**THE HOSPITAL FOR SICK CHILDREN**

**DEPARTMENT OF PSYCHIATRY**

# PARENT INTERVIEW FOR CHILD SYMPTOMS (PICS-7.1)

**Revised for DSM-III - R (1989), DSM-IV (1995, 2008) and DSM-5 (2017)**



## ADMINISTRATIVE GUIDELINES

*We welcome feedback and comments related to any portion of the PICS, which we will review and incorporate. Please e-mail them to avalon.henry@sickkids.ca.*

### Introduction to the PICS-7.1

The PICS-7.1 is a semi-structured diagnostic instrument developed for the purpose of assessing and diagnosing disruptive behaviour disorders, specifically: Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), Conduct Disorder (CD), and Intermittent Explosive Disorder (IED). It also provides a framework for the screening of several anxiety, mood and neurodevelopmental disorders. Note: the PICS does not cover every single childhood disorder in the DSM-5.

**The PICS-7.1 has 3 modules (described in detail later in the guidelines):**

A. General Information Module (GIM)
B. Disruptive Disorders Module (DDM)
C. General Psychopathology Module (GPM)

Guideline for administration:

The PICS is not a structured interview like the DISC or DICA. It does not ask the informant to provide a rating of every symptom nor does it ask informant to judge how severe a symptom or trait is. Rather, it asks the informant to provide a description of child behaviour in a variety of different situations.

The judgment about the presence and severity of each symptom is made by the interviewer according to a variety of standard clinical criteria and not by the informant. For this reason, the PICS should be administered by a clinician trained in child mental health.

It is important to note that the PICS is not an exhaustive step-by-step guide to diagnosis, rather it is a step-by-step guide to interviewing for mental health problems that commonly present in childhood or adolescence. We encourage the interviewers/clinicians to consult DSM5 for detailed diagnostic criteria, exclusion criteria, and rules about comorbidities.

For many, but not all disorders, the PICS-7.1 presents every criterion for diagnostic consideration. For other disorders, the disorder is presented as a single code. Therefore, it is critical that the interviewer be familiar with diagnostic criteria for every disorder.

Accurate diagnosis usually requires that information from informants other than parents be considered. Therefore, the PICS should be used in conjunction with a standardized instrument which permits systematic gathering of information about a child's behaviour at school. For both instruments, inquiry should be based on descriptions of child behaviour in the specified situations only in order to obtain independent assessments of home and school behaviour. If a teacher interview is not possible, a standardized questionnaire can be helpful although the sensitivity and specificity of most teacher questionnaires is limited.

The PICS interview encourages and facilitates the development of rapport with the informant and a precise understanding of the nature of each child's psychiatric disorder to the informant. It is compatible with the tenets of motivational interviewing precisely because it does not place restrictions of wording or order.

The task of the interviewer is to encourage the informant to describe their child's behaviour in detail that is necessary for the interviewer to determine whether the criteria for a symptom have been met.

Because the PICS is primarily an instrument for clinicians to use in a clinical setting, it is most important that each behaviour be explored in detail; it is less important for each question to be asked in a specific way or in a set order. However, the PICS can also be used in a research setting.

**Rather than coding the exact response of the informant, as is done typically in structured diagnostic interviews, the PICS aims to probe the informant's response in sufficient detail to be able to separate the description of actual child behaviour from informant bias, impression or perceptions.**

The PICS, like most clinical interviews, tends to be pathology oriented. Constant focus on pathology may induce a systematic bias in the informant and interviewer. This bias can be minimized by finding and commenting on the positives about the child and about positive parental approaches to child management when evident.

PICS ratings should be based on child behaviour when unmedicated. Consequently, it is important to establish whether the child has been medicated, with what, with what effects, for how long and whether there have been any periods without medication. Remind the informant that you are asking for descriptions of behaviour when the child is off medication. If a child had a drug-free period that is sufficient for the informant to judge the child's behaviour, you should repeatedly refer to this period (for example, "During the period last summer when John was unmedicated...").

The contrast between medicated and unmedicated behaviour can allow the interviewer to assess positive and negative drug effects and get a clearer picture of the severity of the child's unmedicated behaviour, as well as to note the positive and negative effects of each drug or intervention (General Information Module).

The interview should flow well and spontaneously so that the informant is able to give *open* answers to relatively open questions. For this reason, the interview can be conducted in any order depending on the area of greatest concern to a particular informant. It is permissible to vary the order as well as the wording of each individual question. For example, if an informant is clearly eager to discuss or describe their child's anxiety, conduct or other symptoms, it is reasonable and sensible to go into detail on that topic at an early point in the interview, even during the discussion of presenting problems. One might skip over the family history for the same reason and return to it later in the interview.

It is essential that the interviewer questions the informant to the point that they have obtained clear descriptions of the behaviour to be rated (probe if necessary, but not otherwise).

Interviewers should remember that they are making their own judgments about severity and presence of symptoms, not accepting the informant's subjective opinion. Interviewers must avoid deciding on the presence of a behaviour or symptom based on answers to previous questions. Just because a child is very inattentive, it does not follow that the child is also very impulsive even if that is the impression given by the informant. It is particularly important to pursue an issue that the informant continues to raise, thereby indicating an eagerness to discuss a topic, or the impact that it may have on diagnosis. For example, if the informant continually answers with "It depends on my child's mood," then one might pursue the Mood

Disorders Section in the General Psychopathology Module by saying "It seems that John's behavior is quite dependent on his mood. Let's talk about his mood for a bit so that I can get an impression of it."

If the order has been varied, remember to go back and complete any remaining sections that have been skipped.

**Different sections of the PICS require that behaviours be rated over a specific time period**:

The ADHD and ODD sections of the Disruptive Disorders Module are concerned with the child's behaviour over the preceding 6 months. Clarifying this time frame can be done by establishing a point in time as a reference, for example, "since last Christmas" or "since starting school in September." Unlike KSADS, PICS does not have separate ratings for current and lifetime disorder.

