Anxiety Disorders Interview Schedule for DSM–IV

Child Version

Parent Interview Schedule

Wendy K. Silverman
Anne Marie Albano

Contents

Series Introduction

The diagnostic assessment program in this Parent Interview Schedule is part of a series of empirically supported treatment and assessment programs. The purpose of the series is to disseminate knowledge about specific assessments and interventions for which systematic research studies indicate effectiveness. This assessment program, along with others in the series, has been demonstrated to have empirical support for its efficacy in assessing the particular condition you are addressing. However, clinicians operate with a wide variety of patients with different characteristics who are treated in different types of settings. Thus, the manner in which the assessment program is implemented will be the decision of the clinician with his or her unparalleled knowledge of the local clinical situation and the particular patient under care. Although some data indicate that allegiance to the assessment protocol produces the best results in a variety of clinical settings, only the clinician is in a position to judge the degree of flexibility required to achieve optimal results.

We sincerely hope that you find the program, of which this Parent Interview Schedule forms an integral part, useful in your clinical practice. This assessment program is one of several assessment programs for the diagnosis of anxiety disorders and screening of other related disorders. These assessments have been carefully coordinated with the *DSM-IV* for consistently accurate diagnoses for treatment planning and research.

For information on the theoretical approach and empirical work that supports this assessment program, please refer to the Clinician Manual. We encourage review of the Clinician Manual and its references for a comprehensive understanding. Please let us know if you have suggestions for improving our systems for helping you deliver effective psychosocial assessments and treatments for patients under your care.

David H. Barlow, PhD
Distinguished Professor

About the Authors

Wendy K. Silverman, PhD, is professor of psychology and Director of the Child and Family Psychosocial Research Center at Florida International University of Miami. Dr. Silverman has received several grants from the National Institute of Mental Health to design and evaluate psychosocial interventions for children with anxiety disorders. She has published numerous articles and chapters as well as the books *Anxiety and Phobic Disorders: A Pragmatic Approach,* with William M. Kurtines, and *Developmental Issues in the Clinical Treatment of Children and Adolescents,* coedited with Thomas H. Ollendick.

Anne Marie Albano, PhD, is currently an assistant professor of psychology and Co-Director of the Anxiety Research and Treatment Center at the University of Louisville. Dr. Albano is the former program director of the Child and Adolescent Anxiety Disorders Program of the Center for Stress and Anxiety Disorders in Albany, New York. She has published widely in the area of childhood anxiety disorders.

Child's Name: _____ Date of Interview: _____

Gender: _____ Date of Birth: _____ Age: _____

Race/Ethnicity: _____ Religious Affiliation: _____

Case Number: _____
(to facilitate tracking with matching Child Interview Schedule)

Person Being Interviewed: ☐ Mother ☐ Father ☐ Other: _____

Interviewer: _____

Interview Fee: _____ Insurance Plan: _____

Demographic and Family Information

Child's Address: _____

Telephone: _____

Estimated Family Income: _____

Father's Information

Name: _____ Age: _____

Occupation: _____ Education Level: _____

Living with Child? ☐ Yes ☐ No

If No, explain: _____

Mother's Information

Name: _____ Age: _____

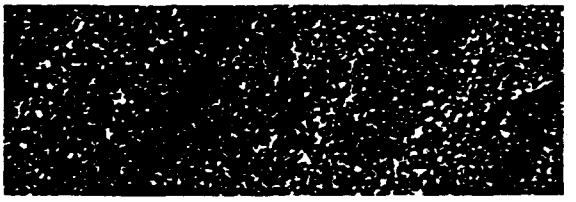
Occupation: _____ Education Level: _____

Living with Child? ☐ Yes ☐ No

If No, explain: _____

Siblings

Name	Gender	Age	Living with Child (Yes/No)



Introduction

The interviewer should begin with a brief introduction and explanation of the purpose of the interview, obtain a brief description of the child's presenting complaint, and ascertain the reasons for seeking professional help at this time.

I have many questions to ask you about your child. I would first like to ask you for a brief description of the problems your child is experiencing. We will get the details during the interview, so here, just a short description is fine.

_____

_____

_____

_____

_____

As I said, I have many questions to ask you. Some of the questions will relate directly to your child's problem or problems, and some might not be relevant at all. We will skip through those sections more quickly, but to ensure that I don't miss anything, it is important that I ask you all of these questions.

Throughout the interview, some questions will represent symptoms or criteria for diagnostic categories and are followed by "Yes," "No," and "Other" responses. For some criteria, a certain number of symptoms must be obtained before those criteria can be assigned. To facilitate the counting of those symptoms, a circle for each symptom is provided in the margin to be checked when a parent endorses the symptom. If the question or series of questions represents a criterion, the question or series of questions is followed by a diamond that the interviewer checks when the parent endorses it. If all required criteria (diamonds) are endorsed, the interviewer may place a check mark in the star at the end of each section to indicate a possible diagnosis of that category.

