Glossary

THE PRESCHOOL AGE PSYCHIATRIC ASSESSMENT (PAPA)

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Center for Developmental Epidemiology
Department of Psychiatry and Behavioral Sciences
Duke University Medical Center
DUMC 3454
Durham, North Carolina 27710

H. Egger, B.H. Ascher, Angold

INTRODUCTION TO THE PRESCHOOL AGE PSYCHIATRIC ASSESSMENT (PAPA)

THE HISTORY AND AIMS OF THE PAPA

The PAPA is one of a suite of interviews that employ a consistent approach to the assessment of psychopathology in childhood, adolescence, and young adulthood. The first of these interviews to be developed (beginning in 1986) was the Child and Adolescent Psychiatric Assessment (CAPA) which collects information from children and adolescents aged 9-18 and their parents. The first edition of the CAPA was developed at the Institute of Psychiatry in London. It has been updated and modified repeatedly since 1986 by the Developmental Epidemiology Program at Duke. A version of the CAPA for use in twin studies (which includes lifetime assessments for some disorders) was produced by the Virginia Twin Study of Adolescent Behavior and Development in 1992. The first edition of the Young Adult Psychiatric Assessment (YAPA) was produced by the Developmental Epidemiology program at Duke in 1998. Work on the first edition of the PAPA was begun in the fall of 1998, and the first edition was finalized during the summer of 1999.

In addition to these assessments of psychopathology, the Developmental Epidemiology Program has also produced companion measures to assess service use in children, adolescents and young adults (the Child and Adolescent Services Assessment - CASA), and the impact of children's psychiatric problems on parental and family life (the Child and Adolescent Impact Assessment - CAIA).

INTERVIEWING PRINCIPLES UNDERLYING THE PAPA, CAPA AND YAPA IN THE CONTEXT OF PSYCHIATRIC INTERVIEWS IN GENERAL

All diagnostic interviews are designed to perform four tasks:

(1) Structure information coverage, so that all interviewers will have collected all relevant information from all interviewees.

(2) Define the ways in which relevant information is to be collected.

(3) Make a diagnosis only after all relevant confirmatory and disconfirmatory information has been collected.

(4) Structure the process by which relevant confirmatory and disconfirmatory information is combined to produce a final diagnosis.

Though all interviews seek to perform these tasks, the way they go about it differs substantially from interview to interview. There is also a very basic distinction between two types of approach to these tasks:

Interviewer- and Respondent-based interviews

A basic distinction has arisen between two different strategies for structuring information coverage and defining ways to collect relevant information. These two methods have been dubbed "interviewer-based" (or sometimes "investigator-based") and "respondent-based" (Angold, Prendergast et al. 1995). This distinction comes down to a difference in *what* is structured, or the level at which information is structured. In an interviewer-based interview, the *mind of the interviewer is structured*. In essence, the interview schedule serves as a tool to guide the interviewer in determining whether symptoms are present, but the interviewer makes the decisions, on the basis of information provided by the child or adult. In order to reduce idiosyncrasies in these interviewer judgments, definitions of symptoms are provided, and the interviewer is expected to question until s/he can decide whether the symptoms described meet these definitions. Interviews of this sort were the first to be developed, since they sprang naturally from clinical practice.

Although early interviewer-based interviews were used extensively in moderately-sized epidemiological surveys, it was clear that the use of clinician interviewers created both logistic and budgetary problems. Very large scale epidemiological studies, such as the Epidemiologic Catchment Area (ECA) studies (Regier, Myers et al. 1984) mandated the use of non-clinician ("lay") interviewers. However, it was felt that such interviewers would be incapable of making the judgments required by interviewer-based interviews, so, respondent-based psychiatric interviews were developed, following methodologies used, by political and marketing surveys. In a respondent-based interview, it is the *questions* put to the interviewee that are structured, and the interviewer makes no decisions about the presence of symptoms. Prescribed questions are asked verbatim in a preset order, and the interviewee's responses are recorded with a minimum of interpretation or clarification by the interviewer. Information variance due to variability in interviewing style or content is thus minimized. The obvious difficulty with such an interview is that, although one knows exactly what has been asked in each interview, and exactly what was answered, there is no control over differences in how interviewees interpret questions or respond to them.

It is important to be aware, however, that the goals of these two interviewing strategies are the same - to reduce information variance as much as possible. Strategies for data combination to produce diagnoses and scale scores have also shown considerable convergence, with computer-scoring emerging as a key diagnostic method for both respondent-based and interviewer-based interviews. It is also important to bear in mind that all interviews are moving targets. Interview developers and users are constantly modifying and updating them in response to changes in nosological systems, the requirements of particular studies, and increasing experience with the strengths and weaknesses of their own and others' measures.

It is perhaps worth noting here that respondent-based interviews have often been referred to as "highly structured", while interviewer-based interviews have been called "semi-structured". These are misnomers, since the issue is not *how much* structure is present, but *what* is structured -- the questions or the definition of symptoms.

The distinction between interviewer- and respondent-based interviews is not hard and fast in actual practice, because there has been considerable cross-fertilization between these approaches. For instance, the Child and Adolescent Psychiatric Assessment, which grew primarily from the interviewer-based tradition, includes a subset of questions that are to be asked of all interviewees in a respondent-based interview, but then allows further questioning for clarification. So it is perhaps best to consider interviews as at various locations lying along three dimensions: (1) Degree of specification of questions, (2) degree of definition of symptom concepts and (3) degree of flexibility in questioning permitted to the interviewers. Interviews that provide extensive definitions and require interviewers to make judgments lie at the interviewer-based end of the spectrum, while those that specify every question and allow no interviewer deviation from those questions lie at the respondent-based end of the scale. Thanks to its extensive glossary of symptom definitions and coding rules, and its demand that interviewers use whatever questions may be necessary to determine whether a child's behavior meets those defined coding criteria, the PAPA clearly lies in the interviewer-based region of interviewing space. However, its specification of certain questions that should be asked of all interviewees derives from the respondent-based tradition. Its developers have tried to incorporate good ideas wherever they may have come from.

Why is the PAPA an interviewer-based interview

The developers of the PAPA have long argued that interviewer-based interviews have certain important advantages when used with older children and their parents and for adult self-reports. But do those supposed advantages apply to a parent-report interview for use with parents of preschoolers? We believe not only that they do, but that there are additional advantages to the interviewer-based approach for this age-group that spring from the parlous state of knowledge in this area. In order to produce an adequate respondent-based interview one needs a great deal of information about exactly what questions to ask, and it *what order* they should be asked if the relevant information is to be collected. The ability to produce such an interview, therefore, depends on having solid information about the usual presentations of problems. Such a knowledge base is singularly lacking for preschoolers. The interviewer flexibility demanded by the PAPA is a great help in such a situation. In essence, each interview can be seen as a structured *mini-focus-group* that can provide information about relevance, appropriateness, cultural sensitivity, and calibration of glossary definitions, coding rules, and questions on the schedule. We have made a great deal of use of interviewer feedback in modifying the CAPA over the years, and we expect that such feedback will be even more important for the PAPA because we start from a weaker knowledge base regarding preschoolers.

Is “diagnosis” appropriate for preschoolers?

The CAPA has been designed to generate DSM-IV and 0-3 diagnoses, but are such diagnostic systems appropriate for preschoolers? Since the dawn of research on psychopathology the topic has been approached both categorically and dimensionally, and these differences in approach have led to intense debates about their pros and cons. The PAPA is designed to implement, as far as possible, two diagnostic schemes. The very

fact that there are two diagnostic schemes immediately signals that neither we, nor anyone else, knows exactly what the "proper" criteria for diagnosing psychiatric disorders in preschoolers ought to be, so the PAPA's "ability" to make "diagnoses" according to these schemes should not be taken as an endorsement of the "rightness" of those schemes. Hence the PAPA's focus on collecting duration and frequency data at the individual symptom level. We hope that such information will help to define appropriate classes of disorder (insofar as they exist) and to generate much information on continuous dimensions. A key feature of the PAPA lies in its attempt to collect as much descriptive information as possible using a minimum of arbitrary cut-points. Sometimes cut-points have to be imposed in order to make information collection feasible, but we have tried to keep them to a minimum. At this point, perhaps it will be helpful to lay out the "measurement theory" underlying the CAPA a little more fully:

All categories are based on little dimensions and all dimensions are based on little categories

Consider the DSM-IV diagnosis of oppositional defiant disorder (p93-94). Eight symptoms are to be considered and four must be present in order for the diagnosis to be given. The second criterion is "often argues with adults". It would seem that the clinician (or computer diagnostic algorithm) must make several judgments in order to determine whether this criterion is met: (1) Does the child manifest the behavior "arguing with adults"? (2) How often does the child manifest that behavior? (3) Is that frequency enough to be called "often". The first question involves a categorical decision about whether the child manifests any behavior that might be called and "argument". The second of these questions involves a dimension and the third the imposition of a cutpoint on that dimension. All of the criteria for oppositional disorder involve the same basic format. That is, all of them require the diagnostician to jump back and forth between categorical and dimensional judgments. Once all the criterial symptoms have been assessed, the number of positives must be counted and if their sum is four or more then the diagnosis is given. Once again, a dimension (number of symptoms) is being constructed and then reduced to a category by means of a cutpoint.

Now consider item 3 of the symptom section of the Child Behavior Checklist (CBCL - a questionnaire that can be used with children aged four and older) - "Argues a lot". This time it is the parent who must make the categorical decision "does my child argue?" Then one must consider how often the child argues (dimensional) and then decide whether that is "a lot" (categorical). The final stage involves a three point choice - deciding whether the result of the earlier deliberations should result in a final answer of "not true", "somewhat or sometimes true" or "very true". This last involves a shift back into dimensional mode, with the minimum number of levels to avoid being a categorical decision. This sort of procedure is repeated for all the items. Then continuous scores are generated on a number of factor analytically-derived dimensions to produce an overall profile. There is even a set of categorical decisions hidden here, because the decisions about which items to include in which factors depended originally on the sizes of the factor loadings in studies used to develop the scales. For each item and each factor a yes/no decision had to be made about whether that item should be included in that factor score.

We have been hard put to come up with any examples of symptoms that do not involve this sort of back and forth. We also note that the same sorts of criticisms have been leveled at the symptom items in both checklists and DSM diagnostic criteria. Cairns and Green (1979) long ago outlined a number of assumptions underlying the use of rating scales, which, it turns out, also underlie the use of diagnostic criteria. First, it must be assumed that the informant shares with the diagnostician or scale developer a common understanding of the behavior or psychological state to be rated. However, it is obvious to any clinician that you often have to work hard to find out what you want to know because non-clinicians do not all use the same psychopathological terms in the same way. It is also obvious to anyone who teaches clinicians that they do not all share the same definition of every symptom. Neither the DSM-IV nor any checklist that we know of provides definitions of symptom items. However, interviewer-based interviews have gone some way towards providing definitions for interviewers and clinicians in an attempt to improve standardization at the symptom level (Angold).

Second, it must be assumed that the informant shares with the diagnostician or scale developer an understanding of exactly which behaviors of the child represent the attribute of interest. Consider CBCL item 5 "behaves like opposite sex". One can hardly expect that everyone has the same notion of what "behaving like the opposite sex" entails. Exactly the same problem arises with the criteria for DSM-IV gender identity disorder. We doubt that any two clinicians will agree on exactly what constitutes "intense desire to participate in the stereotypical games and pastimes of the other sex".

Third, the informant must be able to extract the relevant behaviors or states from the stream of everyday life and determine how often they occur. We would also add that this must also be done in relation to the relevant time frame (e.g. the past six months for the CBCL and a variety of frames for DSM-IV diagnoses).

Fourth, the informant or diagnostician must then reduce the information already extracted to the appropriate metric for the final coding (e.g. not true, somewhat or sometimes true, very true or often true on the CBCL or symptom present/absent for DSM-IV). Ross and Ross showed (1982) that different parents judge the frequencies necessary to fall into such categories very differently. It is also worth noting that there is very little information about what constitutes normative behavior as far as most symptoms are concerned. Until recently, for instance, there have been, as far as we know, no data on how often oppositional disorder symptoms occur in the general population. In other words, the decision as to where in the frequency distribution to set the cutpoint for "often argues with adults" has necessarily been left to the vagaries of individual guesswork.

When are categories *required*?

Some phenomena relevant to psychopathology are self-evidently categorical or so nearly so as to be reasonably regarded as being categorical under most circumstances - gender comes to mind as an example. In other cases, a phenomenon may be so dramatically bimodally distributed that it makes little sense to treat it in any way but categorically,

except in studies that concentrate specifically on the rare individuals who fall between the two common states. It is worth noting here that development is an important generator of such functions. At age six very few girls are biologically competent to become pregnant, but by age 16, most are. Thus in a comparison of six- and 16-year-olds pubertal status has a bimodal distribution. However, if one were studying just 11-year-old girls, a wide range of pubertal statuses would be observed, and pubertal status might best be regarded as being dimensionally distributed.

In certain circumstances, categorical *decisions* must be made. For instance, before treating a child with stimulants, it is necessary to determine whether that child has symptoms of sufficient intensity to warrant such treatment. The DSM-IV category of attention deficit hyperactivity disorder defines a group of children who are likely to benefit from such treatment. However, it is not the case that someone with a minimal amount of ADHD symptomatology will benefit from a minimal amount of stimulant medication. Rather the decision to prescribe stimulants should institute a full trial of stimulants in reasonable doses. Similarly, the decision to start cognitive behavioral therapy for depression is a categorical decision made only when depressive symptomatology to warrant it. It is not the case that individuals with one depressive symptom should be offered half a session, while those with many symptoms should receive longer treatment. It does not matter for the purposes of our argument here *how* the decision to provide treatment is made. It could be argued that such a decision should be based on the results of a well-known questionnaire (such as the Conners scale in the case of ADHD) or even on neuropsychological testing, without recourse to the DSM-IV criteria. But whatever assessment method is used, some cutoff point will have to be used to determine whether to institute treatment or not. Thus, no matter how dimensional the approach used to assessment, at the point at which a decision to treat or not to treat is made, all the assessment information must be reduced to a categorical statement. It is usual to call such a categorical statement a “diagnosis”. The general point here is that when categorical decisions have to be made then assessment must end in a categorical indicator.

A third indication for the use of categories is when data show that some phenomenon functions in a categorical manner, rather than a dimensional manner. In rare cases, the categorical nature of the phenomenon may be revealed by the appearance of a bimodal distribution in scores on a “dimensional” measure. The appearance of a bump at the lower end of the otherwise normal IQ distribution is an indication of the presence of a group of individuals with a range of disorders affecting IQ that are rarely found in the rest of the IQ range. A number of attempts to detect points of rarity and humps in symptom distributions have been made in the service of defining subtypes of depression and distinguishing depression from anxiety, but these have been quite unsuccessful. Unless efforts are made *a priori* to produce non-continuous distributions, it is striking that symptom distributions appear to be resolutely continuous in both adults and older children. There is every reason to suppose that the same will be true of preschoolers. It is perhaps worth noting, however, that “continuous” does not mean “normally distributed”. The form of any distribution of psychopathology will depend on the way in which psychopathology is measured. If one includes high prevalence, low intensity items in one’s symptom scale, it is easy enough to generate a roughly normally distributed curve.

However, most of what clinicians would regard as being symptoms are absent in most people, with the result that general population symptom scores from interviewer-based interviews are heavily skewed to the right (that is most people have zero or very low scores). Even so these Poisson or inverse power curve distributions are still continuous.

Is this evidence that continuous measures are to be preferred? Not necessarily. Just because a distribution is continuous does not mean that the phenomenon underlying it is not categorical. Suppose for a moment that there really were a brain disease called depression and that you either had it or you didn't. Suppose also that at some point in the future some aspects of the mechanism of this disease will be discovered so that an accurate diagnostic test will be available, but for now, we have to rely on asking a lot of questions about phenomena that are related to the real disease but also have a range of other causes. Let us also assume that the disease is not very common (say it affects 4% of the population), but that some of the other causes of individual "depressive" symptoms (e.g. primary sleep disorders, anxiety disorders, bereavement, physical illnesses) are as common, or more common. Let us also take into account that our available questioning techniques are imperfect measures even at the symptom level. In other words we face measurement error at both the symptom and diagnostic levels. What would we expect the distribution of "depressive" symptoms to look like? We suggest that the result would be a distribution in which many people had a few symptoms and a few had many symptoms, with no sharp cutoff between the two. Our "real" depressives would be concentrated in the upper tail of the distribution, but because of the imperfections of our question-based assessment approach, some would be in the heavy lower end of the distribution. Thus even if we were measuring the right symptoms, we could expect that our purely categorical disease would generate a continuous symptom distribution. As a further illustration, suppose for a moment that gender before age five were measurable only from observations of children's play, hair length and parental reports of behavior. We suspect that there would be endless debate over whether gender was a categorical or dimensional phenomenon.

The ability to make a diagnosis does not constrain the user to make a diagnosis

We hope that the above makes it clear, that except in cases where a categorical decision is required for some purpose, we are agnostic as to the utility of current diagnostic schemes for preschoolers and that we believe that we need much more descriptive data before we can decide how best to parse the phenomena of preschool psychopathology. The PAPA will make "diagnoses", but that does not mean that any user of the PAPA is constrained to use those diagnoses. The symptom coding system has been designed to allow maximum flexibility for the construction of all sorts of scales and categories. We believe that such flexibility is absolutely necessary in a situation in which no official or research classification scheme has any but the most tenuous claims to utility or validity.

THE PLACE OF THE PAPA IN THE PSYCHIATRIC ASSESSMENT OF THE PRESCHOOL CHILD

The PAPA collects symptom and impairment information from a parent (or guardian). It is, therefore, but one component in the overall assessment of the preschooler. Any full assessment would need to include observation of the child in the family context, measurement of developmental/intellectual level, interviews with others involved in the child's care, and perhaps tests in experimental settings. In other words, we do not regard the PAPA as a full psychiatric assessment, but as one important component of such an assessment.

Having provided an overview of what the PAPA is designed to do and some background rationale for our approach to doing it, we now turn to some key concepts that underpin the administration of the interview.

THE CURRENT STATUS OF THE PAPA

The first edition of the PAPA is the initial version of a new instrument designed to measure psychiatric symptoms in an age-group where such symptoms have not previously been measured in this way. Experience has taught us that such early versions of new instruments will require much fine-tuning, and sometimes rethinking of substantial portions of the interview. There are currently no reliability or validity data available for the PAPA. In this situation, feedback from users is very helpful in the process of making improvements. However, users of the PAPA should be aware that it is provided "as is", with no guarantees as to its utility for any particular project. The PAPA development team regards the PAPA as a good-faith effort to fill a gap in the assessment armamentarium, and has made every effort to make this first edition as good as we can. While we want to be as helpful to users of the PAPA as possible, we cannot provide unlimited technical support if problems arise with its use. We should also point out that the use of the PAPA requires a substantial amount of training by trainers recognized by the Developmental Epidemiology Program. Individuals "trained" by others may use the PAPA schedule to guide their interviews but they cannot be regarded as administering the PAPA. Similarly, if users of the PAPA decide to make changes in the content of the instrument or the way in which it is administered, they are welcome to do so, provided that they do not claim to be using the PAPA.

STYLE OF QUESTIONING FOR THE PAPA

The interviewer is expected to approach questioning in a flexible, but disciplined way. Questions are not fixed in format, but the presence or absence of all the items in a section must be ascertained. In questioning about a symptom, the interviewer must ask about the context in which it has occurred, aggravating and ameliorating factors, and the consequences it has entailed. Respondents should be allowed to answer questions in their own words and to describe experiences and behavior in their own way. Once a symptom has been thoroughly investigated, all the information obtained is used to match the behavior, emotion, or thought described by the respondent, to appropriate glossary definitions and levels of severity.

It is mandatory to get details of symptoms and not just yes/no answers. It is the interviewer's task to decide what symptoms are present, not the respondent's. Questions are recommended in the text, but the interviewer should ask whatever further questions are necessary to clarify the information to be recorded.

As far as question content is concerned, the usual procedure is to start with an open question that defines the general area under consideration; to follow this with more focused closed questions on the specific symptom to be rated; and to end with open questions designed to obtain examples of the behavior or thought processes reported. For instance, when trying to elicit a child's mood one might start by asking: "How has s/he been feeling in the last month?" Such a question might result in a full description of a depressive episode, at one extreme (in which case the appropriate items should be rated), to an entirely non-committal answer like "O.K.". In the latter case a more specific closed question such as "Has s/he felt miserable or unhappy at all?" would be appropriate. If the answer to this question suggested that the child had experienced low mood, clarification should be sought through open questions that seek examples. These might take the form of: "Can you give me an example of when s/he felt like that?" or "How low did s/he feel then?" or "When was the last time you s/he was like that?". If the answers indicated that the child might have experienced significantly depressed mood, further questions should be framed in order to determine whether the symptom criteria are met.

The task is always to determine conformity to the schedule glossary's criteria for the symptom. A yes/no answer to a closed question almost never decides the rating. Occasionally, it may be necessary to rate a symptom as being present in the face of a categorical denial by the interviewee, or conversely to code its absence despite the respondent's insistence on its presence, in accordance with the directions of the glossary.

THE PROBE STRUCTURE

Detailed guidance on the use of the questions is provided, but the suggested questions are to be used according to the needs of the interview. Two levels of probe are employed:

(1) Mandatory probes: Mandatory probes appear on the schedule in boldface type preceded by an asterisk. For instance ***Does s/he ever get frightened without knowing why?***

All mandatory probes are asked unless the respondent has already provided the necessary information to determine the information being asked. It is important to be sensitive to the respondent's level of understanding in questioning throughout the interview. It will sometimes be necessary to modify the wording of questions for particular individuals and special care must be taken to ensure that respondents understand what they are being asked about. However, a good deal of work has gone into the selection of questions, so the mandatory probes should be asked as written unless there is good reason for modifying them.

If the answers to appropriately worded mandatory probes are convincingly negative, then further questioning in that area is unnecessary and the interviewer should move on to another section. However, *unconvincing* or *doubtful* negatives should lead to further questioning. Similarly, if convincing negatives have already been provided elsewhere, then even the mandatory probes do not have to be asked again, since it is the codings that are required to be consistent, not the questions per se. However, it should be borne in mind that respondents sometimes change their minds and interviewers should be willing to return to sections that have already been covered or skipped if new or better information comes to light as the interview proceeds. When apparently contradictory information is provided about a symptom, further exploration is required.

Detailed written notes on the right hand page should be kept during the interview. Marks should be placed next to the questions that were actually asked, with yes answers being distinguished by a checkmark and negative answers being distinguished by a dash.

Audio recordings should also be made of all interviews for review later in the office, in order to check and finalize the schedule codings.

Detailed notes of actual examples of symptoms or problems should be made. These provide an important resource for data cleaning at a later stage, and also allow anyone reading through the completed schedule to get a much richer picture of the nature of a child's difficulties. This can be of immense value in trying to understand and fill out findings based on statistical analyses of the formal ratings. It is especially important to note examples of psychotic symptoms as it is often difficult to be certain about these in children.

CONTEXT

For many symptoms or behaviours, assessment is made of two contexts:

1) The context of the child's relationship
2) The context of the child's setting

RELATIONSHIP CONTEXT

For specific items, determine with whom the child's symptoms appear. For example, does the child have tantrums with mother only or with most adults? The relationships assessed include: parental figures, teacher/caregiver at daycare or school, babysitters, siblings, peers. Understand the relational context of a young child's behavior is very important for understanding the scope and significance of the child's symptoms.

SETTING CONTEXT

For specific items, determine the frequency of the child's symptoms in three different settings:

1) Home
2) Daycare/School
3) Elsewhere

Many children show disturbances only in particular settings and so this division provides an important reminder that assessment of the sphere of life in which a disturbance occurs is as important as its specific form.

SEVERITY RATINGS

An important feature is the precision of the severity ratings for individual symptoms. The "severity" of a symptom is compounded by a number of aspects which need to be discriminated:

1) The intensity of the symptom itself,
2) Its frequency of occurrence,
3) Its duration when actually present,
4) The length of time since it first appeared, and
5) The amount of secondary incapacity that it causes.

Intensity

Intensity refers to the strength or force of the symptom itself without consideration of features such as frequency or duration. The first aspect of intensity is a threshold below which items are not considered of clinical importance. This is necessary because many "symptoms" (e.g. anxiety or depression) represent features that are both common and normal when present at a lower intensity. The second aspect of intensity is its level within the clinical range.

The criteria for intensity are necessarily different for different types of symptoms. The first group of symptoms consists of those *intrapsychic* phenomena that are normal when present in lesser degree (such as worrying). For these items a symptom's intensity is usually evaluated according to three dimensions:

1) its **intrusiveness** into or interference with other mental activities (as, for instance, in the case of worries intruding into other thoughts),

2) its **lack of modifiability** or the child's inability to modify the phenomenon by action, thought, behavior, or environmental manipulation (as when a miserable child cheers himself up by going out to play football with his friends),

3) its **generalization** or the degree to which symptomatic thoughts or emotions are present across a range of activities that may be quite unrelated to the content of the symptom (as in the case of the child who feels afraid of parental separation in situations where separation is not threatened).

Note that these characteristics are rated for the period during a symptom bout only and are therefore not confounded with the frequency and duration ratings.

The second group of symptoms comprises those where there is a *qualitative* difference that defines the feature as abnormal whenever it occurs, regardless of the level of intensity. Obviously, this applies to psychotic phenomena, but there are various other symptoms when the same approach may be followed on the grounds that the presence of the feature at any intensity is of clinical significance, even though it does not necessarily

imply disorder in the way that is inherent in psychotic phenomena. For example, this approach is used with certain uncommon conduct symptoms (such as fire setting or running away from home), with developmental abnormalities that are unusual in the age group (such as the child not feeding himself or herself), and with certain other disturbances (such as flashbacks in PTSD).

The third group of symptoms comprise *behavioral* disturbances that are abnormal only when they are intense. This applies, for example, to conduct disturbance items such as disobedience and temper tantrums. Sometimes the intensity threshold is implicit in the form of the symptom (for instance tantrums are defined in terms of attempted violence against people or property), but it is sometimes necessary to specify a minimum frequency combined with the requirement of generalization across activities in order to set a threshold.

The fourth group of symptoms is, in a sense, intermediate between the second and third in that they are common but yet are not universally expectable at low intensity in the same way that applies to the first group of intrapsychic phenomena or the third group of conduct disturbances. This group includes such items as stealing and tics. In view of the uncertainty over what intensity of manifestation is clinically relevant, the threshold has been set low so that only clearly trivial manifestations are excluded. The specific requirements are specified individually for each symptom. Throughout the interview, precise rules for coding the intensity of each item are specified in the glossary. For the most part, symptoms and behaviors are scored on a 4-point scale (0, 1, 2, 3) of "intensity".

0 = Symptom absent.

1 = Symptom conforming to the glossary definition in form, and meets most, but not all, of the criteria for "2" on intensity. "1" should also be rated when the available information suggests that the symptom fulfills the overall concept inherent in the intensity criteria but where the details fall just short of the specifics required. N.B. the "1" coding should *not* be used for mild symptoms (code 0) or where information is poor or uncertain (code X). It is intended, in effect, only for symptoms that fall just short of the intensity threshold on technical grounds. A coding of “1" is not intended to be used just because it is difficult to decide whether a coding should be “0" or “2". Interviewers must make every effort to decide whether a symptom is present or absent according to the glossary rules, and codings of “1" should be very uncommon. The only exceptions to this rule occur in a few instances where a coding of “1" is explicitly defined in the glossary and on the schedule. Then the glossary rules should be followed in deciding whether “1" is the appropriate coding.

2 = Symptom present at least at the minimum level of intensity as defined in the glossary.

3 = Symptom present at higher intensity level, as defined in the glossary.

4 = In the Subjective Anxious Affect Section, child has not been in the situation in the past 3 months because of avoidance, but anxious affect would have been present if s/he had been in the situation.

Several codes for various sorts of missing data are also available:

d = Parent does not have sufficient knowledge to rate. Code the intensity with a “d” (for Don’t know) if the parent reports that they just do not know about the information in question, and can not answer your question. However, it is important not to code “d” when the parent really means that the symptom is *absent to the best of his/her knowledge*. For instance, If the parent says "not as far as I know," or "I do not think so," code “0".

S = Structurally missing value; the question is not applicable (for instance, recording frequency of a symptom that has not occurred) or the items are in skip sections and not covered because the responses to the screen questions were negative.

N = Symptom similar to the one being coded, and of sufficient severity to warrant notice, but not conforming to any glossary definition. This coding is particularly useful when developing a new section of an interview, because it provides a means of noting the presence of symptomatology that is poorly addressed by the current format. Whenever an “N” coding is made, careful notes justifying the coding should be made, so that it is clear what action would have to be taken to make such symptoms codable. The existence of the “N” coding is not intended as an excuse for avoiding the determination of whether defined symptoms are present or absent.

X = Information missing, or section not completed. Missing data are to be avoided at all costs, but sometimes individuals are unwilling to provide certain sorts of information, and there is nothing that the interviewer can do about it. It is sometimes thought that it matters less if “X” codings appear in frequency, duration, or onset items than if they appear in intensity items. This is not true. The diagnostic and scoring algorithms typically use frequency, duration, and onset information, and its absence has a severe effect on the accuracy of the final assessment of the diagnostic status of the child.

Some items depart from this format (for instance being coded simply 0, 1, and 2), but in these cases the glossary again provides definitions.

If, in a particular symptom category, there is a **mixture** of intensity levels, these intensities are not averaged to achieve an overall intensity rating; the symptom is coded at its worst, or highest level, with the following proviso for "emotional"/affective symptom categories (Worries, Anxiety, including Separation Anxiety, Ruminations, Obsessions, Compulsions, Depression, and Mania): When there is a "mix" of 2 and 3 level intensities reported, in order to rate at level 3 in overall intensity the symptom must occur at that

level for at least 1 week continuously, or 2 times a week for 3 ½ weeks consecutively, or once a week for 7 weeks consecutively. However, if it is a clear 3, the need for 1 week continuously does not apply. For frequency and duration, **all** episodes that meet criteria (both 2 and 3 level intensities) are included.

PRIMARY PERIOD

The interview is designed to focus on the three months immediately preceding the interview. This is called the primary period. Only in the case of a very few symptoms involving infrequent discrete acts is information sought on symptoms that have occurred only outside the primary period.

DURATION

For those symptoms that exhibit a meaningful degree of continuity over time, the duration of each bout should be recorded. In this context, a symptom bout refers to each bout of continuous occurrence or "attack" of the particular symptom. The duration is recorded as the length of time (most often in hours and minutes) of the average bout during the last three months.

The rating of duration applies to symptom bouts and hence is not used for symptoms where the concept of a symptom bout cannot be used meaningfully. Thus, the duration coding is not made for symptoms that constitute discrete acts (such as stealing or enuresis or encopresis). The day is divided into five hour blocks, so that a morning is coded as five hours, an afternoon is coded as five hours, an evening is coded as five hours and "all day" is coded as 15 hours. If a symptom lasts until its precipitant is withdrawn (as in the case of anxiety in a simple phobia) its duration is coded as 16.00 hours.

FREQUENCY

Ratings of frequency are required for all symptoms that are not continuous. The frequency refers to the number of symptom bouts or discrete acts that have occurred during the last 3 months. If the frequency exceeds 999, 999 should be coded. If a symptom has been continuously present, it should be coded 15 hours under duration and 90 under frequency.

When averaging frequencies (or any aspect of a symptom or behavior), the general rule is that it is best to underestimate symptomatology; the following are guidelines to follow in this process:

a) 2-3 times per week = 2
b) 3-5 times per week = 4
c) 5-10 times per week = 7

For symptoms present at intensity level 3, the frequency ratings reflect frequency of symptoms at both 2 and 3 level. The rationale is that the intensity level tells us about the worst that the symptom gets, and the frequency tells how often the symptom has been present at a codable level.

SYMPTOM ONSET

The date from which the child has suffered from any symptom that has been present during the primary period at intensity level 2 or higher should be recorded. If a symptom has been present on and off over a long period, then an additional rule applies: an asymptomatic period lasting 1 year or more is considered to constitute a break in the symptoms' presence, and the next appearance of the symptom after such a break is regarded as being the date of onset. For example, if a child lacked bladder control from birth until age 2, and then became dry for three years, started wetting again 2 years later, became dry after 6 months and then began to wet again 18 months after that, the last date would be recorded as the onset of enuresis. However, "ever" onsets should be coded as the first time a symptom or behavior occurred; the one-year's absence rule would not apply in this case.

Onset dates are coded as actual dates.

Certain rules also apply to the coding of uncertain dates:

(I) If a date is known only to a particular year, it is coded as occurring on 6/14 of that year (i.e. midway through the year).

(ii) Similarly if only the age (in years) at which a symptom started is known, that is coded as a date six months after the date of the previous birthday (e.g. if a child with DOB 1/1/78 says - "It started when I was seven", that date should be coded as 7/1/85). If the response given is "age 3 or 4", one would code the later age for the onset.

(iii) If the response given is a particular season of the year, the month would be coded as 1 (January) for winter, 4 (April) for spring, 7 (July) for summer, and 10 (October) for Autumn.

(iv) If a grade is given for the onset, use the middle of the year for the month, fourteen for the day, and three for the confidence (refer to Confidence codings below). For example, if someone says a symptom started in the third grade (and s/he was in third grade from September 1984 - June 1985) the onset is 1/14/85, with a confidence of 3.

(v) If a month can be given, the day is coded as the 14th.

(vi) The first week is coded 7 as to day, the second week 14, the third 21, and the fourth 28.

Persistence with date questioning, tied into markers such as holidays, birthdays, and the seasons of the year is often surprisingly effective in getting interviewees to remember onset dates that they were, at first, quite sure they could not specify so exactly.

If the response is "S/he has always been like that", try to help the respondent pin it down (Was she already like that when you moved? What about before then?), but if you can't stir the memory use date of birth.

FLOW OF INFORMATION

A range of different sorts of information is often necessary to describe a symptom. For many items the interviewer must determine (I) the presence (N.B. descriptions are particularly important here), (ii) the intensity, (iii) the frequency, (iv) the duration of each individual occurrence, (v) the date of onset, (vi) the effects on other areas of function (incapacity).

It is important to get a full description of any symptom before proceeding to determine its frequency and duration, since there is no point in collecting this information on items that do not reach the symptom threshold.

The preferred flow of questioning is therefore:

Presence/Absence

Date of Onset

Duration

Frequency

Obviously, this approach should not be followed slavishly. If an interviewee is spontaneously talking about the frequency of episodes of anxiety, s/he should not be made to switch to discussing its duration first.

CODING THE INTERVIEW

After the interview is completed, codings should be determined as soon as possible, in consultation with the glossary.

If a mental state or behavior meets criteria for two or more symptoms, it is coded *only* under the more specific heading - that is, the item which involves the greatest number of the characteristics of that mental state of behavior.

It is not uncommon, however, for a mental state or behavior to be coded under two items, when those items refer to different aspects of that state or behavior. For instance, a child who felt simultaneously depressed and irritable would receive codings under both Depressed Mood and Irritability. The glossary often clarifies the relationships between several symptoms.

CITATIONS

Angold, A., M. Prendergast, et al. (1995). “The Child and Adolescent Psychiatric Assessment (CAPA).” Psychological Medicine **25**: 739-753.

Regier, D. A., J. K. Myers, et al. (1984). “The NIMH Epidemiological Catchment Area Program: Historical context, major objectives, and study population characteristics.” Archives of General Psychiatry **41**(10): 934-941.

BRIEF DEVELOPMENTAL ASSESSMENT

The purpose of this section is to enable the interviewer to place the child within a developmental framework. Clearly, there are major motor, cognitive, emotional, and social differences between two year olds and six year olds. This developmental overview will help the interviewer to understand the child's behaviors and symptoms in the last three months within the context of his/her individual level of development. This section is not meant to substitute for a comprehensive developmental assessment using standard instruments such as the Bayley Scales of Infant Development, the Vineland Adaptive Behavior Scales, the Denver Developmental Screening Test, or other assessment tools including observational protocols.

MOTOR DEVELOPMENT

For each item, measure whether absent or present. If present, record the age when the skill was acquired.

GROSS MOTOR SKILLS

The child's use of his/her arms and legs for movement and coordination.

SITTING

Child is able to rest comfortably on one's bottom without the assistance of arms/hands to maintain balance.

CRAWLING

Child is able to move across floor on hands and knees without stomach touching the floor or scoots quickly by shuffling bottom across the floor.

Assess whether child ever crawled; if s/he did crawl, when s/he began; and if s/he is currently crawling.

WALKING

Child is able to move along on foot without assistance.

WALKING DOWN STAIRS

Child is able to walk down stairs using alternating feet without assistance. Child may use a banister or railing. If the child can descend stairs by putting both feet on each step, code a 2.

RUNNING

Child is able to move along on foot quickly and smoothly.

HOPPING ON ONE FOOT

Child is able to jump up and down on one foot and maintain balance without holding onto something or someone for support. If the child can hop more than twice, code a 0. If the child can hop once or twice only then code a 2. If the child is unable to hop on one foot without losing balance or needing support then code a 3.

FINE MOTOR SKILLS

The child's use of his/her hands and fingers to manipulate objects.

PINCER GRASP TO PICK UP AND RELEASE SMALL OBJECT

Child picks up a small object such as a raisin by placing his/her thumb and forefinger on the object and pinching it. Then child is able to deposit the small object in a container by releasing grasp.

SCRIBBLING

Child is able to hold a crayon, pen, or pencil and make marks on paper. Marks can be random.

DRAWS A CIRCLE

Child is able to hold a crayon, pen, or pencil and make the outline of a circle on paper. The circle need not be perfectly formed but must be closed.

COPIES A SQUARE

Child is able to copy an outline of a square so that the copy looks very similar to the original. The square can be a different size and somewhat irregular, but the four line must meet at the four corners correctly.

WRITES NAME

Child is able to write his/her first or last name on paper. The letters need not be perfectly formed but must be legible to someone other than the child.

CUTS WITH SCISSORS

Child is able to make a cut mark or divide a piece of paper into smaller pieces using a pair of scissors. Scissors may be children's or adult scissors.

HANDEDNESS

Child's predominant use of his/her right hand or left hand for tasks such as coloring, throwing, writing and eating is ascertained. Use of the right or left foot for kicking a ball is also coded. If the child has not yet demonstrated a preference, code both.

HEARING PROBLEM

Child has difficulty perceiving and/or discerning sounds. To meet criteria for a level 2, the child must have a hearing problem that is partially correctable with a hearing aid. To meet criteria for a level 3, the child must have a hearing problem that remains significantly impairing even with the help of a hearing aid or other device. Code whether the hearing problem has been diagnosed/noted by a health professional such as a doctor, school nurse, or visiting nurse.

HEARING AID

Child uses and/or has been prescribed a device to help improve his/her ability to hear.

EVER: FLUID DRAINED FROM EAR(S)

Child has ever had a medical procedure to drain fluid from one or both ears. If present, record the number of times the procedure has been performed and the date of the first occurrence.

EVER: TUBES IN EAR(S)

Child has had a medical procedure in which tubes are placed in one or both ear to promote drainage of fluid from the ear(s). If present, record the number of times the procedure has been performed and the date of the first occurrence.

VISION PROBLEM

Child has difficulty seeing or has a problem with his/her eyes such as an astigmatism. Code whether the vision problem has been diagnosed by a health professional including a school or visiting nurse. Exclude color blindness.

GLASSES

Child has been prescribed glasses or contact lenses to improve his/her vision.

COMMUNICATION

LANGUAGE SPOKEN AT HOME

Dominant language spoken at child's home.

01 = English
02 = Spanish
03 = Other _____ (specify)

ENGLISH IS A SECOND LANGUAGE FOR CHILD

English is the second language that the child learned.

RECEPTIVE LANGUAGE

Child's ability to understand language**.** This area is assessed in three areas:

FOLLOWS VERBAL COMMANDS

Child is able to understand a verbal command. For example, if a person says to the child, "Please bring me the cup," the child is able to comply. If the child does not comply, make sure to make the distinction between *not understanding* the meaning of the request and *understanding but not wanting* to comply with the request.

POINTS TO AT LEAST TWO BODY PARTS WHEN ASKED

Child is able to point to at least TWO body parts when asked to do so.

UNDERSTANDS PRONOUN DISTINCTIONS

Child understands the difference between at least some pronouns. For example, child knows the difference between "you" and "me" or "us" and "them" or "him" and "her." Child need not understand all pronouns but should demonstrate the ability to understand the concept by understanding at least one set of pronouns.

ABLE TO POINT TO FOUR OR MORE COLORS

Child is able to point out four different colors when asked to. The specific colors do not matter.

EXPRESSIVE LANGUAGE

Child's ability to express him/herself using language. This item entails assessment of degree of complexity of the child's language and global assessment of articulation.

LANGUAGE COMPLEXITY

Assess the complexity of speech the child uses the majority (>75%) of the time. Code the highest level that the child uses the majority of the time. In making the distinction between each coding level, assess what is the *dominant complexity* of the child's language. Non-family members may not understand the child's speech due to immature articulation, but the words or sentences used must be recognizable. The meaning that the child attaches to words need not be identical to the meaning of the word in the adult lexicon. For example, a child might use the word "dog" to describe all four legged animals.

1 = Child understands and can use the words "who" "what" "where" "how" and "why" correctly to ask questions

2 = Child's sentences are "complex" more than 15% of the time

3 = Child speaks in sentences of four words or more. Child speaks in sentences of four words or more. For example, "I see the cat;" "I want a cookie now." The grammar of the sentence and articulation of the words need not be perfect. For example, "Me want a cookie," is acceptable

4 = Child speaks in "telegraphic sentences" of two or three words. For example,"Mommy go," "John bye bye," "cat sit car," "I see cat;" "Me go up," "doggy sad"

5 = Child uses single words most of the time and speaks fewer than 50 words . For example, "up," "milk," or "doggie." Idiosyncratic words like "baba" for bottle or "tata" for doggie can be counted as words if their meaning is understood by others

6 = Child uses single words most of the time and speaks 10 words or fewer

7 = Child knows fewer then ten words and primarily babbles, uses other vocalizations, or uses gestures to communicate

ARTICULATION

Child's production of speech sounds.

Problems with articulation are distortion of sounds that make understanding the child's speech difficult. Examples include lisping or letter substitutions ("twee" for "tree"). Do not include very soft speech produced due to shyness. Do include articulations problems that may arise from physical anomalies such as cleft palate or dysarthrias arising from problems with muscle control.

0 = Child's articulation is good enough that child is understood most of the time (>75%) by family and non-family members

2 = Child's articulation is such that the child is understood by family members most of the time (>75%) but is not understood by non-family members most of the time (>50%)

3 = Child's articulation is distorted to the degree that the child is not understood by family members and non-family members most of the time (>75%)

READING

Child's acquisition of reading tools such as knowledge of the alphabet and recognition of letters and the ability to decode words.

RECITES THE ALPHABET

Child able to say the whole alphabet from memory with few errors. Letters may be out of sequence. Code a 2 if the child cannot recite the alphabet from memory without singing but can sing the alphabet song with few errors.

IDENTIFIES LETTERS

Child recognizes all printed letters (lower and uppercase) of the alphabet.

READS WORDS

Child able to decode ten or more words. May be read aloud or silently.

READS SIMPLE STORIES

Child able to read a simple story like "*The Cat in the Hat*" or "*Little Bear*" to a listener.

SELF-CARE SKILLS

Child's ability to perform tasks to take care of basic daily needs such as dressing, washing, and brushing teeth.

ABILITY TO PUT ON CLOTHES INDEPENDENTLY

Child is able to put on simple garments (hat, pants, dress, shirt, shoes) without help in the morning. Garment can be inside out or backwards. Shoes can be on the wrong feet. Shoes laces do not have to be tied. Child need not be able to do fasteners such as buttons, zippers, or snaps without help. Ability to fasten garments is coded below.

