BASC™ 4

Behavior Assessment System for Children, Fourth Edition

Behavior Assessment System for Children, Fourth Edition (BASC™-4)
BASC-4 Teacher Rating Scales-Adolescent
Interpretive Summary Report with Intervention Recommendations
Cecil R. Reynolds, PhD, & Randy W. Kamphaus, PhD

Child Information		Test Information	
ID:		Test date:	20/05/2026
Name:	Sample Report	Rater name:	Sample Report
Sex:	Male	Rater position:	Regular-education teacher
Birth date:	09/05/2014	Time known child:	3-5 months
Age:	12:0	Admin. language:	English
Grade:			
School:			

Normative reference group 1: General separate sex
Normative reference group 2: General combined sex

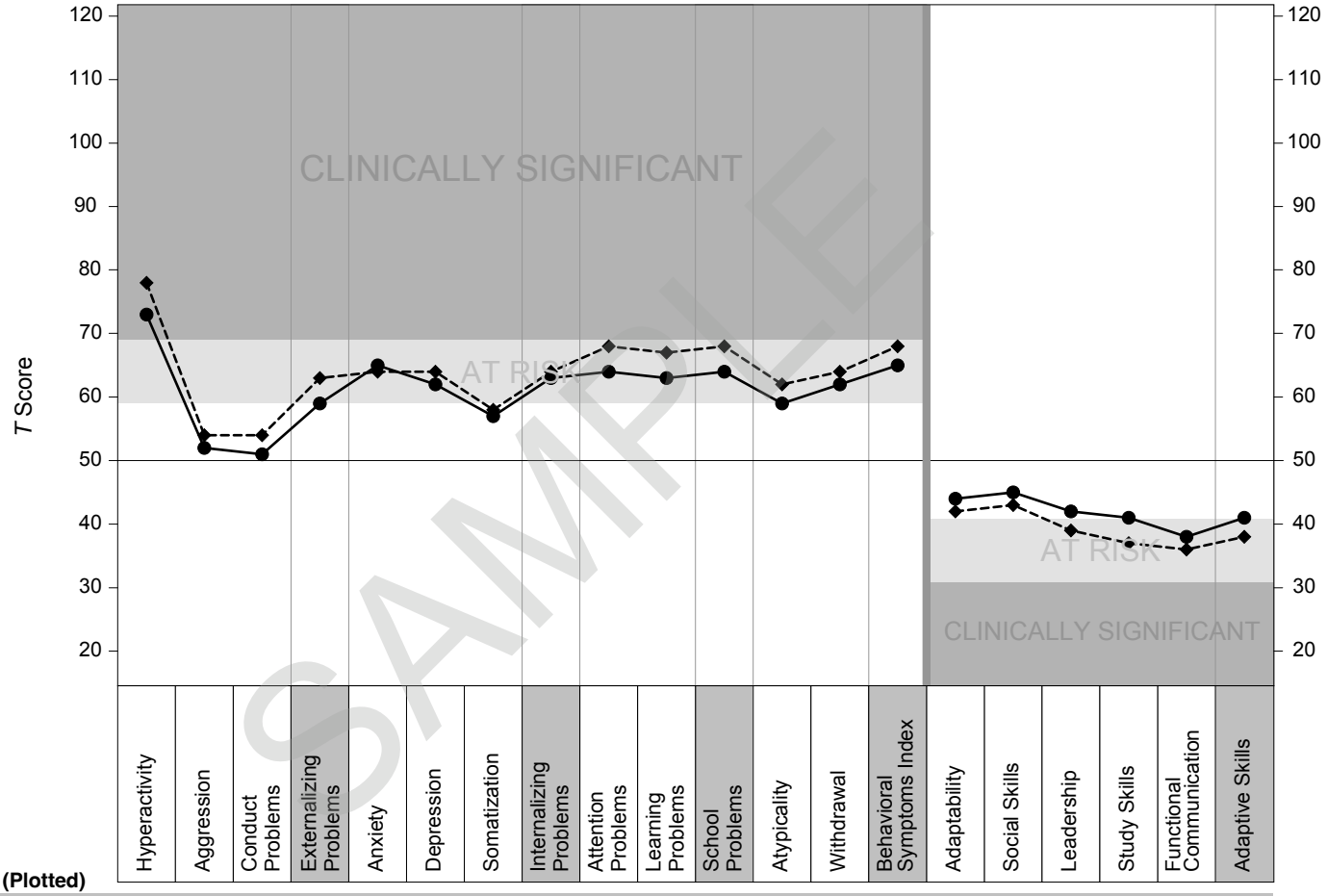
[1.0 / RE1 / QG1]

Pearson

VALIDITY INDEX SUMMARY

F	Consistency	Response Pattern
Acceptable	Acceptable	Acceptable
Raw score: 1	Raw score: 9	Raw score: 102

COMPOSITE AND PRIMARY SCALE *T*-SCORE PROFILE



T Score (Plotted)	Hyperactivity	Aggression	Conduct Problems	Externalizing Problems	Anxiety	Depression	Somatization	Internalizing Problems	Attention Problems	Learning Problems	School Problems	Atypicality	Withdrawal	Behavioral Symptoms Index	Adaptability	Social Skills	Leadership	Study Skills	Functional Communication	Adaptive Skills
● Gen. separate sex	73	52	51	59	65	62	57	63	64	63	64	59	62	65	44	45	42	41	38	41
◆ Gen. combined sex	78	54	54	63	64	64	58	64	68	67	68	62	64	68	42	43	39	37	36	38
Percentile																				
Gen. separate sex	96	75	67	84	92	89	87	90	89	87	88	88	88	91	29	36	23	24	16	24
Gen. combined sex	97	81	76	89	90	91	87	91	93	92	93	91	90	94	23	27	17	15	12	15

COMPOSITE AND PRIMARY SCALE SCORE TABLE: General Separate Sex

Composite Scale Score Summary

	Raw score	*T* score	Percentile rank	90% *T*-score confidence interval
Externalizing Problems	176	59	84	57-61
Internalizing Problems	184	63	90	60-66
School Problems	127	64	88	61-67
Behavioral Symptoms Index	372	65	91	63-67
Adaptive Skills	210	41	24	39-43