If both parents are present and give discrepant responses, the interviewer may wish to specify their responses with an "M" (for the mother) or "F" (for the father) in the appropriate places, as in the following example:

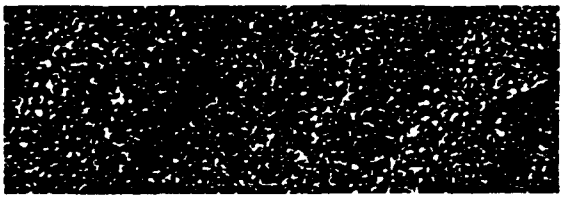
☒ Yes ☒ No ☐ Other

At this point, the interviewer should briefly explain the Feelings Thermometer (found on the back cover of the Clinician Manual).

Throughout the interview, I will ask you to rate how afraid or anxious your child feels in certain situations or about certain things. To get your rating, we will use the same Feelings Thermometer that I used with (child's name).

Explain the 9-point scale, from 0 *(Not at all)* to 8 *(Very, very much)*. Then explain the concept of interference.

I will also ask you to explain how much you think your child's feelings of fear or anxiety disrupt things for (him or her). **For example, if I ask a person who is afraid of dogs how much that disrupts** (his or her) **life, for instance, if it keeps** (him or her) **from playing with friends, walking to school, or going on outings, then** (he or she) **might tell me "A lot"** (point to *A lot* on the thermometer). **Or, if a friend of your child's has a dog that barks a lot and your child is very afraid of it,** (he or she) **might stay away from or avoid going to** (his or her) **friend's house. But if it only bothers your child a little, and** (he or she) **is able to go to that friend's house anyway, you might say "Not at all" or "A little bit." Do you have any questions about these ratings or what I mean by interference? Okay, so let's begin.**



School History

This section contains some general questions about the child's school attendance and performance. If the parent stated at the start of the interview that the child's primary problem is difficulty attending school, then the interviewer should restructure Questions 1–4 to begin with "If your child were in school . . ." (e.g., "where would he or she go?").

1. **Where does your child go to school?** _____
   _____

2. **What grade is your child in?** _____

   During summer: **What grade will your child go into?** _____

3. **What other schools has** (child's name) **attended?** Obtain names of other schools and dates attended. _____
   _____
   _____

4. **What kind of grades does your child get in school?** Inquire for basic subjects such as math, reading, science, and history for the current and previous years. Note *any changes reported* in academic performance. _____
   _____
   _____
   _____

5. **Has your child ever stayed home and had a tutor?** ☐ Yes ☐ No ☐ Other

   If "Yes" or "Other," have the parent explain.
   _____
   _____
   _____
   _____

6. **How many days of school has your child missed since September because of anxiety concerns?** _____

   Calculate the percentage of days missed in present school year.

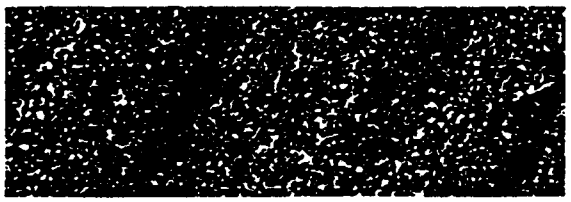
   _____

7. **How many days of school did your child miss last year because of anxiety concerns?** _____

   Calculate the percentage of days missed in previous school year.

   _____

   _____



School Refusal Behavior

In this section, record as "No" responses that reflect "typical" child school-related anxiety and that do not appear to be excessively interfering (e.g., "a little nervous before tests," "a little nervous when he or she forgets his or her homework," etc.).

1. **Does your child have problems attending or staying in school?** ☐ Yes ☐ No ☐ Other

   If "Yes" or "Other," continue.

   If "No," skip to Separation Anxiety Disorder (p. 11).

2. **Does your child get very nervous or scared about having to go to school?** ☐ Yes ☐ No ☐ Other

3. **Does your child stay home or try to stay home from school because** (he or she) **is nervous or scared?** ☐ Yes ☐ No ☐ Other

4. **Does your child ever tell you that** (he or she) **is nervous or scared when** (he or she) **is in school?** ☐ Yes ☐ No ☐ Other

   If "Yes," **Has your child ever left school early because of this, has** (he or she) **made phone calls to you during school hours, or has anyone from the school ever called during school hours on behalf of your child?** ☐ Yes ☐ No ☐ Other

   If "Yes," **How many times has that happened this year?** _____

5. **To your knowledge, does your child often go to see the nurse or often complain of feeling sick while in school?** ☐ Yes ☐ No ☐ Other

   If "Yes," **How many times has that happened this year?** _____

   If "Yes" to any of Questions 1–5, continue inquiry. If "No" to Questions 1–5, skip to Separation Anxiety Disorder (p. 11).

6. **What do you think makes school difficult for your child?** (Ask the parent to elaborate on "Yes" responses.) _____

_____

_____

7. **Do you think your child misses or tries to stay out of** (or leave) **school because** (he or she) **likes it better at home?** ☐ Yes ☐ No ☐ Other

   If "Yes," **How many times has that happened this year?** _____

   If "Yes" or "Other," have the parent explain: _____

   _____

   _____

Fear (Yes or No or Other)

8a. **I am going to give you a list of a few things** (see the list following Question 8c). **I'd like you to tell me if you think anything from the list might be the cause of your child's nervous or scared feelings toward school.**

Fear Ratings (0–8)

8b. For each "Yes" response, use the Feelings Thermometer (found on the back cover of the Clinician Manual) to obtain severity rating.

Interference Rating (0–8)

8c. For those items with a fear severity rating of 4 *(Some)* or greater, a rating of interference should also be obtained with the Feelings Thermometer.

