that will adversely affect their academic performance, such as difficulty focusing or maintaining attention, inability to organize tasks effectively, difficulty making decisions, or difficulty moderating their own activity level. These problems center around the key diagnostic features of ADHD and discriminate at a high level between normal children and those with a Dx of ADHD. Does not differentiate by subtype. Highest Clinical Probability Index in ADHD samples.

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BASC-3 Functional Impairment Index

Indicates the level of difficulty a child has engaging in successful or appropriate behavior across a variety of interactions with others, performing age-appropriate tasks, regulating mood, and performing school-related tasks. Indicates the degree to which maladaptive behaviors interfere with daily functions of life and its enjoyment/success. Functional impairment is central to any Dx. Second highest Clinical Index in ADHD behind the ADHD Index.

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Executive Functioning Indexes New to BASC-3 TRS and PRS: ADHD Kids Perform Poorly on These on Average

- **Problem Solving Index**
- **Attentional Control Index**
- **Behavioral Control Index**
- **Emotional Control Index**
- **Overall Executive Functioning Index** (Their worst score of all the content scales)

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ADHD Profiles on the BASC-3:TRS

- **Composite Scales:**
  - **Highest score=School Problems**
  - **Lowest Score=Adaptive Skills**
- **Clinical Scales:**
  - **Highest Scores: Attention Pxs, Hyperactivity, Learning Pxs**
  - **Lowest Score: Somatization**
- **Adaptive Scales:**
  - **Highest Score: none above 50**
  - **Lowest Scores: Study Skills, Leadership**
- **Content Scales:**
  - **Highest Scores: Executive Functioning, Emotional Self-control**
  - **Lowest Score: Resiliency**

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ADHD Profiles on the BASC-3:PRS

- **Composite Scales:**
  - **Highest score=Externalizing Problems**
  - **Lowest Score=Adaptive Skills (even lower than TRS)**
- **Clinical Scales:**
  - **Highest Scores: ATT, HYP, AGG, CON (all higher than TRS)**
  - **Lowest Score: Somatization**
- **Adaptive Scales:**
  - **Highest Score: none above 45**
  - **Lowest Scores: Activities of Daily Living, Leadership**
- **Content Scales:**
  - **Highest Score: Executive Functioning, Anger Control**
  - **Lowest Score: Resiliency**

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ADHD Profiles on the BASC-3:SRP

- **Composite Scales:**
  - **Highest score=Inattention/Hyperactivity**
  - **Lowest Score=Personal Adjustment Composite**
- **Clinical Scales:**
  - **Highest Scores: Attention Problems, Hyperactivity, Sense of Inadequacy, Attitude To School**
  - **Lowest Score: Somatization**
- **Adaptive Scales:**
  - **Highest Score: none above 50**
  - **Lowest Scores: Self-reliance and Interpersonal Relations**
- **Content Scales:**
  - **Highest Scores: Mania and Anger Control**
  - **Lowest Score: Ego Strength**

Functional Impairment Index is also typically elevated.

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ADHD Clinical Profiles On The BASC-3 PRQ

- **ADHD**
  - **Low on Attachment & Involvement**
  - **High on Relational Frustration**

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Effective Interventions for ADHD

- **Medication**: There are multiple medications, primarily stimulants (e. g., Ritalin) , which work best, but have the greatest side effects, and also noradrenalin and related reuptake inhibitors (e. g., Strattera), which are usually less effective overall but have fewer side effects.
- **Psychosocial Interventions**: Behavioral and cognitive – behavioral interventions are by far the most effective, but must target behavior and not be a general, one-size-fits all plan.
- **Educational Interventions**: Use a direct instruction model to teach learning and study skills, strategic listening, time management, and organizational techniques.
- **Best intervention**—all of the above—make an emphatic choice to adopt multiple interventions. Medication alone should never be the intervention plan, it must be accompanied by Psychosocial and Educational Interventions.

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Some Things That Typically Do Not Work

- Diets—e. g., The Feingold Diet is effective in less than 5% of cases of ADHD.
- Food or vitamin supplements: The exception here is Omega-3 fatty acids from fish or krill (not flax) which have mild beneficial effects in high doses and are widely held to be safe.
- Perceptual-motor programs, exercise programs, movement therapy, sensory-integrative therapy.
- Punishment Paradigms: Persons with ADHD are extremely resistant to punishment as a means of modifying behavior except in the immediate presence of the punisher. No generalizability evidence.

94

Sources for Psychosocial and Educational Interventions

- Psychosocial Interventions:

(1) Reynolds, C., Vannest, K., & Harrison, J. (2012). *The energetic brain: Understanding and managing ADHD*. NY: John Wiley and Sons.

(2) Vannest, K., Reynolds, C., & Kamphaus, R. (2015). *The BASC-3 Behavior intervention guide*. Bloomington, MN: Pearson.

- Educational Interventions:

Vannest, K., Stroud, K., & Reynolds, C. (2011). *Strategies for academic success: An instructional handbook for teaching K-12 students how to study, learn, and take tests*. Los Angeles: Western Psychological Services.

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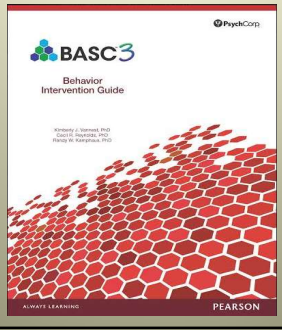
A Comprehensive Text and Software Guide To Detailed, Specific Interventions



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Interventions presented here are organized according to assessment results/problem categories

- Aggression
- Conduct Problems
- Learning Problems
- Adaptability
- Anxiety/Social Stress
- Attention Problems
- Depression
- Functional Communication
- Hyperactivity
- Social Skills/Leadership
- Somatization

For most ADHD cases, you will want to target Attention and Hyperactivity at a minimum. Other domains can be targeted based upon the specific behavioral profile of the student.