Primary Scale Score Summary

	Raw score	*T* score	Percentile rank	90% *T*-score confidence interval	Ipsative comparison of *T* scores		
					Difference	Significance level of difference	Frequency of difference
Hyperactivity	24	73	96	69-77			
Aggression	5	52	75	48-56			
Conduct Problems	5	51	67	47-55			
Anxiety	10	65	92	60-70			
Depression	12	62	89	57-67			
Somatization	3	57	87	52-62			
Attention Problems	23	64	89	60-68			
Learning Problems	15	63	87	59-67			
Atypicality	7	59	88	54-64			
Withdrawal	10	62	88	57-67			
Adaptability	13	44	29	40-48			
Social Skills	12	45	36	41-49			
Leadership	7	42	23	37-47			
Study Skills	10	41	24	38-44			
Functional Communication	13	38	16	33-43			

Note. Consider the standard error of measurement (*SEM*) when making classification decisions and review all case-related information to determine the appropriateness of a classification. See the *BASC-4 Manual* for additional interpretive guidelines. Ipsative comparisons are only available when using the general combined-sex normative reference group.

VALIDITY INDEX NARRATIVES

The BASC-4 TRS includes three validity indexes (F Index, Consistency Index, and Response Pattern Index) that examine different aspects of the responses provided that could negatively impact scale interpretation.

The F Index is within the **Acceptable** range indicating the responses provided are not considered overly negative. The Consistency Index is within the **Acceptable** range indicating that similar responses were provided to items that are typically answered in a similar way. In addition, the Response Pattern Index is within the **Acceptable** range, indicating no unusual response patterns were identified. Responses for all items are available at the end of this report. Carefully review each response set before interpreting the scales and indexes included in this report; see the *BASC-4 Manual* for further interpretive guidance.

VALIDITY INDEX ITEM LISTS

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

F Index
The F Index rating is Acceptable.

Consistency Index
The Consistency Index rating is Acceptable.

COMPOSITE AND PRIMARY SCALE NARRATIVES

This report is based on Sample Report's rating of Sample's behavior using the BASC-4 form. The narrative and scale classifications in this report are based on *T* scores obtained using normative reference samples. Scale scores in the Clinically Significant classification range suggest a high level of maladjustment. Scores in the At-Risk classification range may identify a significant problem that may not be severe enough to require formal treatment or may identify the potential of developing a problem that needs careful monitoring.

Externalizing Problems

The Externalizing Problems composite scale *T* score is 59 with a 90% confidence interval range of 57-61 and a percentile rank of 84.

Sample's *T* score on the Hyperactivity scale is 73 with a percentile rank of 96. This *T* score is within the Clinically Significant classification range and usually warrants follow-up. Sample's teacher reports that Sample engages in many behaviors that are adversely affecting other children in the classroom. Sample is often restless, overactive, and/or impulsive. This behavior, along with the elevated Attention Problems scale score, Executive Functioning scale score, and ADHD Probability Index, warrants strong consideration of an ADHD-related disorder.

Sample's *T* score on the Aggression scale is 52 with a percentile rank of 75. Sample's teacher reports that Sample tends not to act aggressively any more often than others the same age.

Sample's *T* score on the Conduct Problems scale is 51 with a percentile rank of 67. Sample's teacher reports that Sample demonstrates rule-breaking behavior no more often than others the same age.

Internalizing Problems

The Internalizing Problems composite scale *T* score is 63 with a 90% confidence interval range of 60-66 and a percentile rank of 90. Sample's *T* score on this composite scale is within the At-Risk classification range.

Sample's *T* score on the Anxiety scale is 65 with a percentile rank of 92. This *T* score is within the At-Risk classification range and follow-up may be necessary. Sample's teacher reports that Sample sometimes displays behaviors stemming from worry, nervousness, and/or fear. When considering the presence of an anxiety-related disorder, administration of the BASC-4 Structured Developmental History is recommended to aid in establishing the presence of such a disorder and/or to help differentiate among other disorders.

Sample's *T* score on the Depression scale is 62 with a percentile rank of 89. This *T* score is within the At-Risk classification range and follow-up may be necessary. Sample's teacher reports that Sample is at times withdrawn, pessimistic, and/or sad. Scores in this range may warrant assessment of vegetative symptoms (e.g., weight loss or gain, fatigue).

Sample's *T* score on the Somatization scale is 57 with a percentile rank of 87. Sample's teacher reports that Sample complains of health-related problems about as often as others the same age.

School Problems

The School Problems composite scale *T* score is 64 with a 90% confidence interval range of 61-67 and a percentile rank of 88. Sample's *T* score on this composite scale is within the At-Risk classification range.

Sample's *T* score on the Attention Problems scale is 64 with a percentile rank of 89. This *T* score is within the At-Risk classification range and follow-up may be necessary. Sample's teacher reports that Sample has difficulty maintaining necessary levels of attention at school. The problems experienced by Sample might disrupt academic performance and functioning in other areas.

Sample's *T* score on the Learning Problems scale is 63 with a percentile rank of 87. This *T* score is within the At-Risk classification range and follow-up may be necessary. Sample's teacher reports that Sample has difficulty comprehending and completing schoolwork in a variety of academic areas.

Behavioral Symptoms Index

The Behavioral Symptoms Index (BSI) composite scale *T* score is 65 with a 90% confidence interval range of 63-67 and a percentile rank of 91. Sample's *T* score on this composite scale is within the At-Risk classification range. Scale summary information for the Hyperactivity, Aggression, Depression, and Attention Problems scales (included in the BSI) has been provided previously. Scale summary information for the remaining BSI scales is given next.

Sample's *T* score on the Atypicality scale is 59 with a percentile rank of 88. Sample's teacher reports that Sample generally displays clear, logical thought patterns and general situational awareness.

Sample's *T* score on the Withdrawal scale is 62 with a percentile rank of 88. This *T* score is within the At-Risk classification range and follow-up may be necessary. Sample's teacher reports that Sample tends to avoid social contact, is seemingly alone, has difficulty making friends, and/or is sometimes unwilling to join group activities.