Okay, (parent's name) **for the items that were rated as 4 or greater, I want you to tell me, again on a 0–8 scale, how much you feel your child's fear interferes with** (his or her) **life? Does it interfere with** (him or her) **doing things at school and how much does it bother** (him or her)**?**

	Yes	Fear No	Other	Fear Rating (0–8)	Interference Rating (0–8)
The teacher(s) or principal	☐	☐	☐	☐	☐
The other kids	☐	☐	☐	☐	☐
Speaking to other people	☐	☐	☐	☐	☐
Having to talk in class or talk in front of the class	☐	☐	☐	☐	☐
Taking tests	☐	☐	☐	☐	☐
Getting good grades	☐	☐	☐	☐	☐
Writing on the chalkboard	☐	☐	☐	☐	☐
Being away from you because (he or she) **is in school**	☐	☐	☐	☐	☐
The bell ringing	☐	☐	☐	☐	☐
Gym class	☐	☐	☐	☐	☐
Riding on the school bus	☐	☐	☐	☐	☐
Eating in the cafeteria	☐	☐	☐	☐	☐
Homework	☐	☐	☐	☐	☐
Fire drills	☐	☐	☐	☐	☐
Anything else?	☐	☐	☐	☐	☐

9. **Does your child get very upset if** (he or she) **doesn't do well in school?** ☐ Yes ☐ No ☐ Other

   If "Yes," **If your child doesn't do as well as expected, how does** (he or she) **feel?** _____

   _____

   What does (he or she) **do?** _____

   _____

   Does (he or she) **place too much pressure on** (himself or herself) **to do well?** _____

10. **What does your child do when** (he or she) **is not in school? Can you give me an example of a typical day when your child wakes up and doesn't go to school? (What happens? What do you or**

other family members do when your child does not want to go to school?) _____

_____

_____

_____

11. **What methods have you used to encourage your child to attend school?** (Inquire about reinforcement, punishment, threats, etc.) **Do you think any particular method worked better than the others? Why or why not?** _____

_____

_____

12. **Has your child ever been on medication for** (his or her) **difficulty with going to** (or staying in) **school?** ☐ Yes ☐ No ☐ Other

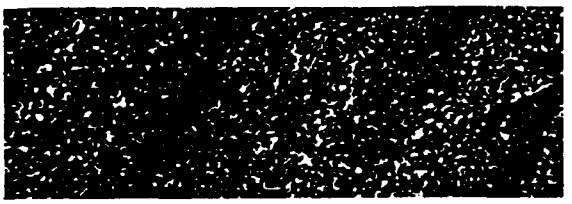
If "Yes," **Could you tell me about that?** (Inquire as to the type of medication, dosage, child's response, and prescribing physician.) _____

_____

13. **How long has your child had this difficulty with going to** (or staying in) **school?** _____

Note. Evidence of significant school refusal behavior warrants clarification and further examination within each of the *DSM–IV* diagnostic categories. School refusal is not a diagnostic category by itself but might be a behavioral manifestation of a clinical disorder.

Age of onset: ____



Separation Anxiety Disorder

Initial Inquiry

Some children (teenagers) worry a lot about being away from their parents or from home.

1a. **When your child is not with you, does** (he or she) **let you know, or have you noticed, that** (he or she) **feels really scared or worried and does whatever** (he or she) **can do to be with you?** ☐ Yes ☐ No ☐ Other

1b. **Does** (he or she) **get very upset, cry, or beg you to stay home when you plan to go somewhere without** (him or her)? ☐ Yes ☐ No ☐ Other

If "Yes," **What does** (he or she) **do?**

_____

_____

1c. **When you leave** (child's name), **does** (he or she) **cry or tell you** (he or she) **feels very bad because** (he or she) **misses you a lot?** ☐ Yes ☐ No ☐ Other

1d. **When you go out somewhere and leave** (child's name) **with a babysitter, friends, or relatives, do they tell you that your child cried while you were gone or felt very bad because** (he or she) **missed you?** ☐ Yes ☐ No ☐ Other

1e. **When you know that you are going to be away from home, does your child get upset ahead of time and then worry about your leaving?** ☐ Yes ☐ No ☐ Other

Count any "Yes" response to Questions 1a–1e as one symptom and place a check mark in the circle. **SYMPTOM**

2. **Does your child tell you that** (he or she) **worries a lot that something bad might happen to you when you are not together? Does** ☐ Yes ☐ No ☐ Other

(he or she) **worry, perhaps, that you might get sick or hurt and die or that you might leave and never come back?**

If "Yes," place a check mark in the circle. **SYMPTOM**

If "Yes," **What does your child think might happen to you? When does your child get these thoughts?** _____

_____

3. **Does your child worry a great deal that something bad might happen to** (him or her), **like being taken or getting lost, so that** (he or she) **couldn't see you or loved ones again?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

If "Yes," **What does your child think might happen to** (him or her)**?**

_____

_____

4. **Are there places to which your child won't go because** (he or she) **is scared to be away from you?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

If "Yes," **What places do you remember** (child's name) **refusing to go to because** (he or she) **would rather be with you at home?**

_____

_____

When was that? _____

If the parent responds "Yes" to any of Questions 1–4, continue. Otherwise, skip to Interpersonal Relationships (p. 15).