0 = Dresses self completely including putting on shoes

2 = Can put on some items but still needs help with other items such as socks or shoes

3 = Unable to dress without assistance but cooperates with process of putting on clothes

4 = Unable to dress without assistance and does not cooperate with the process of putting on clothes

CHOOSES CLOTHES TO WEAR

Child selects type and style of clothes to be worn from dresser or closet. If parent does not allow child to pick own clothes at all, code a 0. This item does not refer to choosing what clothes to buy at the store. If parent occasionally vetoes an outfit, such as shorts on a winter day or a tutu to daycare/school, assess how often the parent intervenes and code level accordingly.

TIES SHOE LACES

Child is able to tie shoelaces. If child always wears slip on shoes or shoes fastened with velcro and has not had the opportunity to learn to tie laces, code as an S. Yet, if child has velcro fastened shoes or slip ons, but also has laced shoes, code a 0 or a 2.

FASTENS FASTENERS

Child is able to put a button in a button hole successfully, zip a zipper, or snap a snap closed. Do not include tying the string of a hood or other string fastened garments.

WASHES AND DRIES HANDS

Child is able to wash and dry his/her hands by him/herself. Child does not have to be able to reach the faucet. The cleanliness of the hands may not actually meet adult standards or expectations. Hands need not be dried on towel (e.g. may be dried on clothes). The levels of coding also assess the child's capacity to wash hands in expected circumstances (e.g. after going to the toilet; after playing in mud) without being reminded.

BRUSHES OWN TEETH

Child brushes own teeth on own. Assess the degree of parental help which could involve either putting on the toothpaste or brushing the child's teeth for him/her. Assess degree to which child needs to be reminded to brush teeth.

WASHES OWN HAIR

Child lathers and rinses own hair. Parent may assist by checking that all of the soap is out of the hair.

PRESCRIBED MEDICATIONS

Any medication prescribed by a medical practitioner (either mainstream or alternative) or given by parents or guardian. Do not include analgesics taken less than once per week for sporadic headaches, etc. However, such drugs should be included if they are taken more regularly than this.

Do not include other people's prescriptions that the child takes (which are coded under substance use).

Minor Tranquilizers - Sedatives:

Ativan
Buspar
Inderal
Valium
Xanax

Major Tranquilizers - Neuroleptics:

Risperidone
Zyprexa
Clozaril
Haldol
Mellaril
Navane
Stelazine
Thorazine

Lithium - Antimanic/Mood Stabilizer:

Lithium (Lithobid)

Stimulants:

Cylert
Benezedrine
Dexedrine
Ritalin
Adderal

Anti - Depressants: SSRIs/Tricyclics/MAOIs, etc:

Prozac
Zoloft
Paxil
Effexor
Anafranil (Clomipramine)
Norpramin (Desipramine)
Tofranil (Imipramine)
Wellbutrin

Anticonvulsants/Mood Stabilizers

Tegretol
Valproate (Valproic Acid)
Gabapentin

Other:

Any other medication prescribed by a medical practitioner or given by a parent.

Aspirin (if taken > once per week)
Asthma medication
Blood Pressure medication

PARENTAL PSYCHOPATHOLOGY

EVER PARENTAL PSYCHOLOGICAL PROBLEMS

Psychological, nervous, or psychiatric problems that have caused a parent to seek treatment, receive treatment, undergo hospitalization, or led to family or social disruption, or to impaired performance in a major life role. Major life roles include the care of children, ability to function normally at work, and the ability to maintain normal social (including marital) relationships.

These ratings refer to the parent's lifetime, not just the last three months. Only code as "S" if the relevant parental figure does not exist in the child's life. Do not include problems due to substance abuse, or physical illness, unless these are also associated with definite psychological problems, such as depression.

It is possible to code the Treatment and Medication boxes a 2, without the parent necessarily coding for Disruption of Life Role (e.g. the case where a parent took medication for depression, yet has never had life role disruption due to his/her depression).

Going into a hospital does not necessarily indicate a disruption in a life role. Role disruption requires that when the parent was available to perform that role (i.e. while s/he was not hospitalized), s/he was unable to do so adequately.

However, if a parent has ever been hospitalized, automatically code that they have ever sought treatment.

Only include family therapy sessions if they addressed the parent's psychological problems, not just the child's difficulties.

EVER PARENTAL SUBSTANCE USE PROBLEMS

A level of alcohol or illicit drug use that has caused a parent to seek treatment, receive treatment, undergo hospitalization, or led to family or social disruption, or to impaired performance in a major life role. Major life roles include the care of children, ability to function normally at work, and the ability to maintain normal social (including marital) relationships.

These ratings refer to the parent's lifetime, not just the last 3 months. If an interviewee responds negatively to the questions on alcohol and drug use in the primary period, be sure to also ask if they have ever had a problem with alcohol or drugs.

CURRENT PARENTAL SUBSTANCE USE

Code current drug use if parent has used illicit drugs at all in the past 3 months. The presence of problems caused by drug use is coded separately. A parent's use of alcohol which has not caused a problem or caused them to seek treatment, is not included in this coding. However, alcohol use that has caused problems or treatment-seeking is included here.

PARENTAL ADULT ARRESTS AND PROSECUTIONS

Arrests and/or prosecutions of the parent since age 18 are coded here. The ratings refer to the parent's lifetime as an adult, not just the past 3 months. Arrests for DWI and/or drug related charges should be coded here, though they are asked about in a previous section.

EVER ARRESTED

0 = No

2 = Yes

EVER ACTION TAKEN BY POLICE

0 = No

2 = Yes

EVER WORST RESULT OF A CHARGE

0 = Not guilty
2 = Probation or community service
3 = Treatment order
9 = Fine
10 = Prison/House arrest

EVER NUMBER OF YEARS IN PRISON/HOUSE ARREST

Code the total number of years and months that the parent has spent in prison or under house arrest during his/her lifetime. Less than one month is coded as one month.

FAMILY STRUCTURE, LIFE, AND FUNCTION

Purposes of the Section

This section has five major functions;

(1) Establishing rapport between the interviewer and the interviewee.
The better the rapport between the interviewer and the interviewee, the better the material collected by the interview is likely to be. Good rapport also makes the interview much more pleasant for both parties and improves the flow of information. The interviewer should appear friendly, alert, and interested, but without being too obviously intrusive. The interviewee should be allowed to talk, and not over-energetically harried with questions. As far as possible the child's interests and activities should be positively connoted, and a non-censorious attitude to his/her limitations and attitudes should be adopted. Attention should be paid to the maintenance of rapport throughout the interview, but the early stages are especially important in setting the tone for the rest of the session.

(2) Establishing the style of the interview.
At the start of the interview the interviewee does not know what to expect of it, or what sort of information s/he is being asked to provide. The early stages of the interview are therefore important in providing an opportunity for the interviewee to learn what is required.

(3) Collecting information about family structure, life and relationships.
This section represents an extension of the original family life and relationship section for use when more detailed information is required. A number of ratings are made of dimensions of family function and dysfunction that have been found to be related to child psychopathology in many studies. Many of these items are modified versions of material contained in the Child Life Events and Long-term Environment Adversity (CLELEA) interview, developed at the Institute of Psychiatry by Seija Sandberg and Michael Rutter.

(4) Finding entries to other sections of the interview.
This section is likely to throw up indications of areas of pathology, which may then be followed up.

(5) Collecting information relevant to the Incapacity ratings.
Many of the questions in these sections are directly relevant to the ratings of Incapacity. It is important, right from the start of the interview, that the interviewer should be thinking about disturbance at the level both of symptoms and incapacity.

Organization of the Section

The section is organized into 4 subareas:

(1) Family structure
(2) Family life and relationships
(3) Relationships with parents
(4) Relationships with siblings

FAMILY STRUCTURE

SIBLINGS

In this context, "siblings" include all children (or adults 18 or older) of the parents or parent substitutes who are responsible for the child, whether they are related by blood or not, and are listed in order of age (oldest first). Therefore, half-siblings and other children by previous marriages who may not be biologically related to the index child are included, as are "adoptive siblings" (which can mean that either the sibling or the child is adopted). This item includes siblings who either live or do not live at home with the index child. At this stage in the interview, the focus is on forming a picture of the current home environment of the child, with some understanding of the complications of the wider family group.

For each sibling, note name, relationship to child, sex, age, and whether the sibling has been in the home for one month of the primary period.

Newborns need not have lived in the home one month to be recorded as living in the home.

For siblings less than 1 year old, mark 0 for age.

1 = Full Sibling
2 = Half Sibling
3 = Step Sibling
4 = Adoptive Sibling
5 = Unrelated Child
6 = Other related child (e.g., cousins)
7 = Biological parent living in the home but non-functional in parental role

A half sibling is one who shares one common parent with the child. For example, a mother who remarries and has another child with her new husband; the half-siblings would both have the same mother.

A step sibling, is related to the child by marriage only, and shares no biological parent with the child.

MULTIPLE BIRTH

Note whether the target child is the product of a multiple birth. Code whether the parent believes the child to be an identical or non identical twin (or triplet, etc.). The child's position in that birth is then coded. A first born twin is coded as 1, even if s/he has older siblings.

Make a note of the evidence for identical/non identical status.
Code the details of the birth order here only if the child is the result of a multiple birth.

OTHERS IN THE HOUSE

Note here the name and status of any adult (other than adult siblings) who has lived in the house for at least 1 month during the previous three months.

Some families have very complicated patterns of relationships, and some children may have lived in various places during the three month primary period. The basis for these codings should be the site where the child has lived for the greatest proportion of the primary period, provided that there was at least one parental figure (that is, one who assumed some responsibility for attempting to control the behavior and discipline of the child) in the household during that time.

If the child has not lived at home for at least 1 month during the primary period, complete the Family Section on the last one-month period that s/he did live at home. If two different family placements of at least one month's duration have occurred during the primary period, the codings are made for the longest lasting of these. If there have been two placements of equal duration, the more recent is the basis for coding.

If there are more than ten others in the house, omit those who are the least closely related to the child. If further discrimination is required, omit those who have been there for the least time.

1 = Biological Parent
2 = Adoptive Parent
3 = Step parent
4 = Live-in partner of one parent (≥ 6 months)
5 = Live-in partner of one parent (< 6 months)
6 = Grandparent
7 = Other relative
8 = Paying Boarder
9 = Other
10 = Foster Parent

AGE AT ADOPTION

Enter the age (in years and months) at which the child was adopted by the current family, or the age at which a child is legally adopted by a step-parent.

FOSTER CARE

If child has ever been in foster care, code the number of foster homes and the earliest date of placement.
If child is currently in foster care, code the date of placement in that home.

BIOLOGICAL PARENTS' MARITAL STATUS

This item refers to the biological parents' latest marital status. Thus, if a couple lived together for a year, were then married for 5 years before being divorced, they would be coded 4 (Divorced).

If biological parents have a common law marriage (i.e. have cohabited for a period that the state determines is common law marriage) then code marital status as cohabited > 6 months.

Biological parents who prefer to live apart or are legally separated are coded as separated.

Note that this item refers only to the *biological* parents, and so does not necessarily refer to those who now "parent" the child.

NUMBER OF YEARS BIOLOGICAL PARENTS LIVED TOGETHER

The number of years that the *biological* parents lived together, regardless of marital status. Include the years that the child's biological parents lived together unwed, or the time biological parents lived together before getting married.

ETHNIC ORIGIN/RACE OF BIOLOGICAL PARENTS AND Child

This refers to the ethnic origin of each biological parent and the child. These categories have been established by the Federal Government for all Federal Grants.

AI = American Indian or Alaskan Native. A person having origins in any of the original peoples of North America, and who maintains a cultural identification through tribal affiliation or community recognition.

AS = Asian or Pacific Islander. A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes China, India, Japan, Korea, the Philippine Islands, and Samoa.

BL = African-American/Black African. A person having origins in any of the black racial groups of Africa.

HI = Hispanic. A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

WH = White (European or Middle Eastern). A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

OT = Other. A person of a previously unspecified origin, or a person insisting on a cultural identification of mixed origins.

If a parent or child has two backgrounds, code the primary ethnic origin (i.e. the ethnic group which the parent more strongly identifies him/herself with, or considers him/herself to be more a part of, or the origin s/he uses when filing taxes). This is important demographic information, however, if a parent feels strongly that s/he is a person of mixed origins, code other.

PARENTAL FIGURES

The term **Parent** refers to any adult who has lived in the child's home for at least 1 month, who assumes some responsibility for attempting to control the behavior and discipline of the child. Thus, a parent's live-in partner is regarded as a parent if s/he is involved in any way in providing discipline or care for the child.

For the entire Family Functioning Section, Parent #1 and Parent #2 refer to parental figures in the home who have lived with the child for at least 1 month in the 3 months being used in the family section. These are coded here as parental figures in the home.

Other Parent #1 and Other Parent #2 refer to parents who no longer live in the home. These may include biological parents, adoptive parents, step parents, or other "parents" who have had an impact on the child's upbringing. These are coded here as parental figures living elsewhere.

This section clarifies who are coded throughout the interview as Parent #1, Parent #2, Other Parent #1, and Other Parent #2. #1 and #2 are used in order to allow coding of atypical combinations of parents (two of the same sex as in having had two previous step-fathers, gay or lesbian parental relationships, or people who are not married as in mother and grandfather).

For the entire Family Functioning Section the mother and father refer to parental figures in the home, except as noted below. Information on who lives in the family home is coded separately under Others in Family Home. The relationship between the "parents" in the home is coded separately under Parental Relationships. The Marital Status of the Biological Parents is coded separately as well.

1 = Biological parent
2 = Adoptive parent
3 = Step parent
4 = Live-in partner of one parent (≥6 months)
5 = Live-in partner of one parent (<6 months)
6 = Grandparent
7 = Other relative
10 = Foster parent
11 = Unrelated adult serving as parent
12 = Deceased biological parent
13 = Deceased non-biological parent

Examples of Codings of Parental Figures: Child in home with both biological parents

If the child lives with both biological parents, code them throughout the section as Parent #1 and Parent #2.

If the biological parents have separated or divorced within the primary period and the parent now living elsewhere was in the family home for at least 1 month, code the biological parents as Parent #1 and Parent #2.

Child in home with one biological parent
If the child lives with one biological parent and a new partner who serves as a parent, and the other biological parent lives elsewhere, code the parent and the new partner as Parent #1 and Parent #2 respectively. Code the other biological parent living elsewhere as Other Parent #1.

If the child lives with one biological parent who does not have a new partner who serves as parent, code that parent at Parent #1, and the absent biological parent as Other Parent #1. As the child may have had very little contact with the biological parent living elsewhere, some of the questions may not be applicable and should be "S"ed.

If the biological parents are separated or divorced and share custody of the child exactly 50/50. the mother counts as Parent #1 and her home is the home used for the section. If the mother is unavailable to interview, and the father is available, the father is coded as Parent #1 with his home being used for the home section, and the mother becomes other Parent #1.

Child in home with no biological parent
If the child lives with adoptive/foster/step parents, both of whom are involved in parenting the child, code them as Parent #1 and Parent #2. If the child has any knowledge of or contact with the biological parents, code them as Other Parent #1 and Other Parent #2.

If only one adoptive/foster/step parent is in the home, with no current partner who parents, code him/her as Parent #1. Code the absent biological parents as Other Parents #1 and #2. If Parent #1's previous partner (who is not biological parent) served as a parent and is still involved in the child's life, you may choose to code him/her as an Other Parent, instead of a biological parent with whom the child has no contact.

If the child lives with another adult (e.g., grandmother, aunt, non-related person) who has a partner who serves as a parent, code them as Parent #1 and Parent #2. Code the absent biological parents as Other Parents #1 and 2.

If the child lives with another adult (e.g. grandmother, aunt, non-related person) who has no partner, code that adult as Parent #1. Code the absent biological parents as Other Parent #1 and #2.

Code aunts/grandparent/adult siblings as parents ONLY if they are acting as parent, instead of the mother or father. For instance, if the child lives with his/her biological mother and grandmother, but the latter does not act as a parent, as defined above, the grandmother would not count as Parent #2.

Child with deceased Parent(s)
If the child's parent(s) died during the primary period, code the parent as deceased. However, because the parent(s) was alive for at least part of the primary period, code information relevant to the child's relationship with that parent wherever possible throughout the Family Section.

If the child's parent(s) died prior to the primary period, code as deceased and complete the following items on the deceased parent: ethnic origin/race of biological parent, parental psychological problems, parental substance abuse problems, and parental arrests and prosecutions. For the age of deceased parents, code the age at time of death.

RELATIONSHIP BETWEEN PARENT #1 AND PARENT #2

The next three items refer to the current "marital" relationship that is the relationship between a "parent" with whom the child is living and his/her "most significant adult other."

In many families this will be the relationship between those coded as Parent #1 and Parent #2 for the Family Section. In other families where the child lives with only one parent, the coding is made for that parent's "significant other" which may be an exclusive or dating relationship.

These items are hierarchically arranged, and only one relationship of these three may be coded as being present. Code the highest possible in the hierarchy with a 2, and the others as 0. If there is no "significant other," all are coded as 0.

MARITAL RELATIONSHIP

A Marital Relationship is a legal marriage or any continuing relationship that a) has lasted at least six months, b) has been ongoing during the last three months, and c) has involved the partners living together in the same home, for at least one of the three months. A couple who have recently separated would still be considered as having a marital relationship here, if the above criteria have been met.

N.B. Include homosexual partnerships, if they fulfill the above criteria.

EXCLUSIVE PARTNERSHIP

An exclusive relationship that has been ongoing for at least three months, including at least one month of the past three months. The partner must also have been in the child's home for at least ten hours per week, during at least one month of the last three months.

DATING

A relationship that fulfills the criteria for an Exclusive Partnership, except that it does not meet the ten hours in the family home criterion.

FAMILY LIFE AND RELATIONSHIPS

Questions in this section can help determine what things the family does together. All the codings in this section require that the interviewer has an overall picture of relationships in the family.

Living at home

This item is coded 0 (yes) if the child has lived in a family home for at least 1 month during the primary period, regardless of whether s/he is actually living at home at the time of the interview. If the child has not lived at home for at least one month of the primary period, this item is coded as 2 (No).

For those children who have not lived at home for one month, the family section will be done on the last month that the child lived at home. If a child lived at home for a few weeks of the primary period, you need only to go back the number of weeks needed to construct a one month period living at home. For example, if a child lived at home for 1 week of the primary period, then you only need to go back 3 weeks.

For some studies where it is determined not to go back to a previous month period, the Family Section would be considered as structurally missing. If so, one would still complete the following items: list of siblings, multiple birth, biological parents' marital status, parental figures, ethnic origin/race of biological parents, living at home, number of weeks in home, other parenting, parental psychological problems, parental substance use problems, and parental arrests and prosecutions. Note that there is also a coding for the number of weeks that the child has lived at home during the last 3 months.

For children not at home for one month during the primary period, code the secondary period as the beginning of the month (or few weeks) time period used for the family section. If the child is in the home for one month of the primary period, S the secondary period.

RELATIONSHIPS WITH PARENTS

There are two basic dimensions of relationships with parents: a quantitative aspect, that is, time actually spent involved with parents; and a qualitative aspect, that is, the quality of the relationship during that time.

ACTIVITIES WITH PARENTS

Activities with parental involvement coded here

Assessed for Parent #1 and, if present, Parent #2

The six types of activities done together by parent and child are assessed: Outdoor activities, playing games and doing puzzles, floor time, watching T.V. or videos, reading, or other activities.

Assess how often the activity occurs. For floor time, outdoor activities, playing games and doing puzzles, floor time, and reading assess duration.

OUTDOOR ACTIVITIES TOGETHER

Activities done together outside of the house

Include here going to the park, playing ball, riding bikes, taking a walk, going to the fair, getting an ice cream cone together.
Do not include activities that the child does with parent that do not have interaction with the child as the main purpose e.g. going food shopping. If shopping together (like for clothes or toys) is an activity that parent and child do together as a way to interact with each other, do include.

PLAYING GAMES/DOING PUZZLES TOGETHER

Playing indoor games (board games, video games, computer games, made-up games) or putting together puzzles with the child

Code games like baseball or hopscotch as Outdoor Activities. Most of the activities coded here are considered indoor games, even if the checker board is brought out to the porch to play checkers on a warm day.

FLOOR TIME

Either playing with the child or giving the child one's full attention while child plays.
The parent need not literally be on the floor with the child but must make a clear attempt to be physically close to the child and engaged in and/or attentive to the child's play activity.

Play here includes fantasy play with dolls or action figures, construction with blocks, or doing art projects or cooking projects together.

WATCHING T.V. OR VIDEOS TOGETHER

Both parent and child attend to T.V. show or video show at the same time.
Exclude being in the same room with the T.V. on with one or neither person actually watching the program.

READING TOGETHER

Reading or looking at books or magazines with each other.
If parent has difficulty reading, s/he may still like to look at picture books with the child.

OTHER ACTIVITY DONE TOGETHER

Other interactive activity described by the parent.

After each of these areas have been discussed, these activities, overall, in which the child is involved with his /her parents, are rated according to the degree of pleasure, displeasure, or disinterest associated with them for the child.

0 = All, or most (at least 75%) shared activities said to be a source of enjoyment to the child.
2 = At least some activities (25-74%) of shared activities are a source of tension, worry or disinterest to the child.
3 = Most (at least 75%) or all shared activities are a source of tension, worry or disinterest to the child.

The coding is made regardless of the interviewer's views as to whether the activities engaged in ought to be enjoyable, and of the duration of such activities (which is coded under separately). If a relationship has changed during the primary period (e.g. a negative relationship which got better after child received treatment), code the worst that the relationship has been during the primary period.

CHILD-PARENT COMMUNICATION

Frequency of conversations between child and each parent, regardless of who initiates the conversations, and regardless of whether the child or parent enjoys the conversation.

Differentiate from Arguments and Criticisms. A conversation is a verbal exchange that does not involve shouting, or aggressive exchanges, and is not explicitly focused on disciplinary matters or criticism.

Separate codings are made for each parent.

Code the number of conversations meeting criteria during the primary period.

PARENT USES CHILD AS CONFIDANT(E)

The parent talks over his/her own problems with child, or looks to the child for emotional support. For instance, expecting comfort from the child when upset.
Separate codings are made for each parent.

2 = Child is sometimes used as a confidant(e), but is not the only person who fulfills this role

3 = Child is the parent's only confidant(e)

PARENTAL SUPERVISION/CONTROL

The parents fail to provide sufficient supervision for a child, as shown by frequent lack of knowledge of the whereabouts of the child, or failure to provide age-appropriate protection. Evidence of inadequate supervision includes lack of exercise or awareness of degree of protection required, plus a lack of concern, or failure to intervene when the child behaves in a deviant fashion, or in a way that is likely to lead him/her into trouble.

0 = An appropriate level of supervision/control for child's age and circumstances.

2 = Some lapses in age appropriate supervision/protection of child.

3 = Clear lapses in age appropriate supervision/protection of child. Also included here is the situation in which a parent has given up trying to supervise/discipline his/her child.

PARENTAL DISCIPLINE

METHODS OF DISCIPLINE

Information is initially about any forms of discipline meted out by each parent separately over the last three months (time out, spanking with hand, spanking with implement, marks or bruises, being sent to a particular room, being locked in a room, closet or other space, and loss of privileges.) Lifetime marks or bruises are also coded. Severe restrictions of a child's activities, for long periods of time, are also included in this rating

DISCIPLINARY STYLE

Disciplinary Style is assessed separately for Parent #1 and Parent #2.

0 = Absent

2 = Physical discipline, delivered coldly, or frequently in anger, unaccompanied by a generally nurturing atmosphere.

Interviewers should be alert to the possibility of physical abuse when this item is positive. In particular, a rating of 2 should be discussed with a supervisor, and the study's protocol for the management of cases of possible child abuse should be set in motion when appropriate.

VERBAL DISPRAISE

Parent addresses child in a derogatory manner, using words and expressions or sarcasm that demean the child. Criticism is not phrased constructively.

The key distinction to be considered here is between condemnation of a child's actions and condemnation of the child him or her self. For instance, if a child is rebuked for pulling the cat's tail, saying "it's bad to hurt the cat" *is not* Verbal Dispraise. Saying "you're a bad boy" *is* Verbal Dispraise.

Do not include jocular or teasing dispraising comments unless such teasing meets PAPA criteria for Teasing.

VERBAL DISPRAISE BY PARENT #1

0 = Absent

2 =Occasional verbal dispraise by parent

3 = Verbally dispraising statements by parent are characteristic

VERBAL DISPRAISE BY PARENT #2

0 = Absent

2 =Occasional verbal dispraise by parent

3 = Verbally dispraising statements by parent are characteristic

VERBAL REJECTION BY PARENT #1

Parent #1 addresses the child with words or a tone that pushes the child away or puts a barrier between them.

0 = Absent

2 = Present

VERBAL REJECTION BY PARENT #2

Parent #2 addresses the child with words or a tone that pushes the child away or puts a barrier between them.

0 = Absent

2 = Present

SELECTIVE NEGATIVE VIEW

The target child is regarded more negatively by his/her parents than the other child(ren) in the family. Just because one child has more problems, it does not mean that s/he will be the subject of a selective negative view. To be rated here, the parent must feel that the child is difficult. The child must actually receive different treatment from the other child(ren). Include different verbal, as well as behavioral, treatment.

Thus, a child who was subjected to the same disciplinary rules as his/her sibling(s), but because of worse behavior was punished more often, would not be regarded as being subjected to a Selective Negative View. This category is reserved for children who are subjected to disciplinary rules that are stricter than those imposed upon their siblings.

0 = Target child treated in same way as rest of children

2 = Target child is consistently treated differently from his/her siblings in a negative manner in some areas.

3 = Target child is regarded as being markedly different from other children in family, and subjected to markedly different rules or restrictions.

The coding should be **3** only when the target child is consistently placed under a more severe regime than his/her sibling(s), and where there is evidence that even when the sibling(s) act in a similar way, they are dealt with less severely. Getting examples of how episodes of disobedience by the target child and his/her sibling(s) are handled by the parents will help to clarify the coding here.

Separate codings are made for each parent.

OTHER PARENTING

Code here any relationship that the child has with Other Parent #1 and/or Other Parent #2.

Number of visits, the average duration of visits, and number of phone calls/letters are also coded.

Relationship with other parent

S = No Relationship (e.g. never met mother, or father left when very young).

0 = No evidence of relationship problems with absent parent.

2 = Relationship with the absent parent has negative aspects (for instance, the child argues with the absent parent, or resents the absent parent's new partner). However, despite these difficulties, the relationship has definite positive aspects, and is valued by the child.

3 = Relationship with the absent parent is almost completely negative (for instance, the child is very unhappy until the visit ends, or is persistently difficult or out of control during visits to, or from, the absent parent). For a 3 to be coded, the child should usually wish to avoid further visits involving the absent parent.

The overall relationship with an absent parent can be coded even if no contact with that person has occurred in the primary period.

SIBLING RELATIONSHIPS

RELATIONSHIPS WITH SIBLINGS

Refers to the quality of the child's relationship with each sibling, regardless of the sibling's place of residence.

0 = The child has a relationship with the sibling that is characterized by a generally positive tone. Interactions are more likely to be harmonious than conflictual; joint activities are usually pleasurable; and it is uncommon for either to try to avoid the other.

1 = The child has a relationship with the sibling which is "Neutral," as in the case of a teenager who is mostly out of the house, and has little to do with his/her brothers and sisters.

2 = The child has a relationship with the sibling that is characterized by a generally negative tone. Interactions are more likely to be conflictual than harmonious and joint activities are usually either avoided or unpleasurable.

S = The child has or knows of relations, such as half-siblings, but there has been basically no contact. Do not use S to indicate that there was a relationship, but they no longer see each other because of a negative relationship. That would more correctly be coded as 2.

CHILDCARE ARRANGEMENTS INCLUDING DAYCARE/SCHOOL SETTINGS

Purpose of the section

The section has 3 major functions:

(1) To provide information about the settings where the child is cared for during the day.

(2) To provide information about the types of people, besides the parents, who care for the child.

(3) To define DAYCARE/SCHOOL so as to provide a reference point for the daycare/school setting referred to through out the PAPA.

Organization of the Section

The section is organized as a single unit.

CHILDCARE ARRANGEMENTS INCLUDING DAYCARE/SCHOOL SETTINGS

Information is gathered about:

(1) the **various settings** where the child is cared for such as at the child's home, at another private home, in a non-home group setting.

(2) the **different people** who care for the child including the child's parental figures, other relatives, and non-relative care givers such as babysitters, teachers, day care workers.

(3) the **number of other children**, sibling and non-sibling whom the child is with when s/he is being cared for.

For the purposes of this section, a **parent figure** is defined as parent #1, parent #2, other parent #1, or other parent #2.

A **non-parental relative** is another related person (either adult or child) who is not a parent figure. Do not include Godparents as related.

Non-sibling children include cousins and other non-sibling child relatives, as well as other children who are not related to the child.

A **child caregiver** is a person younger than 18 years old.

We are looking here for a **pattern of regular care in a typical week**. This excludes occasional (not standing) play dates or the occasional presence of another child in the setting e.g. care giver brings own child once a month or less when the child doesn't have school or is sick. This also excludes being babysat once a month when the parent goes to the movies. Yet, it would include a standing babysitting arrangement i.e. the parent goes out the movies every Thursday night. If the childcare arrangement occurs in three out of four of the weeks of a month code as regularly occurring. If they occur every other week or less, do not code as regular.

A schedule of a week is included with a list of the 28 possible child care arrangement to help the interviewer sort out the variety of the child's child care experiences. Code only settings where the child spends an hour or more a week.

After the interview, code the number of hours per week the child spends in each setting.

For time at home, when it is unclear whether Parent #1 or Parent #2 is providing care (i.e. both are caring for the child), code for both.

TYPES OF CHILDCARE ARRANGEMENT

These are the 28 possible types of child care arrangements.

PARENTAL CARE

0 = Parent #1 provides care with no non-sibling children regularly present

1 = Parent #1 provides care with no more than two non-sibling children regularly present

2 = Parent #1 cares for child and provides group care (3 or more non-sibling children) at the same time

3 = Parent #2 provides care with no non-sibling children regularly present

4 = Parent #2 provides care with no more than two non-sibling children regularly present

5 = Parent #2 cares for child and provides group care (3 or more non-sibling children) at the same time

6 = Other Parent #1 provides care with no non-sibling children regularly present

7 = Other Parent #1 provides care with no more than two non-sibling children regularly present

8 = Other Parent #1 cares for child and provides group care (3 or more non-sibling children) at the same time

9 = Other Parent #2 provides care with no non-sibling children regularly present

10 = Other Parent #2 provides care with no more than two non-sibling children regularly present

11= Other Parent #2 cares for child and provides group care (3 or more non-sibling children) at the same time

IN HOME NON-PARENTAL CARE

NON-GROUP CARE IN CHILD'S HOME

12 = Care provided in child's home by adult relative with no non-sibling children regularly present

13 = Care provided in child's home by adult non-relative with no non-sibling children regularly present

14 = Care provided in child's home by child (< 18 y.o.) with no non-sibling children regularly present

GROUP CARE IN CHILD'S HOME

ONE OR TWO NON-SIBLING CHILDREN

15 = Care provided in child's home by adult relative with no more than two non-sibling children regularly present

# of non-sibling children regularly present

16 =Care provided in child's home by non-adult relative with no more than two non-sibling children regularly present

# of non-sibling children regularly present

17 = Care provided in child's home by child (<18 y.o.) with no more than two non-sibling children regularly present

# of non-sibling children regularly present

THREE OR MORE NON-SIBLING CHILDREN

18 = Group care (3 or more non-sibling children present) provided in child's home by the child's relative

# of children
# of teachers/teacher's aides/daycare providers/care givers present

19 = Group care (3 or more non-sibling children present) provided in child's home by no-relative
# of children
# of teachers/teacher's aides/daycare providers/care givers present

OUT OF HOME NON-PARENTAL CARE

NON-GROUP CARE OUTSIDE OF CHILD'S HOME

20 = Care provided outside of child's home but in a private home by adult relative with no non-sibling children regularly present

21 = Care provided outside child's home but in a private home by adult non-relative with no non-sibling children regularly present

GROUP CARE OUTSIDE OF CHILD'S HOME

ONE OR TWO NON-SIBLING CHILDREN

22 = Care provided outside of child's home but in a private home by adult relative with no more than two non-sibling children regularly present

# of non-sibling children regularly present

23 = Care provided outside child's home but in a private home by adult non-relative with no more than two non-sibling children regularly present

# of non-sibling children regularly present

THREE OR MORE NON-SIBLING CHILDREN

24 = Group care (3 or more non-sibling children present) provided in private home that is not child's home

# of children
# of teachers/teacher's aides/daycare providers/care givers present

GROUP CARE IN SETTINGS OTHER THAN A PRIVATE HOME

25 = Group care (3 or more non-sibling children present) provided in setting other than a private home

# of children
# of teachers/teacher's aides/daycare providers/care givers present

26 = Religious preschool/school provided in setting other than a private home
The school program has a curriculum that includes some religious training or religious practices.

# of children
# of teachers/teacher's aides in the classroom

27 = Secular preschool provided in setting other than a private home

# of children
# of teachers/teacher's aides/daycare providers/care givers present

28 = Other

DAYCARE/SCHOOL SETTINGS

It is necessary to define the subset of childcare arrangement that we call "Daycare/School" so as to provide a reference point for the daycare/school setting referred to through out the PAPA. "Daycare/School" may refer to one setting (e.g. the child goes to preschool only) or to more than one setting (e.g. the child goes to preschool and then in the afternoon goes to an in-home daycare)

CHILD ATTENDS DAYCARE/SCHOOL

Child regularly spends more than 1 hour a week in any of settings #18, #19, and #22-#27.

18 = Group care (3 or more non-sibling children present) provided in child's home by the child's relative
19 = Group care (3 or more non-sibling children present) provided in child's home by no-relative
22 = Care provided outside of child's home but in a private home by adult relative with no more than two non-sibling children regularly present
23 = Care provided outside child's home but in a private home by adult non-relative with no more than two non-sibling children regularly present
24 = Group care (3 or more non-sibling children present) provided in private home that is not child's home
25 = Group care (3 or more non-sibling children present) provided in setting other than a private home
26 = Religious preschool provided in setting other than a private home
27 = Secular preschool provided in setting other than a private home

The settings used to determine if the child goes to daycare/school or not will serve as the reference point for all of the questions in the PAPA that refer to daycare/school setting. Thus, if the child attends more than one program, the child's behavior in all of the programs should be considered in the codings. If the child is more disobedient in one program than another, code for the worst disobedience in any of the program

Determine the number of weeks the child is enrolled in an overall daycare/school setting in the last 3 months, the number of day the child is actually present in the last 3 months, and the number of weeks where the child is present at least 1 day per week in the last 3 months. Exclude weeks of vacation or extended illness. Include weeks when enrolled but missed daycare/school because of worry/anxiety.

ENROLLMENT IN FEDERAL OR STATE ENTITLEMENT PROGRAMS

Child is enrolled in a federally or state funded program to provide education, daycare, health insurance, or food.

ENROLLED IN HEADSTART/SMART START/EARLY HEADSTART PROGRAM

Child enrolled in Head Start or Smart Start or Early Head Start
or other education or daycare enhancement program

ENROLLED IN CHIPS TYPE FEDERAL MEDICAID INSURANCE PROGRAM

Child enrolled in federal Medicaid insurance program

FREE OR REDUCED PRICE MEAL PROGRAM

Qualifies for participation in a federal or other program which offers meals free or at a reduced price to children whose family income does not meet a certain level. If qualifies, but does not utilize, code 2.

OTHER SIMILAR PROGRAM

PLAY/PEER RELATIONSHIPS

Purposes of the Section

The section has 3 major function:

(1) To provide an picture of the range, character and quality of the child's play activities.

(2) To provide information about areas of play that may be associated with psychopathology.

(3) To provide the interviewer with a picture of the range, character and quality of the child's relationships with his/her peer group.

Organization of the Section

The section is organized in 2 sub-areas: Play and Peer Relationships

PLAY

No ratings are made here, but the information collected should be borne in mind for ratings contained later in the interview. A list of possible activities for consideration is provided, but it is obviously not exhaustive and interviewers should ask about any relevant activities that the child may take part in:

Collecting/making things
Sports/physical activities
Out to play with other children
Reading/Being read to
Playing with toys/games
Building
Singing
Drawing
Computer games
TV viewing

PHYSICAL PLAY

Games or other activities that involve mastery and expression of physical skill such as climbing a jungle gym, dancing, playing ball, roller blading, or riding a bike. Physical play is in contrast to more sedentary play such as playing with a doll house, coloring, playing with a train set etc.

0 = Does not enjoy physical play

2 = Enjoys physical play but has a strong preference for sedentary play

3 = Enjoys physical play and has no preference for it over sedentary play

4 = Strongly prefers physical play over sedentary play

Assess how often the child plays this way by him/herself and how often with other children including peers and siblings and with adults.

SYMBOLIC PLAY

Pretend play that uses the imagination to develop simple or complex concepts, stories, and/or games. Pretend play has its own internal logic and rules set by the children playing. Thus, the story may not be logical or even fully comprehensible to adults but has meaning and coherence to the child.

NOTE THAT IMAGINATIVE PLAY AND PHYSICAL PLAY ARE NOT MUTUALLY EXCLUSIVE

COMPLEXITY OF SYMBOLIC PLAY

Complexity is defined by three characteristics. 1. The number of actions or steps in the narrative. 2. The number and subtlety of the roles in the play. Note that the child may play all of the roles! 3. The evolution/creative unfolding of the narrative over time.

Code the level of complexity (0 most complex 3 least complex) that child employs the majority of the time (≥75%)

0 = Elaborate make believe story or game that involves an evolving narrative, with more than one role and multiple steps e.g. playing house, school

1 = Simple elaboration of pretend story that has only two or three steps e.g. calling a doll a baby, feeding it a toy bottle and tucking it into bed
2 = Single acts of pretend play for representation or elaboration of daily activities and/or experiences e.g. pretending to drink from a toy cup, pretending to talk on a toy telephone, pretending a shoe is a telephone

3 = Few or no demonstrations of pretend play

Assess how often the child plays pretend games by him/herself and how often with other children including peers and siblings and with adults.

IMAGINARY FRIEND

Invisible make-believe friend who provides companionship to the child.

The child might set a place at the table for the imaginary friend, tell his/her parent about the imaginary friend's like and dislikes, and may talk to the imaginary friend either alone or in the presence of others. The child might also blame the imaginary friend for his/her own mistakes.
While the child might protest if the existence of the imaginary friend is challenged, the child does not seem in the grip of a delusion or hallucination.

Code for last three months and ever

0 = Absent

2 = Present and one imaginary friend.

3 = Present and more than one imaginary friend at one time.

Code the gender(s) of the imaginary friend(s).

PREOCCUPATION WITH AGGRESSIVE THEMES IN PRETEND PLAY

Child repeatedly and regularly plays fantasy games with aggressive themes, including war, shooting with guns or other weapons, fighting, injury, and blood and gore.
Get examples.

0 = No. Violent and/or aggressive themes do not emerge in play or are present 10% or less of the time

2 = Yes. Violent and/or aggressive themes emerge in play and are present more than 10% of the time

Amount of play with aggressive themes

1 = About a quarter of the play (~25%)

2 = About half the play (~50%)

3 = About three quarters of the play (~75%)

4 = Almost all the play (~100%)

Change

0 = Amount of aggressive play or the intensity of the play has decreased during the last three months

1 = Amount of aggressive play or the intensity of the play has stayed the same during the last three months

2 = Amount of aggressive play or the intensity of the play has increased during the last three months
months

WITHDRAWS INTO IMAGINATION WHEN CHALLENGED OR STRESSED

When faced with a difficult or challenging situation, child tunes out present situation and retreats into own fantasy world.

0 = Does not withdraw into fantasy world when challenged or upset

2 = Withdraws into private fantasy world when challenged or upset but can clearly distinguish between reality and fantasy

3 = Withdraws into private fantasy world when challenged or upset and seems to have difficulty distinguishing between reality and his/her fantasy world

LIMITED RANGE OF PLAY

Child's play is static, unimaginative, and repetitive with a mechanical quality and does not change over time; and/or child has unusual preoccupations that limits the range of his/her play activities.

REPETITIVE STATIC PLAY

0 = Absent. Child may play the same game or with the same toy over and over but the play changes as the child actively uses his/her imagination

2 = Child's play is involves a fixed pattern of activity that changes little

PREOCCUPATION WITH PARTS OF TOYS OR OTHER OBJECTS

0 = Absent

2 = Present

UNUSUAL PREOCCUPATION WITH SPECIAL INTERESTS/ACTIVITIES

Child has a preoccupation with a special interest or activity. The child talks about the interest, or would talk about the interest if allowed, most of the time.

Special interests may include dinosaurs, Pokeman cards, baseball cards, baseball statistics, trains, bus timetables, information about the planets, a video game.

Many if not most young children develop a passion, indeed serial passions, for certain topics, toys, and games. The important things to determine here is whether the child is preoccupied (it is the only thing s/he wants to talk about) and whether the preoccupation interferes with the child's activities.

0 = No preoccupying object, activity or topic of conversation

2 = Special preoccupying interest but does not interfere in activities

3 = Special interest that is preoccupying to the degree that it interfere in at least 2 activities

4 = Special interest that is preoccupying to the degree that it interfere in almost all activities

For the frequency, assess how frequently the child talks about or "does" (e.g. plays with the toys, arranges the cards, etc) his/her special interest.

CONSTRUCTIVE PLAY

Play activity focused on building or constructing/creating objects, inventions, works of art

Constructive here has a narrow definition of play that is involved in the act of construction and making a physical objects.

When assessing frequency, distinguish between the time spent building/creating and the time using the construction for other kinds of play. For example, if a child makes trains out of LEGO, code the time spent building. If the child then plays with the trains in a pretend story about "Thomas the Tank Engine" code the time as symbolic play.

0 = Does not enjoy building or making things

2 = Enjoys constructive play but prefers other kinds of play

3 = Enjoys constructive play and no strong preference for or against it compared with other kinds of play

4 = Strongly prefers constructive play over other kinds of play

Assess how often the child builds or makes things by him/herself and with other children including peers and siblings and with adults.

RULE-DEFINED GAMES

Able to play organized, rule-defined games that require skill and decision making with minimal help from an adult or other children. Games include card games, board games, computer or video games, or ball games

To play an organized, rule-defined game the child must understand the rules or basic structure of the game, have the cognitive or physical skill to play the game, and possess the ability to make decisions about moves or actions during the game.

More than minimal help includes coaching the child through each or most moves, excusing the child's inability to follow the rules etc. Examples of minimal help include giving non-directive advice: "Do you really want to move your checker there?" "It's good to buy Park Place!"
Do not code as a 0 a child who can only a play a game if s/he is on an older child or adult's "team" as a co-player.
Exclude very simple games like Ring around the Rosy or Patty Cake.

Code Cheating in the conduct section

0 = Able to play two or more organized, rule-defined games

1 = Able to play one organized, rule-defined game
2 = Unable to play organized, rule-defined games because of lack of skill, ability to make decisions, and/or inability to understand the rules

Code how frequently the child plays each type of game, alone and with other children including siblings or peers, and with adults.

TELEVISION WATCHING

In general, the amount of time per week the child spends watching television. Watching means attending at least with half attention to the television. Thus, if the television is always on in the house, code the amount of time child actually attends to the shows. But is the child is drawing or playing while also watching television, code as present.

Assess how many hours of television are watched each day and each week.

Also determine if child has a television in his/her own bedroom. If the child sleep with the parents and does not have his/her own room, code as an S.

PEER INTERACTIONS AND RELATIONSHIPS

DOMINANT MODE OF PLAY INTERACTIONS WITH PEERS

Child's dominant play interactions with other children. Play here can refer to physical play, constructive play, symbolic play, or games.

PARALLEL PLAY: Independent play that occurs in close proximity to another child who is engaged in similar play (e.g., the child digs in the same sandbox near to another child who is also playing in the sand). The child does not interact directly with the other child.