Adaptive Skills

The Adaptive Skills composite scale *T* score is 41 with a 90% confidence interval range of 39-43 and a percentile rank of 24.

Sample's *T* score on the Adaptability scale is 44 with a percentile rank of 29. Sample's teacher reports that Sample adapts to a variety of situations as well as most others the same age.

Sample's *T* score on the Social Skills scale is 45 with a percentile rank of 36. Sample's teacher reports that Sample possesses sufficient social skills and generally does not experience problems interacting with others.

Sample's *T* score on the Leadership scale is 42 with a percentile rank of 23. Sample's teacher reports that, when compared to others the same age, Sample demonstrates a typical level of creativity, an ability to work under pressure, and/or an ability to bring others together to complete a work assignment.

Sample's *T* score on the Study Skills scale is 41 with a percentile rank of 24. Sample's teacher reports that Sample generally exhibits adequate organizational and study skills and completes most homework in a timely fashion.

Sample's *T* score on the Functional Communication scale is 38 with a percentile rank of 16. This *T* score is within the At-Risk classification range and follow-up may be necessary. Sample's teacher reports that Sample experiences some difficulty expressing ideas and communicating in a way that others can easily understand.

BASC-4 TRS-A INTERVENTION RECOMMENDATIONS

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

Primary Improvement Areas	Secondary Improvement Areas	Adaptive Skill Strengths
- Hyperactivity	- Anxiety - Attention Problems - Learning Problems (Academic Problems) - Depression - Withdrawal (Anxiety) - Functional Communication	- None

Sample's score on Hyperactivity falls in the clinically significant range and probably should be considered among the first behavioral issues to resolve. Sample's scores on Anxiety and Attention Problems are also elevated and may warrant targeted interventions and/or further monitoring to ensure they don't worsen.

Note that Sample has scores on Learning Problems (Academic Problems), Depression, Withdrawal (Anxiety), and Functional Communication that are areas of concern. Interventions for these areas are not provided in this report. However, these areas may require additional follow up.

Sample's BASC-4 profile indicates significant problems with Hyperactivity, Anxiety, and Attention Problems. Based on Sample Report's ratings, Sample is experiencing problems with the following behaviors:

Hyperactivity

- leaving seat
- disrupting others
- having poor self-control
- being overly active
- not waiting for turn

Anxiety

- worrying about things

Attention Problems

- paying attention
- listening well
- staying focused
- staying organized
- making careless mistakes
- missing deadlines

Primary Improvement Area: Hyperactivity

Hyperactivity problems are considered to be one of Sample's most significant behavioral and emotional areas to address. The *DSM-5-TR*™ lists symptoms such as fidgeting and squirming, leaving a seat unexpectedly, running

or climbing inappropriately, failing to stay quiet, having difficulty waiting for a turn, or frequently interrupting and intruding socially. Hyperactivity problems can occur alone or can co-occur with attention problems and are usually exhibited by children in both home and school settings.

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

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

Detailed summaries of the Contingency Management and Self-Management intervention strategies are provided below. See the BASC-3 Behavior Intervention Guide for more information about these strategies and the other intervention strategies listed above.

Hyperactivity Intervention Option 1: Contingency Management

In contingency management for hyperactivity, behavioral interventions are used to modify consequent events that maintain hyperactive and impulsive behavior. Contingency management involves shaping the child's existing behavior and providing opportunities for the new, desired behavior to become internalized. Contingency management programs for hyperactivity include the individual or combined use of behavioral intervention strategies such as token economies; point systems; verbal praise; response cost; timeout from peers, reinforcers, attention, or privileges; varying amounts and frequency of teacher attention; verbal reprimands; and removal of praise. The goal of contingency management is to decrease the child's activity levels that negatively impact learning by reshaping the environment to reinforce or eliminate behaviors.

The essential elements of Contingency Management include the following:

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

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

PREP

- Select a behavior to target. There may be several that are problematic, but only choose one to start.
- Define the child's behavior in operational terms.
- Identify who will record baseline data on the frequency (i.e., how often) and/or severity (i.e., how much) of the hyperactivity. Use this information as a sample of functioning (e.g., length of time child remains seated, amount of time child waits before blurting out an answer) before the intervention to permit evaluation of the degree of post-intervention improvement.

- Consider the child's preference for reinforcers. For example, if the child enjoys computer games, computer time can be earned or lost. Reinforcement surveys can help to determine reinforcers that are appropriate and meaningful to the child.

IMPLEMENT

- Use the baseline data to set behavioral goals. Common goals include increasing the amount of time spent on task or decreasing the amount of off-task behavior during a specific interval. Modest increases in the amount of time spent on task, such as 20%, are more appropriate than large increases, such as 100%. If age appropriate, review the goals with the child or have the child participate in goal setting.
- Review the rules for providing reinforcers and ensure the child understands them by asking the child to repeat them back or to demonstrate when contingencies will occur and for what.
- Use a 1:1 ratio of behavior to reinforcement (i.e., every time the child performs the appropriate behavior, reinforce it) when teaching new skills. If the behavior is a performance problem and not a skill problem, then it may be sufficient to reinforce less frequently (e.g., one out of three times the child performs the appropriate behavior). Intermittent intervals may also work, such as providing a non-scheduled ratio of reinforcement to behavior.
    * Consider using tokens or points that can be cashed in for reinforcers at the end of a specified time period as a modification to the intervention if necessary. Token systems are typically more effective once basic behavioral goals have been met, and the tokens can be used to maintain the behavior.
- Use an electronic or paper visual aid to track behavior. This will assist the child in understanding progress and which specific behaviors are being targeted.
- Provide the reinforcer to the child when they meet the goal. Do not provide the reinforcer if the goal is not met. Previously earned reinforcers, such as tokens, may be taken away when a goal is not met.