The CD symptoms of the Disruptive Disorders Module refer to the child's behaviour over the preceding 12 months. Clarify whether any of the behaviours endorsed by the informant have occurred within the last 6 or 12 months. A useful probe is "when was the last time you saw that behaviour?"

For some disorders in the General Psychopathology Module, the interviewer probes the child's behaviour over the preceding 6 months as well as any point in the child's past, but ratings are based only on the last 6 months. PICS ratings should indicate current rather than remitted symptoms. However, interviewers are encouraged to note previous disorders that are no longer present.

For those disorders in the General Psychopathology Module which do not follow the 6 month time frame, disorder specific details are included.

**The PICS requires probing:**

**Do not be superficial – always <u>probe</u> for examples of reported behaviours.**

**Responses offered enthusiastically (e.g. "Is he ever aggressive!") still need to be probed.**

When probing for each specific section in the PICS, start by asking the general questions. For example, when exploring outdoor play, one might ask, "What does your child like to do when playing outside?" and "What is s/he like while doing this?"

Then move on to more specific probes such as, "What would I/we see if we were looking out the window while watching him/her play?" or "If we were on the sidelines watching your child play, what would we see?" Follow-up with "When was the last time you saw that?" and then **"**What did you see?" or "Describe the scene to me. Give me a 'video description' of the scene."

Ask the informant to clarify what about the child's behaviour made the informant give a specific or general characterization of behaviour. For instance, if the informant states that the child is "very impulsive," ask what the child does that is impulsive or ask "What makes you say that?" or "When did you last see that?" or "Could you describe that?" This approach will allow the interviewer to build an impression of the criteria that the informant uses to judge severity.

If the informant does not provide a good description of the child's behaviour, begin to narrow your probes. For example say, "Some children are quite attentive and are able to stick to a task for prolonged periods of time or until they are finished. What is your child like?" If an informant is unable to provide a description of child behavior, you may need to probe more specifically, for example, "Would you say that your child is impulsive/inattentive in this situation?" These probes may result in a more detailed description of the child's behaviour or they may result in a closed-ended response such as a yes or no answer. A good follow-up to one of these closed-ended answers might be "What makes you say that?" or "What have you seen?" This strategy will often prompt the informant to provide clear and specific evidence upon which you can base your ratings of the behaviour. Although tedious to implement throughout the interview, this type of probing early on educates the informant about what you are expecting. Make note of the informants' ability to describe child behavior in the case formulation.

It is essential to probe the severity of a symptom. It is insufficient to base a severity rating on the informant's single comment such as, "Oh yes, is he *ever* restless!" or "I do have trouble with her breaking rules" or "He is unable to wait his turn." Ask "How often does the behaviour

occur, what are the consequences, has it been possible to get the child to alter the behaviour?" etc. in order to assess the severity. (See *Definition of Severity* page 8 for more details). Some parents feel that a single temper tantrum in an eight-year-old during a one month period is highly excessive. The interviewer might not agree once a full picture of the tantrums is obtained.

It is important to note that all children, on occasion, behave in a way that could be construed as symptomatic. Adults differ markedly in their tolerance for behavioural excesses and therefore in what they consider to be normal or abnormal. Try to ensure that parents understand that you are interested in marked behaviour problems, not trivial ones. Conversely, parents may trivialize a behaviour that the interviewer rates as more severe. Do not correct the informant with comments such as "I am only interested in serious problems" as those comments could be perceived as judgemental. Rather, consider a comment such as "very few children show this trait all the time and very few never show this trait. How would you place your child? What makes you say that?". Guard against a parent minimizing or maximizing symptom severity based on the comparison with a sibling. For example, you cannot rate a child's behaviour if it is only described as more or less than someone else unless the comparator is a "typical" child.

Distinguish between the frequency of behaviours with siblings versus with others (i.e. parents, adults, peers and other children). Informant descriptions of sibling relationships often occur throughout an interview, requiring ongoing probing and clarification to determine whether the behaviour occurs to the same degree with others c.f., oppositional behavior. This will affect the rating of the severity of the symptom. Generally, symptoms with siblings alone would be given a lower rating than if ones that involve non-family individuals.

Child behaviour typically varies with context. For example, a child may be more symptomatic (e.g. impulsive) when in the company of other symptomatic peers. Rate the actual behavior. If the child is always or for the most part in the context that elicits the symptomatic behaviour, then they will receive a higher severity score. If they are only occasionally in the offending context, the severity score will be lower. Ask the informant about what *usually* happens.

An essential aspect of the PICS is the distinction between oppositional, non-compliant, inattentive and impulsive behaviour. This is a constant theme throughout the interview, and it is critical to separate these, as far as is possible, in order to make a diagnoses of ADHD and ODD. For example, some children do not listen when told what tasks to do or when they are given the rules of a game. The clinician needs to distinguish whether the failure to listen is because the child simply does not want to listen versus the child who does not take in the information. When determining if the child has difficulty following through on instructions,

clarify whether the child takes in and processes the request but refuses to comply, versus the child who hears the instruction then loses it quickly (i.e. in one ear and out the other). Clarifying probes include "Do you have to repeat instructions to be sure the child has paid attention and knows what to do?" or "Do you find yourself only giving one or two short instructions rather than more complex ones so that the child does not lose track of what to do?" or "Does the child not follow through because s/he just doesn't want to do what has been asked or is in a mood?"

Do not ask leading questions, for example: "Based on what you have said before, I can see your child as the type who would blame others." On the other hand, if an informant has given you the information that is necessary to make a rating but has done so during a different part of the interview, there is no need to ask the question again. Try to remember what the informant said. It shows that you are interested and listening. On the other hand, if the available information is insufficient, it is fine to say "Earlier you told me such and such. Could we return to that topic so that I can ask you a few more questions?"