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Go To The Attention Chapter And Here Is What You Would Find

- Characteristics and Conditions
- Theoretical framework
- Definitions and examples
- Annotated bibliography of research studies*
- Preparation for Intervention
- Steps for Implementation
- Examples
- Considerations

* *Not in paper version of manual*

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Intervention Selection

- **All interventions listed demonstrate evidence of effectiveness in the scientific literature.**
- **All interventions listed are documented to be effective with the designated population.**
- **All interventions listed can be done in schools.**
- **Professional judgment is still a requisite for effective treatment. There are multiple effective interventions for each class of behavioral and emotional issues. We need you to match them to your student and your setting.**

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Interventions known to be effective for Attention Problems

- Class-wide Peer Tutoring
- Computer-assisted Instruction
- Contingency Management
- Daily Behavior Report Cards
- Modified Task-presentation Changes
- Multimodal Interventions
- Parent Training
- Self-management Training

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Example of Design

SELF-MANAGEMENT

DESCRIPTION

Self-management strategies for attention problems are techniques that children can use to become more aware and develop better management of their own behavior. Children are taught to focus on their attention through self-observation, self-recording, self-evaluation, self-monitoring, and self-reinforcing (Harris, Friedlander, Saddler, Frizzelle, & Graham, 2005; Mace et al., 2001; Reid et al., 2005). Through self-management strategies, children continuously assess their attention behavior and self-cue appropriate behavior. They eventually learn to inhibit automatic responses (Barkley, 1997). This type of meta-cognitive activity is helpful for children across ages and settings. Children who successfully apply self-management strategies can feel a great sense of self-determination, which can have a positive impact on their opinions of themselves. There are endless variations for children or adults using one or more of the steps, and most adaptations offer similar positive results.

EXAMPLES

Ms. Wilson, an 8th-grade math teacher, instructs her students to turn in the daily assignment at the end of the class period. One student, Linda, turns her paper in with only 6 out of 20 problems completed. When the teacher asks why, Linda says she understands the work but was "thinking about something else" during independent work time. Ms. Wilson assumes Linda was daydreaming or writing a note because she was not disruptive, so Ms. Wilson assigns the remainder of the assignment to Linda as homework. The next day, Linda says that she did the work at home, but she can't find it in her backpack and can't remember where she left it. This situation creates frustration for both Linda and her teacher. A self-monitoring system could help Linda recognize when she is and is not paying attention to a task and why time gets away from her. The system could also be used to help Linda transport her homework from home to school and from her locker or backpack to the teacher's desk.

Joel, another student in Ms. Wilson's class, spends most of the independent work time sitting near the teacher's desk, where he plays with his pencil, invents games with paperclips, and looks around frequently to see what the teacher is doing. Self-monitoring with a cuing system could help Joel pay attention to his assignment and allow him to complete tasks and earn rewards. If he learns to use the system, it could help Joel to start and finish relevant tasks throughout his schooling.

GOAL

Increase the child's awareness of his or her own level of attention in order to produce an automatic response without relying on external reinforcement or prompting.

THE BASICS

1. Teach the child the skill of self-observing.
2. Teach the child the skill of self-monitoring/self-recording.
3. Instruct the child on how to self-evaluate.
4. Teach the child to reinforce him- or herself.

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HOW TO IMPLEMENT SELF-MANAGEMENT

PREP

- Determine the specific area for self-management of attention (e.g., attention to task, completion of assignments, impulsivity control, organizational skills).
- Determine the cuing method for the self-management (e.g., audio cue tape, wrist counter, teacher signal).
- Identify the paper self-recording form.
- Identify a goal.
- Determine a reinforcer.
- Gain commitment for participation from the child.
- Determine if an adult will provide simultaneous monitoring and recording for accuracy checks later. (If so, be sure to demonstrate to both the child and adult during the IMPLEMENT step.)
- Determine if whole group or individual monitoring will take place. Whole classes can record even if one child or a small group of children are the target.

IMPLEMENT

- Explain both the rationale for using self-management techniques and the specific benefits the child might expect in a conversational and nonpunitive manner. For example, it can be important to point out that self-monitoring lets you be in charge of yourself and pay attention to things that you want to do better. It can be helpful to point out real life examples (e.g., used by athletes, strong readers, mathematicians, gamers). Benefits of this technique might include better attention, not getting into trouble as much from parents and teachers, a better reputation at school with friends, improved grades, and feeling better about yourself.
- Identify current performance and set goals. Discuss current classroom functioning using baseline data, and have the child set a goal for the target behavior (e.g., an amount of focused attention, a number of assignments completed, an organizational skill such as being prepared for class).
- Demonstrate the self-monitoring technique, and explain how to use any equipment or forms (e.g., audio cue tape, self-recording form, wrist counter).
- Explain what cuing is and how it will work. Discuss and determine how often the cue will be heard or seen (e.g., every 30 seconds for 10 minutes, or every 1 minute for 20 minutes during a certain class or instructional time).
- Demonstrate how the child will record his or her attention to task when the cue is heard. The cues or prompts can be audio recorded or generated by a watch with intermittent beeps; intervals from 15 seconds up to 2 minutes can be used, depending on the child. At the sound of each prompt, the child records if he or she is or isn't paying attention by placing a checkmark on the self-monitoring sheet.
- Ask the child to demonstrate the techniques and check for his or her understanding.
- Start the cuing and prompt if necessary to remind the child to record.
- Sum and monitor attention levels. Provide a basic level of reinforcement for participation even if goals are not met, and provide a higher level of reinforcement when goals are met.

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Example Considerations

For Teaching
Self-management techniques can be effective even when a child is inaccurate in self-recording. Accuracy and thus attention to detail, can be encouraged by matching the child and teacher ratings. If teacher ratings are not available or viable, the child can submit self-recorded information to another adult (for a contingent reward). The most efficacious rewards however are self-rewards (i. e., those given by the child to the child), not rewards from the adult.

Self-management techniques can be effective in improving many aspects of a child's life that require attention…[T]houghtfully consider the goal of the intervention. If the goal is to increase attention for academic tasks…

For Age and Developmental Level
Sometimes attending to particular stimuli for long periods is a challenge beyond the child's capabilities. The boredom factor in inattention is a lack of stimulation that everyone has experienced at one time or another in long meetings or social activities. Individuals with strong social skills….Individuals with low levels of social skills…It is important to teach children socially acceptable methods of operating in a boring environment. For example, telling the geometry teacher the class is boring has worse consequences than the results of a lesson in social skills and strategic listening that may lead to occasional doodling during the lecture to ward off boredom….