EVALUATE

- Collect and examine data during the use of contingency management. You should expect to see large changes in behavior in a few days. If you do not, reconsider the implementation. Ensure reinforcement opportunities are consistent and not missed. If it seems that reinforcement opportunities have been inconsistent or missed, revisit the implement phase.
- Remain aware of the potential for satiation or boredom with a reinforcer, such as filling up on candy or getting tired of listening to music.
    * After consistent effects are established, thin and fade the schedule of reinforcement to become more unpredictable and more irregular over time to avoid creating dependency on rewards to obtain appropriate behavior.

Hyperactivity Intervention Option 2: Self-Management

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

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

1. Teach the child to monitor their own activity level.

2. Teach the child to record their own activity level.
3. Teach the child to check against self-determined goals.
4. Teach the child to reinforce themself.

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

PREP

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

IMPLEMENT

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

EVALUATE

- If an adult was monitoring the child at the same time, ask the child and adult to compare their recording forms.
    * Place scores on a single graph to facilitate the comparison.
    * Discuss if the scores are dramatically different allowing for some degree of error is acceptable and expected.
    * Highly praise and encourage perfectly matched scores as a goal depending on the number of intervals.

- Encourage the child to self-reinforce the behavior both for displaying appropriate activity levels and consistently and accurately recording the replacement behavior. Reinforcement is phased out as naturally occurring reinforcement takes place (e.g., better grades, better skills, less discipline in classrooms).

Secondary Improvement: Anxiety

Anxiety is considered one of Sample's most significant behavioral and emotional problems. Anxiety disorders are characterized by excessive worry, nervousness, specific or general fears or phobias, and self-deprecation. Children who have anxiety disorders may feel overwhelmed easily; feel a sense of dread; and suffer from obsessive, intrusive, and bothersome thoughts. Anxiety disorders are often accompanied by somatic complaints, and anxiety may itself be a symptom of depression.

Interventions for childhood anxiety - in particular, fears and phobias - are among the oldest evidence-based psychological treatments. A variety of interventions have been shown to reduce, or show promise for reducing, feelings of anxiety. Specific phobias (e.g., fear of dogs, school, water) are typically treated with behavioral interventions, whereas cognitive-behavioral interventions are often used for general anxiety disorders. Several intervention strategies have been shown to effectively remediate anxiety, including:

- Cognitive-Behavioral Therapy Integrated Approach
- Cognitive Restructuring
- Contingency Management
- Exposure-Based Techniques
- Family Therapy
- Modeling
- Psychoeducational Approach
- Relaxation Training
- Self-Monitoring and/or Self-Assessment

Detailed summaries of the Contingency Management and Modeling intervention strategies are provided below. See the BASC-3 Behavior Intervention Guide for more information about these strategies and the other intervention strategies listed above.

<u>Anxiety Intervention Option 1: Contingency Management</u>

As an intervention for anxiety, Contingency Management relies on the use of natural consequences and reinforcers for reducing anxieties associated with specific behaviors or events. Contingency management for anxiety includes shaping, positive reinforcement, and extinction. Its goal is to alter the child's anxious or fear-based behavior by eliminating the contingencies that support them and by creating more powerful contingencies for replacement behavior.

The essential elements of Contingency Management include the following:

1. Identify contingencies currently maintaining the problem behavior resulting from the anxiety.
2. Ignore problem behavior and eliminate any prior contingencies maintaining undesirable behavior.
3. Institute frequent and powerful reinforcers for engaging in the desirable behavior.

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

PREP

- Identify the specific anxiety-related behaviors to be addressed.
- Ask the child to choose from an existing list of preferred reinforcers.
- Create a reinforcement schedule.
- Determine appropriate consequences for maladaptive behaviors (e.g., what will happen if the child responds to anxiety by throwing a tantrum, destroying property, or refusing to engage in a desired activity).

IMPLEMENT

- Review the reinforcement schedule with the child.
- Review the consequences for maladaptive behaviors with the child.
- Use shaping techniques (i.e., reinforce successive approximations to engage in the desired behavior) during the initial stages of treatment.
- Replace tangible reinforcers with social reinforcers. This transition should be planned and gradual at a pace designed to meet the needs of the child while maintaining the effect of the reinforcement for appropriate behavior.

EVALUATE

- Monitor and record the frequency of inappropriate and appropriate behaviors.
- Monitor the strategy use frequency if changes are not at the desired level.
- Reassess the reinforcer strength and reinforcement schedule if the strategy is implemented faithfully with poor results. Consider aspects such as: Is the reinforcement schedule a 1:1 ratio? Is shaping needed? Is the reinforcement maintaining interest?

Anxiety Intervention Option 2: Modeling

Showing children examples of successful outcomes in anxiety-provoking situations can effectively reduce anxiety-related beliefs and behaviors. The goals of modeling are to reduce the child's anxiety by demonstrating the event and consequences in a non-anxiety-provoking manner and to help the child acquire a new skill to handle the anxiety.

The essential elements of Modeling include the following:

1. Identify the anxiety-provoking scenario.
2. Present the scenario live or using a video in a way that demonstrates a desirable and successful outcome.
3. Have the anxious child narrate or debrief the events that happened during modeling and practice what was learned.

The procedural steps for incorporating modeling strategies in the treatment of anxiety problems are summarized below. See the BASC-3 Behavior Intervention Guide for a detailed discussion of this topic.

PREP

- Identify the anxiety-related problem.
- Determine if live or video models will be used.
- Create or acquire a video and any props needed for modeling or recording video.

IMPLEMENT

- Assess the child's current responses to the anxiety-related situation.
- Identify, describe, and discuss the anxiety problem with the child.
- Discuss the concept of watching a model and how it can assist in reducing anxiety.
- Reassure the child that nothing bad will happen during the demonstration.
- Show the child an anxiety-provoking situation or event using live or recorded models.
- Discuss with the child the events in the demonstration.
- Identify the antecedents to the event, the event itself, and the consequences of the event.
- Ask the child to identify the responses and behaviors used by the models that would feel comfortable.
- Ask the child to describe how they would engage in such responses and behaviors.
- Practice the desired responses and behaviors with the child.
- Ask the child (and/or involved adults as appropriate) to track the child's responses to the anxiety-provoking situation.

EVALUATE

- Monitor changes in the child's responses to the anxiety-provoking situation.
- Review practice sessions.
- Provide additional modeling as necessary and appropriate.
- Provide feedback as needed.