Do not go through the PICS item by item, word by word, unless you have an extremely "poor" informant. The interviewer is asking the informant to describe the child's behaviour in specific situations so that the clinician can rate each item. If you have sufficient detail to rate it, you need not probe further. **Prompt if necessary, but do not necessarily prompt!**

If an informant states that s/he has not seen a particular behaviour but surmises that the child would behave in a certain way, then the symptom cannot be rated and would be scored as a 9. For example, a parent might say, "Well, I have never seen him try to join in a game where other kids are already playing, but I imagine that he would butt right in and take over." Although it is best to rate behaviours where the informant has direct evidence, if the informant has very good evidence from other sources it is permissible to rate based on these reports. These reports can play a role in the ratings if they appear to be consistent. For example, a parent might have clear evidence from a sibling about child behaviour outdoors.

The goals of the interviewer are to formulate each case as well as render a clinical and/or research diagnosis. Therefore, note things such as the parents' degree of expressed warmth, criticism, understanding of reasonable (normative) child behaviour, range and descriptions of parenting practices and the way the informant responds to your line of questioning. Note the parents' manner, mood and thought processes. If appropriate, ask how the informant feels about a particular behavior and how they react to it.

**Definition of severity**

After the interviewer determines that a behaviour is present, the interviewer must determine whether the child's behaviour meets criteria for a symptom. Many children are argumentative or restless at various times, for example, when they are overtired, hungry or unwell. The presence of a behaviour by itself does not necessarily mean that the child's behaviour is symptomatic of a disorder. This determination depends on the severity of a behaviour as defined below except in some situations (e.g. fire setting does not need to be severe). A rating of 3 is typically reserved for a symptom that is very frequent, severe, disabling etc.

**The clinician should inquire about the following factors which determine the severity of a child's symptoms:**

1. Impairment or worry to child (the child must miss pleasurable or important activities or worries about the nature of their behaviour);

2. Impairment or worry to family (the family must miss valued activities such as evenings out);

3. Age appropriateness (a temper tantrum at age 5 may be normal but the same behaviour at age 10 may be extreme);

4. Behaviour precipitated by emotional factors (e.g. temper tantrums may arise when a child is ill, tired or hungry; however, they might also be precipitated by being thwarted over some small desire);

5. Degree to which symptom is increasing or decreasing (symptoms which are becoming more severe or frequent are considered more serious);

6. Frequency with which the symptom occurs (for some symptoms such as restlessness, frequency may determine severity to a great extent, while for others such as criminal behaviour, severity may be determined more by the abnormality of the behaviour);

7. Persistence of symptoms despite efforts to alleviate the distress (some children may be very restless or may become depressed but they can recover very quickly with minimal intervention, whereas other children cannot recover no matter what is done to distract them or to alleviate the behaviour);

8. Spontaneity of occurrence or degree of provocation necessary to elicit behaviour (i.e. depression occurring following some major loss is less serious than the same degree of depression which arises without any provocation whatsoever).

**Note:** There are many instances in which a child may not be totally responsible for his or her behaviour. Should the lack of intent mean that the behaviour is given a lower rating? The answer lies in the circumstances. The only DSM behaviours which explicitly require intent are found in the CD section with items such as *Initiates physical fights*, *deliberately set fires with the intention of causing damage, deliberately destroyed others' property*, and *has forced someone into sexual activity*. Otherwise, there is no requirement that the child acted out of free will. Free will or intention is difficult to establish in children and this is especially true when interviewing a parent about behaviors that may not have been observed directly. Therefore, the interviewer should note but not necessarily base their ratings on comments made about intent. For example, many children will be described as irritable or provocative only under circumstances of marked duress. The interviewer will usually have a difficult time determining whether the duress was marked or whether the child has a lower threshold. It is best to rate the behaviour that is observed or described and note the mitigating circumstances. These circumstances may be important in the clinical formulation and clinical consensus diagnosis but might not influence a diagnosis. Another example is a child who has been involved in breaking into homes and cars in his neighbourhood. This behaviour may have been directed, and to some extent, coerced by an older sibling. To what extent was this behaviour coerced or voluntary? It is difficult to tell. Certainly, the role of the older sibling should be considered in the formulation and treatment plan. However, the child should be rated as having been involved in stealing or breaking in.

**Remember, your task is to get the informant to provide enough clear description or related evidence to permit a rating of the extent of psychopathology. It is <u>your</u> impression of the child's disturbance that you are rating, not the impression of the informant.**

## A GENERAL INFORMATION MODULE

The interview starts with a brief unstructured section. The interviewer introduces him/herself to the parent(s) and explains the purpose of the interview. If applicable, request any necessary permissions and the issue of confidentiality.

The initial objective of the interview is to:

- Make the informants comfortable,
- Clarify the purpose of the interview,
- Develop a working rapport with the informant(s), and
- Establish the tone of the interview (should be empathic and attentive to detail)

Tell the informant that you know very little about the child (i.e. you come to the interview with no preconceived ideas). You may have access to information provided by other team members or as part of pre-assessment screening package. Acknowledge that you have looked at this material, but point out that you require further information to truly understand the child.

The introduction gives the interviewer an opportunity to set the tone of the interview by teaching the informant about the depth of information that is sought. If the informant goes into far too much detail, for example about a particular presenting problem, it is appropriate to point out that there will be opportunity to return to these concerns later in the interview (unless the interviewer judges that the issue is pressing and should be explored at this time). Conversely, if the informant does not provide enough information, the interviewer should mention how important it is to learn about the details of the child's behaviour.

During this portion of the interview, the interviewer should obtain some general information about the child's:

- behaviour
- favourite subjects
- grades
- hobbies
- siblings (if applicable)
- family relationships
- social functioning
- friends

## 3. Presenting Concerns

Inquire first about the parent's greatest current concern. Parents may not spontaneously list their concerns in order of priority when asked so it might be useful to ask specifically what their greatest concerns are at the time of the interview (e.g. "Which of these problems is the most serious, worrisome or disabling at the moment?"). The interview will be more helpful if the informant is given an opportunity to discuss their worries. Reassure the informant that you understand their concerns. Some informants go on in great detail about each concern as if they do not understand that this part of the interview is an overview and that there will be more than sufficient time to return to each concern at a later point in the interview.