5a. **Does your child often want to have you (or another adult) stay close to** (him or her) **when it's time to go to sleep at night? For example, does your child like to have you (or your spouse) lie down next to** (him or her) **when it's time to go to bed?** ☐ Yes ☐ No ☐ Other

5b. **Does your child avoid sleeping over at other kids' houses because** (he or she) **does not want to be away from you?** ☐ Yes ☐ No ☐ Other

Count any "Yes" response to Questions 5a and 5b as one symptom and place a check mark in the circle. **SYMPTOM**

6a. **Does your child try as hard as** (he or she) **can to avoid being alone?** ☐ Yes ☐ No ☐ Other

6b. **Is your child afraid to be at home alone?** ☐ Yes ☐ No ☐ Other

6c. **When family members are at home, is your child afraid to be alone in** (his or her) **room or in any other places in the house?** ☐ Yes ☐ No ☐ Other

Count any "Yes" response to Questions 6a–6c as one symptom and place a check mark in the circle. **SYMPTOM**

If "Yes" to any of Questions 1–6, continue. Otherwise, skip to Interpersonal Relationships (p. 15).

7. **Does your child tell you that** (he or she) **often has bad dreams about being away from you or another loved person?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

8. **When your child has to leave home to go to school or somewhere else, does** (he or she) **tell you that** (he or she) **is experiencing some physical symptoms, such as nausea, vomiting, headaches, and so on?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

If "Yes," **What place? What are** (his or her) **symptoms?** _____

_____

_____

If three or more circles for Questions 1–8 are checked, place a check mark in the diamond. **CRITERION**

9. **Has your child's problem of feeling scared or worried when** (he or she) **is not with you been going on for at least four weeks?** ☐ Yes ☐ No ☐ Other

If "Yes," place check mark in the diamond. **CRITERION**

For the child to meet diagnostic criteria for Separation Anxiety Disorder, the parent must respond "Yes" to at least three symptoms from Questions 1–8, report duration greater than 4 weeks in Question 9, and report significant distress or interference in functioning in the following section.

Interference

Now, I want to find out how much you feel this problem interferes with your child's life. That is, how much has it interfered with your child's friendships, caused problems at school or at home, or stopped your child from doing the things (he or she) **would like to do?** (Show the parent the Feelings Thermometer.) **If you could rate the degree of interference from 0 to 8, where 0 is *Not at all*, 4 is *Some*, and 8 is *Very, very much*, what would you say** (record the number corresponding to the parent's anchor response, 0–8)?

Parent's Rating

☐

If clinical interference is indicated (a rating of 4 or greater), place a check mark in the diamond.

CRITERION

If all three diamonds are checked, consider Separation Anxiety Disorder diagnosis and place a check mark in the star.

Age of onset: _____

Interpersonal Relationships

Now I want to ask you some questions about your child and (his or her) **friends.**

1. **First, would you say that your child has**
   - ☐ **More friends than most kids**
   - ☐ **Fewer friends than most kids**
   - ☐ **The same number as most kids**
   - ☐ **Other**

2. **Does your child have a best friend?** ☐ Yes ☐ No ☐ Other

   How long has (he or she) **been friends with that person?** _____

   _____

3. **Do you think your child has trouble making friends?** ☐ Yes ☐ No ☐ Other

4. **Once your child has made friends, do you think** (he or she) **has trouble keeping them?** ☐ Yes ☐ No ☐ Other

   If "Yes" to Question 3 or 4, ask, **What makes friendships difficult for your child?** _____

   _____

5. **What kinds of things does your child like to do with** (his or her) **friends?** _____

   _____

6. **How often does** (child's name) **see** (his or her) **friends outside of school? Does** (he or she) **go over to friends' homes or invite friends to yours? Does your child see** (his or her) **friends on weekends or holidays** (during the summer)? _____

   _____

   _____

7. **Does your child call** (his or her) **friends, or do they typically call your child to do things?** _____

   _____

8a. **Is your child in any club or group or does** (he or she) **play on any sports team?** ☐ Yes ☐ No ☐ Other

8b. If "No," **Did** (he or she) **ever?** ☐ Yes ☐ No ☐ Other

If "Yes" to Question 8a or 8b, **What group(s) or sport(s) or club(s)? When?** _____

_____

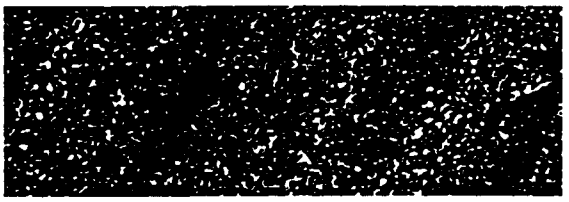
9. **Do you think your child would prefer to spend most of** (his or her) **time alone or with other kids?** ☐ With other kids ☐ Alone ☐ Other

10a. **Does your child get along well with the other members of your family?** ☐ Yes ☐ No ☐ Other

10b. If "No" or "Other," **With whom does your child have difficulty getting along? What problems have you observed?** _____

_____

_____



Social Phobia (Social Anxiety Disorder)

Initial Inquiry

Some kids (teenagers) feel *very* scared and uncomfortable in situations with other people, so scared and uncomfortable that they want to stay away from these places. Some kids (teenagers) might also cry, have a temper tantrum, or get angry when they have to be around other people. They are much more afraid of social situations than are other kids their age.