Secondary Improvement Area: Attention Problems

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

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

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

Detailed summaries of the Daily Behavior Report Cards and Modified Task-Presentation intervention strategies are provided below. See the BASC-3 Behavior Intervention Guide for more information about these strategies and the other intervention strategies listed above.

Attention Problems Intervention Option 1: Daily Behavior Report Cards

Daily behavior report cards (DBRCs) are used to record a child's behavior each day. The goal in implementing a DBRCs strategy is to change behavior by providing systematic feedback on performance and progress to children and parents, followed by appropriate reinforcement. The result is increased attention (or decreased inattention) during specific tasks and conditions.

The essential elements of DBRCs include the following:

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

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

PREP

- Identify the target behaviors for improving attention.
- Identify the rater of the target behavior.
- Identify if the DBRC will be used for communication, monitoring, or performance feedback, and if it will involve contingencies. Contingencies may be delivered at school during feedback sessions and at home for performance at school.
- Create and explain the rating system to raters. For example, assign a letter grade to the child's performance for each day. Each target behavior is rated daily. Letter grades (instead of frequency of behavior, for example) are preferable because they are usually more meaningful to children and parents.
- Explain the behavioral anchors (i.e., typical behavior for earning each grade) to avoid variance among raters or differences in personal tolerance levels. For example, attending during 10 out of 20 minutes of class time may earn a "C," 15 minutes may earn a "B," and 17 minutes or more might earn an "A."

IMPLEMENT

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

EVALUATE

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

* Changes in behavior should be moderate to large when the intervention is used throughout the day.

- Ensure reinforcement has been used consistently if the change is not moderate to large. Reassess reinforcer quality and feedback quality. Consider graphing or charting performance goals if those visual aids are not currently in place.

Attention Problems Intervention Option 2: Modified Task-Presentation

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

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

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

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

PREP

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

IMPLEMENT

- Present the task using the modified strategy.

EVALUATE

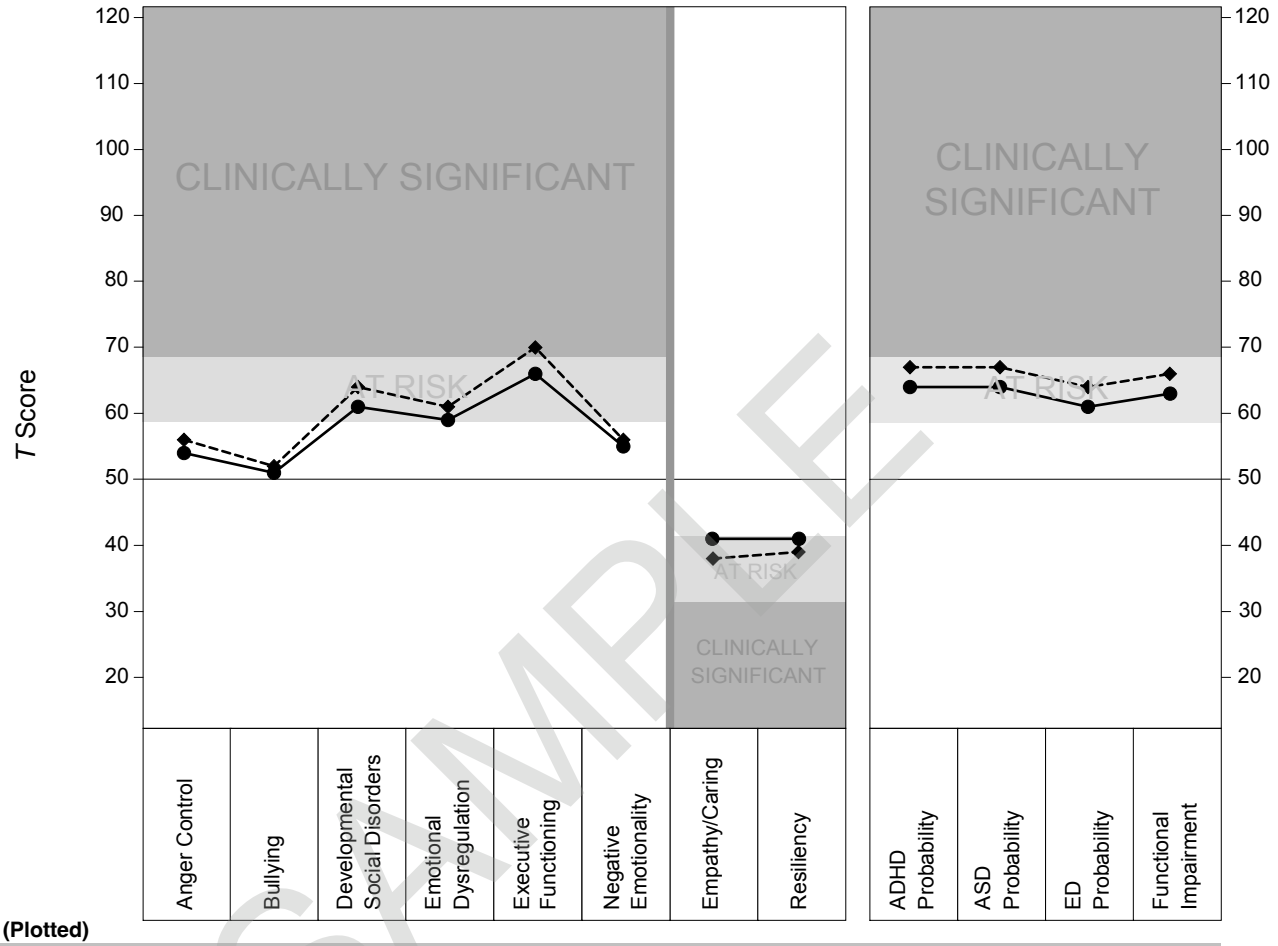
- Engage in direct observation of the child's attention problems and class performance as a whole.
- Determine which modifications seem to have the greatest positive impact and which are ineffective using observational data. Continue use of those modifications that are effective, and discontinue those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

Concluding Recommendations

When using any intervention, it is important to monitor the effectiveness of the interventions you are trying. Regardless of the method used to monitor progress, it is important to document the effectiveness of the interventions you have tried with Sample. The BASC-3 Behavior Intervention Guide Documentation Checklist is designed to facilitate the recording of the steps that have been taken to remediate or manage a child's behavioral or emotional problem(s). It also includes a section to record the fidelity of the intervention approach that has been

used, a factor that is critical to the success of any intervention program.