ASSOCIATIVE PLAY: Play in which the child interacts with another child while using the same play materials (e.g., the child and another child are both building towers from blocks and interact with each other as they build).

COOPERATIVE PLAY: Complex interactive play involving different roles, coordinated actions, and joint construction (e.g., the child plays a pretend games or constructs a space ship out of LEGO with another child).

PREFERS TO PLAY ALONE

If given a choice, child would prefer to play by him/herself rather than with another person.

0 = No

1 = Chooses to play alone at times but also enjoys playing with others

2 = Strongly prefers playing alone and rarely enjoys playing with others

FREQUENCY OF CONTACT WITH PEERS

The frequency with which the child meets with others, who are not family members, during his/her leisure time. Peers can be child's friends, acquaintances, or peers in neighborhood.

0 = Sees at least 1 peer outside of daycare/school more than once per week

2 = Sees at least 1 peer outside of daycare/school between once per week and once every two weeks

3 = Sees less than 1 peer outside of daycare/school in 2 weeks

AGE APPROPRIATENESS OF FRIENDS

The degree to which the child's friends are within two years of his/her own age. Friends, in this context, refer to those with whom the child spends leisure time, and who are not family members.

BEST FRIEND

An intensive, selective, and exclusive, or semi-exclusive friendship with another child (either sex), in which there is an expectation that the dyad does things together and have a special preferential bond. Long distance relationships with infrequent contact do not count. Siblings are not coded as best friends.

To be rated as a best friend, the friend can be no more than 5 years older than the child. There may be one or two "best friends" at any one time, but if the friendship involves three or more peers this would not be included as a definite "best friend" relationship.

0 = Definite best friend in the last year.
1 = Uncertain (three or more close friendships described as "best").
2 = No best friend in the last year.

DIFFICULTY MAKING OR KEEPING FRIENDS

Child has difficulty either forming or maintaining friendships, which is evidenced by having no or few friends. The difficulty may be due to failure to approach other children (withdrawal) or aggressive relationships with other children (discord) or both. Do not include worry or anxiety about friendships unless it leads to difficulty in making or keeping friendships.

2 = Definite difficulty in making or keeping friends, but has managed to maintain friendship for at least 3 months since onset.

3 = As above, but has had no friendship lasting as long as 3 months since the onset of difficulties.

Assess the dominant reason that the child has difficulty making friends:

Shyness
Physical aggression
Verbal aggression
Lack of interest
Other

CONFLICTUAL RELATIONSHIP WITH FRIENDS

The child has relationships with a friend or friends that include substantial amounts of physical or verbal aggression or arguments. This interaction could be considered acceptable among some peer groups, but should still be coded.

Do not include sporadic arguments among peers, this item includes only relationships with an overall conflictual tone.

2 = Present with at least one friend

3 = Most or all friendships characterized by conflictual relationships

Assess whether conflict interferes with child's ability to make or keep friends.

SHYNESS WITH PEERS

Sensitive reluctance to approach peers who are little known to the child.

0 = Absent

2 = Shyness involving definite discomfort on meeting new people with whom the child has no special reason to feel such discomfort, but not involving active avoidance of such contacts.

If shyness is present, consider whether it meets criteria for Social Anxiety, Behavioral Inhibition, or Inhibition during Social Interactions. If it does, both Shyness and other relevant item are coded as being positive.

BEHAVIORAL INHIBITION

Child becomes constricted and constrained and/or withdrawn when confronting or interacting with an unfamiliar adult or child.
Consider also Shyness with Peers, Social Anxiety, and Inhibition during Social Interactions

CHILD IS TEASED/BULLIED

The child is a particular object of mockery, or physical attacks, or threats from other children. Include bullying by siblings.

0 = Absent

2 = Child reports being a particular and preferred object for bullying or teasing. That is s/he is at least somewhat singled out for this sort of attention.

Do not include children who are subject to some bullying, but not to a greater extent than his/her peers.

The frequency of occurrence in 3 environments is then coded.

DEPRESSION

Purposes of the Section

This section has 5 major functions:

(1) To provide information relevant to the diagnosis of a variety of depressive disorders.

(2) To provide an opportunity for the evaluation of the childs' mood state in general.

(3) As a follow up to the worries and anxiety section.

(4) To provide an entry point for the suicide and self-injurious behavior section.

(5) To provide an entry point for the assessment of the child's functional incapacities resulting from his/her psychiatric symptoms.

Organization of the Section

The section is divided into 3 sub-areas:

(1) Depressed affect

(2) Conative problems

(3) Depressive cognitions

DEPRESSED AFFECT

DEPRESSED MOOD

Feelings of low mood. Depressed mood may be described in a number of ways, for instance as feeling unhappy, miserable, blue, low spirited, being down in the dumps or dejected. See page A - 14 of the glossary for coding mix of 2 & 3 intensities.

Distinguish from other unpleasant affects, e.g. Nervous Tension or Anxiety, and from Apathy and Anhedonia. It is also important to make sure that it is the mood itself that is being rated and not its "expected" concomitants (such as apathy, self-depreciation or crying). Items such as these are rated separately and if they are used as evidence of depression as well, spurious relationships will be generated by the interviewer.

0 = Absent

2 = The depressed mood is sometimes intrusive and uncontrollable, but also sometimes alleviated by enjoyable events or activities.

3 = Scarcely anything is able to lift the mood.

EPISODE OF DEPRESSED MOOD

0 = Absent

2 = At least 1 week with 4 days with depressed mood

3 = Period of 2 consecutive weeks where depressed mood present on at least 8 days

PERIOD OF 2 CONTINUOUS MONTHS WITHOUT DEPRESSED MOOD IN LAST YEAR

0 = Yes

2 = No

LOOKS UNHAPPY

Parent's evaluation that the child characteristically looks unhappy. The parent must regard this as being abnormal for the child's age or developmental stage.

0 = Absent

2 = Child looks unhappy in at least 2 activities but looks more cheerful at times

3 = Child hardly ever looks normally cheerful

ALLEVIATION OF DEPRESSED MOOD

This item refers to any means that the child may find effective in alleviating his/her Depressed Mood. It is only applicable if a 2 has been coded under Depressed Mood. Obviously if Depressed Mood is not present as defined in this glossary then it cannot be alleviated. If, on the other hand, it is present at intensity level 3 then it is, by definition, essentially unalleviable.

Two possible mechanisms of mood alleviation should be considered:

(i) Alleviation by Self-Generated Means. The child alleviates the Depressed Mood by actively involving him/herself in other thoughts or activities.

(ii) Alleviation by External Means. Refers to a more passive process in which the child finds that his/her mood is alleviated by the occurrence of other activities or events, without his/her willfully using them for this purpose.

Both mechanisms may be employed by any individual.

0 = Means of Alleviation never employed.

2 = Means of Alleviation employed at least sometimes.

S = Alleviation not applicable, i.e. child is rated 0 or 3 on depressed mood.

DIURNAL VARIATION OF MOOD

Depressed mood is consistently worse either in the first or second half of the day, irrespective of external events. The interviewee must report a difference in the intensity of the depressed mood that is of a degree noticeable to others, even though no one may have noticed or commented on it.

Two possible forms may be coded:

AM worst

0 = Absent

2 = Present

PM worst

0 = Absent

2 = Present

AGITATION

This symptom is an account of markedly *changed* motor activity associated with depressed mood. In moderate degree it is shown by fidgeting various parts of the body and an inability to stay still. In severe degree, it is expressed by pacing up and down and wandering about and an inability to sit down for very long. In all degrees, it must appear to be accompanied by unpleasant affect.

0 = Absent

2 = Agitation is present in at least two activities and cannot be entirely controlled, but sometimes the child can inhibit his/her agitation with effort.

3 = Agitation is almost entirely uncontrollable.

REPORTED TEARFULNESS AND CRYING

Eyes filling with tears or actual shedding of tears as a response to an internal state of unhappiness or misery.

Do not rate crying in response to obvious precipitants (such as sad situations or anger or being spanked or disciplined).

0 = Absent

2 = When feeling miserable, the eyes fill with tears, or shed tears, at least sometimes uncontrollably, in at least 2 activities

3 = When feeling miserable, the eyes nearly always uncontrollably fill with, or shed, tears in most activities

EASILY FRUSTRATED

The child is generally more prone to feelings of frustration, under minor provocation than most children. This pattern need not represent a change in behavior.

0 = Absent

2 = Present

ANGER AND IRRITABILITY

The three items making up this section may lead to confusion unless careful attention is paid to the definitions. In essence, anger and irritability are being assessed at two levels: that of proneness to *feelings* of anger (as in Touchy or Easily Annoyed) , and that of angry behavior (as in Angry or Resentful). For these first two items, a change does not have to have been noted, so that a child who had always been like this would be coded positively here. Irritability requires the presence of *both* increased proneness to feelings of anger *and* angry behavior. It also requires that a change must have been observed, but does *not* stipulate that the mood or behavior need occur more than in most children. Thus all three of these items may be rated as being present in the same person.

TOUCHY OR EASILY ANNOYED

The child is generally more prone to feelings of anger, bad temper, short temper, resentment, sulking, or annoyance, **under minor provocation** than most children.

This pattern need not represent a change in behavior.

0 = Absent

2 = Present

ANGRY OR RESENTFUL

The child is generally more prone to manifestations of anger or resentment (such as snappiness, shouting, quarreling, or sulking) **under minor provocation**, than most children.

This pattern need not represent a change in behavior.

0 = Absent

2 = Present

IRRITABILITY

Increased ease of precipitation of externally directed feelings of anger, bad temper, short temper, resentment or annoyance compared with the child's normal state. The change (increased ease of precipitation) may predate the primary period but the altered state must still be present in the primary period in order to code. These feelings must be overtly expressed to at least some extent, though the child may report that s/he keeps him/herself under control most of the time. Note that this rating is of a change in the child's usual liability to be precipitated into anger, it does not refer to the form of the anger once it has been precipitated. Thus, a child who reported hitting people when angry, whereas he had previously kept his/her feelings to him/herself, but denied getting angry any more easily than usual, would not be rated as being more irritable here.

N.B.: The irritable mood itself is being rated, not just its manifestations; thus, frequency and duration ratings refer to the number and length of episodes of the mood, not of the episodes of snappiness, shouting or quarrelsomeness.

0 = Absent

2 = Irritable mood present in at least 2 activities, manifested by at least one instance of snappiness, shouting or quarrelsomeness, and at least sometimes uncontrollable by child.

3 = Irritable mood present in most activities, accompanied by snappiness, shouting or quarrel-someness, and nearly always uncontrollable by child.

EPISODE OF IRRITABLE MOOD

0 = Absent

2 = At least 1 week with 4 days with irritable mood

3 = Period of 2 consecutive weeks where irritable mood present on at least 8 days

PERIOD OF 2 CONTINUOUS MONTHS WITHOUT IRRITABLE MOOD IN LAST YEAR

0 = Yes

2 = No

CONATIVE PROBLEMS

BOREDOM

A state in which activities that the child actually engages in seem dull and lacking in interest. Everyone gets bored sometimes, so code a child positively here only if s/he is more often bored than not. But code as positive even if the activities are truly dull. It must seem to the child that other potential activities would be of interest even if it is uncertain what these other activities might be.

Differentiate from loss of pleasure and loss of interest, where nothing seems to be of potential interest or likely to give pleasure.

0 = Absent

2 = Bored more than half the time.

3 = Bored almost all the time.

LOSS OF INTEREST

Refers to diminution of the child's interest in his/her usual pursuits and activities. Either some interests have been dropped or the intensity of interest has decreased. Everyone has interests of some sort, but the extent of the diminution must be measured in the context of the range and depth of the child's usual activities. Take into account everyday daycare/school and home activities as well as leisure pursuits, keeping well informed, taking an interest in clothes, food, appearance, toys, etc. Inevitably, those with more intense and varied interests initially will have more room to lose interest than those who have never taken a great interest in things. The lost interest must not have been replaced by other interests, so do not include "growing out" of activities or giving up certain activities to take up new ones.

0 = Absent

2 = Generalized diminution in interest taken in normally interesting activities

3 = The child is completely or almost completely uninterested in everything or almost everything.

LOSS OF INITIATIVE

Diminution of efforts to start interactions, actions, or tasks.

Change may predate the primary period, but must have continued into the primary period.

0 = Absent

2 = Reduction of initiative in at least 2 activities

3 = Child never or almost never initiates activity or interaction

LACK OF PROTEST

Near absence of child's resistance and/or reaction in situations when protest or reaction would be expected.

Change may predate the primary period, but must have continued into the primary period.

0 = No

2 = Yes

ANHEDONIA

A partial or complete (pervasive) loss or diminution of the ability to experience pleasure, enjoy things or have fun during participation in activities that have been attractive to the child. It also refers to basic pleasures like those resulting from eating favorite foods.

Anhedonia concerns the mood state itself. Loss of Interest, Loss of Initiative, Lack of Protest, inability to engage in activities, or loss of the ability to concentrate on looking at books, games, TV or school childs may accompany Anhedonia, so the interviewer may code different aspects under different items. Do not confuse this item with a lack of opportunity to do things or to excessive parental restriction. Comparison should be made with enjoyment when the child is normal. This may not be accessible in episodes of very long duration.

0 = Absent

2 = Generalized diminution in pleasure taken in normally pleasurable activities

3 = Almost nothing gives pleasure.

ANERGIA

The child feels markedly lacking in energy compared with his/her usual condition and describes him/herself as being easily fatigued, or excessively tired. This is a general rating of the child's overall energy level.

0 = Absent

2 = A generalized listlessness and lack of energy

3 = A report of being almost completely without energy.

Differentiate from Fatigability, Motor Slowing, Hypersomnia and Insomnia, although you may double code if criteria for more than one are met.

MOTOR SLOWING

The child is slowed down in his/her movements and speech compared with his/her usual condition.

0 = Absent

2 = Slowing is present and cannot be overcome in at least two activities.

3 = Slowing is present and cannot be overcome in almost all activities.

INDECISIVENESS

Unpleasant difficulty in reaching decisions, even about simple matters; this is a generalized difficulty, and does not refer to making important life decisions in which uncertainty may reasonably be expected.

0 = Absent

2 = Indecisiveness sometimes uncontrollable in at least two activities.

3 = Indecisiveness almost always uncontrollable and occurs in relation to almost all decisions.

DEPRESSIVE THOUGHTS

In the definitions in this section the term "feeling" is frequently used, despite the fact that cognitions are being referred to. For most people, the term "feeling" carries both cognitive and affective components. However, these items refer not to mood states per se, but to certain cognitions, thoughts, opinions or attitudes. In other words, it is the content of the thought that is to be coded, not its affective tone.

LONELINESS

A feeling of being alone and friendless regardless of the apparent justification for that feeling. Adult contacts and peer friendships should be considered. Differentiate from feeling unloved. A child may be lonely but still acknowledge being loved and vice versa.

0 = Absent

2 = The child definitely feels intrusively and uncontrollably lonely in at least two activities.

3 = The child feels lonely almost all the time.

FEELS UNLOVED

A generalized feeling of being unloved and uncared for, or at least less loved and cared for than most people, regardless of the justification for that feeling.
Differentiate from loneliness.

0 = Absent

2 = The child feels that there are others who love him/her or care for him/her, but that s/he is loved, or cared for, less than other people.

3 = The child feels that almost no one loves him/her, or hardly ever believes that anyone does.

SELF-DEPRECIATION AND SELF-HATRED

A generalized, unjustified feeling of inferiority (including unjustified feelings of ugliness) to others. Self-hatred involves severe hostility directed by the child against him/herself, accompanied by expressed dislike or expressed criticism.
Delusional phenomena are not included here.

0 = Absent

2 = The child rates him/herself lower than seems justified, but does not see him/herself as being completely without value, since in some activities s/he does not feel inferior.

3 = The child feels ugly, as well as almost entirely worthless and without saving graces, in nearly all activities, or inferior to almost everyone.

Self-hatred is also coded 3.

FEELING SORRY FOR ONESELF

A feeling that life or people have been unfairly unpleasant or troubling and that the child deserves better. Child feels unlucky. When negative events are ascribed to "bad luck," code here.
Do not include someone *cheerfully* remarking "it's bad luck."

Code regardless of justification.

0 = Absent

2 = The child feels sorry for him/herself but thinks that some aspects of life have not been unfairly troubling or unpleasant.

3 = The child thinks that nothing has occurred according to his/her just deserts, and feels sorry for him/herself in nearly all situations.

PATHOLOGICAL GUILT

Excessive self-blame for minor or non-existent wrongdoings. The child realizes that his/her guilt is exaggerated (otherwise rate as delusional guilt).

0 = Absent

2 = At least partially unmodifiable, excessive self-blame not generalized to all negative events.

3 = The child generalizes the feeling of self-blame to almost everything that goes wrong in his/her environment.

DELUSIONS OF GUILT

Delusional self-blame for minor or non-existent wrongdoings. The child may believe that s/he has brought ruin to his/her family by being in his/her present condition or that his/her symptoms are a punishment for not doing better. Distinguish from pathological guilt without delusional elaboration, in which the child is in general aware that the guilt originates within him/herself and is exaggerated.

0 = Absent

2 = The child has a delusional conviction of having done wrong but there is fluctuating awareness that his/her feelings are an exaggeration of normal guilt.

3 = The child has an unmodifiable delusional conviction that s/he has sinned greatly, etc..

HELPLESSNESS

The child feels that there is nothing that s/he can do to improve his/her situation or psychiatric state, though s/he perceives that a change would be welcome. This is a generalized feeling.

0 = Absent

2 = The child feels helpless and cannot always modify his/her feelings, but can report some positive expectations of being able to help him/herself.

3 = The child expresses almost no hope of being able to help him/herself at all.

HOPELESSNESS

The child has a bleak, negative, pessimistic view of the future, and little hope that his/her situation will improve. This is a generalized feeling.

0 = Absent

2 = The child feels hopeless and cannot always modify his/her feelings, but can report some positive expectations of the future.

3 = The child expresses almost no hope for the future at all.

SUICIDE AND SELF INJURIOUS BEHAVIOR

Purposes of the Section

This section has 1 major function:

(1) To assess the suicidal and self-injurious intentions and actions of the child.

Organization of the Section

The section is organized in 2 sub-areas:

(1)Suicidal ideation and behavior.

(2)Non-suicidal deliberate self-harm.

THINKING ABOUT DEATH

Thoughts about death and dying, whether referred to the self or others. Include thoughts about being the passive subject of a fatal accident or murder and thoughts about how sorry others will be when the child is gone. Include thoughts about not being able to go on any longer and life not being worth living in this rating. If the child has thoughts specifically about taking his/her own life, code under Suicidal Thoughts.

0 = Absent

2 = Present but *not* including thoughts about wanting to die. The thoughts should be intrusive into at least 2 activities and at least sometimes uncontrollable.

3 = Including thoughts about wanting to die. The thoughts should be intrusive into at least two activities and at least sometimes uncontrollable. Do not include thoughts about taking one's own life, these are coded under Suicidal Thoughts.

SUICIDAL THOUGHTS

Refers to thinking specifically about killing oneself, by whatever means. This may accompany thinking about death in general, or may be present if a child has reported a suicidal plan or past attempt.

Do not include suicidal plans.

0 = Absent

2 = At least sometimes uncontrollable suicidal thoughts, recurring in at least two activities.

3 = Usually uncontrollable suicidal thoughts intruding into most activities.

SUICIDAL PLANS

Refer to suicidal thoughts in which the child considers plans for a suicidal act. If a suicidal attempt has been made, determine whether a plan was present prior to the attempt.

0 = Absent

2 = A specific plan, considered on more than 1 occasion, over which no action was taken.

3 = A specific plan, considered on more than 1 occasion, with preparatory action taken, for example storing up tablets.

Note that each of these definitions is mutually exclusive by definition. Obviously, a suicidal plan is a form of suicidal thought in ordinary speech. However, by the specificity coding rule, consideration of a plan for killing oneself is coded only as a Suicidal Plan, and not as Suicidal Thoughts

LIFETIME SUICIDAL BEHAVIOR

Attempted self-harm, with the intention of ending life, occurring at any time in the child's life. Rate here, no matter how unlikely to cause death the attempt was, so long as the child's intention was to die.

0 = Absent

2 = Present

SUICIDAL ATTEMPTS

Episodes of deliberate self-harmful behavior, or potentially self-harmful behavior, involving some intention to die at the time of the attempt.

Differentiate from Non-suicidal Physical Self-damaging Acts.

If a parent is unsure whether his/her child actually had some intention to die, still code this item positive if the parent can describe a clear self-harmful act.

0 = No

2 = Yes

METHOD OF SUICIDE ATTEMPT

Note which of the following methods was employed for a suicidal attempt as defined above. More than one method may have been used, in which case code both or all.

Drug Overdose
Hanging
Stabbing/Cutting
Shooting
Running into traffic
Throwing self down stairs
Jumping from a high place
Other (specify)

SUICIDAL INTENT

Code the highest level of suicidal intent manifested in an attempt. Do not include potentially self-injurious behavior without suicidal intent here; that is coded under "Suicidal" Behavior without Intent.

Ever and 3 month ratings coded separately.

1 = Interviewee reports child's minimal intention to actually kill him/herself. S/he either revealed the attempt to others, or otherwise ensured that there was little risk to take his/her life.

2= Substantial intent to kill self, but associated with ambivalence to a sufficient degree that the intention was not absolute.

3= Absolute (or almost absolute) intention to commit suicide, expressed with little or no ambivalence or uncertainty. If uncertain whether to code 2 or 3, code 2.

LETHALITY OF SUICIDAL ATTEMPT

Code here the degree of threat to life, resulting from the most serious suicidal attempt.

1 = Mild; No medical attention needed or sought.

2 = Moderate; Some medical attention sought or required (e.g., sewing up cuts, stomach lavage)

3 = Serious; The attempt resulted in unconsciousness, the need for resuscitation, assisted respiration, blood transfusion, or operative intervention.

NON-SUICIDAL PHYSICAL SELF-DAMAGING ACTS

Refers to reports of self-mutilation or other potentially self-damaging acts (e.g. wrist-slashing, cigarette burns) not accompanied by any wish or intention to die. Do not include subcultural rituals, such as self-inflicted burns to demonstrate toughness; any self-mutilatory acts that are socially acceptable by the child's peer group, such as tattooing or carving one's initials on the skin for decorative purposes, would not be included here.

0 = Absent

2 = Acts not requiring medical treatment.

3 = Acts requiring medical treatment.

EVER NON-SUICIDAL PHYSICAL SELF-DAMAGING ACTS

Code the number of times the child engaged in non-suicidal physical self-damaging acts, as defined above, in his/her lifetime.

Include only self-damaging acts that require medical treatment (intensity of 3).

HYPOMANIA AND MANIA

Purposes of the Section

The section has 2 major functions:

(1) To assess symptomatology relevant to the diagnosis of hypomania, mania and cyclothymia.

(2) To provide a means of entry to the assessment of functional incapacity resulting from psychiatric disturbance.

Organization of the Section

The section is organized into 2 subareas:

(1) Manic mood disturbance

(2) Other manic symptoms

The presence of manic mood disturbance as rated in (1) is required before symptoms in (2) are counted as being present.

MANIC MOOD DISTURBANCE

EXPANSIVE MOOD

Feelings of euphoria or elation, that represent a substantial change from the subject's usual mood and that are not a response to specific situations.

In response to an introductory question, many respondents state that the child has had such an episode, but when asked to give an example, their descriptions turn out to refer to happiness in response to something good happening to the child. Detailed descriptions are, therefore, critical if proper ratings are to be made here.

0 = Absent

2 = The expansive mood is intrusive into non-elating situations, but can sometimes be controlled when inappropriate

3 = Expansive mood is intrusive and uncontrollable in almost all activities and often inappropriate

IRRITABILITY WITH EXPANSIVE MOOD

Both Irritability and Expansive Mood have been present together, or within the same 24-hour period.

0 = Expansive Mood not accompanied by Irritability.

2 = Expansive Mood accompanied by Irritability.

S = Either Expansive Mood or Irritable Mood absent.

DEPRESSED MOOD WITH EXPANSIVE MOOD

Both Depressed Mood and Expansive Mood present within same 24 hour period. Either the two moods must both separately meet the criteria for each, or if the two rapidly alternate, the two taken together must last at least one continuous hour at a level that meets the other minimum criteria.

0 = Absent

2 = Present, with both moods, either separately or together, meeting the intensity level '2' criteria

PERIOD OF 2 MONTHS WITHOUT EITHER DEPRESSED MOOD OR EXPANSIVE MOOD IN LAST YEAR

0 = Yes

2 = No

0 = Absent

2 = More talkative than usual, intrusive into at least two activities but retains some regard for others' wishes to communicate.

3 = More talkative in most activities with little regard for others' wishes to communicate.

MORE TALKATIVE THAN USUAL

The child is more talkative than usual. Speech may be loud, rapid, nonstop, or difficult to interrupt during periods of Expansive, Expansive/Irritable, or Irritable Mood.

Distinguish from chattiness.

0 = Absent

2 = More talkative than usual, intrusive into at least two activities but retains some regard for others' wishes to communicate

3 = More talkative in most activities with little regard for others' wishes to communicate

PRESSURE OF SPEECH

A description of periods of talking fast, with a sensation of pressure to get words and ideas out, when in Expansive or Expansive/Irritable Mood, or Irritable Mood.

0 = Absent

2 = Pressure of speech intrusive into normal communication in at least 2 activities; but some coherent communication possible, even if with an effort to maintain control

3 = Pressure of speech so intrusive and uncontrollable as essentially to prevent normal communication

FLIGHT OF IDEAS

A description of images and ideas flashing through the mind, each suggesting others at a great rate, when in Expansive or Expansive/Irritable Mood, or Irritable Mood.

2 = Flight of ideas intrusive into normal thinking, involving at least 2 activities, but some coherent thought processes possible, even if with effort to maintain control

3 = Flight of ideas so intrusive as to be almost completely disruptive of normal thought

MOTOR PRESSURE

Feeling of increased physical energy or capacity compared with normal, expressed in motor behavior, when in Expansive or Expansive/Irritable Mood, or Irritable Mood.

0 = Absent

2 = Motor pressure leads to increased activity only within the subject's usual range of activities involving at least 2 activities

3 = Subject actually takes up new physical activities as a result of increased motor activity

AGITATION

Markedly changed motor activity associated with Expansive or Expansive/Irritable or Irritable Mood. Account of a severe level of inappropriate, unpleasant motor restlessness during the mood state, indicated by pacing, wringing of hands, or similar activities.

Do not include simple restlessness or fidgetiness in the absence of mood change.

0 = Absent

2 = Agitation is present in at least 2 activities and cannot be entirely controlled, but sometimes the subject can inhibit his/her agitation with effort

3 = Agitation almost entirely uncontrollable

DISTRACTIBILITY

Inability to screen out irrelevant external stimuli during the period of mood disturbance. May have difficulty keeping thoughts on themes relevant to the topic.

0 = Absent

2 = Present in at least 2 activities and at least sometimes uncontrollable by the child

3 = Present in most activities and at least sometimes uncontrollable by the child or by admonition

DECREASED NEED FOR SLEEP

During the period of mood disturbance, subject feels adequately rested with at least 1 hour less sleep than usual per night, for at least 1 week.

Differentiate from Insomnia, where reduced sleep is associated with a feeling of being inadequately rested.

0 = Absent

2 = 1-2 hours less sleep than usual per night

3 = More than 2 hours less sleep than usual per night

GRANDIOSE IDEAS AND ACTIONS

An unusually increased level of self-esteem or self-appraisal of worth, such as the feeling of being superbly healthy, or exceptionally able, or intelligent, when in Expansive or Expansive/Irritable Mood or Irritable Mood.

The borderline between this symptom and grandiose delusions is difficult to draw, except that grandiose ideas are simply exaggerations of the subject's normal state. For example, s/he may actually be capable and intelligent, or have some particular ability, whereas delusions involve an identification or an assertion that is demonstrably false, for example, that the subject is a famous musician or a pop-star. In either case, however, insight tends to be lacking while the symptom continues.

Distinguish from fantasy play unrelated to mood changes.

0 = Absent

2 = Ideas present but not translated into action

3 = Ideas translated into action

POOR JUDGMENT

Uncharacteristic behaviors performed with disregard for possible negative consequences during Expansive or Expansive/Irritable Mood state or Irritable Mood.

Some people show chronically poor judgment, but that is not rated here because this item requires that the behaviors should be uncharacteristic and directly associated with the manic mood state.

0 = Absent

2 = Behavior that involved definitely poor judgment but which was within the range of socially acceptable irresponsible behavior (e.g. speaking rudely/impertinently to other people, being physically reckless or aggressive)

3 = Behavior that is outside the range of socially acceptable irresponsible behavior (e.g. being overtly insulting to figures of authority, undressing in a public place), or dangerous behavior (e.g., jumping off a roof because child believed s/he could fly) and hence likely to result in negative consequences

CONDUCT PROBLEMS

Purposes of the Section

The section has 4 major functions:

(1) To elucidate a wide range of conduct problem behaviors within 3 settings:

(a) daycare/school
(b) the home
(c) elsewhere.

And within the child's different relationships:

(a) parental figures
(b) siblings
(c) peers
(d) caregivers/teachers and other adults

(2) To provide entry to the Hyperactivity/ADD section, since there is considerable behavioral comorbidity between these disorders and other disruptive behaviors.

(3) To provide entry to the sections covering affective symptomatology through the report of his/her mood and feelings in relation to conduct.

(4) To provide an entry to the assessment of functional incapacity.

Organization of the section
The section includes into 6 major subareas:

(1) Oppositional Behavior

(2) Deception

(3) Conduct Problems Involving Violence Against People

(4) Conduct problems Involving Violence Against Property

(5) Inappropriate Sexual Behavior

(6) Access to Weapons

Situation

For most items in this section it is necessary to note the *frequency* of occurrence of the behaviors of interest.

Three possible situations are coded:

Home
Daycare/School
Elsewhere

The overall intensity can be coded as present as long as the behavior is manifested either in two different situations (e.g. home and daycare/school) or in two different ways in the same situation.

If a behavior is present in only one situation, then that behavior (e.g., disobedience) must manifest itself in at least 2 different ways; for example, if a child is disobedient at home **only** when told to pick up his/her toys but obeys in every other situation at home, then it does not count. However, if at daycare/school s/he refuses (after being so asked) to stop talking in class **and** will not stop running around the room, then this does count. Further, if a child's only form of disobedience is talking during circle time, this does not count; however, if s/he talks in circle time **and** story time, it does count.

If the behavior is present in two or more locations then one manifestation of the behavior in each of two environments is sufficient for coding the overall intensity. If you had to go back in time for either the Home or Daycare/School section, those time periods are used in questioning about and rating the items in the Conduct Section.

For purposes of the PAPA interview, behaviors that occur with a nanny, sitter, or daycare provider in the child's home without a parent present will be considered as occurring in the daycare/school situation.

We will also assess with whom the child's behaviors occur. Does the behavior, such as disobedience, occur only with parent #1, or does it occur with parent #1, the caregiver/teacher, and the babysitter? Or does it occur with all adults?

Admonition

For symptoms which mention in the coding rule a stipulation about being admonished when caught; if the child has never been caught (e.g. for cheating, or disobedience) so that s/he cannot be admonished, the symptom is still regarded as being present, provided that it meets the other criteria.

Do not include accidental acts of destruction, such as breaking a window while playing ball.

Ever Ratings

A few items in the interview are of a kind that are rarely performed, but of great significance even if they have occurred only once. Special ratings are provided in these cases.

Ever: Frequency

Refers to the frequency of occurrence of the behavior *during the child's lifetime.*

Ever: Onset

Refers to the first time that the behavior occurred *in the child's life*.

Ever: Use of weapons

A weapon is any object or instrument used for the purposes of violence against another person. It refers to generally available items, such as sticks and stones or even toys, as well as purpose-built weapons, such as knives or guns.

0 = Absent

2 = Weapon used on one occasion only

3 = Weapon used on more than one occasion

FAMILY HAS RULES

The parent perceives the family as having standing rules for behavior, to which the child is expected to adhere.

U = Child doesn't understand the concept of rules at home

0 = Absent

2 = Present

If the family does not have rules, or if the child does not understand the concept of rules at home, the interviewer proceeds to consideration of rules at daycare/school or elsewhere.

RULE BREAKING

Violation of standing rules at home, at daycare/school or elsewhere.

0 = Absent

U = The child does not understand the concept of rules at daycare/school or elsewhere

2 = The child breaks rules relating to at least 2 activities at home, daycare/school, or elsewhere and at least sometimes responds to admonition by public failure to comply

3 = Rule breaking occurs in most activities at home, at daycare/school, or elsewhere and the child sometimes responds to admonition by disputing or challenging the authority of the person admonishing him/her

DISOBEDIENCE

Refers to failures to carry out specific instructions when directly given. Differentiate from rule-breaking, which refers to violation of formal standing rules.

2 = Disobedience occurs in at least two activities.

3 = Disobedience occurs in most activities.

If Disobedience is present, the presence or absence of defiance (disputing or challenging instructions or requests) is assessed.

When a child's behavior meets criteria for both Rule Breaking and Disobedience, both can be coded. The violation of a standing rule and the negative interaction between the child and an authority are considered to be two different components of the same behavior.

Having established disobedience, the parent's perception of scale score frequency of disobedience with different parental figures, caregives/teachers, and other adults is noted

EVER ASKED TO LEAVE DAYCARE/SCHOOL BECAUSE OF RULE BREAKING OR DISOBEDIENCE

Child sent home (or “parent” requested to take child home) from daycare/school because of rule breaking or disobedience.

Distinguish from other reasons such as fighting or assaults that may have caused the child to be asked to leave daycare/school and which are coded separately.

EVER: ASKED TO LEAVE DAYCARE/PRESCHOOL

0 = No

1 = Preschool/daycare have threatened exclusion of the child, but have not taken action on this threat.

2 = Asked to leave temporarily

3 = Asked to leave permanently

WANDERING OFF

Deliberately leaving home or leaving the parent/caretaker's line of sight when not inside the home, without asking permission.

Distinguish from running away from home.

0 = Absent

2= The child has wandered away from parent/caregiver without permission or become lost at least once in the last 3 months

3=The child has wandered away from parent/caregiver without permission or become lost at least once in the last 3 months; and child was gone at least 15 minutes; and it took effort to find the child

EVER: WANDERING OFF

0 = Absent

2= The child has wandered away from parent/caregiver without permission or become lost at least once in the last 3 months

3=The child has wandered away from parent/caregiver without permission or become lost at least once in the last 3 months; and child was gone at least 15 minutes; and it took effort to find the child

RUNNING AWAY FROM HOME

Leaving the home with the deliberate intention of staying away temporarily or permanently.

0 = Absent

1 = Threatened to run away from home; packed a bag or treasured possessions but did not leave home

2 = Actually left home intending to stay away at time of leaving, but returned before away overnight. Some preparations should have occurred such as packing a bag or taking some treasured possessions.

3 = As 2, and away at least overnight

DURATION
Days/hours away

EVER: RUNNING AWAY FROM HOME

0 = Absent

1 =Threatened to run away from home; packed a bag or treasured possessions but did not leave home

2 = Actually left home intending to stay away at time of leaving, but returned before away overnight. Some preparations should have occurred such as packing a bag or taking some treasured possessions.

3 = As 2, and away at least overnight

TEMPER TANTRUMS

Discrete episodes of excessive temper, frustration or upset, manifested by shouting, crying or stamping, and/or involving violence or attempts at damage directed against oneself, other people, or property.

Violence or damage done here does not constitute Vandalism or Assault.

0 = Absent

2 = Discrete episodes of temper without violence.

3 = Non destructive violence directed only against property (e.g. throwing toys; hitting walls, etc.).

4 = With destructive violence (e.g. breaking toys) or violence against self or others (e.g. hitting, biting, head banging).

STAMPING FEET

0 = No

2 = Yes

BREAKING TOYS

0 = No

2 = Yes

HITTING WALL/FLOOR/TABLE

0 = No

2 = Yes

HITTING OTHERS

0 = No

2 = Yes

HITTING SELF

0 = No

2 = Yes

KICKING OTHERS

0 = No

2 = Yes

KICKING SELF

0 = No

2 = Yes

KICKING OBJECTS

0 = No

2 = Yes

BITING OTHERS

0 = No

2 = Yes

BITING SELF

0 = No

2 = Yes

HOLDING BREATH

0 = No

2 = Yes

HEAD BANGING

0 = No

2 = Yes

OTHER

0 = No

2 = Yes Specify_____

TRIGGERS FOR TEMPER TANTRUMS

May code up to four

S = Not applicable
1 = Frustration: Tantrums occurring as a result of the child's not being allowed or able to do what s/he wants to do
2 = Fatigue: Tantrums resulting from the child's being "over tired"
3 = "Out of the blue": Tantrums occurring without any apparent precipitants
4 = Other _____

DURATION OF AVERAGE TANTRUM

LENGTH OF TIME TO RECOVERY

Average length of time until child returns to status quo emotional state.

ONSET OF TEMPER TANTRUMS

WITH PARENT # 1

WITH PARENT #2

WITH OTHER PARENT #1

WITH OTHER PARENT # 2

WITH BABYSITTER IN HOME

WITH CAREGIVERS/TEACHERS AT DAYCARE/SCHOOL

WITH OTHER ADULTS

ARGUMENTS

An argument is a verbal dispute in which there is strong disagreement or difference of opinion. An argument involves an interaction, or attempted interaction, between two people. An argument begins with a verbal exchange. The PAPA definition of argument implies anger and some form of verbal aggression (raised voices, name calling, taunting) or physical aggression directed towards the person the child is arguing with.

There are elements in common between temper tantrums and arguments. Temper tantrums may be triggered or preceded by an argument but once a tantrum starts, it almost has a "life of its own" that does not involve
interaction or exchange with another person. It is a "display or temper." Physical aggression can be a common element to temper tantrums and arguments. Certainly, arguments and temper tantrum can both be coded.

ARGUMENTS WITH ADULTS

0 = Absent

2 = Present, but without physical violence by child

3 = Present, and one or more argument(s) with physical violence by child

HOME

DAYCARE/SCHOOL

ELSEWHERE

ARGUMENTS WITH SIBLINGS

0 = Absent

2 = Present, but without physical violence by child

3 = Present, and one or more arguments with physical violence by child

HOME

SCHOOL

ELSEWHERE

ARGUMENTS WITH PEERS

0 = Absent

2 = Present, but without physical violence by child

3 = Present, and one or more arguments with physical violence by child

HOME

SCHOOL

ELSEWHERE

ANNOYING BEHAVIOR

Indulgence in active behaviors that annoy or anger peers, siblings, or adults. The child's intention need not be to annoy, but the behaviors would obviously annoy their recipient.
Do not include annoying behaviors that are the result of unintentional acts, for instance, annoyance caused by clumsiness, or failure to understand the rules of games.
Do not include behaviors that conform to the definitions of Rule Breaking and Disobedience.
Do not code the specific annoying behavior of teasing here but in following item.

0 = Absent

2 = Annoying behavior occurs in at least 2 activities and child is at least sometimes unresponsive to admonition.

3 = Annoying behavior occurs in most activities and the child sometimes responds to admonition by disputing or challenging the authority of the person admonishing him/her.

ANNOYS PARENTAL FIGURES

0 = No

2 = Yes

ANNOYS TEACHERS/CAREGIVERS AT DAYCARE/SCHOOL

0 = No

2 = Yes

ANNOYS BABYSITTERS

0 = No

2 = Yes

ANNOYS SIBLINGS

0 = No

2 = Yes

PEERS

0 = No
2 = Yes

TEASING

Intentionally annoying or causing distress to peers or siblings by making fun of them or taunting them, either verbally or physically

Teasing may also be spiteful (a *deliberate* action meant to cause distress) or vindictive in which case Spiteful/Vindictive is also coded.

0 = Absent

2 = Teasing occurs in at least 2 activities

3 = Teasing occurs in at least 2 activities and the child often teases until the teased child cries or responds with physical aggression.

TEASING SIBLINGS

TEASING PEERS

TEASING YOUNGER CHILDREN

FREQUENCY AT HOME, DAYCARE/SCHOOL. AND ELSEWHERE ARE CODED

SPITEFUL OR VINDICTIVE

Spiteful: The child engages in deliberate actions aimed at causing distress to another child or adult.

Vindictive: The child responds to failure to get his/her own way, disappointment, or interpersonal disagreement with adults or peers with deliberate attempts to hurt the other or gain revenge. For instance, by pinching, biting or attempting to get the other person into trouble.

Do not include behaviors coded under Assault, Cruelty, Bullying, or Lying

0 = Absent

2 = Present

DIRECTED AGAINST PARENTAL FIGURES

DIRECTED AGAINST DAYCARE PROVIDER/TEACHERS

DIRECTED AGAINST OTHER CAREGIVERS

DIRECTED AGAINST SIBLINGS

DIRECTED AGAINST PEERS

These last three items are considered less specific than Rule Breaking or Disobedience, so that if a behavior meets criteria for both Annoying Behavior and Disobedience, but was not specifically intended to annoy, it should be rated under Disobedience. However, if the child's intention was to annoy, then this would be rated under Annoying Behavior *and* Disobedience , since these two items would then refer to separate components of the behavior. It is also possible to "double-code" a behavior in which several dynamics are included; for instance, the child was both disobedient to the teacher and annoying to another child during the same behavior.

BULLYING

Attempts to force another to do something against his/her will by using threats, or violence, or intimidation.

Do not include episodes that meet the criteria for stealing involving confrontation.

Differentiate from spiteful and vindictive which does not include attempts to force someone to do something against his/her wishes.

0 = Absent

2 = Using threats only

3 = With actual violence

CRUELTY TO ANIMALS

Deliberate activities involving hurting animals.

Do not include hunting or fishing. Do not include insects. Amphibians and reptiles are included, though their larval forms (e.g. tadpoles) are not.

0 = Absent

2 = Definite cruelty not resulting in obvious or permanent injury to the animal.

3 = Acts resulting in obvious or permanent injury.

EVER: CRUELTY TO ANIMALS
Enter only if at intensity level "3"

CRUELTY TO PEOPLE

An assault involving the deliberate inflicting of pain or fear on the victim beyond the "heat of the moment." Include cutting or burning a restrained or helpless person, attempting to drown a person, ritualized infliction of pain, and sadistic violence or terrorization.

The most common thing to consider here is harming a child who is younger or more helpless than the child (e.g., an infant).

The worst result of an episode of cruelty in the last 3 months is noted.

0 = Absent

2 = Cruelty did not result in any physical injury to either party.

3 = The victim sustained some physical injury as a result (e.g. black eye or cuts).

DIRECTED AGAINST SIBLING(S)

DIRECTED AGAINST PEER(S)

DIRECTED AGAINST ADULT(S)

DIFFICULTY SHARING

Child's inability to tolerate other children playing with his/her toys or to play cooperatively with toys with other children

Exclude sharing a treasured item such as a blanket or favorite stuffed animal

0 = Absent

2= Child has difficulty sharing in at least 2 activities

3= Child has trouble sharing almost all the time

DIFFICULTY SHARING WITH SIBLINGS

DIFFICULTY SHARING WITH PEERS

SWEARING

The use of swear words or obscene language not approved or countenanced by adults in whose presence they are spoken.

Do not include swearing among peers when adults are not present, or with adults who are tolerant of swearing (i.e. do not object to the child's swearing).

The relative "badness" of different swear words is culture and community dependent. Thus a list of included and excluded words or expressions is required for each individual study. In general, however, the use of words or expressions that are disapproved of by the adult listeners who heard them counts as swearing.

0 = Absent

2 = Swearing in the presence of adults, but sometimes stops when admonished.

3 = Swearing in the presence of adults, but is not controlled by admonishment.

If swearing also meets criteria for Rule Breaking, it should be coded under Swearing which is more specific

STEALING

Taking something belonging to another without permission and with the intention of depriving the owner of its use. Do not include items intended eventually for general distribution that will include the child (such as general food from the refrigerator or school erasers).