1a. **When your child is in certain social situations with other people in school, in restaurants, at parties, or when meeting new people, has** (he or she) **told you, or have you noticed, that** (he or she) **is afraid that people might think something** (he or she) **does is stupid or dumb or that they might laugh at** (him or her)?

☐ Yes ☐ No ☐ Other

If "Yes," **Can you tell me about that?** _____

_____

1b. **When** (he or she) **is in these situations with other people, do you know whether** (child's name) **worries that** (he or she) **might do something that will be embarrassing?**

☐ Yes ☐ No ☐ Other

If "Yes," **Can you tell me about that?** _____

_____

If "Yes" to Question 1a or 1b, place a check mark in the diamond.

CRITERION

Fear (Yes or No)

2a. **Some children (teenagers) get very nervous in situations involving other people. I am going to describe some situations** (see list following Question 2c) **and ask you how you think** (child's name) **feels in each situation. First, just tell me "Yes" or "No" if your child has fear of the situation.**

Note. Those situations more common to older children and adolescents are grouped at the end of the list. Also, if the parent responded "No" to Questions 1a and 1b, the interviewer may use discretion in inquiring about the situations listed.

Are there any other times when being around people makes your child nervous or scared? ☐ Yes ☐ No ☐ Other

If "Yes," **Could you tell me about that?** _____

_____

_____

Fear Ratings (0–8)

2b. For each situation to which the parent responded "Yes," find out how much fear exists using the Feelings Thermometer (found on the back cover of the Clinician Manual). Explain the scale again to the parent, if necessary.

Now, using the Feelings Thermometer, how fearful is your child of (specific situation)?

Avoidance/Distress (Yes or No)

2c. For each situation with a fear rating of 4 *(Some)* or greater, inquire about avoidance.

Does your child try to avoid this situation?

If one or more situations are endorsed as either avoided or endured with distress, place a check mark in the diamond.

	Fear		Fear Rating (0–8)	Avoidance Distress	
	Yes	No		Yes	No
Answering questions in class	☐	☐	☐	☐	☐
Oral reports or reading aloud	☐	☐	☐	☐	☐
Asking the teacher a question or asking for help	☐	☐	☐	☐	☐
Taking tests	☐	☐	☐	☐	☐
Writing on the chalkboard	☐	☐	☐	☐	☐
Working or playing with a group	☐	☐	☐	☐	☐
Gym class	☐	☐	☐	☐	☐
Walking in the hallways or standing at (his or her) **locker**	☐	☐	☐	☐	☐
Starting or joining in on a conversation	☐	☐	☐	☐	☐
Using school or public bathrooms	☐	☐	☐	☐	☐
Eating in front of others (e.g., home, school cafeteria, restaurants)	☐	☐	☐	☐	☐
Meetings, such as girl or boy scouts, or team meetings	☐	☐	☐	☐	☐
Answering or talking on the telephone	☐	☐	☐	☐	☐
Musical or athletic performances	☐	☐	☐	☐	☐
Inviting a friend to get together	☐	☐	☐	☐	☐
Speaking to adults (e.g., store clerk, waiters, principal)	☐	☐	☐	☐	☐
Speaking to new or unfamiliar people (strangers)	☐	☐	☐	☐	☐
Attending dances, parties, or activity nights	☐	☐	☐	☐	☐
Having a picture taken (e.g., for the yearbook)	☐	☐	☐	☐	☐
Dating	☐	☐	☐	☐	☐
Being asked to do something that (he or she) **doesn't really want to do but to which** (he or she) **can't say no. For example, if someone wants to borrow** (his or her) **homework or favorite toy, is it hard for** (him or her) **to say no?**	☐	☐	☐	☐	☐
Having someone do something to (him or her) **that** (he or she) **does not like but can't tell them to stop. For example, if someone is teasing** (him or her), **is it really hard for** (him or her) **to say stop?**	☐	☐	☐	☐	☐

If the parent responded "No" to Questions 1a–1b and reports no fear or avoidance in any situation in Question 2, skip to Specific Phobia (p. 23).

For the child to meet diagnostic criteria for Social Phobia, the parent must respond "Yes" to at least one of Questions 1a and 1b, respond "Yes" to at least one situation listed in Question 2, and report that the child either avoids or endures social situations with intense anxiety or distress. In addition, evidence of significant interference in the child's normal routine must be indicated in the Interference section.

Now, I want to find out more details about some of the things that bother your child. When you tell me that (insert specifics of child's fear, e.g., "your child doesn't like to start a conversation"):

3. **Does it make a difference if the people are friends or strangers?** ☐ Yes ☐ No ☐ Other

   If "Yes," **Which is easier?** ☐ Friends ☐ Strangers

4. **Does it make a difference if the group is boys, girls, or boys and girls?** ☐ Yes ☐ No ☐ Other

   If "Yes," **Which is easier?**
   ☐ Boys ☐ Girls ☐ Boys and Girls Together

5. **Does the age of the people matter?** ☐ Yes ☐ No ☐ Other

   If "Yes," **Which is easier, older or younger, or same age?**
   ☐ Older ☐ Younger ☐ Same Age