CONTENT SCALE AND CLINICAL INDEX *T*-SCORE PROFILES



***T* Score (Plotted)**												
● Gen. separate sex	54	51	61	59	66	55	41	41	64	64	61	63
◆ Gen. combined sex	56	52	64	61	70	56	38	39	67	67	64	66
Percentile												
Gen. separate sex	79	70	87	85	93	75	20	23	89	92	87	87
Gen. combined sex	84	77	90	87	95	79	14	16	92	93	89	91

CONTENT SCALE SCORE TABLE: General Separate Sex

	Raw score	*T* score	Percentile rank	90% *T*-score confidence interval
Anger Control	5	54	79	50-58
Bullying	3	51	70	47-55
Developmental Social Disorders	19	61	87	56-66
Emotional Dysregulation	10	59	85	54-64
Executive Functioning	45	66	93	63-69
Negative Emotionality	9	55	75	51-59
Empathy/Caring	32	41	20	37-45
Resiliency	18	41	23	37-45

CONTENT SCALE NARRATIVES

Sample's *T* score on the Anger Control scale is 54 with a percentile rank of 79. Sample's teacher reports that Sample has average self-control and ability to regulate affect compared to others the same age.

Sample's *T* score on the Bullying scale is 51 with a percentile rank of 70. Sample's teacher reports that Sample does not tend to act in a threatening or intrusive manner.

Sample's *T* score on the Developmental Social Disorders scale is 61 with a percentile rank of 87. This *T* score is within the At-Risk classification range and follow-up may be necessary. Sample's teacher reports that Sample has some problems concerning social skills and communication.

Sample's *T* score on the Emotional Dysregulation scale is 59 with a percentile rank of 85. Sample's teacher reports that Sample has average control over reactions to environmental changes compared to others the same age.

Sample's *T* score on the Executive Functioning scale is 66 with a percentile rank of 93. This *T* score is within the At-Risk classification range and follow-up may be necessary. Sample's teacher reports that Sample has difficulty controlling behavior and thoughts compared to others the same age.

Sample's *T* score on the Negative Emotionality scale is 55 with a percentile rank of 75. Sample's teacher reports that Sample reacts to changes in everyday activities or routines in a manner that is typical of others the same age.

Sample's *T* score on the Empathy/Caring scale is 41 with a percentile rank of 20. Sample's teacher reports that Sample typically demonstrates empathy and concern for others about as well as others the same age.

Sample's *T* score on the Resiliency scale is 41 with a percentile rank of 23. Sample's teacher reports that Sample is able to overcome stress and adversity about as well as others the same age.

EMOTIONAL DISTURBANCE QUALIFICATION (EDQ) SCALES SUMMARY

The EDQ scales were developed to reflect clinical and adaptive scale combinations that are grouped specifically to align with the constructs of an emotional disturbance (ED) as represented in the federal Individuals with Disabilities Education Act (IDEA; 2004) disability definition[1]. These constructs serve as the minimum criteria used to determine a student's eligibility for special-education and related services under the classification of an ED. Because of the breadth of information provided by the BASC-4, examiners are advised to consider other BASC-4 content and primary scales, the history of the behaviors they measure, and the duration of any behavioral or emotional problems when making special-education and related services eligibility recommendations.

Emotional Disturbance Qualification (EDQ) scales	Raw score	*T* score	Percentile rank	90% *T*-score confidence interval	Classification
EDQ 1: Unsatisfactory Interpersonal Relationships	339	58	78	56-60	Average
EDQ 2: Inappropriate Behavior/Feelings	423	62	89	60-64	At Risk
EDQ 3: Unhappiness or Depression	117	59	83	56-62	Average
EDQ 4: Physical Symptoms or Fears	122	62	90	58-66	At Risk
EDQ 5[2]: Schizophrenia and Related Disorders of Thought	313	65	91	63-67	At Risk
Social Maladjustment indicator					Absent

[1] The EDQ scales cover five of the six ED criteria as defined by IDEA (2004). The first criteria (An inability to learn that cannot be explained by intellectual, sensory, or health factors) is not covered by the BASC-4.

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

EMOTIONAL DISTURBANCE QUALIFICATION (EDQ) SCALES NARRATIVES

EDQ 1: Unsatisfactory Interpersonal Relationships
Sample's *T* score on the Unsatisfactory Interpersonal Relationships Composite scale is 58 and has a percentile rank of 78. Sample reports Sample having satisfactory interpersonal relationships with others compared to same-age peers.

EDQ 2: Inappropriate Behavior/Feelings
Sample's *T* score on the Inappropriate Behavior/Feelings Composite scale is 62 and has a percentile rank of 89. This *T* score is within the At-Risk classification range and follow-up assessment or intervention may be necessary. Sample reports Sample displays some inappropriate behaviors or feelings under normal circumstances more often than same-age peers.

EDQ 3: Unhappiness or Depression
Sample's *T* score on the Unhappiness or Depression Composite scale is 59 and has a percentile rank of 83. Sample reports Sample displays no signs of pervasive unhappiness or depressive mood when compared to same-age peers.

EDQ 4: Physical Symptoms or Fears
Sample's *T* score on the Physical Symptoms or Fears Composite scale is 62 and has a percentile rank of 90. This *T* score is within the At-Risk classification range and follow-up assessment or intervention may be necessary. Sample reports Sample displays physical symptoms or fears associated with personal or school problems moderately more often than same-age peers.

EDQ 5: Schizophrenia and Related Disorders of Thought
Sample's *T* score on the Schizophrenia and Related Disorders of Thought Composite scale is 65 and has a percentile rank of 91. This *T* score is within the At-Risk classification range and follow-up assessment or intervention may be necessary. Sample reports Sample shows some elevated levels of atypical or withdrawn behavior and may struggle with functional communication compared to same-age peers.