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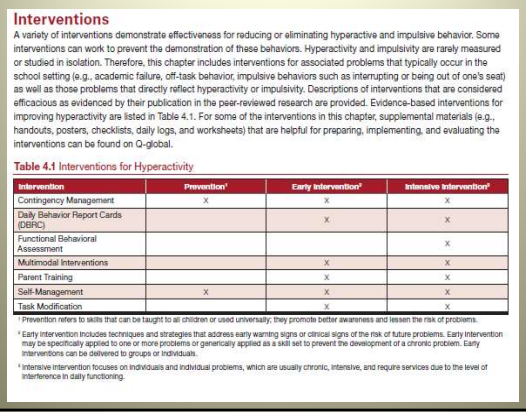
Chapter 4: Interventions for Hyperactivity



Interventions

A variety of interventions demonstrate effectiveness for reducing or eliminating hyperactive and impulsive behavior. Some interventions can work to prevent the demonstration of these behaviors. Hyperactivity and impulsivity are rarely measured or studied in isolation. Therefore, this chapter includes interventions for associated problems that typically occur in the school setting (e.g., academic failure, off-task behavior, impulsive behaviors such as interrupting or being out of one's seat) as well as those problems that directly reflect hyperactivity or impulsivity. Descriptions of interventions that are considered efficacious as evidenced by their publication in the peer-reviewed research are provided. Evidence-based interventions for improving hyperactivity are listed in Table 4.1. For some of the interventions in this chapter, supplemental materials (e.g., handouts, posters, checklists, daily logs, and worksheets) that are helpful for preparing, implementing, and evaluating the interventions can be found on Q-global.

Table 4.1 Interventions for Hyperactivity

Intervention	Prevention[1]	Early Intervention[2]	Intensive Intervention[3]
Contingency Management	X	X	X
Daily Behavior Report Cards (DBRC)		X	X
Functional Behavioral Assessment			X
Multimodal Interventions		X	X
Parent Training		X	X
Self-Management	X	X	X
Task Modification		X	X

[1] Prevention refers to skills that can be taught to all children or used universally; they promote better awareness and lessen the risk of problems.

[2] Early intervention includes techniques and strategies that address early warning signs or clinical signs of the risk of future problems. Early intervention may be specifically applied to one or more problems or generically applied as a skill set to prevent the development of a chronic problem. Early interventions can be delivered to groups or individuals.

[3] Intensive intervention focuses on individuals and individual problems, which are usually chronic, intensive, and require services due to the level of interference in daily functioning.

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Now we have a model to follow…

- For other diagnoses, we can then seek out the most appropriate interventions, psychosocial and educational, that correspond to the specific child or adolescent's symptom pattern.
- Now lets look at BASC-3 profiles for some other diagnoses and their DSM 5 Criteria—the BASC-3 Q-global report will do symptom matching and recommend psychosocial interventions, and always look at the Clinical Probability Indexes

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Depression: DSM Criteria

5 or more of 9 key Sxs present over a 2-week period with either depressed mood or loss of interest or pleasure one of the 5 Sxs.

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The Nine Key Sxs of Depression

1) **Depressed mood most of the day, nearly every day, but in children may be expressed as hyperirritability;**
2) **Markedly diminished interest or pleasure in activities of life.**
3) **Significant unintentional weight gain or loss.**
4) **Insomnia or hypersomnia most days.**
5) **Psychomotor agitation or retardation.**
6) **Fatigue nearly every day.**
7) **Daily feelings of worthlessness or guilt.**
8) **Diminished ability to think or concentrate.**
9) **Recurrent thoughts of death or suicidal ideation.**

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Depression Profiles on the BASC-3:TRS

- **Composite Scales:**
  Highest score=Internalizing Composite
  Lowest Score=Adaptive Composite
- **Clinical Scales:**
  Highest Scores: Somatization, Depression, Aggression, Attention Pxs
  Lowest Score: Learning Problems
- **Adaptive Scales:**
  Highest Score: none above 50
  Lowest Scores: Adaptability and Study Skills
- **Content Scales:**
  Highest Scores: Emotional Self-control, Anger Control
  Lowest Score: Resiliency

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Depression Profiles on the BASC-3:PRS

- **Composite Scales:**
  - **Highest score=BSI Composite**
  - **Lowest Score=Adaptive Composite**
- **Clinical Scales:**
  - **Highest Scores: Depression, Conduct Problems, Aggression**
  - **Lowest Score: Anxiety**
- **Adaptive Scales:**
  - **Highest Score: none above 50**
  - **Lowest Scores: Adaptability and Activities of Daily Living**
- **Content Scales:**
  - **Highest Scores: Emotional Self-control, Negative Affectivity**
  - **Lowest Score: Resiliency**

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Depression Profiles on the BASC-3:SRP

- **Composite Scales:**
  - **Highest score=ESI Composite**
  - **Lowest Score=Personal Adjustment Composite**
- **Clinical Scales:**
  - **Highest Scores: Sense of Inadequacy, Depression, Attention Problems**
  - **Lowest Score: Child=Attitude to Teachers; Adol=Sensation Seeking**
- **Adaptive Scales:**
  - **Highest Score: none above 50**
  - **Lowest Scores: Self-reliance and Interpersonal Relations**
- **Content Scales:**
  - **Highest Scores: Anger Control**
  - **Lowest Score: Ego Strength**

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Autism: DSM Criteria

- Persistent deficits in social communication and social interaction across multiple settings currently or by Hx—listed exs. of these deficits include:
- Deficits in social-emotional reciprocity, nonverbal communicative behaviors used for social interaction, and deficits in developing, maintaining, or understanding relationships.

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Autism: DSM Criteria, cont.

- Restrictive, repetitive patterns of behavior, interests, or activities as manifested in at least 2 areas. Listed exs. of these deficits include:
- Stereotyped or repetitive use of motor movements, objects, or speech; insistence on sameness, inflexibility, and ritualized patterns of behavior; highly restricted or fixated interests; hyper or hypo-reactivity to sensory input or unusual attraction to sensory input.