Items stolen from home or school can be coded, even if the child has not been in the home or school for one month of the primary period. If you have gone back for the home or school section, those time periods (i.e. secondary and/or tertiary) are used when coding the Stealing section.

EVER: STEALING

0 = No

2 = Yes

STEALING AT HOME OR FROM FAMILY

0 = No

2 = Yes

3 = Yes, with concealment

STEALING AT DAYCARE/SCHOOL

0 = No

2 = Yes

3 = Yes, with concealment

STEALING ELSEWHERE

0 = No

2 = Yes

3 = Yes, with concealment

DECEPTION

LYING

Distortion of the truth with intent to deceive others. *Barefaced* lies are told with little or no effort or ability to conceal the untruth, for example the child has cookie crumbs all over his/her face but denies s/he ate a cookie. Subtle lies involve more elaborate alternatives to distort the truth.

Do not include imaginary friends.

0 = No

2 = Made up stories or fictions which are not told for gain or to escape punishment.

3 = Lies told for gain or to escape punishment, in at least 2 activities that do not result in others getting into trouble.

BAREFACED LIES

Child knows s/he is telling an untruth, but does not have the skill or wish to conceal the untruth with “sophisticated” lie.

SUBTLE LIES

Child knows s/he is telling an untruth, but is able to conceal it with elaborate and “successful” lies.

BLAMING

Falsely attributing misdemeanors to another so as to avoid reproach or punishment.

0 = No

2 = Lies in at least two activities, that result in others being blamed for child's misdemeanors or otherwise getting into trouble; or lies which, if believed, would have the same result.

CHEATING

Attempts to gain increased success by unfair means.

There is a need to determine that the child understands the concept of the rules. Do not include making a mistake because s/he does not know the rules.

0 = Absent

2 = Cheating in at least 2 activities and at least sometimes not responsive to admonition if caught.

3 = Cheating may occur in many or most activities and is hardly ever responsive to admonition if caught.

CONDUCT PROBLEMS INVOLVING VIOLENCE

VIOLENCE AGAINST PERSONS

FIGHTS

Physical fights in which both (or all) combatants are actively initiating. One child may be provoked into fighting, but both must be actively involved. Otherwise code as Assault. When there is doubt as to whether to code an episode of interpersonal violence as a fight or an assault, code it as a fight.

Do not include horseplay or friendly fights between siblings. However, any other sibling fights with a serious intent are included.

Victims who "fight" back only in order to protect themselves, should not be rated here or under Assault.

Code worst result of fight in last 3 months.

2 = Fights do not result in any physical injury to either party.

3 = Either combatant has sustained some physical injury as a result (e.g. black eye or cuts).

WITH SIBLINGS

WITH PEERS

HOME

DAYCARE/SCHOOL

ELSEWHERE

EVER: FIGHTS RESULTING IN SERIOUS INJURY

0 = None

2 = As a result of a fight either combatant sustained broken limbs, required hospitalization, or was unconscious for any period.

EVER: USE OF WEAPON IN A FIGHT

0 = No

2 = Yes

Ever use of a knife, scissors, bat, rock, toy or any other item as a weapon in a fight..

EVER: ASKED TO LEAVE DAYCARE/SCHOOL DUE TO FIGHTING

0 = No

2 = Asked to leave temporarily

3 = Asked to leave permanently

ASSAULT

An attack upon, or attempt to hurt, another *without the other's willful involvement in the contact*.
If child is the victim of an attack and fights back only to protect him/herself, do not rate here or under Fights.
The worst result of an assault in the last three months is noted.

SHOVING

0 = Absent

2 = Shoving did not result in any physical injury to either party.

3 = The victim sustained some physical injury as a result (e.g. bruise or wound).

PINCHING

0 = Absent

2 =Isolated pinching with sufficient force to cause pain to other.

3 = Repeated pinching with sufficient force to hurt other

HITTING

0 = Absent

2 = Hitting did not result in any physical injury to either party.

3 = The victim sustained some physical injury as a result (e.g. black eye).

KICKING

0 = Absent

2 = Kicking did not result in any physical injury to either party.

3 = The victim sustained some physical injury as a result (e.g. bruises or cuts).

BITING

0 = Absent

2 = Biting did not result in any physical injury to either party.

3 = The victim sustained some physical injury as a result (e.g. bruise or bite wound).

CHOKING

0 = Absent

2 = Choking did not result in any physical injury to either party.

3 = The victim sustained some physical injury as a result (e.g. bruise or bite wound).

ASSAULT WITH A WEAPON

Weapons may include a knife, scissors, bat, rock, toy used as a weapon, or any other item used as a weapon.

ASSAULTS OF PARENTAL FIGURES, TEACHERS, OTHER CAREGIVERS, SIBLINGS, OR PEERS ARE RECORDED.

EVER: ASSAULT RESULTING IN SERIOUS INJURY

0 = None

2 = As a result of a fight either combatant sustained broken limbs, required hospitalization, or was unconscious for any period.

EVER: USE OF WEAPON IN ASSAULT

0 = No

2 = Yes

TYPE OF WEAPON

Code up to 3

1 = Knife
2 = Scissors
3 = Bat
4 = Rock
5 = Toy
6 = Other_____

EVER: ASKED TO LEAVE DAYCARE/SCHOOL DUE TO ASSAULT

O = No

2 = Asked to leave temporarily

3 = Asked to leave permanently

ACCESS TO WEAPONS

ACCESS TO GUN

0 = No

1 = Family member has gun, but child does not have access because gun locked up.

2 = Child has access to gun belonging to family member or friend.

HANDGUN

0 = No

2 = Yes

SHOTGUN OR RIFLE

0 = No

2 = Yes

OTHER GUN (SEMI-AUTOMATIC, MACHINE GUN, ETC.)

0 = No

2 = Yes

CONDUCT PROBLEMS INVOLVING VIOLENCE AGAINST PROPERTY

VANDALISM

Damage to, or destruction of, property without the intention of gain.

0 = Absent

2 = Writing on walls or similar actions that are not actually destructive of the functions of that object.

3 = Other acts involving damage to, or destruction of, property.

DAMAGE TO PROPERTY IN THE HOME

DAMAGE TO PROPERTY OUT OF THE HOME

VANDALISM DIRECTED AT OWN PROPERTY

VANDALISM DIRECTED AT SIBLINGS' PROPERTY

VANDALISM DIRECTED AT PEERS' PROPERTY

VANDALISM DIRECTED AT PARENTS' PROPERTY

VANDALISM DIRECTED AT PROPERTY OF OTHER ADULTS IN THE CHILD'S LIFE (TEACHERS; BABYSITTERS; ETC)

VANDALISM DIRECTED AT PROPERTY OF PEOPLE THE CHILD DOES NOT KNOW

INAPPROPRIATE SEXUAL BEHAVIOR

INAPPROPRIATE SEXUAL TOUCHING

Touching of genital area without the consent of the person being touched.

Must determine that child is initiating behavior against the wishes of the person against whom the behavior is directed in order to distinguish this behavior from mutual curiosity about genitalia.

EVER: INAPPROPRIATE SEXUAL TOUCHING

0 = No

2 = Yes

LAST 3 MONTHS: INAPPROPRIATE SEXUAL TOUCHING

0 = No

2 = Yes

DIRECTED AGAINST SIBLINGS

DIRECTED AGAINST PEERS

INAPPROPRIATE SEXUAL TALK

Sexual comments directed toward others. Do not include speech that amounts to no more than swearing or which can be seen as "bathroom humor" (e.g., a four-year-old talking about seeing his friend's "bottom" in the bathroom.)

LAST 3 MONTHS: INAPPROPRIATE SEXUAL TALK

0 = No

2 = Yes

FIRE PLAY AND FIRE SETTING

Playing with matches or lighters and/or setting of unsanctioned fires.

Regarding the setting of unsanctioned fires, children and especially adolescents are often given permission to light bonfires and campfires, but these are not included here. For a coding here a fire must have been set for which permission had been denied, or for which permission would likely have been denied, had it been sought.

EVER: FIRE PLAY AND FIRE SETTING

0 = Absent

1 = Plays with matches or lighters without supervision but has not set a fire

2 = Deliberate setting of unsanctioned fires, but without intent to cause damage.

3 = Deliberate setting of unsanctioned fires with deliberate intent to cause damage.

PLAYING WITH MATCHES/LIGHTER (last three months)

0 = Absent

1 = Plays with matches or lighters without supervision but has not set a fire

2 = Deliberate setting of unsanctioned fires, but without intent to cause damage.

3 = Deliberate setting of unsanctioned fires with deliberate intent to cause damage.

HYPERACTIVITY/ADD

Purposes of the Section

This section has 4 major functions:

(1) To collect information relevant to the diagnosis of Hyperactivity/Attention Deficit Disorder.

(2) To provide an entry to the Conduct Disorder Section, since there is considerable behavioral overlap between these two diagnoses.

(3) To provide an entry to the Affective Disorders sections through questioning about feelings about behavioral disturbances.

(4) To provide an entry to the assessment of functional incapacity.

Organization of the Section

The structure differs somewhat from the rest of the interview, on account of the requirements of different diagnostic systems. There are three subareas: overactivity, inattention, and impulsivity. Summary ratings are made for each subarea.

Note, however, that the concept of controllability has an additional feature here, as with many other items relevant to oppositional and conduct disorders, in that control by admonition by others is added to the usual notion of self-control. Thus it is necessary to find out whether being admonished or disciplined for the occurrence of these items brings them under control. Additionally, if a parent must exert a great amount of effort to control the child's behavior, or has given up trying to control the child's behavior, this is to be regarded as evidence of uncontrollability and intrusiveness.

We are looking here for patterns that are characteristic of the way that the child acts. Thus, if an example is given that happened only once or twice and was uncharacteristic of the child, it does not count here.

The question is *does* s/he control the behavior, **not** *can*/*could* s/he control it if s/he wanted to (or if s/he weren't disobeying or being naughty). Many parents are convinced that their children could exercise such control, if they only would; this belief is not to be regarded as evidence of controllability.

Ten minute rule

Some behaviors are not rated if the child is able to stop them, when told to, for at least 10 minutes (without being reminded within the 10 minutes). The 10 minute rule refers to an average of ten minutes. If the admonition must be repeated within a short space of time (10 minutes), then the child's behavior is regarded as not being responsive to admonition and therefore the behavior is not regarded as being controllable.

The 10 minute rule applies to Fidgetiness, Difficulty Remaining Seated When Required, and Difficulty Concentrating on Tasks Requiring Sustained Attention. boxes. It may be applied to Talks Excessively and Doing Things Quietly if one is having difficulty making a general determination. For the other generalized items and the items in the Impulsivity section, control for 10 minutes is not relevant.

Frequency

The parent's perception of frequency of symptoms is coded as a scale score.

0---------1-----------2-----------3

0 = Not at all
1 = Rarely
2 = Sometimes
3 = Often
4 = Most of the time
5 = All of the time

Clearly, there is a great range in children of different ages regarding levels of activity, impulsivity, and the ability to control activity and impulsivity. For example, most two or three year olds have more difficulty sitting at the dinner table than five or six year olds. Nonetheless, code the behavior as described by the parent and defined in the Glossary.

OVERACTIVITY

FIDGETINESS

Unnecessary movements of parts of the body when stationary overall (e.g. tapping of feet, squirming in seat).

0 = Absent

2 = Present in at least 2 activities and at least sometimes uncontrollable by the child or by admonition.

3 = Present in most activities and almost never controllable by the child or by admonition.

FIDGETINESS- SITUATIONAL SPECIFICITY

Unnecessary movements of parts of the body while stationary overall (e.g. foot-tapping, squirming in seat). This item rates the occurrence of Fidgeting in 3 specific situations (home, daycare/school, elsewhere), and in activities that the child considers most interesting. Thus, this item evaluates how the child behaves in the 3 different environments under optimal conditions (i.e. in interesting activities, or least boring, which may be more likely to hold a child's attention longer than in uninteresting activities).

S = Fidgetiness absent

0 = Symptom absent during interesting activity.

2 = At least sometimes uncontrollable by the child or by admonition, in at least two interesting activities in any situation.

3 = Almost never controllable by the child or by admonition in most interesting activities

RESTLESSNESS

DIFFICULTY REMAINING SEATED WHEN REQUIRED

2 = Present in at least two activities and at least sometimes uncontrollable by the child him/herself or by admonition.

3 = Present in most activities and almost never controllable either by child or by admonition.

RUSHES ABOUT OR CLIMBS ON THINGS EXCESSIVELY

2 = Present in at least two activities and at least sometimes uncontrollable by the child him/herself or by admonition.

3 = Present in most activities and almost never controllable either by child or by admonition.

ALWAYS ON THE GO

2 = Present in at least 2 activities and at least sometimes uncontrollable by the child or by admonition.

3 = Present in most activities and almost never controllable by the child or by admonition.

RESTLESSNESS- SITUATIONAL SPECIFICITY

Increased unnecessary whole body movements (e.g. getting up and moving around). This item rates the occurrence of Restlessness in 3 specific situations, and in activities that the child considers most interesting. Thus, this item evaluates how the child behaves in the 3 different environments under optimal conditions (i.e. in interesting activities, or least boring, which may be more likely to hold a child's attention longer than in uninteresting activities).

2 = At least sometimes uncontrollable by the child or by admonition, in at least two interesting activities in any situation

3 = Almost never controllable by the child or by admonition in most interesting activities.

Rate in the following 3 situations:

0 = Absent

2 = Present

(a) Restlessness while playing or involved in an activity that the child regards as interesting at home.

(b) Restlessness during the most interesting (or least boring) school lesson

(c) Restlessness during an interesting activity elsewhere (not at home, not at daycare/school)

TALKS EXCESSIVELY

Material may also be relevant to pressured speech/more talkative than usual in mania section.

0 = Absent

2 = Present in at least 2 activities and at least sometimes uncontrollable by the child or by admonition.

3 = Present in most activities and almost never controllable by the child or by admonition.

DIFFICULTY DOING THINGS QUIETLY

0 = Absent

2 = Present in at least 2 activities and at least sometimes uncontrollable by the child or by admonition.

3 = Present in most activities and almost never controllable by the child or by admonition.

INATTENTION

Inattention refers to failure to maintain involvement on age- and developmental stage-appropriate tasks sufficiently to allow their proper completion.

If the parent or teacher has developed specific routines for assisting the child in completing tasks (for instance, by simplifying instructions or repeating them frequently, or placing the child out of contact with all external stimuli), those routines constitute evidence of the presence of a codable problem.

DIFFICULTY CONCENTRATING ON TASKS REQUIRING SUSTAINED ATTENTION

Difficulty concentrating on a particular task that requires sustained attention. Differentiate from difficulty following through on instructions.

0=Absent

2 = Present in at least 2 activities and at least sometimes uncontrollable by the child or by admonition.

3 = Present in most activities and almost never controllable by the child or by admonition.

DIFFICULTY ORGANIZING TASKS AND ACTIVITIES

Difficulty organizing tasks and activities when structure is not imposed by others (e.g., at a loss to start or structure a project, to have all the right materials on hand to play a game, build a train track, etc.).

0=Absent

2 = Present in at least 2 activities and at least sometimes uncontrollable by the child or by admonition.

3 = Present in most activities and almost never controllable by the child or by admonition.

DIFFICULTY IN FOLLOWING THROUGH INSTRUCTIONS FROM OTHERS

Difficulty following through on instructions involves difficulty following through on a series of particular instructions or a sequence of tasks (not due to oppositional behavior or failure of comprehension).

Differentiate from Disobedience. For codings in this section, consider situations in which the child apparently is willing to try to follow instructions, attempts to, but then cannot follow through. In contrast, the disobedient child challenges the necessity of following the instructions, refuses to, and/or is not willing to try. Both can be present.

0 = Absent

2 = Present in at least two activities and at least sometimes uncontrollable by the child him/herself or by admonition.

3 = Present in most activities and almost never controllable either by child or by admonition.

AVOIDS TASKS REQUIRING SUSTAINED MENTAL EFFORT

0 = Absent

2 = Present in at least 2 activities and at least sometimes uncontrollable by the child or by admonition.

3 = Present in most activities and almost never controllable by the child or by admonition.

EASILY DISTRACTED BY EXTRANEOUS STIMULI

Distraction from activities requiring concentration. Extraneous stimuli may include looking out of a window, hearing people talking, hearing the television or music. Normal daydreaming usually does not code here, unless it is set off by an external stimulus.

0 = Absent

2 = Present in at least two activities and at least sometimes uncontrollable by the child him/herself or by admonition.

3 = Present in most activities and almost never controllable either by the child or by admonition.

FORGETFUL IN DAILY ACTIVITIES

Forgetful in daily activities (e.g., forgets to brush teeth or hair; or to do simple chores).

0 = Absent

2 = Present in at least 2 activities and at least sometimes uncontrollable by the child or by admonition.

3 = Present in most activities and almost never controllable by the child or by admonition.

OFTEN LOSES THINGS THAT ARE NECESSARY FOR TASKS/ACTIVITIES AT DAYCARE/SCHOOL OR AT HOME

0 = Absent

2 = Present in at least 2 activities and at least sometimes uncontrollable by the child or by admonition.

3 = Present in most activities and almost never controllable by the child or by admonition.

OFTEN DOES NOT SEEM TO LISTEN TO WHAT IS BEING SAID TO HIM/HER

This symptom describes a child with adequate physical ability to hear who does not seem to “hear” rather than a disobedient child who does not follow instruction.

0 = Absent

2 = Present in at least 2 activities and at least sometimes uncontrollable by the child or by admonition.

3 = Present in most activities and almost never controllable by the child or by admonition.

FAILS TO PAY ATTENTION TO DETAILS

0 = Absent

2 = Present in at least 2 activities and at least sometimes uncontrollable by the child or by admonition.

3 = Present in most activities and almost never controllable by the child or by admonition.

INATTENTION- SITUATIONAL SPECIFICITY

Failure to maintain sufficient involvement to allow proper completion of an age-appropriate and developmentally-appropriate task. Thus, this item rates the occurrence of Inattention in 3 specific situations, and in activities that the child considers most interesting. This item evaluates how the child behaves in the 3 different environments under optimal conditions (i.e. in interesting, or least boring, activities which may be more likely to hold a child's attention longer than in uninteresting activities).

2 = At least sometimes uncontrollable by the child or by admonition, in at least two interesting activities in any situation.

3 = Almost never controllable by the child or by admonition in most interesting activities.

Rate in the following 3 situations:

0 = Absent

2 = Present

(a) Inattention while playing or involved in an activity that the child regards as interesting at home.

(b) Inattention during the most interesting (or least boring) daycare/school activity

(c) Inattention during an interesting activity elsewhere (not at home, not at school)

IMPULSIVITY

A *pattern* of acting before thinking adequately about the consequences of actions. Everyone is impulsive sometimes, but here the coding requires that impulsivity is a characteristic feature of the child's behavior.

Ratings are made for presence of impulsive patterns in several areas. No distinction is made about location, type of activity, or motivation until the end of the section. No durations are coded and the 10 minute rule is not relevant here.

DIFFICULTY WAITING FOR TURN IN GAMES OR IN GROUP SITUATIONS

0 = Absent

2 = Present in at least 2 activities and at least sometimes uncontrollable by the child or by admonition.

3 = Present in most activities and almost never controllable by the child or by admonition.

OFTEN BLURTS OUT ANSWERS TO QUESTIONS

0 = Absent

2 = Present and at least sometimes uncontrollable by the child or by admonition

3 = Present and almost never controllable by the child or by admonition

OFTEN INTERRUPTS OR INTRUDES ON OTHERS

0 = Absent

2 = Present and at least sometimes uncontrollable by the child or by admonition

3 = Present and almost never controllable by the child or by admonition

ACCIDENT PRONE

Prone to injury and accidents because of impulsive action rather than clumsiness.

0 = Absent

2 = Mildly accident prone in at least 2 activities.

3 = Accident prone in most activities.

IMPULSIVITY - SITUATIONAL SPECIFICITY

Pattern of acting before thinking adequately about the consequences of actions.

INTERVIEWER SHOULD USE INFORMATION ALREADY OBTAINED TO MAKE OVERALL RATINGS FOR IMPULSIVITY.

S = No items in impulsivity section coded

0 = Symptom absent

2 = Present in at least 2 activities, and at least sometimes uncontrollable by the child or by admonition

3 = Present in most activities in a particular situation and almost never controllable by the child or by admonition

TRICHOTILLOMANIA

Recurrent pulling out of one's own hair, resulting in noticeable hair loss from scalp, eyebrows, eyelashes, and/or beard.

Do not include hair loss because of radiation therapy.

1 = No obvious hair loss

2 = Noticeable but partial hair loss

3 = Most or all hair on scalp is missing

TICS

REPORTED MOTOR TICS

Tics are sudden, rapid, stereotyped, repetitive, non-rhythmic, predictable, purposeless, coordinated contractions of functionally related muscle groups. They can usually be suppressed voluntarily for a time and can usually be imitated.

The parent's account of the child's tics is sought here.
To be coded at all, tics should have occurred at least 10 times each day for at least a week during the past three months.

2 = Single motor tics

3 = More than one type of tic

FREQUENCY PER HOUR

1 = less than 10 per hour

2 = more than 10 per hour

3 = more than 100 per hour

NUMBER OF DAYS IN LAST 3 MONTHS

REPORTED PHONIC TICS

Phonic tics are sudden, rapid, stereotyped, repetitive, predictable, purposeless, phonic productions.

To be coded at all, tics should have occurred at least 10 times each day for at least a week during the past three months.

2 = Single phonic tic type

3 = More than one type of tic
includes coprolalia

FREQUENCY PER HOUR

1 = less than 10 per hour

2 = more than 10 per hour

3 = more than 100 per hour

NUMBER OF DAYS IN LAST 3 MONTHS

If phonic tics are present in the last 3 months, ask about coprolalia.

COPROLALIA

A complex phonic tic resulting in the uttering of obscenities.

0 = Absent

2 = Present

STEREOTYPIES AND UNUSUAL SPEECH PATTERNS

Purpose of the section

The section has 2 major functions:

(1) To provide information relevant to the diagnosis of stereotypic movement disorder.

(2) To provide information about unusual speech patterns

Organization of the section

The section is organized into two units.

STEREOTYPIES

STEREOTYPIC MOVEMENTS

Voluntary movements carried out in a uniform, repetitive, often rhythmic fashion, often for long periods of time and at the expense of all other activities; e.g., rocking, finger-flicking, hand-flapping, spinning, head banging, self biting or hitting. Stereotypies can be self injurious or not.

The reference period is the last three months.

Distinguish from habits, compulsions, tics, and trichotillomania which are coded elsewhere.

TYPES OF STEREOTYPIC MOVEMENTS

Body rocking
Head banging
Shaking or waving hands
Spinning
Finger-flicking
Biting self
Hitting self
Other (specify) Other might include prolonged jumping, compulsive masturbation

For each type of stereotypy present code:

0 = Absent

2 = Repeated 3 times or more but not continuous

3 = Almost continuous

Frequency (rough estimate of number of stereotypies per hour)

2 = More than 10

3 = More than 100

INTERFERENCE WITH ACTIVITIES

0 = No

2 = Interferes with at least two activities

3 = Interferes with almost all activities

HAS INJURED SELF

0 = No

2 = Yes

NEEDED MEDICAL TREATMENT

0 = No

2 = Yes

UNUSUAL SPEECH PATTERNS

Uncommon patterns of speech including stuttering, repetitive use of language, echolalia, and clang associations

STUTTERING

Disturbance in the normal fluency and time pattering of speech including sound and syllable repetition, sound prolongations, broken words, blocking, monosyllabic whole word repetitions (“I-I-I-I see him”)

ECHOLALIA

Repeated words or phrases regardless of meaning including continual repetition of jingles or commercials. There may be an involuntary repetition of the words or phrases of another person as though the child was an “echo.”

CLANGING

Associating words together inappropriately because of their meaning or rhyme (“splash-hash-dash-mash-mush-crush-kill”) so that the speech loses its aim and coherence and the child wanders far from the original theme.

OTHER UNUSUAL SPEECH PATTERNS

These may include incoherent speech, poverty of content of speech, or other unusual flights of idea like clanging that lead the child’s speech far from its original theme

For each code:

0 = Absent

2 = Present but does not markedly interfere with communication

3 = Present and causes marked interference with communication

REGULATION

Purpose of the Section

The section serves 4 major functions.

(1) To assess the child's habits.

(2) To assess the child's regulation of emotion in the face of change.

(3) To assess the child's reactivity to sensory input.

(4) To assess one aspect of the child's motor coordination.

Organization of the Section

The section is organized as a single unit.

HABITS

A pattern of behavior acquired through frequent repetition.

Code Thumb sucking and Pacifier Use in the Sleep section.

NAIL BITING

Recurrent tearing away of finger nails or toe nails with teeth.

0 = No

2 = Yes

SKIN PICKING

Picking at, pulling, or scratching pieces of skin or scabs.

0 = No

2 = Yes

OTHER

Other habitual behavior as described by parent.

0 = No

2 = Yes

(Specify):

DIFFICULTY WITH TRANSITIONS

In general, when the child must make a transition from one activity to another s/he becomes behaviorally and emotionally upset. Child may become, angry, physically aggressive, physically resistant, or “wild.”

Examples of transitions include having to stop playing to eat dinner, leaving the house, turning off the T.V. or leaving the park to go home

0 = No or minimal difficulty with transitions

1 = Child has some difficulty with transitions but with a warning before the change occurs, child is able to navigate the change without significant problems

2 = Child has difficulty with transitions as defined above

ABRUPT SHIFTS IN AFFECT

Consider mixed mood states as well.

At least once a week child has sudden changes between extreme affect states.

0 = Absent

2 = Present

DIFFICULTY RESTORING EMOTIONAL EQUILIBRIUM AFTER BECOMING UPSET

Trouble returning to a baseline equilibrium when emotionally upset.

0 = Able to regain emotional equilibrium;

2 = Some difficulty regaining equilibrium after becoming emotionally upset when tired or hungry or stressed

3 = Difficulty regaining equilibrium most of the time after becoming emotionally upset

TACTILE HYPERSENSITIVITY

Child reacts to being touched by others or by objects (e.g. the feeling of fabric/clothes tags on bare skin or brushing against a piece of furniture) with a negative response that seems out of proportion to the stimulus.

The critical point is that the response if beyond what would be expected in most people when faced with the stimulus. For example, if the child is unable to eat dinner with the family and cries and screams because s/he cannot stand the smell of broccoli then code hypersensitivity. If the child just says (even in a rude or disgusted voice) "I hate the smell of broccoli. It is so gross!" then it is not hypersensitivity.

TACTILE DEFENSIVENESS IN RESPONSE TO PHYSICAL CONTACT WITH OTHER PEOPLE

0 = No

2 = When touched, child becomes emotionally upset or physically aggressive

TACTILE DEFENSIVENESS IN RESPONSE TO CONTACT WITH FABRICS, CLOTHES TAGS, OTHER OBJECTS

0 = No

2 = Child is so bothered by the feel of certain fabrics, tags, and/or other objects that s/he is becomes emotionally upset or physically aggressive.

ORAL HYPERSENSITIVITY: TACTILE DEFENSIVENESS IN RESPONSE TO CONTACT WITH CERTAIN FOOD TEXTURES

0 = No

2 = Child's refusal to eat certain types of food (e.g. crunchy food; hard food; soft food) because of their texture significantly limits his/her food choices

Do not include isolated dislikes like the texture of crunchy peanut butter alone.

VISUAL HYPERSENSITIVITY

Child reacts to bright or harsh lights with a negative response that seems out of proportion to the stimuli.

0 = No

2 = Child is so bothered by bright or harsh light that s/he becomes emotionally upset or physically aggressive

HYPERSENSITIVITY TO LOUD OR HIGH-PITCHED NOISES

Child reacts to loud or high-pitched noises with a negative response that seems out of proportion to the stimuli.

0 = No

2 = Child is so bothered by loud or high-pitched noises that s/he becomes emotionally upset or physically aggressive

HYPERSENSITIVITY TO SMELLS

Child reacts to certain smells with a negative response that seems out of proportion to the stimuli.

0 = No

2 =Child is so bothered by certain smells that they seem to make him/her emotionally upset or physically aggressive

Do not include aversions to smells that most people would find noxious.

HYPERSENSITIVITY TO TASTE

Child reacts to certain tastes with a negative response that seems out of proportion to the stimuli.

0 = No

2 = Yes. Child is so bothered by certain tastes that s/he becomes emotionally upset or physically aggressive and/or refuses to eat certain foods in a way that significantly limits his/her food choices.

Do not include aversions to tastes that most people would find noxious.

HYPERSENSITIVITY TO CHANGING SENSATIONS OF MOTION

Overreaction to changing sensations of movement involved in brisk horizontal or vertical movements like swinging on a swing, being tossed in the air, rolling down a hill, or being rocked.

0 = No

2 = Yes. Child is so bothered by changing sensations of movement that s/he becomes emotionally upset or physically aggressive and/or avoids the situations as much as possible

BECOMES CAR SICK

When driving in the car child becomes very nauseous or throws up.

OTHER SENSORY HYPERSENSITIVITY

SENSORY HYPO-SENSITIVITY

Child seems to have decreased reactivity to intense sensory input.

LOUD OR HIGH-PITCHED NOISES

0 = No

2 = Yes

BRIGHT LIGHTS

0 = No

2 = Yes

SENSATIONS OF MOVEMENT

0 = No

2 = Yes

OTHER

0 = No

2 = Yes

CLUMSY

Child has decreased physical grace or skill that results in him/her regularly bumping into people or things, dropping objects, knocking things over, falling, and/or spilling things.

EATING AND FOOD RELATED BEHAVIOR

Purposes of the Section

The section has 5 major functions:

(1) To provide an early feeding history.

(2) To provide an assessment of the child's food related behavior.

(7) To foreshadow elements of Anorexia Nervosa or Bulimia Nervosa.

(4) To provide evidence of appetite disturbance associated with mood disturbance.

(5) To provide evidence of growth retardation.

Organization of the Section

The section is organized as a single unit.

EARLY FEEDING HISTORY

EARLY BREAST FEEDING

Breast feeding refers to the consumption of breast milk (whether taken directly from the breast or expressed and then bottle-fed to the infant). The period to be considered here is that period when milk was the *only food* being provided to the child. The codings should be made to refer to the pattern that persisted longest during that period. For instance, if a mother relied solely on breast-feeding for the first month, but then switched entirely to bottle-feeding for three months, at which point solid food was introduced, the appropriate coding would be 4.

0 =Child received all or almost all milk in the form of breast milk (≥75%)

2 = Child received some milk in the form of breast milk (<75%, >25%)

3 = Child received a small amount of milk in the form of breast milk (≤25%)

4 = Child received all milk in the form of formula

EARLY BREAST FEEDING ATTEMPTS

For this item it is necessary to determine whether, and what, attempts were made to breast feed the child. If breast feeding was attempted, but given up, then reasons for giving it up are coded.

Two types of reasons for stopping breast feeding must be distinguished. A coding of 2 is appropriate when the principal reason given for stopping breast feeding concerns inability to provide adequate supplies of breast milk, or because attempts at breast feeding were unsuccessful in establishing a satisfactory feeding pattern. The second type of reason concerns difficulties with the logistics of breast feeding. Such reasons include, the mother having to work, and, therefore, being unavailable to breast feed, or lacking a refrigerator in which to store expressed mild. When a mixture of logistical and non-logistical reasons is given, code 3 (note that this item is unusual in that the higher of two possible codings is given, rather than the lower).

0 = No breast feeding attempts made

2 = Breast feeding was stopped before the child was introduced to solid food either because an inadequate supply of breast milk was produced, or because of difficulty with establishing a satisfactory feeding pattern, for reasons unconnected with the logistics of breast feeding.

3 = Breast feeding was stopped for logistical reasons.

AMOUNT OF LATER BREAST FEEDING

Later breast feeding refers to breast feeding or formula feeding after solid food was introduced into the child's diet. Note that this period ends at the point at which neither breast milk nor formula is offered to the child. Do not include the use of unformulated cow's milk here. The point at which unformulated cow's milk replaces breast milk or formula marks the end of the period considered for this item.

0 = Child received all or almost all milk in the form of breast milk.

2 = 25%-50% of the child's milk feeds were provided by formula milk.

3 = Over half of the child's milk feeds were provided by formula milk.

4 = All the child's milk feeds were provided by formula milk.

BOTTLE USE

Use of a bottle during the last three months.

0 = Child does not use a bottle

2 = Child uses a bottle

3 = Child uses a bottle and at least sometimes carries it around or has access for extended periods

MANUALLY FED BY PARENT

Parent feeds child with a utensil or hands. Do not include simply helping the child to prepare food for eating (for instance by cutting up meat or mashing potatoes on the plate).

Exclude feeding child with a bottle, which is coded as "bottle feeding."

0 = Child feeds him/herself unaided all or almost all the time.

2 = Parent feeds child at least part of a meal at least once per week

3 = Parent feeds child almost all the time

If the coding for Manually Fed by Parent = 3, ask whether the child had previously been feeding him/herself.

CHILD HAD BEEN FEEDING SELF FOR AT LEAST ONE MONTH PRIOR TO PARENT MANUALLY FEEDING CHILD

0 = No

2 = Yes

DATE PARENT RESUMED FEEDING CHILD AFTER ONE MONTH OF SELF-FEEDING

FOOD PREFERENCES AND APPETITE

FOOD FADS

The child will consume only a restricted range of foods not typical of others of his/her development stage or social group. Do not include simple dislike of cabbage etc., which is typical of many children. To be rated, food fads must be extensive and restrictive to the point of generally interfering with family meals.

2 = The child eats only within the range of his/her fads.

3 = Eating with others is very difficult because of extreme fads.

INDIFFERENCE/AVERSION TO FOOD

Child is indifferent to food (can "take it or leave it"and/or the child has an aversion to food [e.g., finds it's taste, smell or texture repulsive; can barely be in the same room with it]). Distinguish from decreased appetite, which is coded separately. The cause of indifference/aversion is specified if known. Differentiate from food fads and simple dislike of certain foods. Disliked foods may be considered repulsive, but alternative foods are of interest to the child. Indifference/aversion is rated only when there is a general dislike or aversion to all foods. Indifference/aversion must also be distinguished from reluctance to eat when not hungry but the child is subjected to pressure to eat. Children who are always uninterested in eating or always reluctant to eat may say that they are not hungry, however, indifference/aversion *is* coded when it appears that the child would have to be never or almost never hungry for this excuse to be true.

If the child meets criteria for both indifference/aversion to food and reduced appetite (change), both may be coded.

0 = Absent

2 = Child is indifferent to food

3= Child has an aversion to food

CAUSE OF AVERSION is coded if INDIFFERENCE/AVERSION TO FOOD is coded at the 3 level:

1 = Taste
2 = Smell
3 = Texture
4 = Other_____

APPETITE CHANGES

REDUCED APPETITE

Reduction of normal appetite, or reduced interest in, or enthusiasm for, food for one week consecutively.

2 = Food intake has definitely been reduced below the normal level because of lack of appetite for at least one week.

3 = The child can only be induced to eat by marked parental or other persuasion.

WEIGHT LOSS

Code only significant weight loss (at least 2 lbs). Code the number of pounds lost during the last three months.

0 = Absent

2 = Present

EXCESSIVE APPETITE

An increase in appetite outside the normal range of the child for at least one week consecutively. It may still have been present during the previous three months even if reduced appetite and weight loss have also been reported.

0 = Absent

2 = Food consumption has been definitely increased above the child's usual level for at least one week.

CONFLICTS ABOUT FOOD

Struggles between “parent” and child about food. Tension may concern amount of intake or type of food eaten. Not restricted to mealtimes. May cause distress to parent, child or both.

0 =Minimal distressing food issues/conflicts between parent and child

2 = Frequent and distressing conflicts between parent and child about food

Distress to Parent

0 = No

2 = Yes

Distress to Child

0 = No

2 = Yes

CONFLICTS DURING MEAL TIMES

Arguments or conflicts during meal times, about subjects other than food, that cause distress to the child. In order to ask about conflicts, it will first be necessary to ascertain whether the family has eaten meals together as a family at least once per week (for at least four weeks of the primary period.)

EAT MEALS AS A FAMILY AT LEAST 1 TIME PER WEEK

0 = No

2 = Yes

MEAL CONFLICTS

0 = Meals usually pleasant; fewer than five conflicts during meals over the last three months

2 = Conflicts occur during some meals

3 = Conflicts occur during most meals

CHILD'S BODY DISSATISFACTION

The child has complained about body shape or appearance or expressed a wish for a different body shape or appearance. Do not include dissatisfaction with gender, which is coded separately. If meets criteria for body dissatisfaction and worries about being/becoming fat, code under both.

0 = Absent

2 = The child is dissatisfied with his/her body shape and/or appearance

CAUSE(S) FOR DISSATISFACTION
Code up to three

1 = Too fat
2 = Too thin
3 = Too short
4 = Too tall
5 = Hair color
6 = Eye color
7 = Other____

PARENT'S DISSATISFACTION WITH CHILD'S BODY SHAPE OR APPEARANCE

Parent's unhappiness with or concern about the *child's* body shape or appearance. Do not include dissatisfaction with gender, which is coded under separately. If meets criteria for body dissatisfaction and worries about being/becoming fat, code under both.

0 = Absent

2 = The parent is dissatisfied with his/her child's body shape and/or appearance

CAUSE(S) FOR DISSATISFACTION
Code up to three

1 = Too fat
2 = Too thin
3 = Too short
4 = Too tall
5 = Hair color
6 = Eye color
7 = Other____

PRETTY/HANDSOME
The child's subjective judgment as to his/her overall physical attractiveness

PRETTY

S = Not applicable

0 = Yes

2 = No

HANDSOME

s = Not applicable

0 = Yes

2 = No

PRETTY/HANDSOME
The parent's subjective judgment as to the child's overall physical attractiveness

PRETTY

S = Not applicable

0 = Yes

2 = No

HANDSOME

s = Not applicable

0 = Yes

2 = No

WORRY ABOUT BEING/BECOMING FAT

A round of painful, unpleasant or uncomfortable thoughts about becoming (or being) fat or obese.

CHILD WORRIES ABOUT BEING/BECOMING FAT

0 = Absent

2 = Child's worries about being/becoming fat are intrusive into at least 2 activities and at least sometimes uncontrollable

3 = Child's worries about being/becoming fat are intrusive into most all activities and almost always uncontrollable

PARENT WORRIES ABOUT CHILD BEING/BECOMING FAT

0 = Absent

2 = Parent's worries about child being/becoming fat are intrusive into interactions with child and at least sometimes uncontrollable

3 = Parent's worries about child being/becoming fat are intrusive into most activities and almost always uncontrollable

DELIBERATE REDUCTION OF BODY WEIGHT

Deliberate attempts to reduce body weight by dieting
A "**diet**" refers to any attempt to reduce body weight by the deliberate restriction of caloric intake (no matter how feebly adhered to), lasting at least 1 week.
Do not include diets or exercise regimens prescribed by physician or other medical advisor.
Do not include health regimens (e.g., restrict fats) not focused on weight loss.

EVER: PARENT INITIATED
0 = No

2 = Yes

PARENT INITIATED LAST THREE MONTHS

0 = No

2 = Yes

Ask about child initiated diets only if the parent has never initiated a weight loss diet for the child.

EVER: CHILD INITIATED

0 = No

2 = Yes

CHILD INITIATED LAST THREE MONTHS:

0 = No

2 = Yes

AFFECT SENSITIVE EATING PATTERNS

Child responds to sadness, worry/anxiety or anger by eating significantly more or significantly less food than usual for that child. Distinguish from binging, dieting, or overall change in appetite.

0 = No

2 = Eats more

3 = Eats less

SADNESS

0 = No

2 = Yes

WORRY/ANXIETY

0 = No

2 = Yes

ANGER

0 = No

2 = Yes

BULIMIA (EATING BINGES)

Recurrent, discrete, secret episodes of excessive, rapid eating of easily ingested food. Do not include snack "binges" (for instance on return from daycare/school or after sports) where there is no attempt at secrecy. Do not include public displays of greed, or individuals who normally have large appetites.

0 = Absent

2 = Binges at least sometimes uncontrollable

3 = Binges almost always uncontrollable

EPISODE TERMINATED BY:

Code here the presence or absence of a variety of features that often characterize the end of a bout of binging. More than one may be present.

ABDOMINAL PAIN

0 = No

2 = Yes

SELF-INDUCED VOMITING

0 = No

2 = Yes

SLEEP

0 = No

2 = Yes

SOCIAL INTERRUPTION

0 = No

2 = Yes

FOLLOWING A BINGE FEELS:

DEPRESSED

0 = No

2 = Yes

GUILT, SHAME, AND/OR LOW SELF ESTEEM

0 = No

2 = Yes

FOOD HOARDING

Taking and hiding food. There does not have to be any intent to consume the food at a later time. Neither does it matter whether such food would have been available at other times.

0 = No

2 = Yes

SWALLOWING ABNORMALITIES

Difficulties swallowing food including gagging or choking, or having food stuck in child's throat, of sufficient degree to interfere with the normal consumption of a meal.
Do not include the effects of an occasional mouthful "going down the wrong way" or occasional gagging.
If food fads or food aversion are associated with difficulty swallowing non-preferred food, then code *both* the fads/aversion and swallowing abnormality.

0 = No

2 = Swallowing problems sufficient to interfere with the efficient consumption of a normal meal.

3 = Consumption of a normal meal at a normal rate made impossible, or nearly impossible by swallowing problems.

GAGGING

0 = No

2 = Yes

CHOKING

0 = No

2 = Yes

FOOD STUCK IN THROAT

0 = No

2 = Yes

TRIGGERS
Factors that appear to lead to difficulty in swallowing.
Code up to three

1 = Physical problem: Include any known physical deformity or abnormality.
2 = Type of food: Code when particular foods or types of food lead to difficulty in swallowing.
3 = Negative affect: Code when difficulty swallowing appears to accompany one or more negative affective states (unhappiness, worry/anxiety, nervous tension, anger)
4 = Other_____

RUMINATION

Repeated regurgitation of food from the stomach soon after it has been swallowed, re-chewing of the food, and then re-swallowing or spitting out the food.

Distinguish from vomiting or gagging/choking on food

0 = No

2 = Yes

EVER PERIOD OF AS LONG AS A MONTH WHEN CHILD ATE NORMALLY

0 = Period of at least one month of normal functioning

2 = Never period of at least one month of normal functioning

PICA

Persistent eating (chewing and/or swallowing) of non-nutritive substances.

0 = No

2 = Yes

SUBSTANCES
Code up to four

1 = Paint
2 = Plaster
3 = Paper
4 = Clothing
5 = Hair
6 = Animal Droppings
7 = Dirt
8 = Clay
9 = Pebbles
10= Sand
11= Starch
12= Other_____
LEAD IN BLOOD

Toxic levels of lead in the child's bloodstream diagnosed by a blood test.

EVER: DIAGNOSED WITH LEAD IN BLOOD

0 = No

2 = Yes

DATE(S)

EVER: TREATED FOR LEAD IN BLOOD

0 = No

2 = Yes

SOMATIC PROBLEMS

Purposes of the Section

This section has 4 major functions:

(1) To provide an evaluation of the child's subjective attitude towards his/her health.

(2) To provide information about the child's somatic symptoms.

(3) To provide an entry to the Separation Anxiety section.

(4) To provide entry to the assessment of Depression and Anxiety as evidenced by the nature of the child's concern over his/her health.

Organization of the Section

The section is organized as a single unit.

In the schedule, a number of ratings are made for each symptom that the parent describes as present.

MEDICAL CONTACT

The interviewee reports having consulted a physician (include alternative medical practitioners, such as chiropractors, etc.) on account of a particular symptom. This contact can include telephone consultations; it is not necessary for the child to have seen the physician in person.

0 = No medical contact

2 = Any medical contact related to symptoms

TREATMENT

A particular symptom led to the consumption of a medication or other treatment (include alternative medical remedies, such as homeopathic medicines). Include over-the-counter medications only if they are prescribed by a physician to relieve that particular symptom. Do not include self-prescribed medications.