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

CLINICAL INDEX SCORE TABLE: General Separate Sex

	Raw score	*T* score	Percentile rank	90% *T*-score confidence interval
ADHD Probability Index	24	64	89	60-68
ASD Probability Index	13	64	92	60-68
ED Probability Index	16	61	87	57-65
Functional Impairment Index	50	63	87	60-66

CLINICAL INDEX NARRATIVES

The ADHD Probability Index *T* score is 64 with a percentile rank of 89 and is within the At-Risk classification range. This *T* score is similar to scores obtained by children diagnosed with ADHD. Additionally, the Hyperactivity scale score is within the Clinically Significant classification range and both the Attention Problems and Executive Functioning scale scores are within the At-Risk classification range. If an ADHD diagnosis is being considered, additional evaluation using the BASC-4 Narrowband Scales ADHD Forms is recommended along with the completion of the BASC-4 Structured Developmental History.

The ASD Probability Index *T* score is 64 with a percentile rank of 92 and is within the At-Risk classification range. This *T* score is similar to scores obtained by children diagnosed with ASD. Additionally, both the Withdrawal and Developmental Social Disorders scale scores are within the At-Risk classification range. If an ASD diagnosis is being considered, evaluation using the BASC-4 Narrowband Scales ASD Forms is recommended along with the completion of the BASC-4 Structured Developmental History.

The ED Probability Index *T* score is 61 with a percentile rank of 87 and is within the At-Risk classification range. This *T* score is similar to scores obtained by children who have been classified with an emotional disturbance. Additionally, the Depression scale score is within the At-Risk classification range and the Internalizing Problems composite score is within the At-Risk classification range. If a mood-related diagnosis is being considered, evaluation using the BASC-4 Narrowband Scales Mood Disorder Forms is recommended along with the completion of the BASC-4 Structured Developmental History.

The Functional Impairment Index *T* score is 63 with a percentile rank of 87 and is within the At-Risk classification range. Sample reports Sample is engaging in behaviors that reflect impairment in several functional areas including interactions with others, performing age-appropriate tasks, mood regulation, and/or performing school-related tasks. This level of impairment may indicate a level of functioning that is consistent with a clinical diagnosis or educational classification decision.

CLINICAL INTERPRETATION SUMMARY

The BASC-4 items endorsed by Sample's teacher resulted in a clinically significant Hyperactivity scale score. Children with this profile may exhibit problems with behavioral regulation and may be overactive, impulsive, and disruptive. Given this profile, possible diagnostic considerations might include attention-deficit/hyperactivity disorder (ADHD). These problems are likely to occur across multiple settings (e.g., school, home) and to be worse in situations requiring sustained mental effort.

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

Sample also exhibited elevations on the BASC-4 internalizing scales of Depression and Anxiety. This profile indicates Sample is experiencing increased levels of internal distress characterized by depressed mood and anxiety, and additional diagnostic considerations are likely to include depressive disorders (e.g., major depressive disorder, bipolar disorder) and anxiety disorders (e.g., generalized anxiety disorder, panic disorder, obsessive-compulsive disorder). Children with these problems may exhibit inattention and restlessness, which can appear behaviorally similar to ADHD. Furthermore, it is possible that Sample may be acting out because of internal emotional distress, or Sample may be experiencing emotional distress caused by negative feedback that is related to Sample's behavior. Thus, further investigation is warranted to clarify the complex relationship between the various behavioral and mood symptoms included in this report.

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

The pattern of BASC-4 item endorsements by Sample's teacher resulted in an at-risk Withdrawal scale score. Items from the Withdrawal scale measure several core behaviors commonly described in autism spectrum disorder, but it is also possible for scores on this scale to be elevated because of behavioral or mood difficulties. For children who are presenting with hyperactivity and attention problems, withdrawn behavior might reflect the fact that these behaviors can sometimes prevent adaptive engagement in social activities or can be adverse to other children. Thus, further investigation of this domain would likely be helpful to guide diagnostic formulation, risk assessment, and treatment planning.

The pattern of BASC-4 item endorsements by Sample's teacher resulted in an at-risk Learning Problems scale score. Children with behavioral issues may struggle to regulate their behavior in the classroom, defy teacher requests, or commit frequent rule violations. Moreover, children with learning difficulties might exhibit several acting-out behaviors caused by their academic frustrations, which may be reinforced until they become more persistent patterns of functioning. Thus, further investigation is warranted to determine how Sample's behavioral difficulties and learning problems interact, and intervention will likely depend on these findings. For example, if it were determined that Sample's behavioral issues were a longstanding problem that started before entering school, treatment options may be different compared to a case in which behavioral issues emerged after demonstrating a longstanding pattern of academic underachievement. The pattern of BASC-4 item endorsements by Sample's

teacher resulted in an at-risk Executive Functioning content scale score, which may indicate problems with higher order skills such as planning, organization, and behavioral initiation. These skills are critical for successful academic performance, and an elevation on this content scale indicates a possible target area for intervention. Accommodations focused on these skills may lead to improved academic performance. Examples might include guided notes to decrease the organizational demands of note-taking, assignment notebooks to organize homework assignments, or pointed questions before reading assignments to improve comprehension.

The BASC-4 items endorsed by Sample's teacher resulted in an at-risk Developmental Social Disorders content scale score. This suggests Sample may be exhibiting problems with self-stimulation, withdrawal, and inappropriate socialization. This is consistent with the elevated Withdrawal scale score. Diagnostic considerations for this elevated content scale score may include pervasive developmental disorders such as autism spectrum disorder; however, high scores on this scale may also represent poor socialization. Thus, given the complexity of an autism spectrum disorder diagnosis, additional clinical interviewing and history taking will likely be necessary before making diagnostic conclusions.