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Autism: DSM Criteria, cont.

- Sxs must be present in the early developmental period.
- Sxs cause significant impairment in social, occupational, educational, or other important areas of function.
- The Sxs are not better explained by Intellectual Disability or Global Developmental Delay but Autism and ID can be comorbid if communication skills are below intellectual level.

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Autism Profiles on the BASC-3:TRS

- **Composite Scales:**
  - **Highest score=Behavioral Symptoms Index**
  - **Lowest Score=Adaptive Composite**
- **Clinical Scales:**
  - **Highest Scores: Atypicality, Withdrawal, Attention Problems, Learning Problems**
  - **Lowest Score: Somatization**
- **Adaptive Scales:**
  - **Highest Score: none above 50**
  - **Lowest Scores: Functional Communication, Leadership**
- **Content Scales:**
  - **Highest Scores: Developmental Social Disorders, Emotional Self-control, Executive Functioning**
  - **Lowest Score: Resiliency**

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Autism Profiles on the BASC-3:PRS

- Composite Scales:
  - Highest score=Behavioral Symptoms Index
  - Lowest Score=Adaptive Composite
- Clinical Scales:
  - Highest Scores: Atypicality, Withdrawal, Attention Problems, Hyperactivity
  - Lowest Score: Somatization
- Adaptive Scales:
  - Highest Score: none above 50
  - Lowest Scores: Functional Communication, Leadership
- Content Scales:
  - Highest Scores: Developmental Social Disorders, Emotional Self-control, Executive Functioning
  - Lowest Score: Resiliency

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Autism Profiles on the BASC-3:SRP

- Composite Scales:
  - Highest score=Emotional Symptoms Index, Inatt & Hyper near tie.
  - Lowest Score=Personal Adjustment
- Clinical Scales:
  - Highest Scores: Depression, Attention Problems, Social Stress
  - Lowest Score: Attitude to Teachers
- Adaptive Scales:
  - Highest Score: none above 50
  - Lowest Scores: Interpersonal Relations, self-reliance
- Content Scales:
  - Highest Scores: Mania, Anger Control
  - Lowest Score: Test Anxiety

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Clinical Probability Indexes and Autism

- By far the highest scoring group on the Autism Probability Index—no other group even close—both TRS and PRS.
- Also highest scoring group on Functional Impairment Index TRS and PRS and tied for highest on SRP with ADHD.
- BASC-3 is most objective, clearest means of diagnosing Autism available.

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Diagnostic Accuracy of BASC-3 for ASD

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ASD vs. No-diagnosis

- 149 students Dxed with ASD compared to a demographically matched control sample (ages 4-18).
- Autism Probability Index alone:
  - PRS: Sensitivity=.86, specificity=.89
  - TRS: Sensitivity=.95, specificity=.80
- Improves when adding in ATY, WDR, DSD

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ASD vs ADHD Samples

- 118 students Dxed with ASD compared to a demographically matched control sample of children with an ADHD Dx (ages 6-18).
- Autism Probability Index alone:
  - PRS: Sensitivity=.88, specificity=.73
  - TRS: Sensitivity=.81, specificity=.82
- Improves when adding in ATY, WDR, DSD, on the TRS but not the PRS.

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How Does This Compare to ADOS-2 Best Prediction Algorithms in 2017

- In a large clinical sample of children and adolescents (N = 1080, age 1.7 to 20.5), the diagnostic accuracy of ADOS-2 was studied using refined, "best" diagnostic algorithms.
- The revised, best algorithms resulted in:
  - Sensitivity=.85
  - Specificity=.86
- The improved algorithms pertained especially to cases with core autism and to girls. Results also suggested less effective diagnostic differentiation for children and adolescents with internalizing disorders and conduct disorder.

Summarized from: **Diagnostic accuracy of the ADOS-2 taking account of gender effects.**
Kamp-Becker I, et al. Z Kinder Jugendpsychiatr Psychother. 2017. 45(3):193-207. doi: 10.1024/1422-4917/a000492

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How Does This Compare to ADOS-2 Diagnostic Accuracy in 2019

- Using 155 cases from the Autism Assessment Clinic at the University of Vermont Medical Center representing modules 1 through 4 of the ADOS-2, with final clinical diagnoses made by a multidisciplinary team assessment including a child psychiatrist, child psychologist, and speech-language pathologist.
- Overall accuracy across modules was 70.4% (sensitivity = 91; specificity = 66) with a high rate of false positives (28%). Overall accuracy tended to decrease as module number increased (module 1 = 91%; module 2 = 94%; module 3 = 62%; module 4 = 59%). The most common non-spectrum diagnosis for children classified as ASD by the ADOS-2 for modules 2 – 4 (approximately 88%) was ADHD and anxiety.
- Conclusions of the authors: "The ADOS-2 can provide valuable information to a diagnostic team for the clinical evaluation of a child with ASD, however, for the higher modules and in settings where children with numerous developmental disorders are evaluated, the specificity of the instrument is low and the risk is an unacceptable rate of over-identification."
- Consistent with my reading of research, a single spectrum scale over-diagnoses the disorder in its title, and too often misses the presence of comorbidities and mimics of the disorder being assessed. Broad-band, comprehensive assessments are simply better/more accurate for initial diagnosis.
- *T. Hutchins, H. Morris & S. Habermehl University of Vermont, Burlington, VT, Diagnostic accuracy of the ADOS-2. Paper presented at the annual meeting of the International Society for Autism Research, Montreal, May, 2019.*

122

Pediatric Bipolar Disorder: DSM Criteria

- Bipolar I—must meet criteria for a manic episode preceded or followed by a major depressive episode.
- Bipolar II—must meet criteria for a hypomanic episode preceded or followed by a major depressive episode.

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What is a Manic Episode?

- A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed behavior energy lasting at least one week lasting most of each day mostly everyday.
- Hypomanic—4 days instead of 7 days.

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What is a Manic Episode, cont.?