0 = No treatment

2 = Any medical treatment related to symptom.

FUNCTIONING

A particular symptom caused the child to change some aspect of his/her life pattern in such a way as to impair his/her functioning. For instance, s/he may have taken to his/her bed or a wheelchair.

The impaired function should also be considered for rating incapacity.

0 = No change in life pattern

2 = Change in life pattern present

FEELS UNWELL

This item describes a generalized feeling of illness or unwellness.

2 = Feeling physically less well than usual.

3 = Feels physically unwell almost all of the time.

SICKLY

The interviewee states that the child has been sickly for a good part of his/her life. That is, s/he feels the child has been afflicted with one form of illness or another (often unspecified and vague) for considerable periods of time. The interviewer does not have to be convinced that the symptoms are or were ever present as described, or that they were due to any physical illness.

SICKLY

0 = Absent

2 = Present

HEADACHES

For the child who has had headaches over the last three months, data is collected on symptoms of migraine and non-migraine headaches. Note that an individual can have both types of headaches.

0 = Absent

2 = Present

MIGRAINE HEADACHES

CHILD CAN DESCRIBE LOCATION OF HEADACHE PAIN

0 = No

2 = Yes

UNILATERAL (ONE SIDE)

0 = No

2 = Yes

FRONTAL

0 = No

2 = Yes

INHIBITS DAILY ACTIVITIES

0 = No

2 = Yes

PAIN WORSENED BY PHYSICAL ACTIVITY

0 = No

2 = Yes

SICK TO STOMACH/NAUSEA

0 = No

2 = Yes

VOMITING

0 = No

2 = Yes

PHOTOPHOBIC/BOTHERED BY LIGHT

0 = No

2 = Yes

PHONOPHOBIC/BOTHERED BY SOUND

0 = No

2 = Yes

AURA PRECEDES OR PRESENTS WITH HEADACHE

0 = No

2 = Yes

PALLOR PRECEDES OR PRESENTS WITH HEADACHE

0 = No

2 = Yes

IRRITABILITY PRECEDES OR PRESENTS WITH HEADACHE

0 = No

2 = Yes

LOSES DESIRE TO EAT

0 = No

2 = Yes

BIOLOGICAL MOTHER SUFFERS MIGRAINES

0 = No

2 = Yes

BIOLOGICAL FATHER SUFFERS MIGRAINES

0 = No

2 = Yes

ONE OR MORE BIOLOGICAL SIBLINGS SUFFER MIGRAINES

0 = No

2 = Yes

SEVERITY OF MIGRAINES OVER THE LAST THREE MONTHS

Code 1 - 10, with 10 as the most severe

PAIN-FREE INTERVALS

0 = No

2 = Yes

SLEEP AND REST HELP

0 = No

2 = Yes

MIGRAINES LINKED TO:

Parental description suggesting that episodes of migraine headache are associated with particular stimuli or emotional states. Code up to four

0 = No link
1 = Illness (fever etc)
2 = Separation from attachment figure
3 = Daycare/school days
4 = Anxiety/worries
5 = Sadness
6 = Anger
7 = Eating
8 = Particular foods
9 = Other_____

NON-MIGRAINE (TENSION) HEADACHES

CHILD CAN DESCRIBE LOCATION OF HEADACHE PAIN

0 = No

2 = Yes

GENERALIZED LOCATION

0 = No

2 = Yes

BAND-LIKE PRESSURE

0 = No
2 = Yes

SEVERITY OF TENSION HEADACHES OVER THE LAST THREE MONTHS

NON-MIGRAINE HEADACHES LINKED TO:

Parental description suggesting that episodes of non-migraine headache are associated with particular stimuli or emotional states. Code up to four

0 = No link
1 = Illness (fever etc)
2 = Separation from attachment figure
3 = Daycare/school days
4 = Anxiety/worries
5 = Sadness
6 = Anger
7 = Eating
8 = Particular foods
9 = Other_____

ABDOMINAL PAINS

0 = Absent

2 = Abdominal pains present

ABDOMINAL PAIN LINKED TO:
Parental description suggesting that episodes of abdominal pain are associated with particular stimuli or emotional states. Code up to four

0 = No link
1 = Illness (fever etc)
2 = Separation from attachment figure
3 = Daycare/school days
4 = Anxiety/worries
5 = Sadness
6 = Anger
7 = Eating
8 = Particular foods
9 = Other_____

NAUSEA

0 = No

2 = Yes

Parental description suggesting that episodes of nausea are associated with particular stimuli or emotional states. Code up to four

0 = No link
1 = Illness (fever etc)
2 = Separation from attachment figure
3 = Daycare/school days
4 = Anxiety/worries
5 = Sadness
6 = Anger
7 = Eating
8 = Particular foods
9 = Other_____

VOMITING

0 = Absent

2 = Present

Frequency is recorded.

VOMITING LINKED TO:
Parental description suggesting that episodes of vomiting are associated with particular stimuli or emotional states. Code up to four

0 = No link
1 = Illness (fever etc)
2 = Separation from attachment figure
3 = Daycare/school days
4 = Anxiety/worries
5 = Sadness
6 = Anger
7 = Eating
8 = Particular foods
9 = Other_____

MOTION SICKNESS

Becoming ill when traveling in moving vehicle such as a car, bus, boat etc.

0 = Absent

2 = Present

ACHES AND PAINS

Aches and pains in muscles or joints.

Do not include headaches or stomach aches, which are coded separately, or aches and pains resulting only from involvement in sports or other strenuous play.

0 = Absent

2 = Aches and pains present

3 = Aches and pains almost constantly present

AVOIDANCE

0 = Absent

2 = Avoids, or has given up, activities because of pain

ACHES AND PAINS LINKED TO:

Parental description suggesting that episodes of aches and pains are associated with particular stimuli or emotional states. Code up to four

0 = No link
1 = Illness (fever etc)
2 = Separation from attachment figure
3 = Daycare/school days
4 = Anxiety/worries
5 = Sadness
6 = Anger
7 = Eating
8 = Particular foods
9 = Other_____

ABSENCE OF A REACTION TO PHYSICAL INJURY

No visible response to physical injury such as a splinter, cut knee, or a more serious injury, even when it is clear that the injury is painful.

Distinguish from bravery and “stiff upper lip.” In these cases, it will be obvious that the child is controlling his/her response to the injury, rather than having little or no apparent reaction to it.

0 = Displays conventional reaction

2 = When physically injured, child shows minimal reaction and seems indifferent to the injury.

OVERREACTION TO PHYSICAL INJURY

Hypersensitivity to any physical injury, much comfort and multiple band aids needed after even the smallest cut or scrape.

0 = Displays conventional reaction

2 = Becomes extremely upset with even the smallest injury

ELIMINATION BEHAVIORS

While not all children of this age group have passed these milestones, the following section will help us understand the normative development of urinary and fecal continence.

URINARY CONTINENCE

Achievement of voluntary control of urination.

Do not include episodes of wetting directly and exclusively associated with marked physical illness, or wetting that is directly and exclusively associated with lack of toilet facilities.

DIAPERS/PULL-UPS

Has worn diapers/pull-ups during the primary period.

O = No

1 = Yes, night only

2 = Yes, both day and night

EVER: DIURNAL CONTINENCE OF URINE

Has used the toilet (or potty) regularly during the day for one month or more during the day.

0 = Yes

2 = No

DURATION OF LONGEST EVER PERIOD OF DIURNAL CONTINENCE IN MONTHS

S = Not applicable or less than one month

EVER: ONSET CONTINENT OF URINE DURING THE DAY

DIURNAL CONTINENCE OF URINE(LAST THREE MONTHS)

0 = Yes

2 = No

RESISTANCE TO “POTTY TRAINING”

Child may have expressed some interest in becoming dry or “trained” in the past, but avoids compliance either combatively or, while seeming outwardly malleable, simply does not comply.

S = Is “potty trained” during the day

0 = Resistance absent

2 = Resistance present

DIURNAL ENURESIS

Involuntary passage of urine during the day, after the child had achieved a previous period of at least one month of diurnal continence.

Do not include episodes of wetting directly and exclusively associated with marked physical illness, or wetting that is directly and exclusively associated with lack of toilet facilities.

0 = Absent

2 = Any episode of diurnal enuresis that involves the involuntary passage of a substantial amount of urine(i.e., excluding minor dampness associated with careless hygiene or with severe sneezing/laughing)

ONSET OF CURRENT EPISODE OF DIURNAL ENURESIS

NOCTURNAL URINARY CONTINENCE

Dry overnight

EVER: NOCTURNAL URINARY CONTINENCE (Dry at night for at least one month)

0 = Yes

2 = No

EVER: DURATION OF LONGEST PERIOD OF NOCTURNAL CONTINENCE (in months)

S = Not applicable or less than one month

EVER: ONSET OF NOCTURNAL URINARY CONTINENCE

NOCTURNAL ENURESIS

Involuntary passage of urine in bed, during the night, after the child had achieved a previous period of one month of nocturnal continence.

0 = No

2 =Any episode of nocturnal enuresis that involves the involuntary passage of a substantial amount of urine (i.e. excluding minor dampness associated with careless hygiene or with severe sneezing/laughing).

ONSET OF CURRENT EPISODE OF NOCTURNAL ENURESIS

EVER: CONSULTED PHYSICIAN/THERAPIST ABOUT WETTING

0 = No

2 = Yes

CURRENTLY USING TREATMENT TO STOP WETTING

0 = No

2 = Yes

TYPE OF TREATMENT

1 = Bell and pad alarm

2 = Medication (type) _____

3 = Other_____

TREATMENT HELPFUL

0 = Yes

2 = No

FECAL CONTINENCE

Voluntary control of bowel movements.

EVER: FECAL CONTINENCE

Has used the toilet (or potty) to defecate for at least one month.

0 = Yes

2 = No

EVER DURATION: LONGEST PERIOD OF FECAL CONTINENCE

EVER ONSET OF FECAL CONTINENCE

FECAL CONTINENCE, LAST 3 MONTHS

0 = Yes

2 = No

ENCOPRESIS

Establish that bowel, not urinary, function is being asked about.

MEDICAL REASON FOR SYMPTOM

0 = Absent

2 = Present

CONSISTENCY OF STOOL

2 = Loose/slimy/unformed

3 = Formed

STOOL DEPOSITED IN INAPPROPRIATE PLACES

0 = No

2 = Yes

SMEARING

Spreading stools on self, walls or other objects.

0 = No smearing

2 = Stools deliberately smeared on self or walls or other objects (include anal masturbation here)

CONSTIPATION

Frequency of passage of motion reduced by at least one third, compared with child's usual state lasting for at least 1 week.

0 = Absent

2 = Reduced frequency but normal consistency

3 = Reduced frequency of motions and unusually hard in consistency

MEDICAL REASON FOR SYMPTOM
(including taking medication)

0 = Absent

2 = Present

DIARRHEA

Unusually loose, liquid, or frequent bowel movements

0 = No

2 = Yes

MEDICAL REASON FOR SYMPTOM

0 = Absent

2 = Present

SEPARATION ANXIETY

Purpose of the section

The section serves one major function

(8) To provide information on the child's anxiety about separation from significant caregivers.

Organization of the section

The section is organized as a single unit.

SEPARATION WORRIES/ANXIETY

Developmentally inappropriate, excessive worries or fears concerning separation from the persons to whom the affected child is attached. Typically, the child will worry about a major attachment figure coming to some harm, or going away and not returning, or that the child him/herself will get lost or die or be hurt, resulting in separation, from major attachment figures. There is no firm age requirement to count as an attachment figure nor must it necessarily be a parent, although the major attachment figure would most predictably be a parental figure.

Sometimes one might think that the child has separation anxiety because s/he expresses anxiety about being separated from his/her parents while s/he is a patient in the hospital. In this instance one should question further to determine whether this is excessive and whether there is some evidence that the child has experienced this anxiety in the past (prior to the admission), and in relation to other situations in which s/he anticipated separation from his/her parents. Anxiety limited to fear of upcoming novel (and potentially unpleasant) separation such as that presented by hospitalization is not counted here.

2 = Worrying or Subjective Anxious Affect intrusive into at least two activities and uncontrollable at least some of the time.

3 = Worrying or Subjective Anxious Affect intrusive into most activities and nearly always uncontrollable.

There are two subtypes of Separation Worries/Anxiety:

WORRIES/ANXIETY ABOUT POSSIBLE HARM

Unrealistic and persistent Worry or Subjective Anxious Affect about possible harm befalling major attachment figures, or worry or fear that they will leave and not return.

If child has both Fear of What Will Happen at Home When Away and Fear about Possible Harm, code all *unrealistic* fears, that occur either at daycare/school or other separation situations under Fear of Possible Harm, and all fears that occur at daycare/school under Fear of What Will Happen at Home When Away. Thus unrealistic fears occurring at daycare/school are coded under *both* items.

2 = Fear or Worrying intrusive into at least two activities and uncontrollable at least some of the time.

3 = Fear or Worrying intrusive into most activities and nearly always uncontrollable.

WORRIES/ANXIETY ABOUT CALAMITOUS SEPARATION

Unrealistic and persistent Subjective Anxious Affect or Worry that an untoward calamitous event (e.g. car accident, getting lost or kidnaped) will separate the child from a major attachment figure; or that following separation, a calamitous event (such as an accident, mutilation, or death) will occur to the child.

2 = Fear or Worrying intrusive into at least two activities and uncontrollable at least some of the time.

3 = Fear or Worrying intrusive into most activities and nearly always uncontrollable.

AVOIDANCE OF BEING ALONE

Persistent avoidance of being alone due to anxiety about being away from attachment figures.

0 = Absent

2 = At least sometimes tries to avoid being alone because of at least sometimes uncontrollable fear or anxiety about being away from attachment figures.

3 = Almost always tries to avoid being alone because of nearly always uncontrollable fear or anxiety about being away from attachment figures. Follows “parent” around the house.

ANTICIPATORY DISTRESS/RESISTANCE TO SEPARATION

Signs or complaints of excessive distress in anticipation of separation from major attachment figures; or significant reluctance or resistance to separation such as crying, pleading with parents not to leave.

0 = Absent

2 = At least sometimes uncontrollable distress related to potential separation from attachment figures. At least sometimes unresponsive to reassurance and occurring in at least 2 activities.

3 = Nearly always uncontrollable distress related to potential separation from attachment figures. Usually unresponsive to reassurance and occurring in most activities.

ATTACHMENT FIGURES WITH WHOM THIS OCCURS

1 = Parent #1
2 = Parent #2
3 = Other Parent #1
4 = Other Parent #2
5 = Other_____

WITHDRAWAL WHEN ATTACHMENT FIGURE ABSENT

Social withdrawal, apathy, sadness, or difficulty concentrating or playing when not with a major attachment figure.

0 = Absent

2 = At least sometimes uncontrollable withdrawal etc., in at least 2 activities, when not with attachment figures.

3 = Nearly always uncontrollable withdrawal etc., in most activities, when not with attachment figures.

ACTUAL DISTRESS WHEN ATTACHMENT FIGURE ABSENT

Signs or complaints of excessive distress, fear or agitation, when separated from major attachment figure.

0 = Absent

2 = At least sometimes uncontrollable distress etc., in at least 2 activities, when not with attachment figure.

3 = Nearly always uncontrollable distress etc., in most activities, when not with attachment figure.

PHYSICAL SYMPTOMS ON SEPARATION

Complaints of physical symptoms, e.g. stomachaches, headaches, nausea, vomiting, when separation from major attachment figures is anticipated or occurs. Exclude for daycare/school attendance, which is coded below.

0 = No

2 = Yes

Number of days in primary period

"PARENT" CHANGES PLANS TO LEAVE CHILD BECAUSE OF CHILD'S DISTRESS AT SEPARATION

"Parent" changed plans at least once in the last three months because of child's distress or fear in anticipation of separation from major attachment figure

0 = No

2 = Yes, on at least one occasion in last 3 months

PHYSICAL SYMPTOMS OVER SCHOOL/DAYCARE ATTENDANCE

Complaints of physical symptoms, e.g. stomachaches, headaches, nausea, vomiting, when attendance at school/daycare is anticipated or occurs.

0 = No

2 = Yes

Number of days in primary period

FEAR/ANXIETY ABOUT DAYCARE/SCHOOL ATTENDANCE

Fear and/or anxiety specifically related to daycare/school attendance.

EVER: SCARED OR ANXIOUS ABOUT GOING TO DAYCARE OR SCHOOL

0 = No

2 = Yes

EVER: UNABLE TO GO TO DAYCARE/SCHOOL BECAUSE WORRIED OR UPSET

0 = No

2 = Yes

FEAR/ANXIETY ABOUT LEAVING HOME

Fear or subjective anxious affect related to leaving home for daycare/school.

0 = Absent

2 = Anticipatory worry or anticipatory anxiety present and at times is responsive to reassurance

3 = Anticipatory worry or anticipatory anxiety present and almost entirely uncontrollable

ANTICIPATORY FEAR OF DAYCARE/SCHOOL

Anticipatory fear or subjective anxious affect related to daycare/school situation.

0 = Absent

2 = With anticipatory worry or anticipatory anxiety intrusive into at least 2 activities that cannot be entirely controlled.

3 = With anticipatory anxiety occurring, almost entirely uncontrollably, in most activities

CONTENT OF FEARS

Code up to three

1 = Teacher/caregiver
2 = Other children
3 = Recess
4 = Show and Tell
5 = Eating lunch or snack
6 = Going to the bathroom
7 = Other specific activity (e.g., art) _____
8 = Generalized
9 = Unknown

STAYS OUT OF DAYCARE/SCHOOL SOME MORNINGS (FEAR/ANXIETY)

Child stays out of daycare/school because of fear/anxiety/emotional disturbance.

DAYCARE/SCHOOL NON-ATTENDANCE (FEAR/ANXIETY)

0 = Absent

2 = Without marked parental attempts to get him/her to daycare/school

3 = With marked parental attempts to get him/her to daycare/school

MISSING TIME AT DAYCARE/SCHOOL (FEAR/ANXIETY)

Time missed because of fear/anxiety related to daycare/school attendance. Do not include time missed for usually acceptable reasons, such as sickness.

Number of ½ days in daycare/school period when enrolled in daycare/school

PARENT HAS TO TAKE CHILD TO SCHOOL

0 = No

2 = Yes, on at least one occasion in last 3 months

CHILD IS PICKED UP EARLY FROM DAYCARE/SCHOOL (FEAR/ANXIETY)

0 = No

2 = Yes

ATTEMPTS TO LEAVE DAYCARE/SCHOOL (FEAR/ANXIETY)

CHILD <u>TRIES</u> UNSUCCESSFULLY TO LEAVE DAYCARE/SCHOOL (FEAR/ANXIETY)

0 = No

2 = Yes

CHILD LEAVES DAYCARE/SCHOOL (FEAR/ANXIETY)

0 = No

2 = Yes

SLEEP PROBLEMS

Purposes of the Section

The section serves 3 major functions:

(1) To describe sleep arrangements, bedtime rituals and other aspects of putting the child to bed.

(2) To assess sleep disturbances.

(3) To describe behaviors upon waking.

Organization of the Section

The section is organized as a single unit.

SLEEP ARRANGEMENTS

The sleeping arrangement that the child is *supposed* to adhere to. Code actual departures from this arrangement (such as a child's refusal to sleep in his/her own bed) in the appropriate places elsewhere. If the sleep arrangements have changed during the primary period, code the *highest* coding that occurred during the primary period for at least one week.

1 = Own room:	Child sleeps alone in own bedroom.
2 = Shared room	Child sleeps in a room with one or more siblings, but not parent(s), in own bed.
3 = Parental room	Child sleeps in parental room in own bed.
4 = Sibling bed	Shares bed with sibling or other child.
5 = Parental bed:	Shares bed with parent(s).
6 = Other_____	

FAMILY BED

Parents and children sleep together in one bed.

LOCATION OF SLEEP INITIATION

Place where child usually (50% or more) goes to sleep for the night. Place where child falls asleep.

1 = Own bed
2 = Sibling's bed (when own bed available).
3 = Parents' bed
4 = Other_____

RELUCTANCE TO GO TO SLEEP ALONE

Persistent reluctance, or refusal to go to sleep without being near a major attachment figure.

0 = Symptom absent

2 = Sometimes reluctant to go to sleep alone.

3 = Almost always reluctant to go to sleep alone. Protests nearly every night unless family member in room with him/her while s/he falls asleep.

MOST COMMON SCENARIO WHEN CHILD RELUCTANT TO GO TO SLEEP ALONE

1 = Adult caregiver in child's room but not in bed
2 = Adult caregiver in child's bed
3 = Child in adult caregiver's bed with adult caregiver in room
4 = Child is in adult caregiver's bed with adult caregiver in bed
5 = Other_____

SLEEPS WITH FAMILY MEMBER DUE TO A RELUCTANCE TO SLEEP ALONE

Sleeps part of the night or whole night with a family member because of persistent refusal to sleep (through the night) without being near a major attachment figure.

Exclude sleeping in a "family bed" with parents or others, if the child is not expected to sleep elsewhere.

SLEEPS WITH FAMILY MEMBER

0 = Absent

2 = Present

FREQUENCY: # OF NIGHTS

DURATION: HOW MUCH OF NIGHT

1 = Less than 1 hour

2 = More than one hour

3 = All night

BEDTIME

Regular evening time that child actually goes to or is put to bed.

0 = No

2 = Yes

REGULAR WEEKDAY BEDTIME

Hours and Minutes on 24 hour clock

BEDTIME RESISTANCE

Child's regular opposition to stopping daytime activities in order to go to bed for the night.

Code typical level of resistance

0 = No

1 = Mild resistence easily circumvented by parent.

2 = Resistance that deteriorates into conflict between parent and child. May include tears/tantrums on part of child

3 = Resistance is so great that it takes more than an hour once parent has decided it is really time

4 = Parent has given up

BEDTIME RITUALS

Pattern of parent and child interactions that leads up to the child's going to sleep

Distinguish interactions between parent and child from parent sending child to carry out bedtime tasks on his/her own. The latter does not count as a bedtime ritual.

0 = No

2 = Yes

CONTENT OF THE RITUALS

Collect intensity, frequency, and onset for each.

READING

0 = No

2 = Yes

TALKING

0 = No

2 = Yes

SINGING

0 = No

2 = Yes

LISTENING TO MUSIC

0 = No

2 = Yes

WATCHING A VIDEO TAPE

0 = No

2 = Yes

WATCHING T.V.

0 = No

2 = Yes

LIGHT ON

0 = No

2 = Yes

USES A NIGHT LIGHT (If uses night light, consider fear of the dark in anxiety section)

0 = No

2 = Yes

DOOR OPEN

0 = No

2 = Yes

OTHER

Specify_____

PLEASANTNESS OF BEDTIME

The parent's subjective rating of whether, in general (most nights), s/he finds the child's bedtime a pleasant or unpleasant experience.

0 = Neutral

1 = Pleasant

2 = Unpleasant

TIME TO SLEEP INITIATION

From the time the "parent" says goodnight, after any rituals are completed, the average time it takes the child to fall asleep.

EVER: THUMB SUCKING

Thumb sucking refers to a persistent habit that continued for at least one month at some point in the child's development. Since nearly every child sucks his/her thumb at some point, it is important to make sure that this minimum duration criterion is met. However, it is irrelevant whether adults attempted to dissuade the child from thumb sucking.

EVER: DAYTIME

0 = Absent

2 = Present

EVER: SLEEPTIME(Includes night or nap time)

0 = Absent

2 = Present

THUMB SUCKING

A persistent habit that has lasted for at least one month.

DAYTIME

0 = Absent

2 = Present

SLEEPTIME(Includes night or nap time)

0 = Absent

2 = Present

USE OF A PACIFIER

Any use of a pacifier during the primary period.

DAYTIME

0 = Absent

2 = Present

SLEEPTIME (Includes night or nap time)

0 = Absent

2 = Present

SPECIAL OBJECT

A special object is any inanimate object that the child is particularly attached to, and has been attached to for at least one month. The paradigmatic example is the “blanky,” but any object may be involved. Such objects will, however, usually be soft and “snuggly” in one way or another, and appear to act as a source of comfort to the child. Absence of the special object must at least sometimes lead to insistent demands for its return, or its removal from the child must, at least sometimes, lead to protests.

0 = Child does not have a special object.

2 = Child has a special object.

SELF-ROCKING

Child moves self back and forth in rocking motion.

DAYTIME

0 = Absent

2 = Present

SLEEPTIME(Includes night or nap time)

0 = Absent

2 = Present

HEAD - BANGING

Child bangs head against wall, crib, objects, etc. Usually a repetitive motion. Do not include isolated accidental movements.

DAYTIME

0 = Absent

2 = Present

SLEEPTIME (Includes night or nap time)

0 = Absent

2 = Present

CRIES OUT FROM BED

Calling out from bed for “parent,” either due to fear of being alone or desire for comfort from or contact with “parent” or resistance to going to sleep/bed. Occurs prior to initiation of sleep. Include requests for water, etc.

Distinguish from night waking.

0 = Absent

2 = Sometimes calls out from bed but is easily soothed

3 = Calls out from bed every night and difficult to soothe

REASONS
Code up to three

1 = Fear
2 = Request
3 = Desire for contact with parent (i.e., for hug)
4 = Resistance to sleep/being in bed/stalling
5 = Other_____

NUMBER OF NIGHTS IN LAST THREE MONTHS BEHAVIOR HAS OCCURRED

AVERAGE FREQUENCY PER NIGHT ON WHICH BEHAVIOR OCCURRED

LEAVES BED

Leaving bed to go to "parent," either due to fear of being alone or desire for comfort from or contact with "parent" or resistance to going to sleep/bed**.** Occurs prior to going to sleep.

Distinguish from night waking**.**

LEAVES BED PRIOR TO GOING TO SLEEP

0 = Absent

2 = Sometimes leaves bed but is easily resettled

3 = Leaves bed every night and difficult to resettle

REASONS
Code up to three

1 = Fear
2 = Request
3 = Desire for contact with parent (i.e., for hug)
4 = Resistance to sleep/being in bed/stalling
5 = Other_____

NUMBER OF NIGHTS IN LAST THREE MONTHS BEHAVIOR HAS OCCURRED

AVERAGE FREQUENCY PER NIGHT ON WHICH BEHAVIOR OCCURRED

RESTLESS SLEEP

Child physically active during sleep; tossing and turning.

RESTLESS SLEEP

0 = Absent

2 = Present

NOISY BREATHING/SNORING WHILE ASLEEP

Loud breathing or snoring while sleeping.

0 = Absent

2 = Present

EVER: CHILD STOPPED BREATHING DURING SLEEP

0 = Absent

2 = Present

EVER: MEDICAL WORKUP/TREATMENT FOR SNORING/STOPPING BREATHING

0 = Absent

2 = Present

NIGHT WAKING

Child wakes up from sleep during the night.

0 = Child sleeps through the night

2 = Child wakes up during the night

Code up to three
1 = Lies quietly in bed
2 = Cries out for parent
3 = Leaves bed to fetch parent
4 = Leaves bed and gets into parents' bed
5 = Plays contentedly
6 = Leaves bed to urinate
7 = Other _____

LENGTH OF TIME IT TAKES TO GET CHILD BACK TO SLEEP

ONSET OF NIGHT WAKING

RISING TO CHECK ON FAMILY MEMBERS

Rising at night to check that attachment figures are still present and/or free from harm.

0 = Symptom absent

2 = Sometimes rises to check on family members but without waking them.

3 = Wakes family members up when checks on them.

WAKING TIME

Time child usually wakes up in the morning.

Hours and minutes on 24 hour clock.

AVERAGE AMOUNT OF SLEEP PER NIGHT

Number of hours and minutes

DIFFICULT TO ROUSE IN MORNING

Hard to wake child up from sleep in the morning.

0 = Absent

2 = Present

3 = Present and affects family schedule of getting to school, work, commitments.

MORNING DEMEANOR

State upon waking in morning.

CHEERFUL

1 = Sometimes

2 = Often

3 = Mostly

CALM

1 = Sometimes

2 = Often

3 = Mostly

IRRITABLE/CRANKY

1 = Sometimes

2 = Often

3 = Mostly

SLUGGISH

1 = Sometimes

2 = Often

3 = Mostly

OVERACTIVE

1 = Sometimes

2 = Often

3 = Mostly

OTHER

Specify_____

1 = Sometimes

2 = Often

3 = Mostly

NAPS

Periods of sleep during the day.

NAPS

0 = No

2 = Yes

LENGTH OF AVERAGE NAP IN HOURS AND MINUTES

CUMULATIVE HOURS AND MINUTES OF NAPS PER DAY

CHANGE IN NAP PATTERNS IN LAST THREE MONTHS

0 = No

2 = Yes

DESCRIPTION OF CHANGE

1 = Stopped napping
2 = Resumed napping after having stopped
3 = Increased number or length of nap(s)
4 = Decreased number or length of nap(s)

DAYTIME SLEEPINESS

Child falls asleep during the day at times other than scheduled or expected naps.

0 = No

2 = Yes

FALLS ASLEEP IN CARSEAT FOR UNSCHEDULED NAP

0 = No

2 = Yes

NEEDS MORE SLEEP THAN USED TO

0 = No

2 = Yes

TIREDNESS

A feeling of being tired or weary at least half the time.

0 = Absent

2 = Feels tired at least half the time.

3 = Feels tired almost all the time.

FATIGABILITY

Subject becomes tired or "worn out" more easily than usual.

0 = Absent

2 = Increased fatigability not meeting criteria for 3

3 = Even minimal physical activity or play rapidly result in child feeling exhausted, and recovery from that exhaustion is slow.

NIGHTMARES

Frightening dreams that waken the subject with a markedly unpleasant affect on wakening (which may be followed rapidly by feelings of relief).

If nightmares are associated with separation anxiety, code them more specifically as

separation dreams.

If nightmares are associated with traumatic events, and meet criteria for codings, code them here and there also.

0 = Absent

2 = Bad dreams recalled

3 = Bad dreams have woken the subject in the last 3 months.

SEPARATION DREAMS

Unpleasant dreams involving theme of separation.

0 = Absent

2 = Separation dreams recalled

3 = Separation nightmares wake subject

NIGHT TERRORS

Episodes during sleep when the child is not fully conscious and does not wake up, but seems terrified and will usually cry out. The child has no memory of the event.

If night terrors are associated with traumatic events, and meet criteria for codings, code these separate aspects of the same event under night terrors and under traumatic events.

LAST THREE MONTHS

0 = Absent

2= Present

EVER: NIGHT TERRORS

0 = Absent

2= Present

SOMNAMBULISM

Sleep walking.

0 = Absent

2= Present

AVOIDANCE OF SLEEPING AWAY FROM FAMILY

Avoidance, or attempted avoidance, of sleeping away from family, as a result of fear or anxiety about separation from home or family.

S = Opportunity to sleep away from family has not arisen in the last 3 months.

0 = Absent

1 = Child has not slept away in last 3 months, but no active avoidance (e.g., parents feel child too young to sleep away)

2 = Avoidance, or attempted avoidance, in last 3 months, but has slept away from the family at some time.

3 = Avoidance in last 3 months, and has never slept away from family.

SLEEP PATTERNS

REGULARITY OF SLEEP PATTERNS

A regular sleep pattern is one characterized by (1) an identifiable bedtime at which the child is put (or goes) to bed and to sleep the majority of the time; (2) a wake-up time that is also identifiable (either because the child is woken, or because s/he tends to wake up around that time); (3) naps, if they occur are taken at reasonably consistent times. Deviations from these times are to be expected for all sorts of reasons (e.g. differences between weekend and weekday schedules; the child staying up as a treat; being woken early when activities are to take place etc.). The key issue, therefore, is whether any reasonably generalized pattern can be detected. If it can, then the presence of a regular sleep pattern should be coded.

Note that regularity of the sleep pattern does not imply that the pattern is unproblematic. For instance, a child who regularly fell asleep at midnight and woke at 6a.m. has a regular sleep pattern, even though it might be one that was not very acceptable to many parents. Similarly, the presence of other sleep-related difficulties (such as insomnia, or refusal to sleep alone) does not necessarily imply that the sleep pattern is irregular.

REGULAR, PREDICTABLE PATTERN

0 = Yes

2 = No

EVER: REGULAR, PREDICTABLE PATTERN

0 = Yes

2 = No

ANXIETIES

It is important to grasp the distinction between worries and anxieties, because these two different aspects of psychopathology are usually confused in everyday speech. Worries are cognitive phenomena. That is, they refer to thoughts of a particular sort. Anxiety, on the other hand, refers to a mood or feeling state, specifically one of a feeling of fear. Naturally, all sorts of fearful thoughts may accompany this feeling state, but the thoughts themselves are not being coded in the overall ratings of anxiety. Worries will often accompany anxiety, and if they do, both are coded as being present.

With preschoolers, parents may not easily be able to make the distinction between worries and anxiety. However, the interviewer should try to distinguish between the manifestation of fear as an emotion and descriptions of thoughts associated with "feared" situations. In the simplest case, a child may appear to become afraid for no apparent reason - clearly this is an example of anxiety, because there is little cognitive content "attached" to the fear. At the other extreme, a child may spend time thinking painful thoughts about the possibility that his parents are going to split up. In common parlance, such a child may be described as being "*afraid* that his parents will split up." But is clear here that thoughts are the key element and so this is an example of a worry. In many cases, both worrying and anxiety may characterize a particular symptom. For instance, avoidance of a feared object in phobic children obviously involves thinking about the phobic object and coming up with a plan to avoid it. On the other hand, directly observable emotional responses will be apparent when the child comes in contact with the phobic object - in other words, anxiety will be manifested. When such combinations are characteristic of the phenomena being coded, specific instructions are available to guide the coding process.

Purposes of the Section

The section has 3 major functions

(1) To provide information for the diagnosis of a variety of anxiety disorders.

(2) To provide an entry for the elucidation of the child's affect in general, and thereby a path for entry into the depression section.

(3) To provide an entry point for the assessment of the child's functional incapacity.

Organization of the Section

The organization of this section is based upon the important distinctions between;

(1) Anxiety as an affect.

(2) Autonomic symptoms as manifestations of anxiety states.

(3) Avoidance of anxiety provoking situations as a marker of the significance of an anxiety state.

Within each of these sub areas, further distinctions are made in relation to the situations in which the anxiety occurs.

Note that for practical reasons to do with the organization of the interview, separation anxiety and daycare/school fears are to be found in the preceding section. Phenomena that are codable in those sections should *not* be included here.

ANXIOUS AFFECT

NERVOUS TENSION

An unpleasant feeling of "nervousness," "nervous tension," "being on edge," "being keyed up."
Be careful to differentiate Nervous Tension from other mood states, such as Depressed Mood or Subjective Anxious Affect, though these different moods often coexist in the same child.

Do not include in this rating material coded under Separation Anxiety and School Non-Attendance (Worry/Anxiety) even if it conforms to the definition of Nervous Tension.

0 = Absent

2 = Nervous Tension is intrusive into at least two activities, and uncontrollable at least some of the time.

3 = Nervous Tension is intrusive into most activities, and nearly always uncontrollable.

If Nervous Tension is present, be sure to complete the Anxious Autonomic Symptoms.

SUBJECTIVE ANXIOUS AFFECT (FRIGHTENED AFFECT)

Feelings of fear and apprehension. Consider only the mood state itself here, and not its behavioral concomitants.

This overall item is not coded here but it is sub-classified into Free Floating and Situation Specific Anxious Affects at the end of the section.

Be careful to differentiate Subjective Anxious Affect from other mood states, such as Depressed Mood or Nervous Tension, though these different moods often coexist in the same child.

All anxious affect situations refer to anxiety-provoking stressors that affect the child either in the presence of the stressor or just by thinking about it. Whether cued by the presence or by the anticipation of the stressor, the key concept is controllability of the anxiety.

Distress

The situation provoking subjective anxious affect leads to crying, lack of spontaneous speech, or withdrawal from the situation.

Avoidance

Anxiety may be avoided by not entering into situations known to provoke it, and the child may adopt routines that enable him/her to avoid anxiety altogether. Avoidance procedures may generalize until the child is quite unable to leave the house. Do not code this symptom as present unless you are quite satisfied the child was avoiding a situation in which he had, although not necessarily during the past three months, been anxious. Simply living a restricted life is not sufficient evidence. Because very young children often do not control their activities as older children or adults might, we also assess whether the parent changes plans to help the child avoid the feared situation.

Note that there are many techniques of avoidance which do not entail the child becoming house bound (for instance, insisting on being driven to school rather than taking a bus). Write down an example of any avoidance mechanisms found to be present.

Code intensity according to the degree of generalization of the avoidance.

0 =Absent
1 = With accompaniment and reassurance, child is able to remain in feared situation
2 = Parent has regularly changed plans or routines so as to allow child to avoid feared situation
3 = Child lives a highly restricted life because of avoidance of feared situations

SCALE SCORE

In addition to coding intensity, frequency, degree of distress, avoidance and onset, several symptoms of subjective anxious affect are also scored on the parent's perception of the child's fear on a scale of 0 to 3, with 3 indicating the most severe ranking.

0---------1-----------2-----------3

0 = Not at all afraid

1 = Somewhat afraid

2 = Very afraid

3 = Terrified

SOCIAL ANXIETY

Subjective Anxious Affect specific to social interactions. Consider carefully whether this item is present in children who are described as being shy. The child should desire social involvement with familiar people.

Social anxiety relates to new people in general, regardless of age or sex. This symptom refers to a generalized social anxiety.

1 = Fear is intrusive into at least one activity and uncontrollable at least some of the time

2 = Social anxiety is intrusive into at least two activities and uncontrollable at least some of the time.

3 = Social anxiety is intrusive into most activities and nearly always uncontrollable.

4 = The child has not been in the anxiety provoking situation during the past 3 months because of avoidance, but the parent reports that the anxious affect would have occurred if the child had been in such a situation

FEAR OF PUBLIC PERFORMANCE

Subjective Anxious Affect specific to the public performance of activities that do not elicit fear when performed in private. Includes going to the bathroom at daycare/school or other public places, eating in public, speaking up at circle time or participating in “sharing” at daycare/school.

Do not include situations that are normally associated with anxiety, such as performing in public performances of a school play.

1= Fear is intrusive into at least one activity and uncontrollable at least some of the time

2= Fear is intrusive into at least 2 activities and uncontrollable at least some of the time

3= Fear is intrusive into most activities and nearly always uncontrollable.

4= The child has not been in the anxiety provoking situation during the past 3 months because of avoidance, but the parent reports that the anxious affect would have occurred if the child had been in such a situation

AGORAPHOBIA

Subjective anxious affect specific to open spaces or crowds. Typical places and situations relevant to agoraphobia include being outside the home alone, being in a crowd, standing in line, traveling on public transport or by automobile.

Distinguish from acrophobia (fear of heights) when fear of being on bridges etc. is described.

Distinguish from separation-related anxieties and worries, where the central fears or worries concern separation from attachment figures. When there is doubt as to the correct coding in such a case, code *both* the appropriate separation-related symptoms and agoraphobia *and complete the coding indicating possible overlap with separation-related symptoms.*

0 = Absent

2 = Agoraphobia is intrusive into at least two activities and uncontrollable at least some of the time.

3 = Agoraphobia is intrusive into most activities and nearly always uncontrollable.

4= The child has not been in the anxiety provoking situation during the past 3 months because of avoidance, but the parent reports that the anxious affect would have occurred if the child had been in such a situation

SUBTYPE: AGORAPHOBIA MAY OVERLAP WITH SEPARATION-RELATED SYMPTOMS

Anxiety and/or worry may be associated with separation from attachment figures.

0 = Absent

2 = Present

ANIMAL FEARS

Subjective Anxious Affect specific to animals.

Distinguish from Fear of Monsters, remembering that "monsters" can include really existing animals under certain circumstances.

0 =Absent

1 = Fear is intrusive into at least one activity and uncontrollable at least some of the time

2 = Fear is intrusive into at least 2 activities and uncontrollable at least some of the time

3 = Fear is intrusive into most activities and nearly always uncontrollable

4 = The child has not been in the anxiety provoking situation during the past 3 months because of avoidance, but the parent reports that the anxious affect would have occurred if the child had been in such a situation

TYPE OF ANIMAL FEARED

Code up to three
1 = Dogs
2 = Cats
3 = Mice/rats
4 = Other mammals (horses, lions)
5 = Bats
6 = Insects
7 = Spiders
8 = Snakes
9 = Birds
10=Other _____

AVOIDANCE

0 =Absent

1=With parental accompaniment and reassurance, child is able to remain in the feared situation. For example, the child is able to remain in the presence of the feared animal or read a book about feared animal if accompanied by "parent"

2 = Child's "parent" has regularly changed plans or routines so as to allow child to avoid feared situation

3 = Child lives a highly restricted life because of avoidance of feared situations

PRECIPITATING EXPERIENCE WITH AN ANIMAL

Situational anxious affect had its onset following an upsetting experience associated with the relevant situation. For instance a child who develops fear of dogs after having been chased or bitten by a dog.

0 = Absent

2 = Present

FEAR OF ANIMALS PROVOKED BY T.V., MOVIES, BOOKS, ETC.

Fear was provoked by seeing/reading something on T.V., in movies, or in books or stories (e.g., the child was scared by reading a book about an ant swarm consisting of "eight square miles of agonizing death").

0 = Absent

2 = Present

NIGHT-TIME-ONLY ANIMAL FEARS

Afraid at night of animals (e.g., ants) that are not there. A specific night-time fear that does not occur during the day.

0 = Absent

2 = Present

FEAR OF THE DARK

Subjective anxious affect specific to the dark and being in the dark

Differentiate fear of the dark from fear of separating from “parent” or being alone in room at bedtime

0 =Absent

1 = Fear is intrusive into at least one activity and uncontrollable at least some of the time

2 = Fear is intrusive into at least 2 activities and uncontrollable at least some of the time

3 = Fear is intrusive into most activities and nearly always uncontrollable

4 = The child has not been in the anxiety provoking situation during the past 3 months because of avoidance, but the parent reports that the anxious affect would have occurred if the child had been in such a situation

AVOIDANCE

0 =Absent

1=With parental accompaniment and reassurance, child is able to remain in the feared situation. For example, the child can go into a dark room or fall asleep in a dark room when accompanied by parent

2 = Child’s “parent” has regularly changed plans or routines so as to allow child to avoid feared situation

3 = Child lives a highly restricted life because of avoidance of feared situation

PRECIPITATING EXPERIENCE WITH DARKNESS

Situational anxious affect had its onset following an upsetting experience associated with the relevant situation.

0 = Absent

2 = Present

FEAR OF DARK PROVOKED BY T.V., MOVIES, BOOKS, ETC.

Fear was provoked by seeing/reading something on T.V., in movies, or in books or stories.

0 = Absent

2 = Present

FEAR OF "MONSTERS"

Subjective anxious affect specific to monsters, ghosts, mythical creatures or other animals, which do not actually exist (for the purposes of the PAPA, all ghosts are regarded as being non-existent). The fear may concern such monsters being around generally, or may relate more specifically to their being in the room, or under or in the child's bed. Such fears need not be confined to the hours of darkness or to the child's bedroom.

0 =Absent

1 = Fear is intrusive into at least one activity and uncontrollable at least some of the time

2 = Fear is intrusive into at least 2 activities and uncontrollable at least some of the time

3 = Fear is intrusive into most activities and nearly always uncontrollable

4= The child has not been in the anxiety provoking situation during the past 3 months because of avoidance, but the parent reports that the anxious affect would have occurred if the child had been in such a situation

AVOIDANCE

0 =Absent

1=With parental accompaniment and reassurance, child is able to reduce fear of "monsters" and remain in the feared situation

2 = Child's parent has regularly changed plans or routines so as to allow child to avoid "monsters"

3 = Child lives a highly restricted life because of fear of "monsters"

NIGHT-TIME-ONLY FEAR OF "MONSTERS"

Afraid of "monsters" only at night. A specific night-time fear that does not occur during the day.
0 = Absent

2 = Present

FEAR OF "MONSTERS" PROVOKED BY T.V., MOVIES, BOOKS, ETC.