## 4. History of the Presenting Concerns

4.1 Record age of onset in years.

4.2 The objective of this item is to permit coding of *who* first identified the problem. For example, the parent might say that the child's behaviour did not change when he or she first went to school, but that the teacher quickly noticed that the child's behaviour was problematic. This probe also provides a clue to the onset and potential precipitants of the child's behaviour. It is possible to select more than person (i.e. parent and teacher noticed around the same time).

4.3 The objective of this item is to code the *first manifestations* of the child's problem(s). If several problems appeared simultaneously (e.g. overactivity and aggressiveness), please code all problems. However, attempt to determine which specific behaviour was observed initially.

4.4 Ask whether things have been getting better or worse. Behaviours which are getting worse receive higher severity ratings than those which are improving. You can ask why the informant thinks that things are improving. By asking what factors have been responsible for alteration in behaviour, you may obtain information that is useful for treatment planning.

4.5 & 4.6 Note the nature of any previous treatment. If child has been involved in treatment, note the name of the responsible therapist. If medication has been used, note the name of medication, dose and side-effects if possible (see 4.6 for

medication tables). Get an impression of the effectiveness of these interventions, and whether they were implemented with enough rigour or intensity to be adequately assessed. Also, elicit and note parental attitude toward the use of medication at this point. It may be helpful to reassure the informant that:

- We don't recommend medication for all children;
- Parents, not professionals, make decisions about what their child will receive by way of treatment;
- We recommend non-drug treatments as well as drug treatments;
- If medication is recommended, we use a systematic approach to the assessment of stimulant medication effects.

4.7 & 4.8 Precipitating Factors. Note the nature of these factors but rate only those factors which you believe were instrumental in the development of the child's symptoms.

**5. Medical and Developmental History**

Review collateral information and inquire about any developmental or medical problems that are reported there. Inquire about any questions which were left blank. Prompts are provided for an overview of the child's developmental history. Ask if there were any other medical or developmental concerns. Rate the child's overall rating of delay in development and overall rating of past medical history. Ask whether the child has any current medical conditions.

**6. Family History**

Inquiring about family history is informative for formulation of the child's problems (e.g. he or she reminds parent of someone else in the family) and it is helpful in establishing the presence of genetic risk factors.

If necessary, draw a family tree. Obtain a complete family history for first degree relatives (i.e. mother, father, brothers and/or sisters) and second-degree relatives (i.e. grandparents, aunt and uncles). Review more briefly, family history of other family members. Ask whether any family members have had a problem with the areas listed. Note: Discussing family issues often leads informants to go off on tangents providing details of the personalities and problems of extended family members. It is important that the interviewer stay on track and not lose time delving into extraneous issues. Note these points and move on.

## B DISRUPTIVE DISORDERS MODULE

This module deals with disruptive behaviour disorders (ADHD, ODD, CD and IED). This section is unique in several ways that are important to the diagnosis of ADHD and the distinction between ADHD, ODD, CD and IED symptoms. The interview is structured around child behaviours that are evident in a variety of different situations (such as outdoor play, leisure time indoors). In each case the interviewer asks the informant to describe their child in that specific situation. All disorders in this module are multiple symptom disorders.

**The clinician/interviewer should rate the severity of symptoms on the following scale:**

**0** = absent
**1** = dubious or trivial abnormality and no impairment
**2** = definite abnormality and some impairment
**3** = marked abnormality and severely impairing
**9** = not known or unable to rate

**Ratings of 2 or 3 are clinically significant and contribute to a diagnosis (see Scoring Guidelines for more details). A rating of 3 is typically reserved for a symptom that is very frequent, severe, disabling etc.**

**Clarify whether the child has taken medication on the day of the assessment.**

**PICS ratings should be based on child behaviour when the child is unmedicated** - it is important to establish whether there has been a window of time when the child was unmedicated on which to base your ratings.

Some children have been continuously medicated without interruption. For these children, it might be necessary to assess unmedicated behaviour based on times when the medication has worn off (e.g. after school).

**The flow of the interview may be as follows:**

Interviewer: "Now I would like to ask you about your child's behaviour in a variety of different situations. I do that because it is very common for children to behave very differently in different situations. I will be asking you about a lot of different situations and problems. Not all situations may be problematic for your child. I ask everyone the same questions in the same

way. It doesn't mean that I think that your child has or should have the difficulties that I will ask about."

"I am particularly interested in your child's behaviour during the last 6 months, say since…" (choose some appropriate point in time such as Christmas, or when s/he started school in the fall, or his/her last birthday as a reference point).

"What are his/her favourite outdoor activities? When was the last time you saw your child while playing outdoors? What was he doing the last time you saw him playing outdoors? Describe his/her behaviour to me so that I can get a picture in my own mind of what I might have seen had I been watching with you."

"How would you compare your child's behaviour to the behaviour of other children that were there at the time or to what you might consider to be typical or normal behaviour for a child of your son or daughter's age?" Most parents will compare their child's behaviour with that of others. While this information can be useful, descriptions of the child's actual behaviour are most useful for ratings.

**Restlessness, fidgetiness, running and climbing and driven by a motor** are difficult to discriminate although most people have an intuitive sense of how they differ.

- **Fidgetiness** refers to activity of small parts of the body: fingers, hands, arms, feet, legs.

- **Restlessness** refers to movement of the entire torso.

- **Running or climbing** refers to movements that are inappropriate for the context; running from room to room for no particular reason, climbing on kitchen counters or bookshelves. If running or climbing is an amplitude measure, driven by a motor is a frequency measure. It refers to the extent to which a child's overly active behaviour is sustained.

- **Driven by a motor** refers to the extent to which a child's overly active behaviour is sustained. Driven by a motor is an epithet used to describe a child who is either moving, talking, fidgeting or fiddling with things most of the time. It is possible (although perhaps unlikely) that a child may rush unnecessarily from place to place but settle frequently. This child would be running but not necessarily driven by a motor.