- **During the period of mood disturbance, 3 of the following are present to a significant degree:**

- Inflated self-esteem or grandiosity.
- Decreased need for sleep.
- Increased talking or pressured speech.
- Flight of ideas or racing thoughts.
- Distractibility.
- Increased goal-directed activity or psychomotor agitation.
- Excessive involvement in activities at high risk for adverse consequences.

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Is Bipolar Disorder Different in Children?

- Controversial—some argue yes and others no.
- But, more difficult to diagnose accurately in children.
- Pediatric mania overlaps with diagnoses of:
  - Conduct Disorder (especially aggressive symptoms).
  - Depression (especially hyperirritability).
  - ADHD with high comorbidity (60+%) present.
  - High comorbidity with anxiety disorders, especially panic disorder (estimates are around 50%).
- Pediatric onset of bipolar disorder is rarely biphasic as is most common in adolescents and adults.
- Pediatric onset of bipolar disorder is usually chronic and mixed with simultaneous development of depression and mania.

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Pediatric Bipolar Profiles on BASC-3: TRS and PRS—Very Consistent and Very Severe

- Clinical Scales: Highest scores on Hyp, Agg, and Con (consistently all over 65) followed by Dep. BSI usually at 70 or higher.
- Adaptive Scales: Lowest scores Adaptability, Activities of Daily Living
- Content Scales: Highest scores on Emotional Regulation and Executive Functioning, with very low score on Resiliency.
- Clinical Probability Indexes: High on ADHD, EBD, and Functional Impairment.

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Bipolar Profiles on the BASC-3:SRP Very Similar to ADHD but Lower Overall

- **Composite Scales:**
  - **Highest score=Inattention/Hyperactivity**
  - **Lowest Score=Personal Adjustment Composite**
- **Clinical Scales:**
  - **Highest Scores: Hyperactivity, Attention Problems, Sense of Inadequacy, Attitude To School**
  - **Lowest Score: Somatization**
- **Adaptive Scales:**
  - **Highest Score: none above 50**
  - **Lowest Scores: Self-reliance and Interpersonal Relations**
- **Content Scales:**
  - **Highest Scores: Mania and Anger Control**
  - **Lowest Score: Ego Strength**

Functional Impairment Index is also typically elevated.

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No matter the Diagnosis--Involve the Parents: Recent research summarized in the APA clinician's digest…

Recent work, including an extensive meta-analysis, demonstrates that when parents are included as part of the treatment/intervention process for children and adolescents with EBDs, treatment effects improve between .5 and 1.0 SDs.

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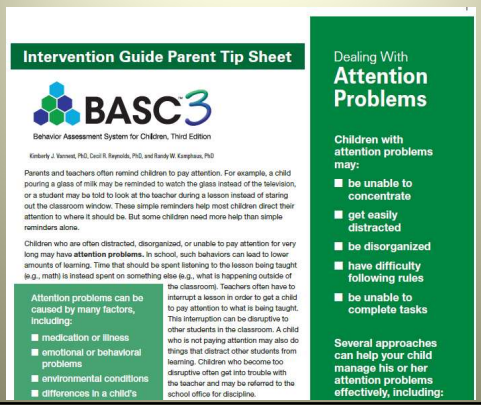
We Must Also Partner With Parents: Parent Tip Sheets



Intervention Guide Parent Tip Sheet

BASC3

Behavior Assessment System for Children, Third Edition

Kimberly J. Vannest, PhD, Cecil R. Reynolds, PhD, and Randy W. Kamphaus, PhD

Parents and teachers often remind children to pay attention. For example, a child pouring a glass of milk may be reminded to watch the glass instead of the television, or a student may be told to look at the teacher during a lesson instead of staring out the classroom window. These simple reminders help most children direct their attention to where it should be. But some children need more help than simple reminders alone.

Children who are often distracted, disorganized, or unable to pay attention for very long may have **attention problems.** In school, such behaviors can lead to lower amounts of learning. Time that should be spent listening to the lesson being taught (e.g., math) is instead spent on something else (e.g., what is happening outside of the classroom). Teachers often have to interrupt a lesson in order to get a child to pay attention to what is being taught. This interruption can be disruptive to other students in the classroom. A child who is not paying attention may also do things that distract other students from learning. Children who become too disruptive often get into trouble with the teacher and may be referred to the school office for discipline.

Attention problems can be caused by many factors, including:

- medication or illness
- emotional or behavioral problems
- environmental conditions
- differences in a child's

Dealing With **Attention Problems**

Children with attention problems may:

- be unable to concentrate
- get easily distracted
- be disorganized
- have difficulty following rules
- be unable to complete tasks

Several approaches can help your child manage his or her attention problems effectively, including:

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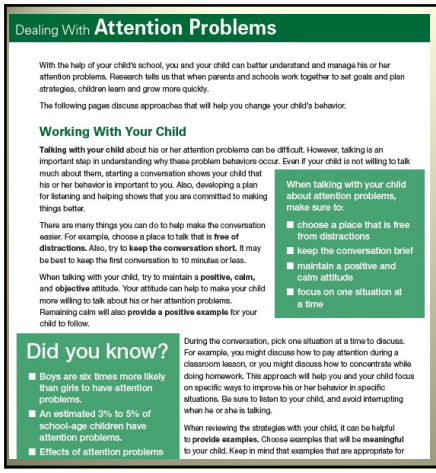

Dealing With **Attention Problems**

With the help of your child's school, you and your child can better understand and manage his or her attention problems. Research tells us that when parents and schools work together to set goals and plan strategies, children learn and grow more quickly.

The following pages discuss approaches that will help you change your child's behavior.

Working With Your Child

Talking with your child about his or her attention problems can be difficult. However, talking is an important step in understanding why these problem behaviors occur. Even if your child is not willing to talk much about them, starting a conversation shows your child that his or her behavior is important to you. Also, developing a plan for listening and helping shows that you are committed to making things better.

There are many things you can do to help make the conversation easier. For example, choose a place to talk that is **free of distractions.** Also, try to **keep the conversation short.** It may be best to keep the first conversation to 10 minutes or less.