Fear was provoked by seeing/reading something on T.V., in movies, or in books or stories.

0 = Absent

2 = Present

FEAR OF BURGLARS, ROBBERS, KIDNAPPERS, PIRATES

Subjective anxious affect specific to burglars, robbers kidnappers, pirates.

Differentiate from Fear of the Dark or Fear of Separation from Attachment Figure or Fear of Being Alone.

0 =Absent

1 = Fear is intrusive into at least one activity and uncontrollable at least some of the time

2 = Fear is intrusive into at least 2 activities and uncontrollable at least some of the time

3 = Fear is intrusive into most activities and nearly always uncontrollable

4 = The child has not been in the anxiety provoking situation during the past 3 months because of avoidance, but the parent reports that the anxious affect would have occurred if the child had been in such a situation

AVOIDANCE

0 =Absent

1=With parental accompaniment and reassurance, child is able to reduce fear

2 = Child's "parent" has regularly changed plans or routines so as to allow child to avoid feared situation

3 = Child lives a highly restricted life because of avoidance of feared situation

PRECIPITATING EXPERIENCE WITH BURGLARS, ROBBERS, KIDNAPPERS

Situational anxious affect had its onset following an upsetting experience associated with the relevant situation.

0 = Absent

2 = Present

FEAR OF BURGLARS, ROBBERS KIDNAPPERS, PIRATES PROVOKED BY T.V., MOVIES, BOOKS, ETC.

Fear was provoked by seeing/reading something on T.V., in movies, or in books or stories.

0 = Absent

2 = Present

NIGHT-TIME-ONLY FEAR OF BURGLARS, ROBBERS, KIDNAPPERS, OR PIRATES

Afraid of burglars, robbers kidnappers, pirates only at night. A specific night-time fear that does not occur during the day.

0 = Absent

2 = Present

FEAR OF STORMS, THUNDER, AND/OR LIGHTNING

Subjective anxious affect specific to storms, thunder, and/or lightning.

0 =Absent

2 = Fear is uncontrollable at least some of the time and occurs in the presence of storms, thunder, and/or lightning

3 = Fear is nearly always uncontrollable

4 = No storm occurred during the primary period, but the child would have been afraid if one had occurred

PRECIPITATING EXPERIENCE WITH STORMS, THUNDER, AND/OR LIGHTNING

Situational anxious affect had its onset following an upsetting experience associated with the relevant situation.

0 = Absent

2 = Present

FEAR OF STORMS, THUNDER, AND/OR LIGHTNING PROVOKED BY T.V., MOVIES, BOOKS, ETC.

Fear was provoked by seeing/reading something on T.V., in movies, or in books or stories.

0 = Absent

2 = Present

NIGHT-TIME-ONLY FEAR OF STORMS, THUNDER, AND/OR LIGHTNING

Afraid of storms, thunder and/or lightning only at night. A specific night-time fear that does not occur during the day.

0 = Absent

2 = Present

FEAR OF INJURY

Subjective anxious affect specific to the possibility of being hurt.

Do not include anxious affect experienced during an activity with a realistic potential for injury.

0 =Absent

1 = Fear is intrusive into at least one activity and uncontrollable at least some of the time

2 = Fear is intrusive into at least 2 activities and uncontrollable at least some of the time

3 = Fear is intrusive into most activities and nearly always uncontrollable

4 = The child has not been in the anxiety provoking situation during the past 3 months because of avoidance, but the parent reports that the anxious affect would have occurred if the child had been in such a situation

AVOIDANCE

0 =Absent

1=With parental accompaniment and reassurance, child is able to reduce fear of injury

2 = Child and "parent" have developed routines that enable him/her to avoid most situations in which s/he feared s/he could get hurt or injured

3 = Child lives a highly restricted life because of fear of being hurt or injured

PRECIPITATING EXPERIENCE WITH INJURY

Situational anxious affect had its onset following an upsetting experience associated with the relevant situation.

0 = Absent

2 = Present

FEAR OF INJURY PROVOKED BY T.V., MOVIES, BOOKS, ETC.

Fear was provoked by seeing/reading something on T.V., in movies, or in books or stories

0 = Absent

2 = Present

NIGHT-TIME-ONLY FEAR OF INJURY

Afraid at night of injury. A specific night-time fear that does not occur during the day.

0 = Absent

2 = Present

FEAR OF DOCTOR OR DENTIST

Subjective anxious affect related to going to or anticipating going to the doctor or the dentist

Distinguish from Fear of Blood/Injection

Include fear that arises on the day of or during a visit to the doctor or dentist, but only code as positive if the fear is uncontrollable at least some of the time.

0 =Absent

1 = Fear is intrusive into at least one activity and uncontrollable at least some of the time

2 = Fear is intrusive into at least 2 activities and uncontrollable at least some of the time

3 = Fear is intrusive into most activities and nearly always uncontrollable

4 = The child has not been in the anxiety provoking situation during the past 3 months because of avoidance, but the parent reports that the anxious affect would have occurred if the child had been in such a situation

AVOIDANCE

0 =Absent

1=With parental accompaniment and reassurance, child is able to go to doctor or dentist and be examined

2 = Child's "parent" has regularly changed plans or routines so as to allow child to avoid feared situation, including avoiding taking child to doctor or dentist

PRECIPITATING EXPERIENCE WITH DOCTOR/DENTIST

Situational anxious affect had its onset following an upsetting experience associated with the relevant situation.

0 = Absent

2 = Present

FEAR OF DOCTOR/DENTIST PROVOKED BY T.V., MOVIES, BOOKS, ETC.

Fear was provoked by seeing/reading something on T.V., in movies, or in books or stories.

0 = Absent

2 = Present

NIGHT-TIME-ONLY FEAR OF DOCTOR/DENTIST

Afraid of doctor/dentist only at night. A specific night-time fear that does not occur during the day.

0 = Absent

2 = Present

FEAR OF BLOOD/INJECTION

Subjective anxious affect in relation to sight of blood, receipt or sight of injections, or anticipation of sight of blood or injections.

AIDS-related issues are not coded here.

Distinguish from Fear of Doctor/Dentist.

0 =Absent

1 = Fear is intrusive into at least one activity and uncontrollable at least some of the time

2 = Fear is intrusive into at least 2 activities and uncontrollable at least some of the time

3 = Fear is intrusive into most activities and nearly always uncontrollable

4 = The child has not been in the anxiety provoking situation during the past 3 months because of avoidance, but the parent reports that the anxious affect would have occurred if the child had been in such a situation

AVOIDANCE

0 =Absent

2 = Child can be reassured about the sight of blood or cooperate about receiving a shot if accompanied/reassured by “parent”

3= “Parent” has developed routines that allow child to avoid feared situation including postponing shots or immunizations

PRECIPITATING EXPERIENCE WITH BLOOD/INJECTION

Situational anxious affect had its onset following an upsetting experience associated with the relevant situation.

0 = Absent

2 = Present

FEAR OF BLOOD/INJECTION PROVOKED BY T.V., MOVIES, BOOKS, ETC.

Fear was provoked by seeing/reading something on T.V., in movies, or in books or stories.

0 = Absent

2 = Present

NIGHT-TIME-ONLY FEAR OF BLOOD/INJECTION

Afraid of blood/injection only at night. A specific night-time fear that does not occur during the day.

0 = Absent

2 = Present

OTHER FEARS

Subjective anxious affect specific to things not elsewhere specified.

0 =Absent

1 = Fear is intrusive into at least one activity and uncontrollable at least some of the time

2 = Fear is intrusive into at least 2 activities and uncontrollable at least some of the time

3 = Fear is intrusive into most activities and nearly always uncontrollable

4 = The child has not been in the anxiety provoking situation during the past 3 months because of avoidance, but the parent reports that the anxious affect would have occurred if the child had been in such a situation
Specify_____
_____

AVOIDANCE

0 =Absent

1=With parental accompaniment and reassurance, child is able to remain in the feared situation

2 = Child's "parent" has regularly changed plans or routines so as to allow child to avoid feared situation

3 = Child lives a highly restricted life because of avoidance of feared situation

PRECIPITATING EXPERIENCE WITH "OTHER"

Situational anxious affect had its onset following an upsetting experience associated with the relevant situation.

0 = Absent

2 = Present

FEAR OF "OTHER" PROVOKED BY T.V., MOVIES, BOOKS, ETC.

Fear was provoked by seeing/reading something on T.V., in movies, or in books or stories.

0 = Absent

2 = Present

NIGHT-TIME-ONLY

Afraid of "other" only at night. A specific night-time fear that does not occur during the day.

0 = Absent

2 = Present

SITUATIONAL ANXIOUS AFFECT

Situational Subjective Anxious Affect conforms to the definition of Subjective Anxious Affect, but this affect occurs only in certain specific situations or environments (e.g. in open spaces).

Do not include in this rating material coded under Separation Anxiety and School Non-Attendance (Worry/Anxiety) even if it conforms to the definition of Situational Anxious Affect.

2 = The child feels fear, or experiences anticipatory anxiety, that is at least sometimes uncontrollable in more than one activity, or requires excessive reassurance.

3 = The child feels fear, or experiences anticipatory anxiety, that is almost completely uncontrollable in most activities.

The frequency coding for Subjective Anxious Affect is a summary coding for the various types of anxious affect. The intensity is a summary of the predominant intensity, not the worst.

The frequency and duration of the anxious bouts are not rated if due to avoidance that child has not experienced anxiety in the primary time period (i.e. the child rated a 4 for intensity on all symptom areas in the section). Similarly, the Anxious Autonomic symptoms are not completed if total avoidance of the feared situation occurred throughout the primary period

FREE FLOATING ANXIOUS AFFECT

Free Floating Subjective Anxious Affect conforms to the definition of Subjective Anxious Affect, but the anxious affect is not associated with particular restricted situations. It may occur in any setting and is often unpredictable in its onset, with the child being unable to describe specific environmental precipitants of the anxiety.

Note that Free Floating Anxious Affect and Situational Anxious Affect may co-exist, in which case both should be coded as being present.

2 = The child feels fear, or experiences free-floating anxiety, that is at least sometimes uncontrollable in more than one activity, or requires excessive reassurance.

3 = The child feels fear, or experiences free-floating anxiety, that is almost completely uncontrollable, even with reassurance, in most activities.

STARTLE RESPONSE

Exaggerated startle response to minor stimuli. Do not include startling in response to situations that would make most people jump.

Startle response may be present in PTSD. If so, code in both places.

0 = Absent

2 = Startles to an exaggerated degree on slight provocation

CONCENTRATION DIFFICULTIES

Difficulty in concentrating, or mind "going blank" when feeling anxious.

0 = Absent

2 = Concentration impairment sufficient to interfere with ongoing activities

EASY FATIGABILITY

Child becomes easily fatigued when anxious.

0 = Absent

2 = Feels fatigued after slight exertion but continues with tasks at hand

3 = Fatigue leads to reduced performance of tasks at hand

ANXIOUS AUTONOMIC SYMPTOMS

Autonomic symptoms (see Aide-memoir below) accompanied by Subjective Anxious Affect. These symptoms are asked about only regarding those fears that rated positively in the section, i.e. that were actually experienced in the last 3 months.

MUSCLE TENSION
JUMPINESS
RESTLESSNESS
DIZZINESS/FAINTNESS
CHOKING/SMOTHERING
DIFFICULTY BREATHING
RAPID BREATHING
PALPITATIONS/TACHYCARDIA
TIGHTNESS OR PAIN IN CHEST
SWEATING
NAUSEA
TREMBLING/SHAKING/TWITCHING
FLUSHING OR CHILLS
PARASTHESIAE

SELECTIVE MUTISM

Reluctance or inability to speak to certain persons or in certain situations, while being able to speak adequately to other people or in other situations. Do not include those who have difficulty speaking in all situations.

Also, do not include here those children who are "sullen" and/or will not discuss certain topics with their parents or others, but who can participate in everyday conversations with parents or others on other topics.

Selective Mutism, refers to a change in speaking patterns that occur in certain situations. If the child is never able to verbalize well, it does not count. If a symptom can be coded in both Selective Mutism and Fear of Public Performance, code in the latter, because it is more specific. If the child experiences Selective Mutism only while depressed, it still counts, but should be carefully distinguished from generalized mutism (i.e. mutism occurring in most or all situations), which is not coded here.

Typically a child with Selective Mutism will not speak in one situation, like school, yet talks freely in other situations. Do not include children who are too shy to talk in some situations here, (but consider codings of Shyness, Behavioral Inhibition and Social Anxiety), or a child who is too inhibited to speak to his/her doctor on first contact with him/her.

2 = Speech is limited in volume or amount to an extent that substantially interferes with communication in certain settings or to certain people. There should be marked discrepancy with the child's adequate speech usage in other circumstances.

3 = Almost complete absence of speech in particular settings or to particular people.

WORRIES

A round of *painful, unpleasant, or uncomfortable* thoughts, that cannot be stopped voluntarily, and that occur across more than one activity.

Since almost everyone worries sometimes, it is particularly necessary to be careful to question to criteria in this section. It is important to rule out everyday concerns, and yet code those worries that are unpleasant, intrusive, at least sometimes uncontrollable, and with a minimum daily duration of at least one hour. Intrusiveness into activities refers not only to external activities, but to internal, mental activities as well.

2 = Worrying is intrusive into at least two activities and uncontrollable at least some of the time.

3 = Worrying is intrusive into most activities and nearly always uncontrollable.

A child who goes to extraordinary lengths to control his/her worries, should be coded as a 3. Even though the interviewee may say their worries are controllable, these excessive and elaborate attempts to assuage or stop their worries are an indication of the severity of this symptom.

Distinguish from Rumination (which need not be painful, unpleasant or uncomfortable) and Obsessions (which are regarded as being foolish, absurd or "ego-alien"). These distinctions are conceptually among the most difficult to make at first. Take care to compare and contrast the definitions of these items, and see the detailed discussion of them under Rumination, Rituals and Repetitions/Obsessions and Compulsions. It is particularly important to ask whether repetitive thoughts are painful or unpleasant, since this is a defining characteristic of Worries.

Content Areas further define the topics of worry coded in the overall rating of Worries, and can be chosen from the list below. For a Content Area to be coded as present, it must be an intrusive, uncontrollable, and unpleasant worry which either on it's own, or in combination with other intrusive and uncontrollable worries, meets the duration criteria of worrying for one hour in daily total.

Hypochondriasis (Worry about being physically ill): All the characteristics of worrying are present, but the worrying is specifically concentrated on the possibility of disease or physiological malfunction in the child; these worries can be "well-founded" and need not be excessive or unrealistic.

Worry that family members will become ill: Worries, conforming to the definition above, that relate to the health of people in the child's extended family.

Worry about the future: Worries, conforming to the definition above, that relate to what will happen to the child in the future, or what will happen in the future in general. For instance, worrying about nuclear war or being a "big kid."

Worry about natural calamity: Worries, conforming to the definition above, about fire, hurricane, earthquake, etc.

Worry about past behavior: Worries, conforming to the definition above, that relate to the child's past actions, speech, or behavior. For instance, worrying about having offended someone some weeks before.

Worries about competence or performance: Worries, conforming to the definition above, that relate to the child's physical, intellectual, social, or emotional abilities.

Worries about appearance: Worries, conforming to the definition above, that relate to the child's perception of his/her appearance or to what the child thinks other's may think about his/her appearance.

Worries about money/food: Worries, conforming to the definition above, that relate to the child or his/her family having enough money or food.

Other Worries: Worries, conforming to the definition above, that did not fit into any of the above content areas.

Particular worries may sometimes conform to two or more of these definitions. As usual, the most specific category is the appropriate one. If it is impossible to decide which category is most specific, code the area occurring earliest in the above list.

The nine Content Areas of worries are used to find out more about the types of worries a child has experienced during the primary period, or can be used as probing tools in the event that the interviewee previously responded negatively to worrying in general.

The symptom being coded on this page is the overall occurrence of Worrying, which is intrusive, and at least sometimes uncontrollable. These criteria distinguish a "normal" worry, or common degree of worrying, from a more incapacitating and intrusive worry of PAPA severity. The overall ratings code the general severity of the child's worries and the

overall amount of time a child spends worrying at the level of PAPA severity. Since a child most likely will report both "normal" worries and more severe worries, first determine which of the reported worries meet PAPA criteria (i.e. intrusive, uncontrollable, unpleasant). Then determine the frequency and duration of only the worries meeting the PAPA criteria. It is possible for a child to worry about different topics of worry in the same day and therefore meet the criterion with more than one Content Area.

EXCESSIVE NEED FOR REASSURANCE

The child seeks reassurance from others about at least two topics of worry, but the worries continue in spite of such reassurance. Excessive need for reassurance can only be coded positively if worries are present; all types of worries are included here (e.g. "generic" worries or those related to school attendance, separation and hypochondriasis).

0 = Absent
2 = Seeks reassurance at least weekly, but not to the extent of interfering with ordinary social discourse.
3 = Seeks reassurance to such an extent that ordinary social discourse with at least one person is interfered with, as evidenced by loss of patience, or avoidance of contact with the child by that person.

If it has been established that the child did not code for any worries meeting CAPA criteria (including daycare/school worries, separation worries, general worries, and worries about physical illness) then this item can be "S"d.

RITUALS AND REPETITIONS

Purpose of the section

The section has 1 major function

(1) To provide information relevant to a prospective examination of later obsessive-compulsive behavior.

Organization of the section

The section is organized as a single unit.

NEED FOR OBJECTS TO BE IN ORDER

A preference and insistence that objects be in a particular order or "in the right place."

Consider also compulsions.

0 = Absent

1 = Present as a preference but child is able to tolerate things being out of order

2 = Present as a preference and child at least sometimes insists (or attempts to insist) on ordering objects and protests when patterns/order is disturbed

3 = Present as a preference and child nearly always insists (or attempts to insist) on ordering objects and protests when patterns/order is disturbed

THE CHILD'S NEED FOR ORDER INTERFERES WITH SETTING ACTIVITIES AND ROUTINES

0 = Absent

2 = Present, causes disruption or inconvenience

Code for each setting.

INSISTENCE ON SAMENESS

Strong preference and demand that routines and other patterns of behavior remain the same. Clear examples are often drawn from the sleep and food sections.

Most young children love routine. It makes them feel safe and feel that their world is stable and understandable. What we are coding here is a very strong preference expressed in a *demand* for sameness that leads to having to perform routines or behaviors in *exactly* the same way each time.

0 = Absent

2 = Present and does not significantly interfere with setting routines or schedules

3 = Present and interferes with setting routines or schedules

AVERSION TO DIRT AND MESSINESS

Strong dislike of dirt and messiness.

Exclude an aversion to wearing a soiled diaper.

Consider whether the aversion reaches the level of a Fear of Dirt and Contamination and if it is accompanied by a Compulsion to clean.

0 = Absent

2 = Present and interferes with at least two activities

3 = Present and interferes almost all the time with child's activities

HOARDING

Gathering objects and *secretly* storing them for the sake of keeping and accumulating the objects, not necessarily to use them.

Distinguish from stealing. When a child steals, s/he takes something belonging to another without permission and with the intention of depriving the owner of its use. The child who hoards takes things not with the intention of depriving the owner of its use, but with the intention of accumulating and storing the objects. Objects hoarded may be of no value to the "owner" or the child e.g. leaves, bits of fluff, string. If food is the hoarded object, code as Food Hoarding. Do not include collecting (e.g. stamps, rocks, dolls, trading cards, spoons) as hoarding because it does not include the element of secrecy.

Do not include hiding objects from younger siblings so as to keep them away from one's collected possessions.

0 = Absent

2 = Present without limitation of play

3 = Present and principle play activity

AVERSION TO THROWING THINGS AWAY

Generalized strong dislike and resistance to discarding things, even if they are no longer useful, needed, or sanitary, and distress if these things are thrown out.

Exclude discarding treasured objects like an old blanket, pacifier, a favorite shirt, or especially beloved toys.

Code as present even if the parent insists on throwing things out. The important feature is the child's strong dislike and resistance to throwing things out and his/her distress if things are thrown out or almost thrown out.

0 = Absent

2 = Present and leads (or could lead) to an accumulation of objects but does not cause conflicts in the family

3 = Present, leads (or could lead) to an accumulation of objects and causes conflicts in the family

COGNITIVE RUMINATION

Dwelling on particular themes, but the content lacks the unpleasant quality of worrying or the alien quality of obsessions.

Distinguish from rumination of food in eating and food related behaviors section. Also distinguish from insistence on sameness and repetitive actions.

0 = Absent

2 = Rumination intrusive into at least 2 activities and uncontrollable at least sometimes

3 = Rumination intrusive into almost all activities and hardly ever controllable

OBSESSIONAL THOUGHTS

Recurrent *ideas, thoughts*, or *images* that the child experiences as intrusive and unwanted, but does not regard as being external implants. The child will often describe feeling s/he "has to" think the obsessional thoughts, despite not wanting to. When the child is asked why s/he has to think the thoughts, the proffered explanation may often be vague, but will sometimes involve the idea that something (frequently unspecified) terrible will happen if s/he does not.

A repetitive purposeless thought (rumination) would be considered an Obsessional Thought if the child described having to think the thought a certain number of times before stopping, or that some specified or unspecified ill would befall him/her, were she not to think the thought. For example, this would include a child who thinks about what she had for lunch today, yet continues to repeat the same thought 4 times, and if that did not "feel right," she would repeat the thought in sets of 4 until she "felt a sense of completeness." The child might also describe that, if the thoughts were not repeated the "right" number of times, she would have bad luck. If there is doubt about whether Obsessional Thoughts are present, code them as being absent. When an obsessive-compulsive disorder is present, the description of the intrusive thoughts will usually be quite distinctive, so a high threshold for coding here is appropriate. If Obsessional Thoughts are associated with traumatic events, and meet criteria for codings in the PTSD section, code them there as well.

2 = Thoughts are intrusive and uncontrollable in at least two activities at least sometimes.

3 = Thoughts are intrusive into most activities and almost always uncontrollable.

Situation

After the criteria for the overall intensity has been met, code the frequency of Obsessions in each of the 3 specific situations: Home, Daycare/School, and Elsewhere.

RESISTANCE NOT MEETING CRITERIA FOR OBSESSIONAL RITUAL

Resistance refers to attempts by the child to avoid thinking the obsessional thoughts or performing the obsessional mental routines.

0 = Absent.

2 = The child tries to resist thinking the obsessional thoughts at least sometimes.

3 = The child usually tries to resist.

OBSESSIONAL RITUALS

Recurrent, repetitive ideas, thoughts, images, or mental rituals engaged in to reduce or extinguish the mental discomfort generated by obsessional thoughts.

2 = Obsessional Rituals are intrusive and uncontrollable in at least two activities at least sometimes.

3 = Obsessional Rituals are intrusive into most activities and almost always uncontrollable.

RESISTANCE TO OBSESSIONAL RITUAL

Resistance refers to attempts by the child to avoid thinking the obsessional rituals.

0 = Absent.

2 = The child tries to resist thinking the obsessional rituals at least sometimes.

3 = The child usually tries to resist thinking the obsessional rituals.

CONTENT OF OBSESSIONS

Code the theme or content of the obsessional ideas. Obsessions may belong to more than one thematic group, in which case code both or all of the groups represented.

0 = Absent

2 = Present

The following categories should be considered:

Transmitting disease
The child's obsessional thoughts center around the possibility of catching or transmitting diseases. Such thoughts will often be accompanied by compulsive disease avoidance rituals or excessive washing and the like.

Magical, e.g., warding off danger
The child will not usually describe obsessions or compulsions as having "magic" properties. What is intended here is to code those obsessions that seem to be maintained by a feeling that they ward off some ill by an indirect or magical process. The child will not usually be able to explain exactly how the danger is avoided, and will often agree that both the feeling of danger and the obsessional warding off are silly, senseless, or ridiculous.

Sex related
Code obsessional concern with sexual material here. Sex-related obsessions are often also characterized by concerns with dirt and disease as well.

Other
Code here any obsessions that cannot be included under the four preceding categories.

COMPULSIONS

Repetitive, purposeful and intentional *acts* associated with a subjective feeling of compulsion arising within the child and not forced by any external power or agency. When the child is asked why s/he has to perform the compulsive acts, the proffered explanation may often be vague, but will sometimes involve the idea that something (frequently unspecified) terrible will happen if the s/he does not.

2 = Compulsions are intrusive into at least two activities and are at least sometimes uncontrollable.

3 = Compulsions are intrusive into most activities and are almost always uncontrollable.

For the duration coding on compulsions, a bout is considered the length of time a child spends executing the compulsive ritual. For example, the child who intermittently experiences the compulsion to touch the corner of a table 3 times before passing by, may only code for a duration of 1 minute. Yet for an individual with more complex and time consuming rituals, or those who have a series of compulsions running together, code the duration of the entire time the person felt compelled to execute their rituals (e.g. a person who has a series of rituals for getting ready in the morning which are performed for 2 hours each day, would have a duration of 2 hours, rather than coding the durations of each specific shoe and shirt related ritual separately.

If a child reports that his/her ritualistic behaviors are controlled by an external force (e.g. radio waves, Martians), these are not Compulsions but should be coded in the Psychosis section.

If Compulsions are associated with traumatic events, and meet criteria for codings in the PTSD section, code them there as well.

Resistance

Resistance refers to attempts by the child to avoid performing his/her compulsions or compulsive routines.

2 = The child tries to resist performing the compulsive act at least sometimes.

3 = The child usually tries to resist.

Situation

After the criteria for the overall intensity has been met, code the frequency of Obsessions in each of the 3 specific situations: Home, Daycare/Daycare/School, and Elsewhere.

TYPE OF COMPULSION

The following five types of compulsion are coded. More than one type may be present, in which case code both or all as being present.

Checking

The child feels compelled to check and recheck things (at least 3 times), such as that s/he has his/her keys or that the gas is turned off.

Avoiding

The child compulsively avoids certain items or situations, often because of a fear of contamination.

Touching

The child feels compelled to touch certain objects, often in a ritualistic way, or to perform touching rituals involving a variety of objects.

Washing/Cleaning

The child feels compelled to wash or clean items, him/herself or the house repeatedly, despite the object of the cleaning being quite adequately clean already.

Repeating

The child feels compelled to repeat words or actions, other than those already mentioned above.

Other

Code here any compulsions which can not be included under the 5 preceding categories.

0 = Absent

2 = Present

OBSESSIONAL SLOWNESS

Normal actions take an unreasonable amount of time due to internal concerns about doing things "correctly" or to obsessional thought patterns, though the child may be unable to explain clearly why these actions take so long. The important point is that the child's physical movements are slowed down or frozen.

Movements and actions in progress (generally unrelated to obsessions and compulsions) are performed more slowly due to concern over doing things correctly or the need to think about the obsessions a certain number of times. Do not include slowness in performing an act caused by the rituals themselves. Thus a person with a complex dressing ritual, may take hours to dress, but if the physical movements included in dressing are individually performed at a normal speed (even though they may be repeated over and over again), that is *not* Obsessional Slowness. However, if individual movements are slowed down, or frozen for a period, this would count as Obsessional Slowness.

Minor degrees of slowness or dawdling are not coded here.

2 = Obsessional slowness intrusive into at least two activities that at least sometimes cannot be overcome.

3 = Obsessional slowness affecting most activities that can hardly ever be overcome.

PSYCHOTIC DISTURBANCES

Purposes of the Section

This section has 2 major functions:

(1) To provide for ratings of a wide range of psychotic symptoms. This task requires particular clinical skill and care, because it is easy to over diagnose psychotic phenomena. In completing this section, perhaps more than any other, it is absolutely vital to note examples of the phenomena described by the interviewee.

(2) To provide an entry point for ratings of functional disability due to psychiatric symptoms.

N.B. The Psychosis section is not coded for symptoms temporally related to periods of substance use (alcohol and/or other psychoactive substance) that do not occur at other times.

Long and short forms of the Psychotic Disturbances section are available. Whether the long or short form will be used depends on the requirements of the particular study. However, the use of the short form still requires that interviewers should be familiar with the contents of the long form, in order to ensure proper coding of psychotic phenomena.

Organization of the section

The section is divided into 3 sub areas:

(1) Perceptual disorders and hallucinations

(a) Changes in perception
(b) Visual hallucinations
(c) Auditory hallucinations
(d) Other hallucinations
(e) General ratings of hallucinations

(2) "Psychotic" abnormalities in thought processes

(3) Delusions

(a) Delusions proper
(b) Delusional interpretations
(c) General ratings of delusions

PERCEPTUAL DISORDERS AND HALLUCINATIONS
CHANGES IN PERCEPTION

Purposes of the Section

The section has 2 major functions:

(1) To assess the presence of certain symptoms which may be normal phenomena, in mild form.

(2) To avoid the overdiagnosis of psychotic symptoms by carefully differentiating the items in this section from them.

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Interviewers should maintain a high threshold for completing this section. Check to see whether symptoms are the result of other conditions such as: being half asleep, being ill or feverish, having fit or seizure. (A list of such phenomena are found on X -2 to help you distinguish perceptual phenomena that are frequently confused with hallucinations.) Also see the list in the Glossary.

The fullest possible notes should be taken, including verbatim records of the interviewee's statements.

Organization of the Section

The section is organized as a single unit.

DEJA VU

The child has the feeling that s/he has seen or experienced and lived through the current situation before. The child knows this feeling to be inaccurate.

0 = Absent
2 = Present

JAMAIS VU

The child feels that a familiar situation is unfamiliar, but knows this feeling to be inaccurate.

0 = Absent
2 = Present

DEREALIZATION

The child experiences his/her surroundings as unreal. A classroom or a bus or a street seem like a stage set with actors, rather than real people going about their ordinary business. Everything may seem colorless, artificial and dead.

In the less intense form of the symptom, the child simply experiences a lack of color and life, so that any tendency towards the artificial tends to be exaggerated. People seem to be pretending their emotions. Code this condition as 2.

In a more severe form of the symptom, the child feels "as though the world is made of plastic," "as though it is not really there at all," as though "people are puppets on strings without any real life of their own." Code this condition as 3.

The child retains a measure of understanding and knows the condition is abnormal.

Do not include any delusional explanation or elaboration of this experience in the rating.

DEPERSONALIZATION

The child feels as if s/he *him/herself* is unreal, that s/he is acting a part rather than being spontaneous and natural, that s/he is a sham, a shadow of a real person. S/he feels detached from his/her experiences, as though s/he were viewing them from a long way off, or through the wrong end of a telescope. This condition should be rated 2.

A more severe form of the symptom occurs when the child feels as if s/he is actually dead. S/he may feel that when s/he looks in the mirror s/he cannot see a proper reflection, or

that part of his/her body does not belong to him/her, or that s/he is living in some entirely different "parallel world" and cannot interact in this one. Code this condition as 3. Derealization is often present at the same time and should be rated independently. The child retains a measure of understanding and knows the condition is abnormal.

Do not include delusional explanations or elaborations of this experience in the rating.

CHANGED PERCEPTION

Heightened Perception

Sounds seem unnaturally clear or loud or intense, colors appear more brilliant or beautiful, details of the environment seem to stand out in a particularly interesting way, and any sensation may be experienced exceptionally vividly. The pattern on a wallpaper, or the cracks in a ceiling may become insistently noticeable.

Once the experience is past, the child often finds it difficult to remember or describe, and the interviewer must use judgment to rate its presence. In such a case rate 1.

2 = Heightened perception has quite clearly and definitely been present during the past 3 months, even briefly.

Dulled Perception

This symptom is the opposite of Heightened Perception. The child experiences things as being dark or grey, uniform and uninteresting and flat. Tastes and appetites are blunted, colors may appear to be muddy or dirty, sounds to be ugly or impure.

Once the symptom has disappeared it may be difficult for the child to remember or describe it, and the interviewer must use judgement to rate its presence. In such a case rate 1.

2 = The symptom has quite clearly and definitely been present during the past 3 months, even if briefly.

Dulled Perception should be rated present only when there is a definite perceptual change, e.g. lack of interest would not qualify.

Other Changed Perception

Include here any change in perception that is not included under the symptoms of Heightened and Dulled Perception. The child may complain that objects change in shape or size or color or that people change their appearance.

Once the symptom has disappeared it may be difficult for the child to remember or

describe it and the interviewer must use judgement to rate its presence. In such a case rate 1.

2 = The symptom has quite clearly and definitely been present during the past 3 months, even if briefly.

CHANGED PERCEPTION OF TIME

The child's perception of time seems to change, so that events appear to move very slowly or very rapidly or to change their tempo or to be completely timeless. Time may appear to stop altogether.

Once the symptom has disappeared it may be difficult for the child to remember or describe it, and the interviewer must use judgement to rate its presence. In such a case rate 1.

2 = The symptom has quite clearly and definitely been present during the past 3 months, even if briefly.

DELUSIONAL MOOD

The child feels that his/her familiar surroundings have changed in a puzzling way, which s/he may be unable to describe, but which seems to be specially significant for him/her. S/he may simply say that everything seems odd and strange and that s/he cannot understand what is going on. S/he may experience this as ominous or threatening, or simply appear puzzled.

2 = The child attempts an explanation couched in the form of delusions.

3 = The meaning of these puzzling feelings becomes clear to the child when a delusional concept or a delusion is formed.

Rate 3 only when this delusional crystallization has been present during the past 3 months.

Differentiate from Derealization and Depersonalization.

Delusional mood sometimes results in a primary delusion. This is rated separately if it occurs.

PERCEPTUAL PHENOMENA FREQUENTLY CONFUSED WITH DIAGNOSTICALLY SIGNIFICANT HALLUCINATIONS IN CHILDHOOD

HYPNOGOGIC HALLUCINATIONS

These are true hallucinations occurring only when the patient is falling asleep, not just lying in bed or just in the dark. They are usually very vivid and should be distinguished from dreams.

HYPNOPOMPIC HALLUCINATIONS

These are true hallucinations occurring when the child is awakening from sleep. They should also be distinguished from dreams.

EIDETIC IMAGERY

Some children have the ability voluntarily to produce vivid almost perfectly visual images, which are never confused with reality.

ELABORATED FANTASIES

Refer to experiences that are typical of childhood fantasy play and that most children readily admit are fantasies but a few children reiterate with apparent belief. They are distinguished from hallucinations by the absence of a clearly experienced perception.

IMAGINARY COMPANIONS

The child describes a clear image of another child in external objective space, which he treats as real with complex interactions. Nevertheless, most of the time he would acknowledge that this is only his imagination.

ILLUSIONS

Illusions are false perceptions stimulated by perceptions which are momentarily transformed. They are often due to poor perceptual resolution (darkness, noisy locale, etc.) or inattention or confusion, and they are corrected when attention is focused on the external sensory stimulus or when perceptual resolution improves.

HALLUCINATIONS

AUDITORY HALLUCINATIONS

NON-VERBAL HALLUCINATIONS AND NON-SPECIFIC VERBAL HALLUCINATIONS

Non-Verbal Hallucinations

This symptom includes noises, other than words, that have no real origin in the world outside the child, but also no explicable origin in bodily processes, and which the child regards as separate from his/her own mental processes. Thus tinnitus or the sound of the child's heart beating are not included, nor is the memory of a piece of music. Consciousness is clear. Any auditory hallucinations taking the form of recognizable words are excluded.

2 = The child hears noises such as music, tapping, central heating noises, etc. when they demonstrably are not occurring in reality and are not part of the child's memories or voluntary imaginings or the child hears whispering, muttering or mumbling but cannot make out the words (though occasionally he may "know" what is being said without hearing the words).

Non-Specific Verbal Hallucinations

This symptom excludes *non*-verbal auditory hallucinations. The most common form of the symptom is a voice calling the child's name or simply saying one or two words only (often the voice of someone with whom the child has had strong affective ties; the typical situation is shortly after a bereavement). Consciousness is clear.

Be careful to distinguish this symptom from delusions of reference in which the child thinks that other people talk about him/her, usually disparagingly, because s/he thinks he sees them glance meaningfully at him/her while talking amongst themselves, or thinks that some remark is dropped which is meant especially for him/her, but does not actually hear the words spoken. In most such cases the child is not experiencing auditory hallucinations but making a *delusional misinterpretation*. If in doubt in such a situation, do *not* rate both auditory hallucinations and delusions of reference as present but give preference to the latter.

3 = The child hears a voice (which may include name being called), but not recognizable words.

HALLUCINATIONS SPECIFICALLY ASSOCIATED WITH BEREAVEMENT
The child has recently (within past 1 year) been bereaved and hears only the dead friend or relative. These hallucinations are often brief and may be comforting. The hallucinations must be confined to the voice or other sounds (e.g. footsteps) of the dead person and they must have arisen following the death of that person during the last 12 months.

VERBAL HALLUCINATIONS SPOKEN *ABOUT* THE CHILD

This symptom includes only a voice or voices heard by the child speaking about him/her, and therefore referring to him/her in the third person. Consciousness is clear.

Do not include voices saying one or two words only, which are included under Non-Specific Hallucinations.

Be careful to distinguish the symptom from delusions of reference in which the child thinks that other people talk about him/her usually disparagingly, because s/he thinks s/he sees them glance meaningfully at him/her while talking amongst themselves, or thinks that some remark is dropped which is meant especially for him/her, but does not actually hear the words spoken. In most cases, the child is not experiencing auditory hallucinations but making a delusional misinterpretation. If in doubt in such a situation, do not rate both auditory hallucinations and delusions of reference, but give preference to the latter.

2 = The child hears the voice *commenting* on his/her thoughts or actions, and thus speaking about him/her in the third person.

3 = The child hears voices *talking to each other* about him/her in the third person.

VERBAL HALLUCINATIONS SPOKEN *TO* THE CHILD

This symptom includes only a voice or voices heard by the child speaking directly to him/her. Consciousness is clear.

Do not include voices saying one or two words only, which are included under non-specific hallucinations.

Do not include voices which talk about the child in the third person.

Be careful to distinguish the symptom from delusions of reference in which the child thinks that other people talk about him/her, usually disparagingly, because s/he thinks s/he sees them glance meaningfully at him/her while talking amongst themselves, or thinks that some remark is dropped which is meant especially for him/her, but does not actually hear the words spoken. In most such cases, the child is not experiencing auditory hallucinations but making a delusional misinterpretation. If in doubt in such a situation, do not rate both auditory hallucinations and delusions of reference, but give preference to the latter.

2 = The tone and content are pleasant, supportive or neutral.

3 = The tone and content are hostile or threatening or accusatory.

LOCATION OF AUDITORY HALLUCINATORY EXPERIENCES

TRUE HALLUCINATIONS

A true hallucination is experienced as occurring in the outside world.

0 = Absent; 2 = Present

PSEUDOHALLUCINATION

A pseudohallucination is experienced as occurring inside the child's head or mind, but still has the other qualities of a perception.

0 = Absent; 2 = Present

(Both may be present)

VISUAL HALLUCINATIONS

VISUAL HALLUCINATIONS IN CLEAR CONSCIOUSNESS

2 = The child simply sees formless images, shadows or colored lights.

3 = The child sees objects, people, images which other people cannot see. Consciousness is clear. The vision may appear to be in the external world (true hallucination) or within the child's own mind (pseudohallucination).

Distinguish from misinterpretation of real stimuli (such as an anxious person thinking there is an intruder in the shadows). These should be coded as illusions if they meet the criteria.

HALLUCINATIONS SPECIFICALLY ASSOCIATED WITH BEREAVEMENT

The child has recently (within the past 1 year) been bereaved and sees only the dead friend or relative. These hallucinations are often brief and may be comforting. The hallucinations must be confined to seeing of the dead person and they must have arisen following the death of that person during the last 12 months.

LOCATION OF VISUAL HALLUCINATORY EXPERIENCES

True Visual Hallucinations

A true hallucination is experienced as occurring in the outside world.

0 = Absent; 2 = Present

Visual Pseudohallucination

A pseudohallucination is experienced as occurring inside the child's head or mind, but still has the other qualities of a perception.

Code 0 = Absent; 2 = Present

(Both may be present)

HALLUCINATIONS OCCURRING ONLY AS PART OF A SEIZURE

The child may have almost any variety of visual experience from complete scenes witnessed as on a stage to flashes of light. Small animals are not particularly characteristic. Include both true and pseudohallucinations. The hallucinations must be confined to the period during or immediately after an epileptic fit.

2 = The child simply sees formless images, shadows or colored lights.

3 = The child sees objects, people, images that other people cannot see.

HALLUCINATIONS OCCURRING ONLY IN A CLOUDED SENSORIUM

The hallucinations are strictly confined to a period of high fever or illness or post-traumatic confusion when the child has clouding of consciousness.

2 = The child simply sees formless images, shadows or colored lights.

3 = The child sees objects, people, images that other people cannot see.

OTHER HALLUCINATIONS

OLFACTORY HALLUCINATIONS AND DELUSIONS

Simple olfactory hallucinations, such as a smell of orange peel or perfume, or a smell of "death" or burning, which other people cannot smell, are rated 2. Be sure that there is no more obvious cause such as sinusitis, or a misinterpretation of a smell that really is present.

If the experience is delusionally elaborated, e.g. the child not only smells gas but thinks that gas is deliberately being let into the room, rate 3.

If the child thinks that he himself smells rate this as a delusion that the child smells. These two symptoms can, of course, co-exist.

Be careful to exclude epileptic phenomena as far as possible if olfactory or gustatory hallucinations are reported.

DELUSION THAT CHILD SMELLS

The child thinks that s/he gives off a smell (though others cannot smell it). Exclude preoccupation with body odor, e.g. in an anxious child who sweats a lot.

Distinguish from other olfactory hallucinations and delusional elaborations.

Enuretic and encopretic childs who believe they smell of urine or feces are not rated here. If the child really does smell, rate this in the appropriate observational section and do not rate it here.

2 = The child is uncertain, or simply thinks it possible.

3 = The child is certain that s/he gives off a smell and that others notice it and react accordingly.

OTHER HALLUCINATIONS AND DELUSIONAL ELABORATIONS

Refers to hallucinations that are other than auditory, visual, or olfactory, e.g. food tastes burnt or acid, something seems to touch him/her, ants seem to crawl over his/her skin.

It is usually impossible to distinguish whether these experiences are truly hallucinatory or delusional. Delusional elaborations are rated in the appropriate section. Some childs will score here and on delusional elaboration. Other childs will only be rated on one of these categories.

Exclude other obvious explanations for the experience.

2 = The child does not delusionally elaborate.

3 = There is delusional elaboration.

"PSYCHOTIC" ABNORMALITIES IN THOUGHT PROCESSES

THOUGHT INTRUSION/INSERTION

The essence of the symptom is that the child experiences thoughts *that are not his/her own* intruding into his/her mind. The symptom is not that s/he has been caused to have unusual thoughts (for example, if s/he thinks that Devil is making him/her think evil thoughts) but that the thoughts themselves are not his/hers. Sometimes the child may say that s/he does not know where the alien thoughts came from, although s/he is quite clear that they are not his/her own.

2 = In very rare instances, the child may postulate that they come from his/her own unconscious mind, while still consciously experiencing them as alien.

3 = In the most typical case, the alien thoughts are said to have been inserted into the mind from outside, by means of radar or telepathy or some other means. In such a case there is an explanatory delusion as well. However, a rating of 3 does not depend upon the presence of an explanatory delusion, but simply on the conviction that alien thoughts are present which have been inserted from outside.

This symptom is frequently recorded as being present on inadequate evidence. Interviewees often answer affirmatively to the initial question without having understood it. If interviewers, too, do not have the specific symptom in mind but some more general approximation to it, and thus fail to ask the most important extra questions, there are bound to be errors in rating. The symptom is very significant diagnostically and so the greatest care must be taken never to rate it as present without good evidence and a written example.

Several confusing problems, often leading to a false positive rating, are discussed below:

(i) Some interviewees, because of an inadequate intellectual level or poor verbal ability, are quite unable to grasp what is being asked, or to give a rateable answer. In such cases, do not give the benefit of the doubt: make use of U, if there is some possibility that the symptom has not been excluded.

(ii) Symptoms such as Inefficient Thinking, Subjective Flight of Ideas, and Ruminations are often confused with this symptom. The interviewer should have no difficulty, however, since in none of these cases are alien thoughts experienced as being inserted into the mind.