DSM-5-TR™ DIAGNOSTIC CRITERIA

Listed below are DSM-5-TR Diagnostic Criteria based on the ratings obtained from Sample on the TRS-A rating form. The DSM-5-TR Diagnostic Criteria are presented when accompanied by an elevated BASC scale score that corresponds to a clinical domain. Each section first presents a list of symptoms of the disorder, along with TRS-A items that correspond to these symptoms. ICD-10-CM codes are presented next to the DSM-5-TR disorder name. 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-4 TRS-A form (e.g., observations of behavior, clinical interviews) when making a formal diagnosis. Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition Text Revision (Copyright © 2022).

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

List of Symptoms

	Symptoms for ADHD: Inattention	*Relevant BASC-4 TRS-A Items and Sample Report's Responses*
X	Does not pay close attention to details, or makes careless mistakes	Note: Item Responses omitted from this sample for copyright protection.
X	Has difficulty sustaining attention	
X	Does not seem to listen when spoken to	
X	Does not follow through on instructions and fails to finish tasks	
__	Has trouble organizing activities/tasks	
X	Dislikes/avoids tasks that involve sustained mental effort	
__	Loses necessary materials	
X	Is easily distracted	
__	Is often forgetful	

Symptoms for ADHD: Hyperactivity/Impulsivity	*Relevant BASC-4 TRS-A Items and Sample Report's Responses*
__ Fidgets or squirms excessively	Note: Item Responses omitted from this sample for copyright protection.
X Leaves seat inappropriately	
__ Feels restless	
__ Has difficulty engaging in activities quietly	
X Acts as if "driven by a motor"	
__ Talks excessively	
__ Blurts out answers	
X Has trouble waiting own turn	
X Interrupts others' conversations or activities	

Generalized Anxiety Disorder F41.1

List of Symptoms

Area 1: Presence of Significant Worry/Anxiety	*Relevant BASC-4 TRS-A Items and Sample Report's Responses*
X Difficult to control, excessive anxiety and worry about a number of events/activities	Note: Item Responses omitted from this sample for copyright protection.

Area 2: Symptoms Associated With Worry/Anxiety
__ Feels restless, keyed up, or on edge
__ Tires easily
__ Has trouble concentrating or mind goes blank
__ Is irritable
__ Experiences muscle tension
__ Has trouble sleeping

Major Depressive Disorder F32.x

List of Symptoms

	Symptoms for Major Depressive Episode	*Relevant BASC-4 TRS-A Items and Sample Report's Responses*
X	Depressed (or irritable) mood most of the day, almost every day	Note: Item Responses omitted from this sample for copyright protection.
__	Greatly decreased interest or pleasure in all, or almost all, activities most of the day, almost every day	
__	Significant weight gain/loss without dieting, or increase/decrease in appetite almost every day	
__	Insomnia or excessive sleep almost every day	
__	Observable psychomotor agitation/retardation almost every day	
__	Fatigue/loss of energy almost every day	
X	Feelings of worthlessness or excessive/inappropriate guilt almost every day	
X	Difficulty thinking, concentrating, or making decisions almost every day	
__	Recurrent thoughts about death or suicide, a suicide attempt, or a specific suicide plan	

Autism Spectrum Disorder F84.0

List of Symptoms

Symptoms for Area 1: Social Communication and Interaction Deficits		*Relevant BASC-4 TRS-A Items and Sample Report's Responses*
X	Has impaired emotional/social reciprocation	Note: Item Responses omitted from this sample for copyright protection.
__	Shows notable deficits in nonverbal communication	
X	Has difficulty in developing peer relationships appropriate to developmental level	

Symptoms for Area 2: Restricted, Repetitive Behaviors		Note: Item Responses omitted from this sample for copyright protection.
__	Engages in stereotyped, repetitive motor movements, speech, or use of objects	
__	Rigidly adheres to routines/rituals	
__	Has interests that are abnormally restricted, fixated, focused, or intense	
__	Has extreme (hyperreactivity) or indifferent (hyporeactivity) responses to sensory input	

Persistent Depressive Disorder F34.1

List of Symptoms

Area 1: Depressed Mood	*Relevant BASC-4 TRS-A Items and Sample Report's Responses*
X Depressed mood	Note: Item Responses omitted from this sample for copyright protection.

Area 2: Symptoms Associated With Depressed Mood	
__ Overeating or decreased appetite	Note: Item Responses omitted from this sample for copyright protection.
__ Insomnia or excessive sleep	
__ Fatigue or decreased energy	
__ Poor self-esteem	
X Difficulty making decisions or concentrating	
X Feeling hopeless	

DSM-5-TR™ DIAGNOSTIC CONSIDERATIONS

The BASC-4 TRS-A contains items related to a number of DSM-5-TR criteria for the diagnosis of disorders. Listed below are ALL items related to DSM-5-TR criteria regardless of their responses. 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-4 TRS-A form (e.g., observations of behavior, clinical interviews) when making a formal diagnosis.

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

Related BASC-4 items:

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

Generalized Anxiety Disorder F41.1

Related BASC-4 items:

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

Major Depressive Disorder F32.x

Related BASC-4 items:

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

Autism Spectrum Disorder F84.0

Related BASC-4 items:

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

Persistent Depressive Disorder F34.1

Related BASC-4 items:

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

TARGET BEHAVIORS FOR INTERVENTION

The responses given to items listed below indicate behaviors that may be concerning or warrant further attention; as such, these behaviors may be appropriate targets for intervention or treatment. Similar behaviors are grouped together and are listed in order of severity within the grouping. Progress on behavioral objectives that are implemented can be determined by additional administrations of BASC-4 components.

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

CRITICAL ITEMS

Bolded items may be of particular interest.

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

ITEMS BY SCALE: PRIMARY SCALES

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

ITEMS BY SCALE: CONTENT SCALES

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

ITEMS BY SCALE: CLINICAL INDEXES

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

COMMENTS AND CONCERNS

Sample Report did not include any comments or concerns when completing the form.

The Behavior Assessment System for Children (4th ed.; BASC-4) is an integrated system designed to facilitate the differential diagnosis and classification of a variety of emotional and behavioral disorders of children and to aid in the design of treatment plans. This computer-generated report should not be the sole basis for making important diagnostic or treatment decisions.

End of Report

ITEM RESPONSES

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