**ATTENTION DEFICIT HYPERACTIVITY DISORDER**

Note: ADHD symptoms in the Disruptive Disorders Module are accompanied by numbers which correspond with the descriptions below.

**Outdoors**

201-208 Emphasize that you are wanting to get a description of child behaviour outdoors. If the informant starts to describe other situations, try to bring them back to the topic at hand. You can score these items if the information provided is sufficient. If the informant is desperate to discuss another area you can shift to that topic.

205 Many parents say that they gather up the child's play things and equipment. It is important to ascertain what would happen if the parents did not do this – would the child take responsibility for his/her things or lose them? One might ask "What would happen if you did not collect the child's belongings?" and "Why do you say that?"

206, 207 Difficulty waiting his/her turn and butting into other children's games on the surface may seem to refer to the same behaviour. However, they may be distinguished if butting in is taken to refer to how the child enters into an activity (e.g. waits to get invited, asks to join in, charges in or takes over) and waiting for his/her turn refers to the child's behaviour once entry has been secured.

**Leisure Time Indoors**

This section is usually started by asking what a child generally likes to do when alone indoors, with their leisure time. Remember that the interviewer wants to obtain a picture of the child in general, not a limited picture of when the child is at his/her best or worst. Avoid rating a child solely on playing with the computer, video games, tablet etc. Probe to find other activities in which the child engaged or played in the last 6 months.

There are children who do nothing else other than computer games and they typically avoid other more demanding tasks. For these children, ask whether the child ever takes on a new challenge in these games.

"What does your child do when s/he has free time or unstructured time on his/her own indoors?" "Can s/he structure his/her own time?" "What activities does s/he do of his/her own choice?"

211 This symptom refers to the child finding something to do on his/her own versus someone having to organize the child's activities by suggesting or finding things to do, helping the child get ready, or looking for items for the activity. A useful probe is to ask, "If your son or daughter asks you to play and you respond by saying that you are busy and s/he should find something to do, what happens?"

212 Often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort. "Is this a child who prefers or limits themselves to games that require thought and effort or rather easy or action oriented games or activities?" "What would happen if they were exposed to a game or activity that requires greater effort?"

213, 214 Distractibility reflects losing one's focus due to external causes (e.g. a cat runs by, or a fork drops on the kitchen floor), whereas difficulty concentrating reflects losing one's focus due to internal causes.

215 A useful probe to determine whether a child pays attention to details is to ask about his/her drawings and creations with building toys, asking if the product is fairly basic or more intricate (e.g. the picture has clouds in the sky and leaves on the tree, or the creation with Lego includes details with small pieces).

216 As in 205, probe to ascertain whether the child is responsible for putting away his/her play things and what happens. If the parent takes on this responsibility, why do they have to do so?

**Playing indoors with parent**

221 This item refers to the child's attention to instructions and his ability to take them in when spoken to directly, not whether the child likes the rules or wishes to abide by them. If the informant says the child "always likes to make up his/her own rules" you should probe to determine whether this is because the child did not pay attention and listen to the instructions or because s/he doesn't like the rules, or for instance cheats to win. The issue is whether the child is taking in the information (e.g. making eye contact).

223 Following through on instructions refers to acting in accord with stated rules. If the child does not do this, clarify whether this is done on purpose to win or to spoil the game, versus the child having difficulty in following through with stated instructions.

224 Forgetfulness refers to the child's ability to hold the rules/instructions in mind over time as opposed to losing track of what s/he is doing. For some children, instructions go "in one ear and out the other."

**Playing indoors with other children**

These situations include play with other children at home, clubs, daycare, etc.

231-234 Avoid rating these symptoms based solely on the child playing computer games, etc. with his/her friends. Probe to find other activities in the preceding 6 months that the child has played with friends.

233 Shouting out, interrupting is the vocal analogue of butting in to the play activities of peers.

234 The symptom being rated is whether the child talks excessively when playing with others. It should not be confused with noise level.

**TV/device other than gaming**

241 Sustained attention refers to opposite of a deterioration in concentration over time. A child who takes in information and persists with a particular program over time (e.g. 30 minutes) without constant channel surfing has good sustained attention.

**Homework**

251 This rating should not reflect whether or not a child *likes* homework; rather it is an effort to code the child's reluctance or avoidance to participate in these kinds of tasks.

252 Does the child have the required materials arranged in an appropriate way? Does s/he follow reasonable steps in starting and completing a homework task?

253 When probing as to whether the child pays attention to detail, a parent may say that the child's writing or printing is very messy. This is a comment on neatness and is not sufficient for this rating. In order to rate this item, ask the parent questions like "If the child is doing a math sheet, does s/he notice when signs change from addition to subtraction?" or "Does s/he do homework without reading through the instructions carefully?"

254 Many parents comment that they have to sit beside the child in order for homework to be completed. When rating this item, determine whether the child stays seated because the parent is constantly supervising, and what happens if the parents gets up or leaves the room. Is the locus of control internal or external?

**Dinner Table**

261-263 Self-explanatory.

**OPPOSITIONAL DEFIANT DISORDER**

Note: ODD symptoms in the Disruptive Disorders Module are accompanied by numbers which correspond with the descriptions below.

264-266 The first three items are rated as symptoms of ADHD but can also provide insight into symptoms of ODD. Do not ask about attention and compliance in situations in which the assigned or required task is desirable, but suggest alternative scenarios such as "If you ask him/her to run an extra errand, tidy up or make the bed, etc. how would s/he respond?"

271-278 This section is introduced by asking about chores, household rules, routines and expectations with respect to how the child manages these. Some parents have difficulty in pinpointing specifics. If this is the case, ask if there are expectations/rules around routines such as getting ready for school, bedtime (e.g. brushing teeth), or tidying up. In some cases, there are very few rules because getting the child to comply is very difficult. Try to identify the last time

that the child was asked to comply with a household rule or had a chore with some household expectation.