(iii) Auditory pseudohallucination (voices experienced as being within the mind) may be very difficult to distinguish since sometimes the child is unable to say whether the experience is a voice or a thought. In such cases rate as an auditory pseudohallucination. If the experience is of a voiced thought not alien to the child, rate as Thought Broadcast or Thought Sharing.

(iv) The child may explain the experience of Thought Insertion in delusional terms (e.g. as being due to hypnotism or telepathy). In such a case rate both symptoms as present. However, if the child merely complains that s/he is being influenced, or even simply that his/her thoughts are being read, take care! A Delusion of Influence is not the same as Thought Insertion. In particular, a delusion that a child's thoughts are being read or that telepathy or hypnotism is going on often does *not* mean that s/he experiences thoughts being inserted. S/he often means that somehow people seem to know what s/he is thinking (either they can infer his/her thoughts from his/her behavior, or they seem to have extraordinary powers). Similarly, delusions of religious influence do not mean thought insertion ipso facto; although the content of thinking is influenced by God or the Devil, etc., the thoughts are usually the child's own thoughts.

(v) An elated subject may speak as if his/her thoughts were coming from elsewhere, e.g. they are so magnificent that it seems as if they must have come from the sun, so good that they must have come from God, etc. But in such cases the child knows they are his/her thoughts. If s/he describes them as 'God's' thoughts, this is only a manner of speaking.

THOUGHT BROADCAST OR THOUGHT SHARING

2 = If the child says that his/her own thoughts seem to sound 'aloud' in his/her head, almost as though someone standing nearby could hear them. If thoughts are repeated, rate as 'Thought Echo'.

3 = The child experiences his/her thoughts actually being shared with others, often with large numbers of people (irrespective of the mechanism suggested by the child; but this is usually said to be some form of 'broadcasting').

The symptom is a rare one. Distinguish it from a Delusion of Thoughts Being Read. Children quite often say their thoughts are being read, without having had the experience of thought broadcast. What they mean is that other people can tell from their expression, or from their habits, what they are likely to be thinking. Thought reading can also be an explanatory delusion. For example, if the child has an extensive system of delusions of reference so that wherever s/he goes s/he seems to be followed, or people are making signs at him/her, s/he may say that whoever is organizing it can read his/her thoughts, thus knowing where s/he is going to go and how to instruct others to react to him/her. Thought Broadcast is *only* rated when the child actually experiences his/her thoughts being shared with others. There is very rarely any doubt when the symptom is present, as even a rather unintelligent or uneducated patient can describe it quite accurately.

Distinguish from pseudohallucination in which the child hears voices within his/her mind, not through the ears. The voice is not, however, said to be the child's own thoughts.

Distinguish also from Thought Withdrawal in which thoughts are not experienced as broadcast or shared, but as withdrawn so that the child has no thoughts. See the definition of Thought Insertion. The general remarks also apply to the present symptom which is often rated positively on insufficient evidence.

THOUGHT ECHO OR COMMENTARY

The child experiences his/her own thoughts as being repeated or echoed (not just spoken aloud) with very little interval between the original and the echo. The repetition may not be a simple echo, however, but subtly or grossly changed in quality.

2 = Repetition may not be a simple echo, however, but subtly or grossly changed in quality.

3 = The child experiences alien *thoughts* in association with his/her own, or as comments upon his/her own.

This experience is very rare but, when it occurs, the child can describe it exactly. It is not the same as voices commenting on the child's thoughts.

See the definition of Thought Insertion. The general remarks apply also to the present symptom which is often rated positively on insufficient evidence.

THOUGHT BLOCK OR THOUGHT WITHDRAWAL

Thought block is extremely rare and should only be rated as present when the examiner is quite sure of its presence. If there is any doubt, it is probably not present.

The child experiences a sudden stopping of his/her thoughts, quite unexpectedly, while they are flowing freely, and in the absence of anxiety. When it occurs it is fairly dramatic and it happens on several occasions.

2 = Child just experiences a sudden stopping of his/her thoughts.

3 = The child may be unable to describe pure thought block, but it is sometimes very recognizable in the form of an explanatory delusion of thought withdrawal. The child says that his/her thoughts have been removed from his/her head so that s/he has no thoughts.

Distinguish from the somewhat similar Delusion of Depersonalization in which the child may say that s/he has no thoughts, but *not* that his/her thoughts have suddenly stopped, or that they have withdrawn. It is the element of withdrawal that makes the symptom recognizable. Withdrawal may be present without thought block being experienced.

Distinguish also from Thought Broadcast or Sharing, in which the child still has plenty of thoughts, but experiences them as being available to others besides him/herself.

DELUSIONS OF THOUGHTS BEING READ

This is usually an explanatory delusion. It often occurs with Delusions of Reference or Misinterpretation, which require some explanation of how other people know so much about the child's future movements. It may be an elaboration of Thought Broadcast, Thought Insertion, Auditory Hallucinations, Delusions of Control, Delusions of Persecution or Delusions of Influence. It can even occur with Expansive Delusions (the child wishing to explain how Einstein, for example, stole his/her original ideas). It is most important that it should not be mistaken for diagnostically more important symptoms such as Thought Insertion or Broadcast.

Exclude those who think that people can read their thoughts as a result of belonging to a group that practices 'thought reading'.

2 = The child seriously entertains the possibility that his thoughts might be read, but is not certain about it.

3 = Delusional conviction.

DELUSIONS

PARTIAL AND FULL DELUSIONS

Most delusional symptoms are rated according to whether there is partial or full conviction. Partial delusions are expressed with doubt, as a possibility which the child is prepared to entertain but is not certain about.

If the child has had full conviction during the past three months, e.g., if he has acted as though the delusional belief were true, the rating should be 3 irrespective of the degree of conviction at the time of interview.

However, if the delusion does not seem to have been formed fully, but is still at the stage of being only one conceivable explanation for some unusual experience, rate 2.

DELUSIONS OF CONTROL

This is a symptom (like Thought Insertion and Thought Broadcast) that tends to be rated present when it is in fact absent. The essence of the symptom is that the child experiences his/her will as being *replaced* by that of some other force or agency. Unless the examiner is confident that the child has indeed had this experience during the past three months, the symptom is absent.

The basic experience may be elaborated in various ways. The child may believe that someone else's words are coming out using his/her voice, or that what s/he writes is not his/her own, or that s/he is the victim of possession, a zombie or a robot controlled by someone else's will, even his/her bodily movements being willed by some other power.

2 = Partial delusion

3 = Full delusional conviction

A simple statement that the child is 'being controlled' or 'being influenced' is not sufficient to rate the symptoms as present. The child may mean only that his/her life is planned and directed by fate, or that the future is already present in embryo, or that s/he is not very strong willed. S/he may think that voices are giving him/her orders. S/he may mean that s/he thinks that God is omnipotent and controls everything, him/herself included, or that s/he him/herself is God (this is a Religious Delusion). None of these alternatives should be included if the essential element is missing. Only close cross-questioning can establish whether delusions of control are indeed present.

Do not include here if an elated child says s/he is 'under God's control' meaning that his/her will, far from being replaced, is greatly strengthened, as if it were God's.

NOTES ON 'POSSESSION' STATES

The difference between subcultural or hysterical possession states and delusions of control lies first in the *state of consciousness*. The former occur in a state of dissociation. The latter occur in clear consciousness.

A second differentiating point is that the subcultural possession state is a culturally normative experience, that is, the *child's claim to be possessed is endorsed by other members of his/her group.* The hysterical possession state may not be so endorsed but its subcultural origins should still be clear and the motivation for the symptom will usually be obvious. A Delusion of Control should not be rated present if there is any doubt on these two points.

A third point is that subcultural possession states are ego-enhancing in their effect, since the child becomes identified with a more powerful being. Delusions of Control, however, express an experience of loss rather than acquisition of identity, and they are often based on other abnormal experiences, rated elsewhere.

DELUSIONS OF REFERENCE

Ideas of reference are rated elsewhere. Delusions of Reference consist of a further elaboration of this experience in so far as other *people* are involved. Thus what is said may have a double meaning, or someone makes a gesture which the child construes as a deliberate message, e.g., a man crossing his legs may be taken to mean that the child is a homosexual. The whole neighborhood may seem to be gossiping about the child, far beyond the bounds of possibility, or s/he may see references to him/herself on the television or in newspapers. The child may hear someone on the radio or television say something connected with some topic that s/he has just been thinking about (incidentally, this is not Thought Broadcast, which is a specific experience and should be rated separately). The child may seem to be followed, his/her movements observed and what s/he says tape-recorded.

Delusions of Reference may be based upon guilt (people are blaming or accusing the child) or upon elation (they are interested in the child because s/he is so important and noteworthy) or they may be primary delusions - sudden convictions that a particular gesture or set of events refer to the child and have a special significance. Code any referential aspects of the delusions here and their other features elsewhere as appropriate.

Consider Auditory Hallucinations as well. It is, of course, possible for a child to have both symptoms but they are not identical. If the child thinks people are talking about him/her, or making remarks intended for him/her to overhear, when they are in his/her presence, it is most likely that s/he is misinterpreting, not hearing, voices. Careful questioning should enable the interviewer to judge whether one or other or both symptoms are present.

DELUSIONS OF MISINTERPRETATION AND MISIDENTIFICATION

This symptom is a further extension of the Delusion of Reference in that not only do people seem to refer to the child directly but situations seem to be created that have a special meaning. Things seem to be arranged to test him/her, objects are arranged so that they have a special significance for him/her, street signs or advertisements on buses or patterns of color seem to have been put there in order to give him/her a message. This may go so far that the whole armies of people may seem to be employed simply in order to discover what s/he is doing, or to convey some message to him/her. S/he may think s/he sees people s/he knew in the distant past, especially planted in his/her way so as to remind him/her of something. The child does not necessarily feel persecuted or grandiose or interpret these beliefs in some other delusional way. S/he may simply be puzzled as to why these events are going on.

2 = Partial delusion

3 = Full delusional conviction

DELUSIONS OF PERSECUTION

The child believes that someone, or some organization, or some force or power, is trying to harm him/her in some way, to damage his/her reputation, to cause him/her bodily injury, to drive him/her mad or to bring about his/her death.

The symptom may take many forms, from the direct belief that people are hunting him/her down, to complex and bizarre plots with every kind of science fiction elaboration.

A simple delusion of reference, e.g. that the child is being followed or spied upon, is not included unless the child believes that harm is intended, in which case rate both symptoms as present.

2 = Partial delusion

3 = Full delusional conviction

DELUSIONS OF ASSISTANCE

The child believes that someone, or some organization, or some force or power, is trying to help him/her. This delusion may arise as an explanation for experiences which are expressed as Delusions of Reference (in the same way that Delusions of Persecution can arise). Delusions of Assistance may be simple, e.g. people make signs to the child in order to persuade him/her to be a better person, because they want to help him/her, or complicated, e.g. angels organize everything so that the child's life is directed in the most advantageous way. Grandiose or Religious Delusions may be present at the same time.

2 = Partial delusion

3 = Full delusional conviction

DELUSIONS OF GUILT

This symptom appears to be grounded in a depressed mood. The child thinks s/he has brought ruin to his/her family by being in his/her present condition or that his/her symptoms are a punishment for not doing better.

2 = The child may have a fluctuating awareness that his/her feelings are an exaggeration of normal guilt.

3 = The more severe form of the symptom, where the child has a delusional conviction that s/he has sinned greatly, or committed some terrible crime, or brought ruin upon the world, i.e. there may be a grandiose quality to the delusion. S/he may feel that s/he deserves punishment, even death or hell-fire, because of it. S/he may say that his/her offence and the punishment s/he has merited are unnameable in which case s/he may be able to draw it.

Distinguish from pathological guilt without delusional elaboration, in which the child is in general aware that the guilt originates within him/herself and is exaggerated.

DELUSIONS OF DEPERSONALIZATION OR NIHILISM

The child has a strong feeling as if s/he had no brain, a hollow within his/her skull, no thoughts in his/her head, etc.. Exclude Delusional Elaboration, e.g. that some other force or agency has taken over the child's mind and body so that s/he now has another identity and no will of his own.

2 = Partial delusion

3 = Full delusional conviction

HYPOCHONDRIACAL DELUSIONS

This symptom is in many ways similar to Delusions of Depersonalization. The child feels that his/her body is unhealthy, rotten or diseased and can only be reassured for a brief while that this is not the case.

2 = Partial delusion

3 = Full delusional conviction

If the symptom is more intense, so that the child has a delusional conviction that s/he has incurable cancer, that his/her bowels are stopped up or rotting away, etc., rate 3. Sometimes it is difficult to decide whether the symptom is Nihilistic or Hypochondriacal as when the child says s/he is hollow and has no inner existence because all his/her insides have rotted away. In this instance, it is legitimate to rate both symptoms positively. In general, when in doubt rate Hypochondriacal rather than Nihilistic delusions.

SIMPLE DELUSIONS CONCERNING APPEARANCE

The child has a strong feeling that something is wrong with his/her appearance. S/he looks old or ugly or dead, his/her skin is cracked, his/her teeth misshapen, his/her nose too large or his/her body crooked. Other people do not notice anything especially wrong, but the child can be reassured only momentarily, if at all. There may only be one particular complaint but there is no elaboration of any kind (e.g. if the child says s/he has a metal nose, rate as a Fantastic Delusion).

2 = Partial delusion

3 = Full delusional conviction

If the child has actually acted on the delusion, e.g. has had either his/her teeth out or a plastic operation on his/her nose, or been to see a surgeon, etc., within the past three months, rate 3.

Exclude Self-consciousness, concern about real skin disease, e.g. acne, etc.. Differentiate from Depersonalization and Delusions of Depersonalization.

Differentiate from the body image disturbance of Anorexia Nervosa, which relates specifically to a misperception of fatness.

DELUSIONS OF GRANDIOSE ABILITY OR IDENTITY

Delusions of Grandiose Ability

The child thinks s/he is chosen by some power, or by destiny, for a special mission or purpose, because of his/her unusual talents. S/he may think that s/he is able to read people's thoughts, or that s/he is particularly good at helping them, that s/he is much more clever than anyone else, that s/he has invented machines, composed music, solved mathematical problems, etc. beyond most people's comprehension.

Delusions of Grandiose Identity

The child believes s/he is famous, rich, a pop star or superhero or sports hero, titled or related to prominent people. S/he may believe that s/he is a changeling and that his/her real parents are royalty, from another planet, etc..

Note: Fantasies of grandiose abilities and grandiose identification are features of many childhood games particularly those of groups of young boys (Batman, Superman, etc.). These are not rated here unless they possess the necessary additional defining characteristics.

2 = Partial delusion
3 = Full delusional conviction

DELUSIONAL EXPLANATIONS

Include here any delusional explanation or elaboration of other abnormal experiences (as defined in this schedule) e.g. explanations of Thought Broadcast in terms of occult phenomena or alien mind control.

2 = Partial delusion

3 = Full delusional conviction

PRIMARY DELUSIONS

Primary Delusions are based upon sensory experiences (delusional perceptions) in which a child suddenly becomes convinced that a particular set of events has a special meaning. For example, a child undergoing liver biopsy felt, as the needle was inserted, that he had been chosen by God. The moment the delusions occurred can often be described as precisely as this. The delusion cannot be explained, except in terms of a delusional perception, and it is not explained in his way by other members of the child's cultural and social group. It frequently follows a Delusional Mood. The experience often results in a Delusion of Reference or Misinterpretation, but it may lead to a Religious or Grandiose or Persecutory delusion, or to various types of Explanatory delusion. The child must be able to describe this experience precisely. If there is any doubt about the primary nature of the delusion do not rate it here. Always rate the resulting or explanatory delusion as well. Do not, or course, include delusions that are explanations of other phenomena, such as Thought Insertion, Hallucinations, subcultural beliefs, etc., as most are.

2 = Partial delusion

It will rarely be necessary to rate Primary Delusions as partial, since primary delusions enter the mind with full conviction.

3 = Full delusional conviction

DELUSIONAL MATERIAL NOT SPECIFIED ELSEWHERE

Morbid Jealousy

The child, without good reason, thinks that his/her sexual partner is unfaithful.

If s/he is still doubtful about this but cannot help feeling that it might be the case, or if s/he entertains that possibility without actually yielding to conviction, rate 2.

If the child seeks for evidence, interprets innocent patterns of events as proof, or makes accusations of unfaithfulness, rate 3. Sibling jealousy is not rated here, since the jealousy must be specifically sexual.

Sexual delusions

Any other delusions with a sexual content, for instance of a fantasy lover or sex changing, is included here.

2 = Partial delusion

3 = Full delusional conviction

GENERAL RATINGS OF DELUSIONS AND HALLUCINATIONS

Consider both delusions and hallucinations in the following ratings:

SYSTEMATIZATION OF DELUSIONS

0 = Delusions and hallucinations are not elaborated into a general system affecting much of the child's experience. Include encapsulated delusions or isolated hallucinations.

2 = Some systematic elaboration but substantial areas of the child's experience are not affected.

3 = The child interprets practically all experiences in delusional terms.

EVASIVENESS CONCERNING DELUSIONS AND/OR HALLUCINATIONS

0 = No attempt at concealment is suspected.

2 = The interviewer suspects there may be either delusions or hallucinations in the background but the child is not concealing much of the psychopathology.

3 = The interviewer suspects there is a considerable preoccupation with delusions or even a delusional system but the child tries to conceal it.

PREOCCUPATION WITH DELUSIONS AND HALLUCINATIONS

2 = At least sometimes uncontrollably preoccupied with delusions or hallucinations in at least two activities.

3 = Uncontrollably preoccupied with delusions or hallucinations in most activities.

ACTING UPON DELUSIONS OR HALLUCINATIONS

2 = The child has acted upon the delusions or hallucinations during the past three months, or expressed them in public (i.e. outside the small circle of people who would be expected to be sympathetic). This has not, however, resulted in severe social disturbance or a social crisis.

3 = As 2 but the acting out, or public expression, has resulted in severe social disturbance or a social crisis, e.g. the child has attacked a stranger at the command of a hallucinatory voice.

THEMATIC CONSISTENCY OF DELUSIONS OR HALLUCINATIONS WITH MOOD DISORDER

The extent to which the contents of the delusions or hallucinations are consistent with either Elated or Depressed Mood.

2 = Partial Mood Congruence
3 = Delusions are almost entirely mood congruent

Associated Mood: Depressed Mood or Anhedonia

0 = Absent
2 = Present

Associated Mood: Elated

0 = Absent
2 = Present

TEMPORAL CO-OCCURRENCE OF DELUSIONS OR HALLUCINATIONS WITH MOOD DISORDER

The extent, onset, and course of delusions or hallucinations are temporally related to the onset and course of mood disorder of sufficient severity to be rated elsewhere in the interview. The associated mood may be Depressed Mood, Elation or Irritability.

2 = Partial temporal co-occurrence; i.e. delusions or hallucinations are sometimes associated with the mood disorder

3 = Delusions/hallucinations are only present in association with the mood disorder

HALLUCINATIONS OR DELUSIONS OCCURRING ONLY DURING PERIODS OF ALCOHOL OR OTHER PSYCHOACTIVE SUBSTANCE INTAKE
The onset and cause of delusions or hallucinations are temporally related to periods of alcohol and/or other psychoactive substance use and do not occur at other times.

REACTIVE ATTACHMENT DISORDER

Purpose of the Section

This section has 1 major function:

(1) To provide information on patterns of behavior related to the child's ability to interact affectively and emotionally with other people.

The diagnosis of Reactive Attachment Disorder requires knowledge that the child has been abused or neglected. It is not possible to make a clear connection between the child's abuse/neglect history and these behaviors using a parent report alone. Nonetheless, information gathered in this section will help the interviewer to assess whether the child exhibits abnormal relatedness similar to that described for Reactive Attachment Disorder.

Behaviors presented in this section may also be helpful in assessing whether the child might need further evaluation/assessment for a Pervasive Developmental Disorder such as Autism.

INHIBITION DURING SOCIAL INTERACTIONS

Child is constricted and withdrawn during most, if not all, social interactions and this behavior contributes to a disturbance in the child's social relatedness. To meet criteria, child must fail to initiate social interaction due to inhibition.

Child will probably also meet criteria for Behavioral Inhibition if s/he meets criteria for this item. Child may also meet criteria for Social Anxiety. Note that this item refers to *all* interactions, not only interactions with unfamiliar people.

0 = No

2 = Child is inhibited in most social interactions and this behavior interferes with child's ability to have relationships with others

LACK OF INTEREST IN PEOPLE

The child has a pervasive lack of interest in people; does not seek increased contact with them; and lacks any sense of closeness or involvement with other people, often with limitations in empathy/sensitivity to others' feelings.

If it is already established that the child has a best friend or is engaged in other positive, active relationships, then it is not necessary to ask about lack of interest in people; it cannot be present by definition.

LACK OF EMPATHY/EMOTIONAL SENSITIVITY

A lack of sensitivity to, and awareness of, other people's feelings. That is lack of ability to perceive or detect another's feelings, regardless of the child's willingness to respond to those feelings (i.e. do not include a child who is aware of other's feelings, yet responds with callous disregard for them). This lack is pervasive and not specific to any particular relationship.

0 = Absent
2 = Present

APPROACH/AVOIDANCE RESPONSES TO CAREGIVERS AND OTHERS

On a regular basis, child responds to parents or other caregivers (such as grandparents, teachers) in contradictory ways. Child may approach a person for help and then withdraw, avoid, or reject that person as s/he tries to respond to the needs/requests of the child. This behavior contributes to a disturbance in the child's social relatedness.

0 = Symptom absent

2 = Contradictory responses to overtures by caregivers occurs in at least two activities and interferes with child's relationships with others

3 =Contradictory responses to overtures by caregivers occurs in almost all activities and interferes with child's relationships with others

DIFFICULTY BEING AFFECTIONATE

Lack of warmth or emotional or physical affection in multiple interactions with major attachment figures.

Multiple interactions means that the lack of affection is pervasive and recurrent in many interactions. Do not code a child's lack of affection if s/he is angry at a parent or is preoccupied with another task. This item is addressing a pervasive, not an episodic, lack of affection or inability to show affection.

0 = Absent

2 = Present

INDISCRIMINATE ADULT RELATIONSHIPS

The child is reported to be willing to be friendly towards almost any adult, to a degree unusual for his/her developmental age, social group, and familiarity with the adult. Behavior is inappropriate for contact with unfamiliar adults.

For example, a child might ask a person on a bus to take him/her home or s/he might sit on a woman's lap, kiss and hug her, and tell her s/he love her within five minutes of meeting her.
Often the child appears "needy" or "clingy," and behaves inappropriately with unfamiliar adults. This item should only be coded as being present when the child's behavior is clearly outside normal limits. If in doubt, code this item of being absent. A child who is simply friendly or polite to adults would not code here.

0 = Absent

2 = Indiscriminate in adult relationships but parent does not regard this as a problem

3 = Indiscriminate in adult relationships to degree that parent regards as a problem

INDISCRIMINATE PEER RELATIONSHIPS

The child is reported to be willing to be friendly towards almost any peer, to a degree unusual for his/her developmental age, social group, and familiarity with the peer in question. Behavior is inappropriate for contact with unfamiliar peers.

For example, the child might call another child his/her best friend or ask another child to give him/her the child's toy right after meeting him/her. Or hug, kiss, or touch another child who is unfamiliar to the child.

Often the child appears "needy" or "clingy," and behaves inappropriately with unfamiliar peers. This item should only be coded as being present when the child's behavior is clearly outside normal limits. If in doubt, code this item of being absent. A child who is simply friendly or polite to peers would not code here.

0 = Absent

2 = Indiscriminate in peer relationships but parent does not regard this as a problem

3 = Indiscriminate in peer relationships to degree that parent regards as a problem

AVOIDS PHYSICAL CONTACT

Parent's evaluation that the child tries to avoid being physically close with others

0 = Absent

2 = Child often avoids physical contact but can sometimes be physically close to others

3 = Child always tries to avoid physical contact with others

Using the frequency scale score, assess how often child avoids physical contact with each of the people listed.

RESISTANCE TO COMFORT

Often physically or verbally rejects offers of physical or verbal comfort, when hurt, frightened, or ill.

0 = Rarely resists being comforted

2 = Resists being comforted in at least two activities

3 = Resists being comforted in most activities

NEGATIVE REUNION RESPONSES

Failure to establish a positive interaction after separations. Examples include ignoring/avoiding behaviors, intense anger, or lack of affection.

0 = Absent

2 = Present, but positive interaction can be re-established at time of reunion within one hour

3 = Present and positive interaction cannot be restored at time of reunion within one hour.

Using the frequency scale score, assess how often child has a negative reunion response with each of the people listed.

CONSTRICTED RANGE OF FACIAL EXPRESSION

Parent's evaluation that the child appear to have little facial expression.

0 = Absent

2 = Child appearance lacks emotional expression most of the time

AVOIDS EYE CONTACT

Parent's generalized evaluation that the child characteristically avoids making eye contact with others and that s/he often turns his/her eyes away when others try to initiate eye contact.

Distinguish from avoidance of eye contact which occurs with shyness e.g. when the child meets new people or is in an unfamiliar setting

0 = Absent

2 = Child generally avoids eye contact with others

HYPERVIGILANCE

Increased general level of awareness and alertness towards surroundings in the absence of imminent danger.

Hypervigilance is also assessed in the PTSD section. Code both if criteria are met for both items.

0 = Absent

2 = Behavioral manifestations of hypervigilance (e.g. taking care over seating or scanning environment for danger) but does not limit activities to any major extent

3 = Behavioral manifestations of hypervigilance interferes with at least two activities

4 = Behavioral manifestations of hypervigilance interferes with most activities

LIFE EVENTS

Purposes of the Section

The section has 3 major functions:

(1) To provide information about stressful events in the life and environment of the child

(2) To provide information about events that have the potential to cause the kinds of symptoms recorded elsewhere in the PAPA, or to which such symptoms are often causally attributed.

(3) To provide an entry point to the Post-Traumatic Stress Disorder (PTSD) section.

Organization of the Section

The section looks at two kinds of stressful events:

(A) Life events that are considered as potential causes of symptoms related to PTSD only if they occurred in the primary period

Onsets for A events are generally within the three month period. Exceptions are Lives/Attends Daycare/School in a Chronically Unsafe Environment and Reduction in Standard of Living, which may predate but extend into the primary period.

(B) Life events that are considered as potential causes of symptoms related to PTSD if they occurred at any point in the child's life

Onsets are clearly marked as the three month or ever variety.

LIFE EVENTS

Life events are events occurring in the life and environment of the child that have the potential to cause the kinds of symptoms recorded elsewhere in the PAPA, or to which such symptoms are often causally attributed. For each event, probes are made about whether it occurred, and if it did, a detailed description is obtained. For events like earthquakes, riots, or wars, details are gotten of how closely the child was involved in the event (e.g., building s/he was in was damaged in a hurricane).

PERIOD OF INQUIRY
Note that some events (e.g., arrival of a new child in the home; change of daycare/school/childcare provider) are recorded only if they occurred during the primary period; others (e.g., death of loved one; accidents) are recorded if they ever occurred.

In the case of serious physical illness, it is necessary to enquire both about occurrence ever and relapse or recurrence of symptoms during the primary period.

ATTRIBUTION
If an event has occurred that meets criteria for a "2" or higher intensity rating, ask the parent whether the life event has affected any of the problems (symptom areas) or behaviors already discussed in other sections of the PAPA. (These problem areas need only be codable in the PAPA. They do not necessarily have to have reached threshold for coding.) Code up to six. The interviewer may probe possibilities. Attributions are derived from the parent's perception.

01=Separation anxiety (increased clinginess)
02=New or increased fears/anxiety
03=Increased crying
04=Irritability
05=Being depressed and/or withdrawn
06=Regression of toileting skills
07=Regression in language (e.g. return of baby talk)
08=Physical symptoms
09=Eating/Food-related behavior
10=Sleep behavior
11=Hyperactivity
12=Difficulty concentrating
13=Oppositional behavior (including disobedience and tantrums)
14=Increased aggression
15=Relationship with parent #1
16=Relationship with parent #2
17=Relationship with other parent #1
18=Relationship with other parent #2
19=Relationships with other adults including daycare provider/teacher
20=Sibling relationships
21=Peer relationships

GROUP A EVENTS

NEW CHILD(REN) LIVING IN HOME

Child or children have come to live permanently in the child's home.

Include newborn or adopted child/ren of parents, foster child/ren, or child/ren of a previous relationship. Do not include visiting child/ren, or those who came for an indeterminate period until their own parents can take them back (e.g., cousins staying while aunt is in hospital). Code only if the new child is apparently going to be cared for as his/her own by the child's parental figure.

Code each child with the identifying numbers used on pages C - 1 through C - 5.

PARENTAL SEPARATION

Parental figures have split up or separated during the primary period. One of the parental figures has moved out of child's home, apparently permanently. Either parent may have begun divorce proceedings.

Do not code if parent has gone with the intention of returning, however long or uncertain the period of absence (e.g., if father is in the military and posted abroad or is on active service).

PARENTAL DIVORCE

Parental divorce proceedings, begun before the primary period, have been finalized.

NEW PARENTAL FIGURE

A new parental figure has moved into the child's home, as the result of remarriage or the establishment of an apparently permanent relationship by the child's parental figure. Do not code here unless the relationship meets criteria for at least an exclusive relationship, and the individual acts in a parental role toward the child; i.e., assumes some responsibility for attempting to control the behavior and discipline of the child.

MOVING HOUSE

The child moved from one residence to another during the primary period. Include only moves where the apparent intention was that the move should be permanent; i.e., do not code if the family went on vacation. Do code if child is removed and place in foster home. If a move occurred during the primary period, inquire about separation from parents, change of daycare/school/regular caregiver, and loss of significant adults and/or friends. Clarify that any problems arising are attributable to the move itself, not to changes that result from the move such as change of daycare/school.

CHANGE OF DAYCARE/SCHOOLS/CHILDCARE PROVIDER

The child changed daycare/school or childcare provider during the primary period. If change is present, code type of change and reasons for change. If more than one change, code for the most upsetting.

CHANGE

CODE THE ONE ITEM THAT BEST REFLECTS THE CHANGE THAT OCCURRED

New daycare/school with friend(s): Child moves to a new daycare center or to a new school with peers s/he knows.
New daycare/school without friend(s): Child moves to a new daycare center or to a new school without peers s/he knows.
New class in same daycare/school: Child moves to a new class in the same daycare or school.
Starting daycare/school for first time: Child attends a group-based daycare or school setting for the first time. If child is starting school after having been in a daycare, do not code.
Starting non-parental childcare for the first time: Child has been in been primarily in the care of a parent and begins to be cared for by a non-parental caregiver such as a babysitter or nanny for the first time. Include starting care with a relative such as a grandmother. Exclude group care (coded above).
Change in non-parental childcare provider: Child is cared for by a new non-parental childcare provider e.g. a new babysitter or nanny.
Change in daycare/school caregiver/teacher: Child remains in the same daycare/school setting but is cared for and/or taught by a new caregiver or teacher. Include only a change in the head or lead teacher not a change in a teacher's aide.
Other

REASON(S) FOR CHANGE IN DAYCARE/SCHOOLS/CHILDCARE PROVIDER

CODE THE ONE ITEM THAT BEST REFLECTS THE REASONS FOR THE CHANGE

Primary caretaking parent returned to work: Parent who had cared for child during most of the day returned to work. Here work refers to activities outside of the home or inside the home that make necessary a new childcare arrangement.
Primary caretaking parent unable to care for the child: Parent who had cared for child during most of the day is unable because of illness, stress, or other incapacity to provide care for the child.
Planned change of non-parental childcare providers: Change in non-parental childcare provider is planned because the previous caregiver is taking leaving, changing jobs, etc.
Promotion: Child is promoted from one class to another.
Move: Child moved and thus had to change childcare setting/school arrangements.
Family preference: Parents' prefer to choose a different settings for child**.** This choice could be made for positive reason e.g. selecting a more stimulating program or negative reasons e.g. feeling that child was being mistreated in the previous setting**.**
Need for special services: Child needs special services such as medical care, psychiatric care, tutoring, structure, etc. that could not be provided in the previous setting.
Expulsion from previous setting: Child is asked to leave previous setting.
Other

LOSS OF SIGNIFICANT PERSON THROUGH MOVING
Move by child or significant figure resulted in the end of a close relationship, with significant figure no longer available for friendship and companionship. Code 0 if the relationship is maintained after the move through regular phone calls, letters, and/or visits.

SIGNIFICANT FIGURE INCLUDES
1 = Parent #1
2 = Parent #2
3 = Other parent #1
4 = Other parent #2
5 = Foster parent
6 = Grandparent (or step grandparent)
7 = Babysitter/Childcare provider
8 = Other adult: include other relatives and non-relatives
9 = Friend
10 = Sibling: include half-siblings
11= Other

May code more than one person.

DEATH OF A PET

Death of a pet to whom the child was closely attached. Pets may include dogs, cats, rodents such as mice or gerbils, fish, birds, snakes, ferrets, or other animals. Do not include death of an animal living in the wild such as a squirrel or hedgehog. The pet need not belong exclusively to the child, but the child must have been very attached to the animal, must have spent time with it, and helped care for it.

LIVES/ATTENDS DAYCARE/SCHOOL IN A CHRONICALLY UNSAFE ENVIRONMENT

Child lives/attends daycare/school in an area seen as chronically unsafe or threatening. Onset may predate primary period. If the situation existed, but then ended, during the primary period, it must have been present at least one month of the primary period to code. Cases in which the child is in the situation at the end of the primary period, and has been in it less than one month, may be coded by showing actual onset and rounding up duration to one month. One incident or person is unlikely to make the neighborhood or daycare/school generally unsafe.

REDUCTION IN STANDARD OF LIVING

Noticeable reduction in the child's family's standard of living as evidenced by inability to pay bills, need to sell things, need to move (including in with relatives), going on welfare or food stamps, inadequate food, clothing, and heat. May be result of changes in household status and needs such as parental separation or divorce, death, taking in additional dependents, high medical bills or loss of household income due to cutback in hours, layoff or loss of job, inability to find employment, under-employment, loss of employment benefits, depletion of savings, etc. Onset may predate primary period, however, the child must be old enough to notice the change.

LOSS OF HOME WITHOUT SEPARATION FROM FAMILY MEMBERS

Child and family loses home because of eviction, end of lease, damage to home by a fire or natural disaster, or other reason and are not resettled in a home for at least one month. During that time, the child and family could be at a shelter, on the street, staying temporarily at a friend or relative's home, at a hotel etc. Do not include intentional moves to a new setting. The place where the family is staying or stayed for at least one month must not have been considered a permanent resettlement. Onset may predate primary period. If the situation existed, but then ended, during the primary period, it must have been present at least one month of the primary period to code. Cases in which the child is in the situation at the end of the primary period, and has been in it less than one month, may be coded by showing actual onset and rounding up duration to one month.

If cause of loss of home is one of the other life events (e.g. fire, hurricane), code in both places.

TEMPORARY HOUSING

1 = Shelter: Include homeless shelter, emergency shelter
2 = Homeless, on the street
3 = In a vehicle (e.g. car, truck, rv)
4 = At friend or relative's home
5 = Hotel
6 = Other

PARENTAL ARREST

Any parental figure was arrested during the primary period. This could include Parent #1, Parent #2, Other Parent #1 or Other Parent #2, as labeled in the PAPA. Arrested means taken into custody, whether or not a charge was filed. If a parent was arrested more than once, or both parents were arrested, code for the most upsetting.

PARENTAL HOSPITALIZATION

Child's parental figure is hospitalized for 24 hours or more. Hospitalized here means evaluated or treated in an emergency room of a hospital and/or admitted to a hospital. A hospital could be a private or public hospital or an inpatient treatment facility. Do not include visits to out-patient clinics. This could include Parent #1, Parent #2, Other Parent #1 or Other Parent #2, as labeled in the PAPA. If a parent was hospitalized more than once, or both parents were hospitalized, code for the most upsetting.

REASON(S)
May code more than one reason. If more than one episode or parent, code the reason for the most upsetting hospitalization.

1 = Medical Problem(s): include injuries resulting from an accident, acute illness, or sequelae of a chronic illness
2 = Psychiatric Problem(s)
3 = Drugs or Alcohol Problem(s)
4 = Other Problem(s)

SEPARATION FROM "PARENT" FOR MORE THAN A WEEK

Child is apart from any parent or "other" parent for more than a week.

In the last three months, the child has been separated from his/her parent for at least one week. Code only if child apart from parent #1, parent #2, other parent #1, and other parent #2 for at least 7 days.

Child may be in the home or away from home. Include visits to grandparents, other relatives, friends, if necessitated by adult needs (e.g. mother in hospital, going on vacation or a business trip) not solely child's wishes. Include removal from home for more than a week due to abuse or neglect or inability of parent(s) to care for the child.

Do not include regularly scheduled visitations with non-custodial parent. Do not include camp, even if child is reluctant to go.

Code hospitalization of child and captivity (which includes kidnapping) elsewhere.
If cause of separation was hospitalization of parent, code here and in hospitalization of parent.

Code whether the child was with sibling during the time s/he was separated from parents. If more than one occurrence, code whether sibling present during the longest separation from home.

If a separation of more than one continuous week (7 days) occurred, code the number of such separations in the primary period. If child was separated for three two-week periods, code as three. Then code total number of days of separation in primary period. Thus, for the same three two-week separations, code 42.

Code the onset date and the reason for the longest separation

REASON FOR SEPARATION

01 = Illness of parent. Parent may be in the hospital, treatment facility, or hospice
02 = Illness of other person requiring "parent" to leave child with others
03 = Parental vacation
04 = Parental business/work/school trip
05 = Removal of child from home because of abuse and/or neglect
06 = Other

GROUP B EVENTS

From this point in the section, events are coded if they have *ever* occurred.

Enter in column B of the check sheet if the event occurred in the primary period or if it occurred before that.

ACCIDENTS AND INJURIES

An accident is an unplanned event leading to serious injury or the potential for serious injury that is caused involuntarily to the child by him/herself or others. Do not include any physical harm codable as a Suicide Attempt or Non-Suicidal Physical Self-harm. If an accident sets off a train of events (e.g., a car crash led to a fire), code under the first event. If the first event was a fire (e.g., house or forest fire), code under Fire .

If harm is intentional, code under Victim Of Physical Violence or Physical Abuse.

Seven different types of severe accidents and injuries are included in this section: vehicular accident with child in vehicle; child struck by vehicle; poisoning; accident causing a burn; near drowning; accidental serious fall; attack and/or injury by an animal. After these accidents and injuries are described, the number of bones child has broken, in any type of accident, are recorded.

For each type of accident, the lethality of the accident is assessed

LETHALITY

0 = Mild: No medical attention needed or sought (e.g. no injury or mild injury that could be tended without medical attention such as a cut requiring a band-aid)

2 = Moderate: Medical attention needed and/or sought but intervention/treatment did not require continuing care or hospitalization (e.g. stitches for cuts; ointment for abrasions)

3 = Serious: Medical attention required because of the seriousness of the injuries (concussion, loss of consciousness, broken bone(s)) Assess the seriousness of the interventions (resuscitation, assisted respiration on a ventilator, blood transfusion, operative intervention, admission to the hospital)

4 = Serious medical attention required and child has lasting physical effects from the event such as a scar, limp, no spleen etc.

VEHICULAR ACCIDENT

Child within a vehicle when a serious vehicular accident occurred.

Vehicle can include car, truck, van, train, plane, boat, etc. A serious accident is one that had the potential to be life-threatening or carried the risk of an injury requiring medical attention. Life-threatening means that there was a reasonable possibility that the child could have been killed.

Code whether serious vehicular accidents have ever occurred and whether they have occurred in the last three month.

Code the overall occurrence of vehicular accidents. Then for up to four vehicular accidents, code the onset date, the type of vehicle, whether the child was wearing a seat belt or in a car seat, and the lethality of the accident.

TYPE OF VEHICLE

Code the type of vehicle child was in when the accident occurred. If the child is in a car that collides with a train, code the vehicle type as a car.

SEATBELT/CAR SEAT

Code whether the child was wearing a seatbelt or strapped in a car seat when the vehicular accident occurred.

OTHERS INJURED IN THE ACCIDENT

Finally, for the *worst* vehicular accident code if other were injured in the accident. If others were injured, code who was injured and the lethality of the injury. The injured person need not have been in the car with the child. An injured person could be a passenger in the other car or a pedestrian. If the parent does not know the full extent of the person's injury, code only what is known. For example, if s/he only knows that the person was taken away in an ambulance, then code a 3.

STRUCK BY VEHICLE

Child struck by moving vehicle

Vehicle can include a motor vehicle, a bicycle, or other vehicle. To be coded, the event must be a serious accident that had the potential to be life-threatening or carried the risk of an injury requiring medical attention.

POISONING

Ingestion of an agent capable of producing an acute morbid, noxious, or deadly effect upon the child.

Distinguish from ingestion of lead paint chips which may produce “lead poisoning” or pica, the persistent eating (chewing and/or swallowing) of non-nutritive substances. Both ingestion of lead-toxic substances (potentially as a result of pica) and pica occur over an extended period of time and the poisoning that results is therefore not an acute event.

Code the type of substance ingested.

ACCIDENTAL BURNING

Accidently, child suffers an injury caused by fire or excessive or intense heat.

Code intentional burns elsewhere as VICTIM OF PHYSICAL ABUSE or VICTIM OF PHYSICAL VIOLENCE BY NON-FAMILY MEMBER OR SELF HARM.

If the burn results from a fire, code both ACCIDENTAL BURNING and FIRE
Assess the extent of the burn and code accordingly

0 = Absent or **1st degree burn**: red, somewhat painful, non-blistering, like a sunburn

2 = **2nd degree burn**: skin red, painful, blistered

3 = **3rd degree burn**: skin white, without sensation

4 = Any burn requiring **skin graft(s)**. A skin graft is skin that is moved from one part of the body to another or an artificial material used to replace skin.

SOURCE OF BURN

Code the source of the burn: Fire (e.g. candle flame, camp fire); Hot liquid (e.g. boiling water); Fireworks; Hot surface (e.g. stove top); Other.

NEAR DROWNING

To be nearly suffocated in water or other fluid; to come close to perishing in water or other fluid

To be coded, the event must be a serious accident that had the potential to be life-threatening or carried the risk of an injury requiring medical attention.

Code intentional attempt to drown the child as VICTIM OF PHYSICAL VIOLENCE BY NON-FAMILY MEMBER or PHYSICAL ABUSE

If NEAR DROWNING occurs as a result of a natural disaster such as a flood, code here and code NATURAL DISASTER

ACCIDENTAL SERIOUS FALL

Fall from high place, steep place, or object such as a bicycle that resulted in, or could have resulted in, serious injury or death to the child

Types of falls include falling from a tree house, from a window, down a staircase, over a stair rail, off of a high playground structure such as a slide or jungle gym, off of a bicycle, etc.

To be coded, the fall must be a serious accident that had the potential to be life-threatening or carried the risk of an injury requiring medical attention.

If child is intentionally pushed, code VICTIM OF PHYSICAL VIOLENCE or PHYSICAL ABUSE

ATTACKED BY AN ANIMAL

Mauled and/or bitten by an animal

To be coded, the animal attack must have had the potential to be life-threatening or carried the risk of an injury requiring medical attention.

Exclude roughhousing or tussling with a puppy unless the puppy seriously bit or scratched the child.

Code whether the animal was a dog or other animal.

BROKEN BONES

Fracture of child's bone(s)

Include all broken bones what ever the cause. The cause could be an accident, an intentional injury, or a bone disease that results in bone fractures. Code the causes in other relevant places.

Code the number of occurrences. Occurrences here mean the number of bone(s) broken not the number of events that led to one or more broken bones.
For up to four broken bones code the type of bone broken.