When talking with your child, try to maintain a **positive, calm,** and **objective** attitude. Your attitude can help to make your child more willing to talk about his or her attention problems. Remaining calm will also **provide a positive example** for your child to follow.

When talking with your child about attention problems, make sure to:

- choose a place that is free from distractions
- keep the conversation brief
- maintain a positive and calm attitude
- focus on one situation at a time

Did you know?

- Boys are six times more likely than girls to have attention problems.
- An estimated 3% to 5% of school-age children have attention problems.
- Effects of attention problems

During the conversation, pick one situation at a time to discuss. For example, you might discuss how to pay attention during a classroom lesson, or you might discuss how to concentrate while doing homework. This approach will help you and your child focus on specific ways to improve his or her behavior in specific situations. Be sure to listen to your child, and avoid interrupting when he or she is talking.

When reviewing the strategies with your child, it can be helpful to **provide examples.** Choose examples that will be **meaningful** to your child. Keep in mind that examples that are appropriate for

Tools For Partnership

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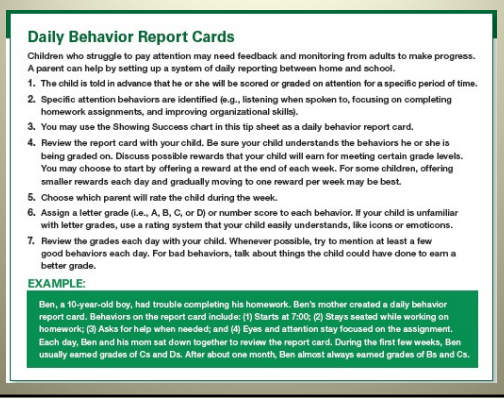
Multiple Steps and Examples



Daily Behavior Report Cards

Children who struggle to pay attention may need feedback and monitoring from adults to make progress. A parent can help by setting up a system of daily reporting between home and school.

1. The child is told in advance that he or she will be scored or graded on attention for a specific period of time.
2. Specific attention behaviors are identified (e.g., listening when spoken to, focusing on completing homework assignments, and improving organizational skills).
3. You may use the Showing Success chart in this tip sheet as a daily behavior report card.
4. Review the report card with your child. Be sure your child understands the behaviors he or she is being graded on. Discuss possible rewards that your child will earn for meeting certain grade levels. You may choose to start by offering a reward at the end of each week. For some children, offering smaller rewards each day and gradually moving to one reward per week may be best.
5. Choose which parent will rate the child during the week.
6. Assign a letter grade (i.e., A, B, C, or D) or number score to each behavior. If your child is unfamiliar with letter grades, use a rating system that your child easily understands, like icons or emoticons.
7. Review the grades each day with your child. Whenever possible, try to mention at least a few good behaviors each day. For bad behaviors, talk about things the child could have done to earn a better grade.

EXAMPLE:

Ben, a 10-year-old boy, had trouble completing his homework. Ben's mother created a daily behavior report card. Behaviors on the report card include: (1) Starts at 7:00; (2) Stays seated while working on homework; (3) Asks for help when needed; and (4) Eyes and attention stay focused on the assignment. Each day, Ben and his mom sat down together to review the report card. During the first few weeks, Ben usually earned grades of Cs and Ds. After about one month, Ben almost always earned grades of Bs and Cs.

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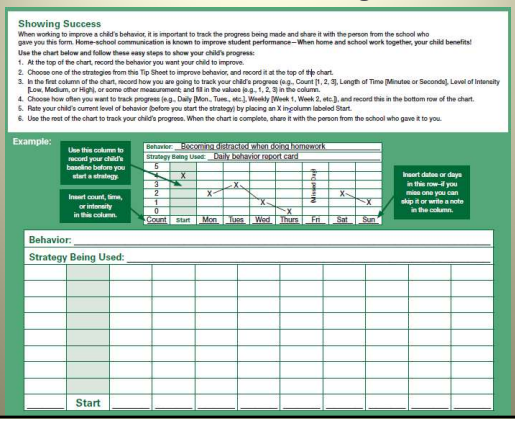
Communication with Caregivers


Showing Success

When working to improve a child's behavior, it is important to track the progress being made and share it with the person from the school who gave you this form. Home-school communication is known to improve student performance—When home and school work together, your child benefits!

Use the chart below and follow these easy steps to show your child's progress:

1. At the top of the chart, record the behavior you want your child to improve.
2. Choose one of the strategies from this Tip Sheet to improve behavior, and record it at the top of the chart.
3. In the first column of the chart, record how you are going to track your child's progress (e.g., Count [1, 2, 3], Length of Time [Minutes or Seconds], Level of Intensity [Low, Medium, or High], or some other measurement; and fill in the values (e.g., 1, 2, 3) in the column.
4. Choose how often you want to track progress (e.g., Daily [Mon., Tues., etc.], Weekly [Week 1, Week 2, etc.]), and record this in the bottom row of the chart.
5. Rate your child's current level of behavior (before you start the strategy) by placing an X in column labeled Start.
6. Use the rest of the chart to track your child's progress. When the chart is complete, share it with the person from the school who gave it to you.

Example:

Use this column to record your child's baseline before you start a strategy.

Insert count, time, or intensity in this column.

Behavior: Becoming distracted when doing homework

Strategy Being Used: Daily behavior report card

Insert dates or days in this row–if you miss one you can skip it or write a note in the column.

Behavior: _____

Strategy Being Used: _____

Start

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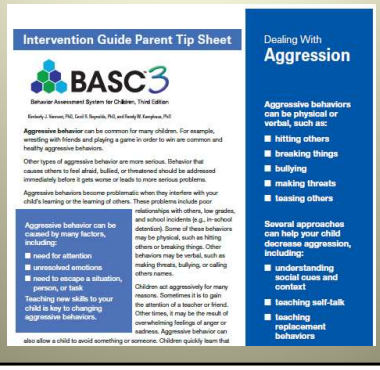
Tip Sheets Exist in All Areas of Concern


Intervention Guide Parent Tip Sheet

BASC-3

Behavior Assessment System for Children, Third Edition

Dealing With Aggression

Aggressive behavior can be common for many children. For example, wrestling with friends and playing a game in order to win are common and healthy aggressive behaviors.