- The interviewer is trying to determine whether the child fails to comply with instructions because of inattentiveness, a short attention span, or a lack of willingness to comply.

- The usual criteria for severity rating apply to ODD symptoms as well as to ADHD symptoms. For example, more persistent, more extreme, more easily precipitated, more impairing symptoms in older children are given higher ratings.

- Oppositional defiant behaviour which is limited to the relationship with a single person (e.g. with a sibling or with one parent or attachment figure) would receive a lower severity rating than similar behaviour which characterizes the relationship with several family and non-family adults. For example, a child whose only oppositional behaviour was annoying his younger sister would likely receive a rating of 1.

- It may be difficult to distinguish oppositional and mood symptoms. For example, depressed children may be touchy or easily annoyed, angry, argumentative or may even have tempers. Code what is evident rather than what you think is the cause. You can reflect your opinion/formulation of the aetiology of the child's behaviour in the clinical feedback (if applicable). The family and you can use the symptom priority rating to indicate that you think the child is depressed rather than oppositional. Oppositional behaviour that is evident during periods of depressed moods would receive low ratings for ODD. If necessary, shift to the Mood Disorders section in the General Psychopathology Module and return to ODD afterwards.

271 It is important to understand the context of behaviours like temper tantrums, not just their frequency. When do they happen? Are they in response to a request? Is the child touchy in the sense that the informant feel that s/he is walking on eggshells or having to measure his/her words carefully so as not to create an outburst or temper tantrum?

276 It is important to appraise whether the annoyance or provocation is deliberate on the part of the child or a perception and response to a normal parenting situation from a vulnerable parent. You can say "What is it about this behaviour that is annoying for you?"

**CONDUCT DISORDER**

Note: CD symptoms in the Disruptive Disorders Module are accompanied by numbers which correspond with the descriptions below.

- Introduce this section by telling the informants that you are going to ask questions about behaviours that "cross the social line of acceptable behaviour." Many parents interpret these items as extreme, so it is helpful to remind them that you must ask about each symptom, as there are children who display some of these behaviours.

- CD symptoms are to be rated for the preceding 12 months with at least 3 symptoms present in the last 12 months and 1 present in the last 6 months. Therefore, tell informants that you would like them to clarify whether any of the CD behaviours have occurred within the past 6 or 12 months.

- Note that severity, age and persistence of behaviour each impact the severity rating for CD items. The severity of an act (e.g. pushing someone off a play structure versus pushing someone into a locker) does make a difference although both acts require the same force. Similarly, some CD behaviour (e.g. stealing with confrontation, breaking into others' homes) is less common among younger children than older children and therefore carries greater diagnostic importance for younger persons.

- Most CD behaviours must occur on more than one occasion to constitute a CD symptom (initiating fights, using an instrument/weapon in a fight, bullying). This is consistent with the requirement that CD represents a *persistent pattern* of behaviour. Behaviours which are serious and interesting but not persistent enough to warrant a rating of 2 or 3 could nevertheless be given a rating of 1. However, some symptoms (theft with confrontation, forced or coerced sex, or deliberate fire-setting) are so atypical that they would meet criteria for a symptom should they occur only once.

- By contrast, intent or the extent to which behaviour is proactive or planned does not impact ratings except for CD 2 *initiates physical fights* (282). There is always some degree of provocation and DSM makes no specific reference to provocation. Initiation of fights, whether provoked or not, counts as CD 2. However, initiation of a fight under extreme provocation would decrease the severity rating of this item. Initiation is difficult to define. Some children have a very low threshold for being provoked. Consequently,

initiation of fights should not be limited to instances in which the child started something out of the blue. On the other hand, if someone started to fight with the child and the child responded in kind, that would seem not to be initiation.

One should probe the circumstances surrounding typical aggressive episodes so that you can code the type of CD (see below).

283 Using a weapon refers to the use of an object rather than one's hands. Even threatening to use a weapon would count toward the rating of this item if it were marked and frequent.

284 Cruelty is difficult to define but implies use of more force or the causing of more pain to another than is required by the situation. For example, if someone else starts a fight or teases it may be appropriate to fight back or tease in turn. Cruelty is defined by the prolonged or exaggerated use of these strategies.

287 This question can be broached by asking if the child has any interest in sexual activities or has been involved in any sexual activities. The details can be probed subsequently. Any suspicions of child abuse must be addressed with the clinical team, and if deemed appropriate, reported to the relevant child protection services (Children's Aid Society/Child Welfare Services).

289 This symptom sometimes comes up when discussing whether a child is spiteful or vindictive. Some children when angry with a sibling or peer will break or tear one of their possessions. Generally, for this item to be rated a 2 or a 3 the destruction of property must be clearly intentional and repetitive.

291 Lying to get out of trouble ("I didn't do it!") is more normal than lying (or conning someone) to enhance oneself or to obtain some objective.

295 *Often* here refers to more than twice in a 6 month period on the grounds that truancy is highly infrequent in elementary school-age children.

**Type of Conduct Disorder**

This coding should be done subsequent to the completion of the entire interview.

- If there is no evidence of physical or verbal aggression, there should be a coding of 0 for physical and for verbal aggression. Consequently, there will be no rating for *reactive – proactive* and *hostile – instrumental*.

- If there is a code greater than 0 for either physical or verbal aggression, there should be a code for *reactive – proactive* and for *hostile – instrumental*

- A typical scenario is that a child's aggression may be hostile some of the time and instrumental on other occasions or reactive some time and proactive other times. If that is the case, you rate somewhere between the two extremes (e.g. a 2 or a 3 to reflect the proportion of time or acts). If the child's aggression is always reactive, then you code a 0 on the *reactive – proactive* and scale no matter how severe the child's aggression.

- The child who is only somewhat aggressive, but is always reactive gets the same reactive rating as the child who is frequently aggressive (and is typically reactive). Consequently, it is important to ask whether the aggressive acts that are being described are typical of the child's behaviour.