Type of bone broken can include:

01 = Leg bone(s)
02 = Arm bone(s)
03 = Ankle bone(s)
04 = Foot bone(s)
05 = Wrist bone(s)
06 = Hand bone(s)
07 = Collarbone
08 = Skull
09 = Other bone(s). Other could be a pelvis bone, a shoulder bone, a vertebrae etc.

Do not assess attribution due to broken bones. Broken bones does not appear on the PTSD checklist. This item is included in this section because of its logical connection to accidents.

DIAGNOSIS OF PHYSICAL ILLNESS

An illness was diagnosed that carries a risk of death within the next twenty years (e.g., AIDS, lymphoma, cystic fibrosis) or chronic disability (e.g., diabetes). Do not include illnesses, however severe, from which the child has recovered completely or is likely to recover completely. Code ever onset date, and date of any recurrence or relapse during the primary period.

Life-threatening means that there was a reasonable possibility that the child could have died.

The diagnosis of a physical illness might result in hospitalization of the child. If so, code in both places.

HOSPITALIZATION OF CHILD
The child was admitted to a medical or psychiatric hospital for more than 24 hours or spent more than 24 hours in a hospital emergency room.

Code the type of hospital to which the child was admitted.

DEATH OF ADULT LOVED ONE

The death of someone close to the child: a biological parent, other parental figure, other relative with whom child had close ties (e.g. a grandmother who brought the child up), or an adult who played a significant role in the child's life (e.g., an adult confidant). Code the death of a sibling or peer in the next section. Code death of a pet elsewhere. If the child reports more than two such deaths, code attribution for the most upsetting.

DEATH OF SIBLING OR PEER

Death of the child's sibling (including step, adoptive, or foster siblings), best friend, or other friend or peer. If the child reports more than two such deaths, code attribution for the most upsetting.

Ask specifically about suicides in the child's peer group. Do not include deaths, where the child knew of the death but did not know the victim personally.

NATURAL DISASTER

An event not caused by intentional human action (e.g., a hurricane, tornado, or flood) in which people actually died or were badly injured, or property was extensively damaged, or there was serious risk of death or severe injury. Code only if the child was actually within the orbit of the disaster, or the family home was within its orbit. Do not include disasters that the child simply knew about (e.g., having seen hurricane Hugo on TV), or if the family had moved away from the danger area and their current home was not damaged.

FIRE

Fire, either accidentally or deliberately set, in which people were killed or badly injured, or property was extensively damaged, or there was serious risk of these outcomes.

Do not include fires which occurred as the result of another natural disaster (e.g., an earthquake), or man-made event (e.g., bombing), which are coded under the precipitating cause (Natural disaster, War).

Code whether fire occurred accidentally or was set intentionally.

If the child was burned in the fire, code in the accidents' section of life events as well.

WAR, TERRORISM

The child has lived for at least one day in an area in which civil law was disrupted; e.g., in a country at war, or in an area in which civil war or terrorism has disrupted normal daily life.

Do not include gang warfare here, code that under Riots or Urban Violence.

WITNESS TO EVENT THAT CAUSED, OR HAD POTENTIAL TO CAUSE, DEATH OR SEVERE INJURY

The child witnessed, but was not the victim of, an event carrying serious threat to life or a serious threat of severe physical injury.

Serious means at least that there was a reasonable possibility of death or severe physical injury.

Severe means physical damage such as unconsciousness, broken limb, or injury requiring a transfusion.

Include seeing someone shot or killed, hearing someone raped or beaten in an adjacent room, seeing another person killed or severely injured in an accident.

Do not include events seen in movies or on the news.

If child was also at risk, code the event under "Accident," "War," "Riots," etc., as appropriate. Include here only serious events in which the child was not personally at risk.

> Code the relationship to the child of the person/s injured. If there was more than one person involved, code the closest relationship.
>
> 0 = Absent
> 2 = Injury to stranger
> 3 = Injury to acquaintance
> 4 = Injury to friend
> 5 = Injury to family member

Perpetrator

Code whether the perpetrator of the event (e.g. the driver involved in killing a pedestrian) was known to the child. If there was more than one perpetrator, code the closest relationship.

0 = No perpetrator
2 = Unknown perpetrator
3 = Acquaintance
4 = Friend
5 = Family member

CAUSING DEATH OR SEVERE HARM

The child caused an event that resulted in death or severe physical damage to others. Include causing a car accident(e.g. by climbing into the front seat; throwing a toy), shooting another person, or starting a fire that injured others. Include situations in which the child accompanied someone else who harmed another person, *and* in which the child was somehow involved in the cause of harm.

Do not code an *uninvolved* witness, even if they accompanied the person causing harm. Do not include delusional guilt over events not under the child's control. Code intensity, the degree of relationship with the person hurt, and intentionality. If more than one person was involved, code the closest relationship and the highest level of intentionality.

Person Hurt

2 = Stranger
3 = Acquaintance
4 = Friend
5 = Family member

Intentionality

0 = The harm was accidental. Include situations in which the child only intended to frighten the victim.

2 = The child intended to hurt or injure the victim

3 = The child intended to kill

VICTIM OF PHYSICAL VIOLENCE (NOT ABUSE)

The child was the victim of intentional physical violence. One or more people have used force against the child with potential to cause death or injury. Injury may have been serious, involving a broken limb, unconsciousness, or requiring hospitalization, or it may have been milder, involving for example a black eye, cuts or bruises. Include violence used for its own sake (e.g. assault, fighting, torture) and violence used to obtain something from the child (e.g. mugging, robbery).

Code the degree of relationship with the person using force:

Person Using Force

2 = Known peer
3 = known non-familial adult
4 = Unknown adult
5 = Unknown peer
6 = More than one person

Do not include abuse by a family member, which is code under Physical Abuse.

Threatened with weapon

0 = Absent
2 = A weapon was used to threaten but not to hurt the child
3 = A weapon was used to injure the child

PHYSICAL ABUSE

The child has been the victim of intentional physical abuse or injury by a family member. Include any form of physical violence against the child sufficiently severe to leave marks, bruises, or cuts, or require medical treatment. Include burns if deliberately inflicted. Include violence that meets criteria for abuse even if it was intended to punish the child for alleged misdeeds.

Do not include socially sanctioned physical punishment, unless it left marks, bruises, or cuts, or require medical treatment or was applied with markedly unusual severity.

"Family members" include parental figures, grandparents, other adult family members, and siblings, if the sibling was in a position of power over the child.

Do not include fights between siblings.

Person Using Force

1 = Parent #1
2 = Parent #2
3 = Other parent #1
4 = Other parent #2
5 = Grandparent (including step grandparent)
6 = Other adult family member
7 = Sibling in the home
8 = Sibling not in the home
9 = Other

Code any instrument used to threaten or inflict harm. A belt, hairbrush, or cigarette may be a weapon if used intentionally to hurt the child.

If Abuse is present, complete the **Seeking Help** section. Otherwise, skip to Sexual Abuse section.

IF THE ABUSE MEETS THE CRITERIA SET OUT IN THE GUIDELINES FROM DSS, REPORT TO YOUR TEAM LEADER IMMEDIATELY AFTER THE INTERVIEW, COMPLETE A REPORT FILED FORM FOR THE CHILD'S FILE, AND ENSURE THAT THE NECESSARY REPORTS ARE FILED WITH THE APPROPRIATE AGENCIES.

SEEKING HELP (Physical Abuse)

Three forms of supportive response to requests for help are coded: listening, which could provide social support and emotional relief; personal intervention, i.e., the individual personally attempts to prevent a recurrence of the situation; and intervention involving a professional agency, which could include phoning the police, contacting a service agency, referring a child to such services, or having a child removed from home.

Unsupportive responses include unwillingness to listen, reluctance to get involved, denying the truth of the story, or threatening the child with harm if anyone else is told.

A child might tell a peer (including a sibling up to 5 years older); a family member (including a sibling more than 5 years older), or another adult. A child may tell more than one person. If s/he tells people from different categories, code the response of each. If s/he tells multiple people from the same category, code the highest level of response from anyone in that category.

EVER: REMOVED FROM HOME DUE TO PHYSICAL ABUSE

Code whether the child has ever been removed from his/her home because of physical abuse. Child could be removed by a social service agency, the police, or concerned relative. For a 2, record the duration of the longest removal from home. For a 3, code the onset date when the parental rights were terminated.

0 = Absent

2 = Child removed temporarily from home

3 = Child removed permanently from home. Parental rights terminated.

CAPTIVITY

Being held against one's will, usually by someone older, e.g., being kidnapped by a parent in a custody battle, or held hostage in a robbery.

Do not include grounding, time out, or being required to stay with a non-desired person or in a non-desired setting for legitimate reasons; e.g., day care, summer camp, or hospital.

2 = Being held captive against one's will for at least one day, in circumstances that are frightening but not necessarily life-threatening (e.g., being kidnapped by a parent).

3 = Being held captive for at least one hour in circumstances that entail the possibility of death, severe injury, or sexual or physical assault, or never seeing one's family again (e.g. being kidnapped for a ransom).

SEXUAL ABUSE OR RAPE

A sexual abuse episode in which a person (perpetrator) involves a child or adolescent in activities for the purpose of the perpetrators own sexual gratification. These activities can include kissing, of a kind that makes the child uncomfortable, genital fondling (over or under the child's clothing), oral-genital or oral-anal contact, genital or anal intercourse, or the use of instruments.

Sexual abuse does not include medical exams or “playing doctor” with a same aged peer.

Rape is a sudden, unexpected, usually isolated event involving sexual intercourse.

If more than one episode, or more than one perpetrator is reported, code the first and the most recent.

Take detailed notes, including both the questions asked and the child's responses verbatim.

The section on Sexual Abuse has a preliminary screen section. If there is evidence of sexual abuse, complete the remaining sections on Coercion, Seeking Help, Attribution, and Painful Recall. If there is no evidence of sexual abuse, skip to Other Event.

Coercion (Sexual Abuse)

The use of threat or violence to constrain the child to become involved in activities for the purpose of the perpetrators sexual gratification. If more than one incident of sexual abuse, or more than one perpetrator is reported, code for the most coercive.

2 = Little threat of injury or death, but use of criticism, rewards, or threat of loss of privileges to constrain the child.

3 = Threats of death or injury to the child or another person, but no actual use of force.

4 = The use of force involving the threat of death or injury to child or another person.

Seeking Help (Sexual Abuse)

Three forms of supportive response to requests for help are coded: listening, which could provide social support and emotional relief; personal intervention, i.e., the individual personally attempts to prevent a recurrence of the situation; and intervention involving a professional agency, which could include phoning the police, contacting a service agency, referring a child to such services, or having a child removed from home.

Unsupportive responses include unwillingness to listen, reluctance to get involved, denying the truth of the story, or threatening the child with harm if anyone else is told.

A child might tell a peer (including a sibling up to 5 years older); a family member (including a sibling more than 5 years older), or another adult. A child may tell more than one person. If s/he tells people from different categories, code the response of each. If s/he tells multiple people from the same category, code the highest level of response of anyone in that category.

A child might tell more than one person, getting a supportive response from one and an unsupportive response from another.

IF THE ABUSE MEETS THE CRITERIA SET OUT IN THE GUIDELINES FROM DSS, REPORT TO YOUR TEAM LEADER IMMEDIATELY AFTER THE INTERVIEW, COMPLETE A REPORT FILED FORM FOR THE CHILD'S FILE, AND ENSURE THAT THE NECESSARY REPORTS ARE FILED WITH THE APPROPRIATE AGENCIES.

OTHER EVENT

Any other distressful life event which made the child feel terrible, upset, frightened, or "shook up."

POST TRAUMATIC STRESS

Purposes of the Section
The section has 2 major functions:

(1) To provide information about the effects of particularly stressful events in the life and environment of the child that may have associated PTSD symptoms.

(2) To determine if events that may have caused symptoms recorded elsewhere in the CAPA, are actually related to PTSD.

Organization of the Section

The section has several subsections:

1) Acute Responses to the Traumatic Event
2) Re-experiencing
3) Hyperarousal
4) Regression
5) New or Worsening Fears
5) Other Behaviors

As you complete the Life Events section, check off the events on the Life Events Checklist.

Events in Group A will only have been coded if they occurred during the primary period. Events in Group B are coded whether they occurred in the primary period or earlier.

If there is more than one checkmark in the Group A column, have the parent choose the event that was most upsetting to the child, then complete the PTSD symptom section for that event.

If there is more than one checkmark in the Group B column, have the parent rank the three events most upsetting to the child, then complete the PTSD symptom section for these events (i.e. 1B through 3B).

Complete the PTSD section first for the Group B events and then for the Group A event. The maximum times the PTSD section may have to be administered is four.

Remember that except for the section ACUTE RESPONSES TO TRAUMATIC EVENT, the items in the PTSD section refer to symptoms and/or behaviors that have occurred in the last three months and that are linked to the traumatic event.

Symptoms and/or behaviors that have already been coded in the earlier sections of the PAPA might also show up here. It is appropriate to code in both places if indicated. For example, if the child is having nightmares since the life event, code here and in the sleep section.

ACUTE RESPONSES TO TRAUMATIC EVENT

Emotional and behavioral responses at the time of the event.

ACUTE EMOTIONAL RESPONSES

Emotional responses to the event when it occurred. This is a subjective report, so although several categories are similar to those in the CAPA, the child does not need to meet CAPA criteria to code for these responses.

All items are coded:
0 = Absent
2 = Present

Surprise Feeling that the event was not expected or predictable.

Fear Being fearful, frightened, or apprehensive.

Helplessness Recognition of powerlessness to change the outcome of the event.

Worry Painful, unpleasant or uncomfortable thoughts about safety or death.

Sad Feeling sad, blue, miserable, or unhappy at the time of the event.

Anger Feeling angry, resentful, annoyed, or enraged.

Emotional Numbness Not feeling anything at all, or feeling substantially blunted feelings. The child may talk about being in shock.

Other: Other feelings might include feeling:

Confused Loss of mental clarity or ability to think clearly during the event.
Detached Feeling unreal in the context of event
Guilty A feeling that the child should or could have prevented and changed the outcome of the event, regardless of his/her actual ability to do so.
Betrayed A sense that interpersonal trust had been violated in some aspect of the event.
Embarrassed A feeling of being self-consciously distressed in the context of the event.

ACUTE BEHAVIORAL REACTIONS

Behavioral responses to the life event when it occurred. Behavioral responses include: **Crying; Screaming; Physically agitated; Aggressive toward people; Aggressive toward things; Confused; Quiet; Sick; or Other behavioral reactions.**

The duration of the acute behavioral reaction is noted for each behavior.

RE-EXPERIENCING

EXTERNALLY CUED PAINFUL RECALL OF LIFE EVENT

Unwanted, painful and distressing recollections, memories, thoughts, or images of life event occurring in response to external cues or stimuli, such as particular sights, sounds, smells or situations.

2 = Painful recall is intrusive into at least two activities and uncontrollable at least some of the time

3 = Painful recall is intrusive into most activities and nearly always uncontrollable

Avoidance

2 = Avoids situations that might provoke painful recall at least sometimes, but not to a degree that prevents a normal life-style

3 = Avoidance leads to disruption of normal life and activities and results in a highly restricted life-style

Suppression

0 = Absent

2 = Uses thoughts, rituals, or other behaviors in attempt to reduce painful recall

Painful Recall Noticeable to Others

0 = No

2 = Child reports others notice changes in behavior during bouts of Painful Recall (e.g. anxiety, daydreaming, etc.)

Autonomic Effects

Physical symptoms such as a racing heart, shortness of breath, shakiness, nausea, vomiting, or others occur when child recalls the event

2 = Autonomic changes occurring during bouts of Painful Recall not amounting to panic attacks

3 = Panic Attacks during bouts of Painful Recall

POST-TRAUMATIC PLAY

A change in the content and/or quality of play and/or the affect associated with play that began after the occurrence of the "life event."

PLAY RECAPITULATING LIFE EVENT

Play involving activities that recapitulate all or some aspects of life event (e.g. preoccupation with crashing toy cars after being in a car accident).

If there is play imitating the life event, then assess 2 aspects of the play:

1) Does the Game/Story recapitulating the life event change over time?

0 = Yes and play continues to evolve. An example of this is: A child is bitten by a dog. After that event the child begins to play dog and baby. At first, the theme of the play is the baby being frightened when s/he is bitten by the bad dog. Then, over the time, the baby gets mad at the dog and punishes the dog. And eventually, the link with the dog bite is still apparent but the child has modified the story by changing the ending or the beginning or the feelings associated with the event.

2 = Yes but core part of the play imitating the life event remains the same. An example of this is: A child is bitten by a dog. After that event the child begins to play dog and baby. In the interaction between the dog and the baby, the dog always hurts the baby. The name of the dog, the type of stuffed animal used to represent the dog or the baby, the ancillary cast of characters might change but the central theme of the story does not change.

3 = No. The play remains nearly the same each time. An example of this is: A child is bitten by a dog. After that event the child begins to play dog and baby. The play does not change and seems almost like a record needle skipping back and back on a scratched record. The play has an almost robot-like sameness.

2) What are the **dominant** feelings that the child shows when s/he plays in this way?

Code two most prominent feelings.

1 = Enjoyment/pleasure

2 = Excitement

3 = Fear

4 = Anxiety

5 = Anger

6 = Sadness

7 = No affect

8 = Other

CHANGES IN OTHER PLAY

Changes in play other than the play imitating the life event. Changes must have been noted since the life event and may include repetitive play, play without feelings, and more aggressive play. Play here is all play other than play recapitulating the life event.

REPETITIVE PLAY NOT ABOUT "LIFE EVENT"

Since the life event, the child's play has a rote feeling, as though the child is "going through the motions." The child's play does not seem as imaginative, creative, or generative.

AFFECT ASSOCIATED WITH PLAY DECREASED SINCE THE LIFE EVENT

Since the life event, the child shows little feeling or emotion when s/he plays.

MORE PHYSICALLY AGGRESSIVE PLAY

Since the life event, the child's play is more physically aggressive either toward people or objects. Examples would include more shoving, hitting, kicking or breaking toys etc.

MORE AGGRESSIVE/VIOLENT THEMES IN PLAY THAN PRIOR TO THE LIFE EVENT

Since the life event, the child's play has more aggressive themes. For example, the introduction of killing, maiming, and violent disaster.

RE-TELLING OF THE LIFE EVENT

Child tells and re-tells all or some part of the story of the "life events. Child does not need to be distressed while telling the story. Descriptions/narrative may differ over time from the actual event but narrative thread to "life event" must be apparent.

Distinguish between re-telling of the story of the life event and play that imitates the life event.

Assess the affect when telling the story by coding the two most prominent emotions. Code whether the content of the story has changed since the child began telling it. Code if the child gets distressed if s/he is interrupted or told to stop telling the story. And finally code to whom the child tells the story.

FAILURES OF RECALL

Inability to recall important aspects of the life event, such as the names and faces of participants, or parts of the chronology of the event.

Do not include deliberate attempts not to recall the event.

1 = Some difficulty recalling certain aspects of the event that can usually be overcome by a concentrated attempt to remember

2 = At least some aspects of the event cannot be recalled, even with effort

3 = Most or all details of the event cannot be recalled

Many traumatized children exhibit temporal and/or spatial distortions within otherwise well preserved memories of the trauma; some exhibit amnesia (lack of recall) for parts of the event. Dense amnesia is uncommon except in childhood sexual abuse. Distortions include such things as thinking that the trauma took longer than it actually did or placing oneself farther away from the trauma than was actually the case. Thus code distortions as 1, microamnesia as 2, and dense amnesia as 3.

RELIVING OF LIFE EVENT

Behaving or feeling as though the life event were recurring. The experience may involve a sense of reliving the event, illusory or hallucinatory phenomena, or flashbacks. Flashbacks involve hallucinatory phenomena of sufficient intensity to impair perception of the real world to a substantial degree.

Do not include Nightmares or Night Terrors

2 = Able to report sensory phenomena associated with the life event, but still aware of real surroundings to at least some extent

3 = No, or almost no, awareness of real surroundings (flashback)

Hypnogogic (on falling asleep)

0 = Absent

2 = Present

Hypnopompic (on waking)

0 = Absent

2 = Present

Nocturnal

0 = Absent

2 = Present

Daylight (when up and about)

0 = Absent

2 = Present

NIGHTMARES

Frightening dreams that waken child, with content related to the life event (either about life event or reminding the child of it). Unpleasant affect is apparent on wakening, which may be followed rapidly by feelings of relief.

0 = Absent

2 = Present. Onset of nightmare was prior to the life event but now the content of nightmares is related to the life event

3 = Present. Onset of nightmares after the life event

Autonomic Effects

Child has noticeable autonomic changes like a racing heart, sweating, shortness of breath and/or child complains of nausea or dizziness in response to nightmares

Reassurance

0 = Absent

2 = Upon waking from nightmare, child seeks time limited reassurance or contact, lasting less than 15 minutes

3 = Upon waking, child seeks extended reassurance or contact (e.g. won't go back to bed, conflict arises over need for excessive reassurance)

Anticipatory Reassurance

0 = Absent

2 = At bedtime, seeks time limited reassurance or contact (e.g. extended bedtime ritual lasting less than 15 minutes)

3 = Seeks extended reassurance or contact (e.g. will not go to bed or conflict arises over need for excessive reassurance)

NIGHT TERRORS

Episodes during sleep when the child is not fully conscious and does not wake up, but seems terrified and will usually cry out. The child has no memory of the event. Night terrors began or increased in frequency since the "life event."

0 = Absent

2 = Present; Onset prior to "life event" but worsening of symptom since the "life event"

3 = Present; Onset after "life event"

HYPERAROUSAL

SLEEP

Changes in child's ability to go to sleep and remain asleep since the life event.

DIFFICULTY INITIATING SLEEP

Since the "life event" child has had difficulty going to sleep or settling down to sleep at bed time and/or nap time.

NIGHT WAKING

Since the "life event" child has had difficulty staying asleep during the night; Child wakes up during the night for reasons other than nightmares or night terrors.

If child wakes up because of nightmare, code Nightmare rather than Night Waking.
If the parent wakes child after a night terror, code Night Terror rather than Night Waking.

DECREASED CONCENTRATION/ ATTENTION SPAN

Difficulty maintaining sufficient involvement to allow completion of tasks requiring concentration or attention.

2 = Decreased concentration occurs in at least 2 activities

3 = Decreased concentration occurs in most activities

Phasic Exacerbation

The child's decreased concentration and attention seems to occur or worsen in response to cues that trigger recall or re-living of the life event.

IRRITABILITY

Increased ease of precipitation of externally directed feelings of anger, bad temper, short temper, resentment, or annoyance.

2 = Irritability occurs in at least 2 activities

3 = Irritability occurs in most activities

Phasic Exacerbation

The child's irritability seems to occur or worsen in response to cues that trigger recall or re-living of the life event.

INCREASED PHYSICAL AGGRESSION

Child is more physically combative and/or assaultive since the “life event.”

2 = Aggression occurs in at least 2 activities

3 = Aggression occurs in most activities

Assess how often the aggression is **PROVOKED:** Seems to be stimulated by an event or interaction.
Assess how often the aggression **UNPROVOKED:** Seems to “come out of the blue.”

Phasic exacerbation

The child’s aggression occurs or increases in response to cues prompting recall or reliving of the life event.

Aggression targeted towards:

Parent #1
Parent #2
Other Parent #1
Other Parent #2
Other adult family members
Unrelated but familiar adults
Siblings
Peers
Strangers
Animals
Objects (toys, pillows, walls, etc.)

Code how frequently the child’s aggression is targeted towards each of these people or towards animals and/or objects.

Settings

Code how frequently the child’s aggression occurs in each of the these settings: HOME, DAYCARE/SCHOOL, ELSEWHERE.

HYPERVIGILANCE

Increased general level of awareness and alertness toward the child's surroundings, in the absence of imminent danger. Hypervigilance may be manifested by an exaggerated startle response, jumpiness, scanning the environment for danger, or taking special precautions to avoid danger (for example, taking care always to sit with his/her back against the wall).

0 = Absent or hypervigilance not manifested in any overt behavioral change

2 = Behavioral manifestations of hypervigilance, such as scanning the environment for danger, that do not limit normal activities to any substantial degree.

3 = Behavioral manifestations of hypervigilance that preclude performance of many normal activities.

Phasic exacerbation

The child’s hypervigilance occurs or increases in response to cues prompting recall or reliving of the life event

EXAGGERATED STARTLE RESPONSE

Increase in susceptibility to being startled by minor unexpected stimuli since life event.

2 = Present, but not noticeable to others

3 = Present, noticeable to others

INTERVIEWER SHOULD DEMONSTRATE STARTLE RESPONSE

Phasic exacerbation

The child’s startle response occurs or increases in response to cues prompting recall or reliving of the life event.

NUMBING

SOCIAL WITHDRAWAL

Retreat from participation in social interactions include play with other children.

2 = Social withdrawal occurs in at least 2 activities

3 = Social withdrawal occurs in most activities

Reassurance

Reassurance can include encouragement or coaxing. The parent, or someone else, might stay near by the child to provide reassurance.

0 = With reassurance, child interacts with others

2 = Despite reassurance, child remains withdrawn and resistant to interacting with other

Phasic exacerbation

The child's social withdrawal occurs or increases in response to cues prompting recall or reliving of the life event.

LOSS OF AFFECT

Loss of a previously existing ability to feel or experience emotion since the life event.

Loss of positive affect and loss of negative affect are coded separately

Loss of Positive Affect

2 = Loss of affect in at least 2 activities and uncontrollable at least some of the time

3 = Affect is felt to be lost in almost all activities

Loss of Negative Affect

2 = Loss of affect in at least 2 activities and uncontrollable at least some of the time

3 = Affect is felt to be lost in almost all activities

LOSS OF EMOTIONAL EXPRESSION

Since the life event, the child is unable or unwilling to express emotions to the degree existing before the life event.

Do not include inexpressiveness that predated the life-event unless there has clearly been an exacerbation following the life event. Positive and negative emotional expression are coded separately.

Loss of Positive Emotional Expression

2 = Less able or willing to talk about emotions, or to discuss topics with positive emotional content or which stimulate positive emotions

3 = Almost always unable or unwilling to talk about emotions or to discuss topics with positive emotional content or which stimulate positive emotions

Loss of Negative Emotional Expression

2 = Less able or willing to talk about emotions, or to discuss topics with negative emotional content or which stimulate negative emotions

3 = Almost always unable or unwilling to talk about emotions or to discuss topics with emotional content or which stimulate negative emotions

LOSS OF PREVIOUSLY ACQUIRED SKILLS

Child moved backward in skills, such as the use of the toilet rather than diapers, speaking in sentences, or walking, that had previously been mastered

Code as present only if child had the skill and then, after the “life event,” the child no longer has the same level of skill.

REGRESSION IN TOILETING

Since the life event , the child has lost the previously achieved ability to use the toilet, wear underpants rather than diapers, be continent of urine or feces during the day and/or during the night.

REGRESSION IN LANGUAGE

Decrease in the complexity or amount of language that child had been using prior to the life event.

REGRESSION IN MOTOR SKILLS

Loss of previously achieved gross motor skills such as sitting, crawling, walking, or running or fine motor skills such as drawing, cutting, or manipulating small objects.

OTHER AREAS OF REGRESSION

NEW ONSET OF FEARS OR INTENSIFICATION OF ALREADY PRESENT FEARS

Child has developed new fears or has experienced a distinct intensification of already present fears. Specific fears are assessed: the fear of going to the bathroom by him/herself, fear of the dark, fear of being apart from his/her significant caretaker, or other fears.

For each type of fear, code whether it is:

0 = Absent

2 = New since the "life event"

3 = Present prior to the "life event" but intensified since the "life event"

FEAR OF GOING TO THE BATHROOM ALONE

Anxiety and/or terror of going to the toilet without another person present or thinking of going to the toilet without another person present.

FEAR OF THE DARK

Anxiety and/or terror of being in the dark or thinking about being in the dark.

SEPARATION FEARS

Anxiety and/or terror associated with the thought of or actual separation from a significant attachment figure.

OTHER

OTHER BEHAVIORS

DANGEROUS ACTIVITIES

Increased activities that physically endanger the child or others since the life event.

0 = Absent

2 = Present

OMEN FORMATION

Following the life event, child has developed superstitious beliefs or practices to mitigate or prevent recurrences of the event or other possible or imagined life events.

1 = Superstitious beliefs not resulting in any overt behavior

2 = Superstitious beliefs that have resulted in overt behavior (e.g. carrying charms or rabbits' feet)

3 = Activities meeting criteria for obsessional rituals or compulsive behaviors

SURVIVOR GUILT

A subjective belief or feeling of responsibility for the life event or its prevention, or a feeling that the child should have substituted (or been substituted) for another who was more severely affected.

0 = Absent

2 = Present

REVENGE FANTASIES

Child imagines something that punishes the cause of the trauma. Punishment may be imagined as coming from the child or someone or something else.

0 = Absent

2 = Present

REPEAT PSTD SECTION

WITH B EVENTS

INCAPACITY RATINGS

Purposes

The incapacity rating has 2 functions:

(1) To determine the overall affect of behaviors and feelings on broad areas of functioning in specific settings and in specific relationships.

(2) To determine the level of that impairment.

(9) To determine if the child has received treatment for these behaviors

Organization

The incapacity rating is placed at the end of each of sections assessing psychopathology. It is not a free-standing section.

IMPAIRMENT/INCAPACITY

Two levels of disturbance or impaired functioning are distinguished:

0 = Absent

2 = Partial Incapacity; refers to a notable reduction of function in a particular area. If a person is still able to do things, but does them less well, or more slowly, then code as a Partial Incapacity.

3 = Severe Incapacity; refers to a complete, or almost complete, inability to function in a particular area.

With the exception of the lifelong symptoms mentioned below, most incapacities require a decrement or change in functioning. The decrement can predate the primary period but must still be present during the primary period.

SYMPTOM DEPENDENCE

For incapacity to be rated it must arise demonstrably from the presence of some particular symptoms or disordered behaviors. For instance, a child who has lost friends because her mother would not allow her to associate with them, would not have that loss of friends rated as an incapacity here. Although, of course, it might have had crippling effects on her social life, it would not count as an incapacity because it was not secondary to any psychopathology of the child. However, it would count if the child was too frightened to leave the house and lost her friends because of it.

The specific area of psychopathology responsible for the secondary incapacity should be noted. It is not enough to record that a child was incapacitated in certain ways and that the child had certain psychopathological problems. The incapacity must be linked to the problems that seem to have generated it. Often this is difficult when children have multiple problems and incapacities, but the attempt should be made nevertheless. However, this does not mean that a particular incapacity has to be assigned to one single problem. It will sometimes be the case that several symptoms of different types will contribute to a particular incapacity. When this is the case, each contributing problem area should be recorded.

It follows that if an incapacity is to be seen as being secondary to other symptoms, then those other symptoms must have been present before the onset of that incapacity. They must also have resulted in a fall-off from a previous level of attainment or proficiency if they are to be regarded as having resulted in an incapacity. Thus a child who had previously been able to function well enough in class might show a reduced ability to participate in group activities, because he felt too miserable to do so. This would be regarded as an incapacity secondary to the affective symptoms. On the other if a child had always been unable to participate in group activities and later became depressed, an

incapacity, secondary to depression, would be recorded only if his capacity to participate in group activities suffered a further decrement from its already low level. If there had been no further decrement, an incapacity in relation to depression would not be recorded.

LIFELONG SYMPTOMS/BEHAVIORS

In the case of symptoms that have been present throughout life, it will be impossible to show a decrement secondary to the symptoms, because both the symptoms and the putative incapacity will have been present simultaneously. In this situation, provided always that the incapacity can be directly related to the symptoms, it is acceptable to rate it as such. An example might be the social incapacities of a hyperactive child who had always shown such behavior from his earliest years and thus always had disturbed peer relationships.

SITUATION NOT ENTERED

If the subject has not entered a particular social situation (e.g. daycare/school) during the preceding three months, but there is clear evidence from past experience that incapacity would have been manifested had s/he been in the situation (e.g. discordant peer relationships would have been present) then that incapacity is rated as being present, and its date of onset should be determined. The intensity rating should not be higher than the previously actually occurring highest intensity. Quite often in such a situation, the incapacity will have been contributory to the failure to enter the social situation under consideration.

The incapacitating effects of the psychopathology do not have to be directly due to the behavior of the child but may be mediated by others. For instance, if a boy were excluded from school for constant fighting and trouble making, that would be counted as an incapacitation of school performance just as much as if the child had failed to attend because of his own anxiety about leaving home.

ONSETS

The rules for dating the onset of incapacities are essentially the same as those for dating symptom onsets. That is, the decision is first made as to whether or not a particular incapacity was present during the 3 month primary period. If it was, then its onset is coded as the date it appeared at the minimum criterion level required by the glossary definition. Once again, there is a proviso that if the incapacity has been present only intermittently, the onset is dated from when the incapacity began again following the last period of one year (or longer) without incapacity. The dates of exacerbations from partial to complete incapacity are also recorded.

Even if a child did not code for any problems in the a particular section of the PAPA, the Incapacity section can not be skipped. If you have enough information, not every question needs to be asked.

TREATMENT

Referrals to professional agencies or professional concerned with child's symptoms or behavior.
Note the name of the site where treatment was received and the professionals seen.
Treatment may be coded even if symptoms did not code in the PAPA.

GLOSSARY

THE CHILD AND ADOLESCENT IMPACT ASSESSMENT (CAIA)

Purpose of the Instrument

The instrument has 2 major functions.

(1) To assess the impact/burdens placed on the family by having a child with mental health or substance abuse problems.

(2) To give the parent a chance to focus him/herself and his/her partner and their own needs in the context of looking at the child's needs.

Organization of the Instrument

The CAIA is one section, with separate questions concerning:

a) Economic Impact
b) Impact on Family Relationships
c) Impact on Other Relationships
d) Restrictions on Activities
e) Responsibility for Problems
f) Impact on Feelings of Personal Well-Being

The CAIA was designed to be administered after completion of a diagnostic interview, most comonly the Child and Adolescent Psychiatric Assessment(CAPA), or the Preschool Age Psychiatric Assessment(PAPA).. If no problems are reported throughout those assessments, the Impact Assessment can be skipped. Operationalization of "no problems" should be determined at the beginning of all studies so that principal investigators may decide under what circumstances the CAIA should be administered. These guidelines are intended to eliminate the CAIA in those cases in which it would be completely absurd to administer it (i.e., to the parent of a completely “well” child).

When administering the CAIA, ***starred probes** are questions that must be asked of all subjects unless the information has already been provided by that subject. Unstarred probes are suggested additional questions that provide guidance for the clarification of details. These questions, or similar questions that the interviewer feels necessary, will be asked, as appropriate, in order to collect the details necessary for the ratings.

Tick marks should be placed next to the questions asked, with “no” answers designated by a dash, and “yes” answers designated by a checkmark. Detailed notes may be taken on other verbal responses.

Coding rules are written on the page for each item. Other possible codings are: S for “skip” or “non-applicable; X for refusal to answer or interviewer error, and D for “don’t know”.

ECONOMIC IMPACT

EXPENSES

The monetary expenses associated with getting services for the child's emotional or behavioral problems. Include costs of medication.

0 = No expenses
1 = Expenses but affordable
2 = Expenses causing effects on other areas of the family budget

Do not include income lost because of the child's problems, which is coded under Loss of Income.

Impact on Expenses

1 = Using savings
2 = Necessitate cutting back on other expenditures
3 = Necessitate working additional hours/job

Debts

2 = Incurred debts but envision no serious problems with pay back
3 = Incurred debts and envision will have problems with pay back

LOSS OF INCOME

Loss of income that results from the need to get professional services for the child's emotional or behavioral problems or from the need to provide an increased level of care at home, or from the other things directly associated with the child's problem.

0 = No income lost
2 = Time lost at work, or hours reduced
3 = Unable to work or lost job

Do not include actual expenditures incurred from the child's problems, which are coded under Expenses.

Loss of Income of Parent(s), child, and other family members is coded separately.

IMPACT ON FAMILY AND OTHER RELATIONSHIPS

IMPACT ON PARENT'S CURRENT RELATIONSHIP

The impact of the child's emotional or behavioral problems on the parent's "marital relationship."

Both the negative and positive impact is coded.

IMPACT ON PARENT'S PREVIOUS PARTNERSHIP

The impact of the child's emotional or behavioral problems on the parent's relationship with the child's "Other Parent" who no longer lives in the home.

"Other Parent" may be either a biological parent who lives elsewhere or another person who lives elsewhere that has played a significant part in raising the child.

The impact on both the breakdown of the previous relationship and current relationship with the previous partner is coded.

IMPACT ON PARENT'S RELATIONSHIPS WITH OTHER CHILD(REN)

The impact of the child's emotional or behavioral problems on the parent's relationship with other child(ren) in the family.

If there are no other children in the house, skip to Impact On Other Relationships.

IMPACT ON OTHER CHILDREN

The impact of the child's emotional or behavioral problems on the relationships between the children in the home. Include the impact of the subject's problems on the behavior of the other children in the home.

Include both the relationships with the index child and between other children in the home.

IMPACT ON RELATIONSHIPS WITH OTHER FAMILY MEMBERS

The impact of the child's emotional or behavioral problems on the parent's relationship with other family members.

Include relationships with the parent's parents, siblings, or other close relatives.

IMPACT ON RELATIONSHIPS WITH FRIENDS

The impact of the child's emotional or behavioral problems on the parent's relationships with his/her friends.

RESTRICTIONS ON ACTIVITIES

RESTRICTIONS ON PARENT'S PERSONAL ACTIVITIES

Restrictions on the parent's personal life and activities that have resulted from the child's problems.

Do not include changes in employment, which is coded under Expenses and Loss of Income, or changes in family social activities which is coded under Restrictions on Family's Social Activities.

RESTRICTIONS ON FAMILY'S SOCIAL ACTIVITIES

Restrictions on the family's social life that results from the child's problems.

STIGMA

The child's problems have resulted in the parent's feeling that other disapprove or blame him/her and/or his/her partner.

RESPONSIBILITY FOR PROBLEMS

ATTRIBUTION OF CAUSE OF PROBLEMS

Parent's view of what has caused the child's problems, including attribution to various causes or individuals.

Key codings are the answers to the emphasized questions. Other questions can be asked to give the parent the idea, but all do not need to be asked.

Include self-blame by a parent who feels responsible for having caused the child's problems, or for the child's lack of progress in dealing with the problems.

1 = Vague or indefinite attribution
2 = Partially responsible for child's problems
3 = Completely or almost completely responsible for child's problems

IMPACT OF FEELINGS OF PERSONAL WELL-BEING

PSYCHOLOGICAL ADJUSTMENT

Parent's psychological adjustment to the child's problems.

This item separately codes the parent's Depression, Worries, Tiredness, and/or other mental and physical health problems related to or influenced by the child's behavioral or emotional problems.

OTHER FAMILY INFORMATION

PARENTAL EDUCATION

Code the highest level of education completed by each parent.

1 = 0 - 8 years completed
2 = Some high school
3 = GED or high school equivalency
4 = high school degree
5 = post high school training (vocational, technical, job training)
6 = some college (0-2 years)
7 = 2 year associate degree
8 = some college (more than 2 years)
9 = 4 year college degree (Bachelor's degree)
10 = some graduate or professional school training
11 = completed graduate or professional degree

PARENTAL EMPLOYMENT AND OCCUPATION

CURRENT EMPLOYMENT STATUS

Code each parent's current employment status. If more than one answer applies, code the one that brings the most income.

1 = Employed full-time
2 = Employed full-time or part-time
3 = Employed part-time (1 or more jobs)
4 = Not employed outside of the home
5 = Student
6 = Retired
7 = Disabled
8 = Unemployed

If a parent is a student, retired, disabled, or unemployed, question him/her about the most recent period of past employment for Type of Employment, Occupation, and Industry.

TYPE OF EMPLOYMENT (CURRENT OR MOST RECENT)

The parent's type of employment. If a parent is a student, retired, disabled, or unemployed question him/her about the most recent period of past employment.

1 = Employee of private business
2 = Government employee
3 = Self-employed
4 = Working without pay

OCCUPATION (CURRENT OR MOST RECENT)

Occupation refers to the parent's specific kind of work (e.g. teacher, dental hygienist, manager, etc.). Enter the 3 digit code from the Census Index of Industries and Occupations.

INDUSTRY (CURRENT OR MOST RECENT)

Industry refers to the parent's kind of business (e.g. university, dentist's office, chemical plant, etc.). Enter the 3 digit code from the Census Index of Industries and Occupations.

DATE LAST EMPLOYED

Code the date that the parent was last employed, if s/he is not employed at the time of the interview.

FAMILY FINANCIAL INFORMATION

Information about payment for health care, insurance coverage, and general finances, is sought at the end of the interview.

COVERAGE

The parent's perception of how well the family income covers their financial needs.

0 = Very well
1 = Fairly well
2 = Poorly
X = Do not know

INCOME SOURCES

Include all sources of family financial income in order of magnitude (as far as possible).

FAMILY INCOME

The total annual family income before taxes, including all salaries, wages, investments, social security, pensions, unemployment, disability, alimony, child support, and welfare.

RESPONSIBILITY FOR HEALTH CARE PAYMENT

The person responsible for arranging for payment of health care services.

0 = Parent
1 = Other
2 = Child

PRIVATE HEALTH INSURANCE
The child's coverage by private health insurance.

0 = Private Plan (e.g. BC/BS, Aetna)
This selection implies that the subject/parent has free choice of provider
1 = Health Plan (Health maintenance Plan [HMO], Preferred Professional Organization [PP0])
Usually dictates where you go for care, at least as far as facility if not specific physician
2 = Private Insurance but do not know the name
3 = Not covered by private health insurance
5 = Insurance but do not know what kind

MEDICARE
The child's coverage by Medicare.

0 = Part A and Part B
1 = Part A only
2 = Part B only
3 = Medicare but do not know which part
4 = Not covered by Medicare
5 = Insurance but do not know what kind

MEDICAID OR OTHER PUBLIC PROGRAM
The child's coverage by Medicaid or Other public program.

0 = Covered by Medicaid
1 = Covered by other public program
2 = Covered by public program but do not know the name
4 = Not covered by Medicaid
5 = Insurance but do not know what kind

INSURANCE BY COVERAGE
For the group of items specifying coverage (either private or public), if there is more than one policy or type of coverage, the answers would represent a composite.

0 = Covers all
1 = Covers part
2 = Covers some but do not know if all or part
3 = Does not cover

LIMIT FOR MENTAL HEALTH CARE

0 = No limit
2 = Limit but not reached
3 = Limit has been reached

QUALITY OF INTERVIEW

ADEQUACY OF INTERVIEW

Code your subjective impression as to the quality of the information collected in the interview. The subject may have refused to provide adequate descriptions of symptoms or been deliberately misleading on occasion. Psychotic phenomena may have led to claims and reports that seem patently impossible, or at least highly likely to be misleading.

2 = the interview is inadequate, in relation to the specified area, only in certain parts of the interview. Note the sections where data is probably unreliable

3 = the whole interview is inadequate

The following items are coded:

ADEQUACY OF INTERVIEW

MISLEADING ANSWERS OR LIES

DID NOT ANSWER MANY QUESTIONS VERBALLY

GUARDED INFORMANT

REFUSED TO CONTINUE

IMPAIRED CONSCIOUSNESS

INTOXICATED WITH ALCOHOL OR DRUGS

UNSUITABLE INTERVIEW ENVIRONMENT

IMPOVERISHED HOME ENVIRONMENT

Rating of the negative physical qualities of the home environment, especially in relation to the unpleasant or unsafe qualities that affect the child. Do not rate except in cases where it is clear that the housing is substandard.

2 = somewhat inadequate or inferior home environment evidenced by such things as run down structure (large areas of peeling paint, broken windows or doors), noticeably uncomfortable temperature, or considerable dirt

3 = severely impoverished home environment evidenced by such things as major structural damage (holes in walls or roof), extensive interruptions in heat or running water, broken plumbing, exposed and unsafe electrical wires, unpleasant odors not related to food preparation, or filth or infestation

ADDITIONAL COMMENTS

Include any additional comments about the child, the parent, or the interview in general.