Other types of aggressive behavior are more serious. Behavior that causes others to feel afraid, bullied, or threatened should be addressed immediately before it gets worse or leads to more serious problems.

Aggressive behaviors become problematic when they interfere with your child's learning or the learning of others. These problems include poor relationships with others, low grades, and school incidents (e.g., in-school detention). Some of these behaviors may be physical, such as hitting others or breaking things. Other behaviors may be verbal, such as making threats, bullying, or calling others names.

Children act aggressively for many reasons. Sometimes it is to gain the attention of a teacher or friend. Other times, it may be the result of overwhelming feelings of anger or sadness. Aggressive behavior can also allow a child to avoid something or someone. Children quickly learn that

Aggressive behavior can be caused by many factors, including:

- need for attention
- unresolved emotions
- need to escape a situation, person, or task

Teaching new skills to your child is key to changing aggressive behaviors.

Aggressive behaviors can be physical or verbal, such as:

- hitting others
- breaking things
- bullying
- making threats
- teasing others

Several approaches can help your child decrease aggression, including:

- understanding social cues and context
- teaching self-talk
- teaching replacement behaviors

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Educational Interventions: Strategies for Academic Success

Students with EBDs commonly lack learning and study and test taking strategies. E. g., For most students with ADHD, you will want to teach learning and study skills, strategic listening, time management, and organizational techniques—however, you can also assess such areas and tailor the teaching to the individual student. In Depression, note-taking and listening skills, writing and research skills, and test-taking skills most often deficient.

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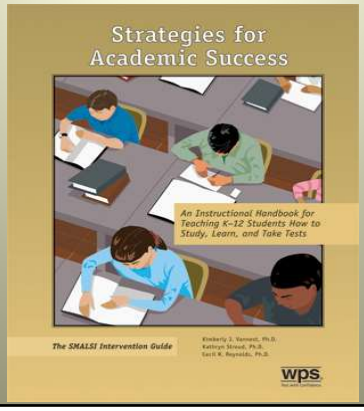
An Educational Intervention Manual



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This Intervention Manual Has 3 Sections

- **Section I: An Introduction to Learning Strategies**

Chapter 1: An Introduction to Learning Strategies: Assessment and Development

Chapter 2. The Research Evidence From the Education Sciences: How Teaching Learning and Study Strategies Enhances Learning

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Section II: Strategies for Developing Learning Strengths

7 Chapters—one for each of the following areas of academic skill.

How to teach:

Study Strategies
Writing and Research Strategies
Reading Comprehension Strategies
Note-taking Strategies
Listening Skills
Time Management and Organizational Strategies
Test-taking Strategies

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Ex. Chapter Outline; Section II

- Chapter 3. Teaching Study Strategies

Assessment of Study Strategies
What Are the Best Study Strategies?
Teaching the Best Study Strategies
Teaching Students to Improve Their Concentration When Studying
Teaching Students to Improve Memorization
Teaching Students to Develop Associations With Prior Learning
Teaching Students to Use Self-Talk During Study
Teaching Students to Use Concept Maps
Teaching Students to Use Multiple Sources of Information
Summary

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Section III: Strategies for Overcoming Academic Liabilities

3 Chapters—one for each of the following areas.

Teaching students to:

Understand and Ameliorate Test Anxiety
Develop Concentration and Attention Strategies
Increase Academic Motivation

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Section III: Strategies for Overcoming Academic Liabilities, ex.

- Chapter 11. Teaching Concentration and Attention Strategies
  Assessing Attention and Concentration in the Academic Setting
  What Are the Best Concentration and Attention Strategies?
  Teaching the Best Concentration and Attention Strategies
  Teaching Students to Organize Study
  Teaching Students Increase Focus
  Teaching Students Self-motivation to Concentrate
  Teaching Students to Self-advocate
  Teaching Students to Self-manage Attention and Concentration

Summary

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Also 2 Helpful Appendices

- Appendix A: Web Sites With Supplemental Information on Improving Learning and Study Strategies
- Appendix B: Reproducible Figures
- References

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Q: **What teaching strategies are most effective for teaching strategies?**

A: Education science says Direct Instruction is the best way to teach strategies for academic success and our teaching guidelines, scripts, and rubrics follow this method closely:

The most effective strategy for teaching strategies is clear, direct instruction that includes **4** components:

- Direct explanation
- Modeling by the teacher
- Guided practice
- Application and Evaluation

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We Must Monitor Intervention Effects

- Monitor quantitatively using instruments with known psychometric properties.
- Monitor on a regular schedule
- Avoid subjective approaches or informal surveys or checklists.
- You can use the Flex Monitor to make a sound monitoring scale that is case or program specific.

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BASC-3 Flex Monitor: What is it?

- A psychometrically sound means of developing user customized teacher and parent behavior rating scales and self-report of personality forms tailored to the needs of:
  1) the individual practitioner
  2) an individual case
  3) an individual program need
- **Reliability data and standardized scores are then obtainable for each unique form developed for your unique need.**

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BASC-3 Flex Monitor

- The BASC-3 Flex Monitor can be used to monitor behavioral and emotional functioning over a desired period of time
- Users will have the ability to:
  - Choose an existing monitoring form.
  - Create a form using an item bank.
  - Choose a rater (teacher, parent, or student).
  - Administer digital or paper forms.
  - Set up recurring administrations over a specified time period.
  - Generate monitoring reports to evaluate change over time.
  - Parent ratings and self-report are available in Spanish.

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Predetermined Forms You Can Choose

- 4 Standard forms with preselected items are available as Teacher and Parent Rating Scales for progress monitoring all on Q-global.
- Age-appropriate predetermined forms are available for monitoring behaviors associated with:
  1) Attention-Deficit/Hyperactivity Disorder (ADHD)
  2) Internalizing Problems
  3) Disruptive Behaviors, and
  4) Developmental Social Disorders.
- For self-report, 2 forms are available for monitoring behaviors associated with:
  1) Internalizing Problems, and
  2) School Problems.