6. **Does the size of the group make a difference?** ☐ Yes ☐ No ☐ Other

   If "Yes," **Which is easier?**
   ☐ Big ☐ Small ☐ Medium

7. **Does your child almost always get scared or nervous in these situations?** ☐ Yes ☐ No ☐ Other

8. **When your child is in these types of situations, such as** (list several situations identified by the parent), **does** (he or she) **ever cry, get upset or angry, or freeze up as if** (he or she) **can't talk?** ☐ Yes ☐ No ☐ Other

   If "Yes," **Tell me about that.** _____

   _____

   _____

Interference

Parent's Rating

☐

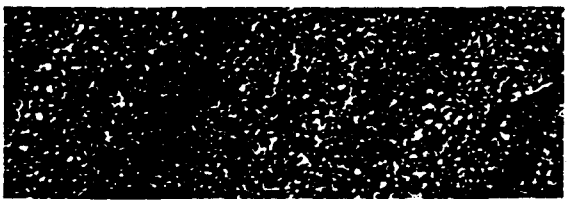
Now, I want to find out how much you feel this problem interferes with your child's life. That is, how much has it interfered with your child's friendships, caused problems at school or at home, and stopped your child from doing the things (he or she) **would like to do?** (Show the parent the Feelings Thermometer.) **If you could rate the degree of interference from 0 to 8, where 0 is *Not at all*, 4 is *Some*,** and 8 is ***Very, very much*, what would you say** (record the number corresponding to the parent's anchor response, 0–8)**?**

If clinical interference is indicated (a rating of 4 or greater), place a check mark in the diamond.

If all three diamonds are checked, consider Social Phobia (Social Anxiety Disorder) diagnosis and place a check mark in the star.

CRITERION

Age of onset: _____



Specific Phobia

Initial Inquiry

Many kids (teenagers) feel *very* scared and uncomfortable, so much so that they might want to stay away from certain, specific things. Some kids (teenagers) might also cry, have a temper tantrum, or get angry when they have to be around these things. They might be told to be around these things, but they would rather not. I want to know if (child's name) **is more afraid of things than are other kids** (his or her) **age. Does this sound like** (child's name)?

☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the diamond. **CRITERION**

If "Yes" or "Other," **Can you tell me about that?** _____

_____

_____

Fear (Yes or No)

1a. **I have a list of some things** (see the list following Question 1e) **that children might be afraid of. Tell me whether you feel your child is more afraid of these things than are other kids** (his or her) **age. First, just tell me "Yes" or "No."**

Fear Ratings (0–8)

1b. **For those things to which you said "Yes," meaning you feel your child is more afraid of that thing than are other kids, I would like you to tell me how scared** (he or she) **is. Use the Feelings Thermometer, where 0 means *Not at all*, 4 means *Some*, and 8 means *Very, very much.***

For any fear ratings of 4 or greater, place a check mark in the diamond. **CRITERION**

If no fears are reported in Question 1a or if all severity ratings in Question 1b are less than 4 *(Some)*, skip to Panic Disorder (p. 27).

Avoidance (Yes or No)

For each item in Question 1b that the parent endorsed with a fear rating of 4 or greater, inquire about the child's avoidance behavior.

1c. **Okay,** (parent's name), **I want you to tell me whether your child tries to avoid the situations or objects that you rated 4 *(Some)* or more. Just tell me "Yes" or "No."**

If one or more "Yes" responses to inquiry, place a check mark in the diamond. **CRITERION**

Interference (0–8)

1d. For each identified specific phobia with a rating of 4 *(Some)* or greater, ask the following question:

Now, when you say you feel (child's name) **is afraid of** (phobic stimulus), **is** (he or she) **so afraid that it interferes with things such as friends, school, or family activities? Does it stop** (him or her) **from doing the things** (he or she) **likes to do? Please use the Feelings Thermometer.**

For any specific phobia endorsed with an interference rating of 4 or greater, place a check mark in the diamond. **CRITERION**

1e. **Has your child been afraid of** (phobic stimulus) **for at least six months?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the diamond. **CRITERION**

	Fear Yes	Fear No	Fear Rating (0–8)	Avoidance Yes	Avoidance No	Interference (0–8)
Animal Type						
Snakes, spiders, dogs, bees/insects Specify:	☐	☐	☐	☐	☐	☐
Natural Environment Type						
High places, going up a ladder or a very tall building	☐	☐	☐	☐	☐	☐
Thunderstorms/lightning	☐	☐	☐	☐	☐	☐
Water	☐	☐	☐	☐	☐	☐
Darkness	☐	☐	☐	☐	☐	☐
Blood-Injection or Injury Type						
Getting shots	☐	☐	☐	☐	☐	☐
Having blood tests	☐	☐	☐	☐	☐	☐
Seeing blood from a cut or scrape	☐	☐	☐	☐	☐	☐

Does your child ever feel faint or has (he or she) **ever actually fainted when** (phobic stimulus, e.g., having blood drawn)? ☐ Yes ☐ No ☐ Other

If "Yes" or "Other," say, **Tell me about that.** _____

_____

_____

The interviewer should evaluate for vasovagal response and fainting characteristic of this specific phobia subtype. Inquire for triggers to fainting episodes.