## C GENERAL PSYCHOPATHOLOGY MODULE

This module follows a somewhat different format than that of the Disruptive Disorders Module. We do not expect that the interviewer will rate every symptom of every DSM diagnosis in detail in the presence of a positive screen. However, it is important for the interviewer to cover all pertinent symptoms and criteria for a disorder if appropriate. These disorders rest on the experience of the interviewer and their knowledge of all symptoms and criteria for disorders, even if not explicitly stated or listed in the interview. Two major sections of this module (Anxiety and Related Disorders and Mood Disorders) begin with a general probe related to that area of psychopathology.

Note that this module covers behaviour observed by parents or reported to them by significant others in the child's life (e.g. club leaders, sport coaches), but does not deal with behaviours reported by the child's teacher. School behaviours are covered by the Teacher Telephone Interview or by questionnaires.

- Most of the anxiety and affective disorders covered in this section require a history of 6 months of impairment. Other disorders, such as tics, have their own specific duration requirements.

- The symptoms and disorders which are covered in the General Psychopathology Module may arise as a result of medication use, medical conditions, substance use or traumatic life events. For every symptom that is endorsed, inquire about these precipitants.

- If there is information about a question from a previous comment made by the informant, the interviewer could introduce the item by saying **"**As you mentioned previously…" This will ensure that the informant get the feeling that you attending and listening to their earlier replies.

- Record replies that seem to you to be evidence of psychopathology or those that you would like to review with the clinical team.

- At the end of each section of this module, the interviewer may ask if any of the behaviours, symptoms or problems that you have just discussed have been observed at any time in the child's life.

**NOTE:** The General Psychopathology Module contains two different types of disorders:

1. Those for which **multiple symptoms** are listed and scored
2. Those which receive only a **single code**

For **multiple symptom disorders,** the clinician/interviewer should rate the severity of symptoms on the following scale:

**0** = absent
**1** = dubious or trivial abnormality and no impairment
**2** = definite abnormality and some impairment
**3** = marked abnormality and severely impairing
**9** = not known or unable to rate

Ratings of 2 or 3 are clinically significant and contribute to a diagnosis (see Scoring Guidelines for more details). A rating of 3 is typically reserved for a symptom that is very frequent, severe, disabling etc.

For multiple symptom disorders, there is no reason to continue probing for secondary symptoms if the screens are not positive. For example, with Generalized Anxiety Disorder there is no sense in asking if additional symptoms are associated with worry if the child does not worry. Similarly, Acute Stress Disorder and Post-Traumatic Stress Disorder do not need to be screened for if there are no concerns about anxiety in the child (even though they are single code disorders).

**Single code** disorders (surrounded by a standalone box, as shown here), are rated as follows:

**0** = no symptoms
**1** = some symptoms
**2** = disorder is present meets criteria
**3** = disorder present with marked severity
**9** = not known or unable to rate

| | Multiple Symptom Disorder | Single Code Disorder |
|---|---|---|
| ***ANXIETY AND RELATED DISORDERS*** | | |
| Separation Anxiety Disorder | ✓ | |
| Generalized Anxiety Disorder | ✓ | |
| Acute Stress Disorder | | ✓ |
| Post-Traumatic Stress Disorder | | ✓ |
| Adjustment Disorder | | ✓ |
| Panic Disorder | | ✓ |
| Social Anxiety | | ✓ |
| Specific Phobia | | ✓ |
| Obsessive-Compulsive Disorder | ✓ | |
| Hoarding | | ✓ |
| Tic Disorders (there are 3 separate tic disorders in this section, each is a single code) | | ✓ |
| Stereotypic Movement Disorder | | ✓ |
| Sleep-Wake Disorders | | ✓ |
| Eating Problems | | ✓ |
| Enuresis | | ✓ |
| Encopresis | | ✓ |
| ***MOOD DISORDERS*** | | |
| Major Depressive Disorder | ✓ | |
| Persistent Depressive Disorder | ✓ | |
| Disruptive Mood Dysregulation Disorder | ✓ | |
| ***NEURODEVELOPMENTAL DISORDERS*** | | |
| Autism Spectrum Disorder | | ✓ |
| Social Pragmatic Disorder | | ✓ |

**Disorders screened for using *a 0 = No, 1 = Yes, 9 = unknown or unable to rate* system:**

- **Mania/Hypomania**
- **Cyclothymic Disorder**
- **Brief Psychotic Disorder**

**COMPLETION OF THE INTERVIEW**

When the interviewer has finished covering all the material in the 3 modules, close the session by asking whether the informant:

- Feels there is anything important for us to know that has not already been discussed. (**"**Is there anything that we missed that would be important for us to know?");
- Has any opinions or theories about the child's difficulties and what might help these;
- Would like anything clarified about the day; or
- Has any concerns regarding confidentiality or the transfer of records to referral sources (if applicable).

**SPECIFIC PROBLEMS IN INTERVIEWING**

**1. Insufficient sample of behaviour**

It is rarely the case that informants cannot provide enough information to rate all areas. However, sometimes it is not possible to get a valid description of a child's behaviour in a specific situation. For example, the family may live in a high-rise apartment building and the child plays out of sight of the parents. In this case, the parent may not have observed the child in this situation. Should this be the case:

- Ask the informant to describe the most recent time that they had reasonable evidence about what the child was like provided it was within the last 6 months.
- If it is not possible to get a clear idea from the informant in this way, the interviewer might inquire as to whether the child's behaviour has been described to them by a third person such as an older brother or sister. The clinician should use his/her judgement about the quality of the information being given in order to rate the symptom or record a 9.
- If an informant responds that their child is definitely like the description, respond by asking for an example of what is meant. In other words, always follow a closed question with an open question to be certain of the presence and severity of the behaviour.