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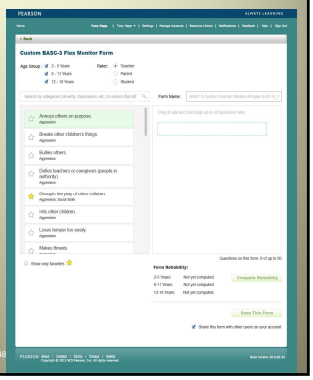
BASC-3 Flex Monitor – How does it work? You Build Your Own Custom Form

- **For custom forms, you choose from our item pool and start "building" a form.**
- **Items can be filtered/searched.**
- **When building the form, you can compute the estimated reliability of the form, based on the full BASC-3 standardization data sample.**
- **Adjustments can be made to the form based on the user's needs.**
- **You can share the form at any point with others or keep it private.**



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BASC-3 Flex Monitor – How does it work?

- Forms can be saved, and shared with other users within a school, clinic, or other hierarchy.
- Reliability data are provided to the creator of the form based on the BASC-3 standardization sample.
- Reports include T scores that are generated based on the TRS/PRS/SRP standardization samples
  - This enables comparisons with a normative population, describing the extremeness of scores on your unique form.
  - Intra-individual comparisons (i.e., comparing time 1 vs. time 2, time 3, etc.) are also provided.
  - Comparisons are based on reliable change metrics.

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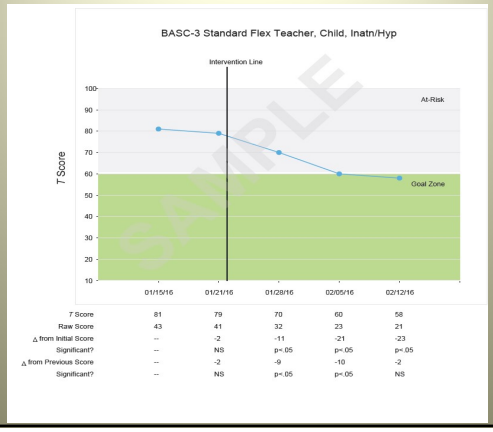
Sample Graph from Flex Monitor Report



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BASC-3 Flex Monitor – Why choose the Flex Monitor?

- Its premise is based on the authors' desires to move the field toward better practice and to make you more efficacious in your work.
- Forms can be created for monitoring program success as well as individual success or change. This equates to Customized forms for personalized scenarios.
- Over 700 items can be used to create forms that are tailored to specific monitoring situations.
- Items can be filtered by form type, child's age, or behavior type (e.g., aggression, internalizing problems, etc.).
- Forms are created using heavily vetted, validated items with known characteristics and content relevance, e. g.
- **All 700+ items have been:**

- Professionally edited.
- Vetted by clinicians for content and construct consistency.
- Subjected to extensive item analyses, including statistical evaluations for gender and ethnic bias.
- Equated at the item level for equivalent applications in English and in Spanish.

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Why the Flex Monitor, cont.?

- No need for informal assessments or guesstimates of the accuracy of change—or guessing if you have written items that are culturally biased or gender biased.
- In every other area of assessment, psychometric properties of the instruments being used are paramount; however, we tend to ignore them when using monitoring tools.
- **Comprehensive Reporting:**

Individual reports include comparisons of current scores to a baseline. Graphs provide a snapshot of how a student is performing over time, including a trend analysis of scores to help evaluate pre-intervention levels of functioning (when available), and student performance over time.

- The BASC-3 Flex Monitor is a unique offering that is simply unmatched elsewhere.

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Which leads to prompter report writing too!!

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Writing Effective Reports

- We write reports for different purposes in different settings. There is also a natural tension between writing a report that relevant audience members will read in its entirety and preparing an archival document for future reference—however, the latter is why we have appendices!! Over many more years than I want to admit of both writing reports and teaching report writing to doctoral students, I have boiled it down to what I think are six key principles of writing a report that is readable, and that can help the client.

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Cecil's 6 Things to do to Write Reports People Will Read

- **Write individualized reports.**

Understand that there is no such thing to the person you are writing about as a routine report. If we do not as psychologists understand this, who can? Use no fill-in-the blank templates or macros. If you feel this simply takes too long, checkout current dictation software. Dictation software over the last 4-5 years has become amazingly accurate, will learn your nuances and vocabulary quickly, and can keep up with you pretty much no matter how fast you talk. Dictation and a quick review and edit go pretty fast with minimal practice.

- **Write about people, not tests.**

I hate to read a psychological report that is simply a test recital and especially one that fails to integrate all of the testing results with the history and interview into a complete picture of a person. Not every task needs to be described in detail and not every score needs to be reported in a table or narrative text. Use Appendices if you feel compelled to report at that level of detail—obviously the more salient and influential tasks upon which you draw important conclusions should be emphasized in the body of a report, but be clear and be succinct.

- **Tell the story of the person.**

Who doesn't like a good story!! And who better to tell the story of a person's development and life and why they were seen than a psychologist. Storytelling is also one of the oldest, if not the oldest, means of effective transition of knowledge—and it is still very effective in getting across your findings and recommendations.

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Cecil's 6 Things to do to Write Reports People Will Read, cont….

- **Be accurate.**

Never confuse clients (templates will eventually catch up with you). Be certain that all of the scores you report or otherwise rely on are accurate and that you have checked everything for clerical errors. Having had a forensic practice for more than 35 years, I can hardly count the number of times I have found clerical and related errors in score reporting, ranging from table look ups to addition errors or just transposition mistakes.

- **Write using proper grammar, spelling, and formal writing conventions.**

Write like a competent, well-educated professional (which you are), and understand all of the above will affect your credibility, one way or another. You get to choose which way.

- **Have a great ending that addresses the referral question and gives both hopeful and helpful guidance to the reader.**

If you do not address the referral question clearly, you simply have not done your job. If you want to argue the referral question was vague, then you haven't done your job either. Be sure you are clear on the expectations for the psychological testing or assessments done before you evaluate, and know what the expectations of the referral source are specifically—and address them thoroughly. Hopeful and helpful guidance translates to a happy ending—and who doesn't like that!

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Q&A??

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THE END!!

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