Situational Type						
Cars, planes, buses, or any other way of traveling Specify:	☐	☐	☐	☐	☐	☐
Elevators or small enclosed places	☐	☐	☐	☐	☐	☐
Other Type						
Doctors or dentists	☐	☐	☐	☐	☐	☐
Vomiting	☐	☐	☐	☐	☐	☐

	Fear Yes	Fear No	Fear Rating (0–8)	Avoidance Yes	Avoidance No	Interference (0–8)
Loud noises	☐	☐	☐	☐	☐	☐
Costumed characters	☐	☐	☐	☐	☐	☐
Choking	☐	☐	☐	☐	☐	☐
Contracting an illness or disease	☐	☐	☐	☐	☐	☐
Other (specify):	☐	☐	☐	☐	☐	☐

For the child to meet diagnostic criteria for Specific Phobia, the parent must endorse a fear of an object or situation with a fear rating of 4 *(Some)* or greater; report an anxiety response that might be expressed by avoidance or by crying, tantrums, freezing, or clinging; and report a duration of 6 months or longer.

2. **Are there ever times when your child is able to** (e.g., be around dogs, get a shot) **without getting frightened?** ☐ Yes ☐ No ☐ Other

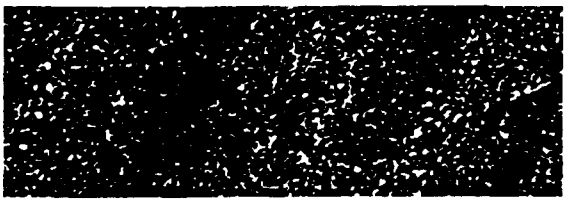
   If "Yes," **Can you tell me about that? When? Does** (he or she) **need to have someone with** (him or her)**? What makes it easier for** (him or her)? _____

   _____

   _____

If all five diamonds are endorsed, consider Specific Phobia diagnosis and place a check mark in the star.

Age of onset: _____



Panic Disorder

Initial Inquiry

1a. **Okay, we just discussed the fact that sometimes people get frightened due to a specific object. But occasionally, some people feel very frightened for no reason at all. They are not in a frightening situation, there is nothing to scare them, and they are not thinking frightening thoughts. But suddenly, out of the blue, they feel really frightened and they don't know why. Has your child ever told you, or have you ever noticed, that this happened to** (him or her)?

☐ Yes ☐ No ☐ Other

If "No," skip to Agoraphobia Without History of Panic Disorder (Question 1b on p. 31). Otherwise, continue.

1b. **What exactly happened? Where was your child when that happened? Was there anything to make** (him or her) **afraid at that time?** _____

_____

_____

_____

Make sure any "Yes" response is not simply caused by exposure to a certain situation or object (Specific Phobia), being the focus of attention (Social Phobia), being separated from parents (Separation Anxiety), and so on. If the parent gives examples that are the result of another anxiety disorder (e.g., specific, social, separation, etc.), or elaboration of the response to Question 1b suggests that the parent does not seem to understand Question 1a, then ask Question 1c to reassess presence of "unexpected" panic attacks (i.e., those that do not occur immediately, before, or on exposure to a situation that almost always causes anxiety).

If the parent does give examples of "unexpected" panic attacks, skip to Question 2.

Additional Probe

1c. **Okay, you just told me how** (child's name) **gets scared when** (give specifics of situations mentioned by parent, e.g., being near a dog). **Now, at that time,** (child's name) **was probably scared that** (give specifics, e.g., the dog would bite him or her), **right? I'm talking about having that scared feeling at other times for no reason at all! That is, there is nothing to be scared of, but your child feels scared anyway. Do you know if that has ever happened to your child?**

☐ Yes ☐ No ☐ Other

If "No," skip to Agoraphobia Without History of Panic Disorder (Question 1b on p. 31).

If "Yes," **What exactly happened? Where was your child when that happened? Was there anything to make** (him or her) **afraid at that time?** _____

_____

_____

If the parent still gives an example that is the result of another anxiety disorder, or if the parent still does not understand the question, then skip to Agoraphobia Without History of Panic Disorder (p. 31). Otherwise, continue.

2. **Do you have any idea how many times your child has had these feelings** (in place described by the parent)? _____

_____

_____

If more than once, ask the parent to elaborate. _____

_____

_____

3a. **Has your child told you about or have you ever noticed this happening to your child in other places besides** (place described by parent)?

☐ Yes ☐ No ☐ Other

If "No," skip to Question 4.

3b. **Where else has it happened?** _____

_____

For each place the parent mentions, obtain frequency and elaboration. _____

_____

_____

4a. **Does your child complain of any troubling physical sensations during these episodes?** ☐ Yes ☐ No ☐ Other

If "Yes," **What sensations has** (he or she) **told you about?**

_____

_____

4b. **Has your child ever told you that** (he or she) **is afraid that something is really wrong with** (him or her), **or that** (he or she) **will be unable to control** (himself or herself) **when these sensations occur?** ☐ Yes ☐ No ☐ Other

If "Yes" to Question 4a or 4b, place a check mark in the diamond and continue. **CRITERION**

If "Yes," **Could you tell me about that?** _____

_____

_____

If the parent endorses symptoms consistent with unexpected panic attacks and responds "Yes" to Question 4a or 4b, consider diagnosis of Panic Disorder.