**2. Parental/informant disagreement about behaviour**

It is common for parents to disagree about the nature of their child's symptoms. This situation can raise serious coding problems for the interviewer as a behaviour could be symptomatic according to one informant and not according to another. The interviewer:

The interviewer should feel free to interrupt the interview at any point to deal with these process issues;

Can comment on the extent to which informants disagree, and ask informants to speculate on the reason and nature of these disagreements - hopefully discussing the issue of interparental disagreement directly will allow the parents to achieve greater agreement; and

Rates the severity of the symptom based to a greater extent on the description provided by the parent who spends most time with the child in that particular situation or activity.

**3. Systematic reporter bias**

An informant may systematically seem to be under or over reporting symptoms, or giving conflicting information. The impression that this is happening may develop as the interview progresses. You might notice that the informant states that their child shows extremes of behaviour but when probed, the interviewer finds little agreement between these first descriptions of behaviour and what appears after specific probing. The interviewer:

Should feel free to interrupt the interview to discuss this issue – the subsequent interview may proceed more smoothly if this is done;

Might comment, “I ask everyone the same questions in the same way and don’t expect that your child will have a problem with every one of these behaviours. I am mostly interested in the marked or more impairing behavioural problems”;

May attempt to determine how problematic a behaviour is by asking, “How do you feel about these behaviours? You seem quite worried?”

**4. Child varies in behaviour**

It is quite common for informants to describe child behaviour as being quite variable. For example, they might say that their child “is sometimes like this and sometimes like that”. Behaviour may vary with the desirability of the activity (e.g. John is very attentive when playing video games but not while doing homework) or setting (e.g. John behaves differently when he is with me than when he is with his father). This predicament raises several issues and demands several interview strategies.

First is the question of how much of the time the child is like this and how of the time s/he is like that? This issue can be sorted out with the following probes:

- "What proportion of the time is s/he like that? Is it most of the time, half the time, occasionally?"
- "When was the last time you observed that behaviour?"
- "Can you describe what you saw?"
- "What were the consequences of that behaviour?" (Serious consequences arising from infrequent behaviours, [e.g. arrest for fire setting, may result in high ratings of severity]).

A frequent variant of this scenario is a child who is described as able to manage a situation or to behave "if they want to" or "if he really likes the game." This is a common characteristic of all children. No matter how impaired a child may be, motivation plays a major role in shaping child behaviour. Using the following probes, ask for a description of the child's behaviour in each situation.

- "Can you describe a situation in which your child is motivated and does succeed or manage well?"
- "When did that last happen?"
- "How often does that situation arise?"
- "Describe a situation in which the child is not motivated? How often does this occur?"
- "What are the consequences of each of these types of behaviour?"

Another variant is the child who has been symptomatic at some point in the past but is no longer. In general, such improvement would lead to a lowering of the severity ratings especially in reference to ratings of ADHD, ODD and CD symptoms. However, if a child has met full criteria (e.g. full CD or MDE criteria); the ratings should reflect this fact. Improvement can be considered in formulating the child's overall difficulties.

Many parents will report that their children are less symptomatic if they are given some assistance. For example, a child might be able to finish their homework "if I give her the help that she needs" or might be able to sit still at the dinner table "if I constantly remind him to stay put." This indicates that considerable assistance is required to minimize symptoms. The ratings should be based on what the child would be like if no assistance were provided. You can determine the appropriate rating by:

- Asking about child behaviour in the absence of these supports;
- Judging by the amount of support that is typically provided; and
- Inquiring about why the informant feels it is necessary to provide that degree of support

**5. Non-custodial parent attends interview**

It is not uncommon for a non-custodial parent to attend the interview. There should be an open discussion early in the interview of who prompted the assessment and for what reason. There should be a discussion of who should participate in the interview. This may be particularly important if there are custody disputes, marked differences in parenting practices or divergent perceptions of child behaviour. It may be necessary to conduct a preliminary interview with both parents, followed by the PICS with the custodial parent and then a follow up interview with the non-custodial parent.

**6. Parent generates symptoms in child**

On occasion, the interviewer gets the impression that one parent generates the bulk of the child's symptoms through their own chaotic or maladaptive child management strategies (from physically abusive management strategies to highly expressed emotions). This scenario can be clarified by asking about child management strategies:

- "Hum, that sounds like a difficult behaviour. How do you handle it?"
- "What is the result?"
- "What happens when someone else encounters the same behaviour?"
- "How do they fare?"

Clear evidence that the child's symptoms are precipitated by maladaptive parenting practices (chaotic or inappropriate strategies) would result in lower severity ratings for child symptoms.

**7. Difference between clinician opinion and symptomatic ratings**

Often, the clinician feels that a child's diagnosis and the phenomenological diagnosis based on the PICS differ. That is as it should be and can be handled at the time of the consensus diagnosis. However, this impression should not alter the rating process. For example, one might feel that the child's problems are due to his anxiety, but one should not alter ratings of other symptoms based on this impression. Another example is a child who appears to be inattentive due to intellectual or learning problems. Rate what you see. Think of what would happen if the child proves not to have an intellectual or learning problem on assessment.

**8. Informant provides too much detail**

There are several reasons that an informant might provide too much detail. The most obvious reason might be that they are uncertain about what amount of detail is required. This can be handled by repeating the requirements. There is a need to have a description of the behaviours in question but there is no need for detail beyond that. The interviewer might try saying:

- "I think that gives me the picture. We had better move on."

**9. Informant talks too much and interview takes too long**

If the informant talks too much the interviewer might begin to feel tired, bored or irritated. Allow yourself to identify this feeling and then decide on an intervention strategy. Try:

- Repeat the instructions; or
- Note that the time is getting on and state that unless you (the interviewer) do a better job of keeping things on track, there will be insufficient time to discuss all the important issues.

A further reason for extra detail might be the informant's anxiety about the issues being discussed. It may be necessary to deal with this dynamic directly, possibly by asking the informant:

- How s/he feels as the history is being discussed?
- Whether s/he feels worried, nervous or upset?
- If s/he has any questions about how the interview is going?