Interference

Now, I want to find out how much you feel this problem interferes with your child's life. That is, how much has it interfered with your child's friendships, caused problems at school or at home, and stopped your child from doing the things (he or she) **would like to do? If you could rate the degree of interference from 0 to 8, where 0 is *Not at all*, 4 is *Some*, and 8 is *Very, very much*, what would you say** (record the number corresponding to the parent's anchor response, 0–8)?

Parent's Rating ☐

If clinical interference is indicated (a rating of 4 or greater), place a check mark in the diamond. **CRITERION**

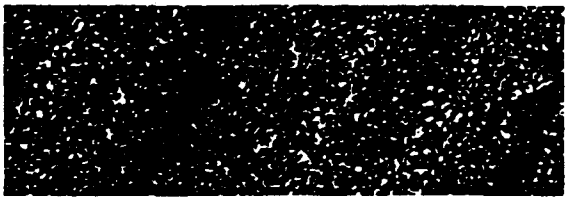
If both diamonds are marked, continue. Otherwise, skip to Agoraphobia (p. 31).

Age of onset: _____

Are there places your child doesn't like to go because (he or she) **is afraid that** (he or she) **will all of a sudden get scared and** (he or she) **won't be able to get away or get help?**

If "no," consider diagnosis of Panic Disorder Without Agoraphobia, mark the star below, and skip to Generalized Anxiety Disorder (p. 39). If "yes," proceed to the next section for possible diagnosis of Panic Disorder With Agoraphobia.

Presence or absence of Agoraphobia must be assessed before it can be determined whether diagnosis will be Panic Disorder With Agoraphobia or Panic Disorder Without Agoraphobia.



Agoraphobia (With or Without Panic Disorder)

Initial Inquiry

If Panic Disorder was diagnosed, ask Question 1a. If Panic Disorder has not been diagnosed, ask Question 1b.

Panic Disorder With Agoraphobia

1a. **Okay, you just told me how, occasionally, your child suddenly got scared for no reason at all. Are there any places your child doesn't like to go to because** (he or she) **is afraid that** (he or she) **will all of a sudden get scared and** (he or she) **won't be able to get away or to get help?**

☐ Yes ☐ No ☐ Other

If "Yes"to Question 1a, place a check mark in the circle and skip to Question 2.

SYMPTOM

If "No," Panic Disorder Without Agoraphobia should have been diagnosed. Skip to Generalized Anxiety Disorder (p. 39).

Agoraphobia Without History of Panic Disorder

1b. **Occasionally, some people don't want to go places, such as a shopping mall or a crowded place, *not* because they're afraid of those places, but because when they get there, they're afraid they might have an uncomfortable feeling in their body, such as dizziness or a fast-beating heart, and then they won't be able to escape or get help. Do you know whether your child has ever felt this way?**

☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle and continue.

SYMPTOM

If "No" to Question 1a or 1b, skip to Generalized Anxiety Disorder (p. 39).

If "Yes" to Question 1a or 1b, ask Question 2.

2. **What exactly happened? When did that happen? Where were you when that happened? Was there anything to make your child afraid then? How many times has it happened? Has it happened in any other place?** _____

_____

_____

If the parent's response to Question 2 suggests that he or she did not understand Question 1a or 1b; or if the parent's "Yes" response to Question 1a or 1b appears to be the result of the child's exposure to a certain situation or object (Specific Phobia), being the focus of attention (Social Phobia), being separated from parents (Separation Anxiety), and so forth; or if the parent cites an obvious nonagoraphobic situation, then review Question 1a or 1b, emphasizing, rewording, and clarifying the specifics with which the parent had difficulty. For example, for Question 1a, the parent might not have understood that the child must appear to be afraid "for no reason at all."

Continue with Question 3 only if the parent reports the child's experiencing a "true" agoraphobic experience in response to Question 2 or after further probing. Otherwise, skip to Generalized Anxiety Disorder (p. 39).

Fear Ratings (0–8) and Avoidance (Yes or No)

3. **Okay, considering the places you just mentioned** (list specific situations provided by the parent in Question 2), **I want to know how much they scare your child and whether you think** (he or she) **tries to avoid those places. I would like you to use the Feelings Thermometer to answer.** (Review the Feelings Thermometer with the parent, if necessary.)

Situations Mentioned by Parent	Fear Rating (0–8)	Avoidance Yes	Avoidance No
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

If Panic Disorder has been diagnosed and the answer to Question 1a was "yes", continue. If no diagnosis of Panic Disorder was indicated and Question 1b was asked, then skip to Questions 5a–5c.

Panic Disorder With Agoraphobia

Fear (Yes or No)

4a. **Okay, now I'm going to list some other places** (see the list following Question 4c), **and I would like you to tell me if you think your child is scared to go there because** (he or she) **thinks** (he or she) **might get scared for no reason and it would be hard to get away or to get help. First, just tell me "Yes" or "No."**

Fear Ratings (0–8)

4b. For those situations to which the parent responded "Yes," obtain fear ratings using the Feelings Thermometer.

Now, using the Feelings Thermometer, tell me how scared (specific situation) **makes your child.**

Avoidance/Distress (Yes or No)

4c. For those situations that the parent endorsed with a fear rating of 4 (*Some*) or greater, inquire for avoidance.

Does your child try to stay away from or avoid (specific situation)?

If one or more situations have a rating of 4 or greater and are avoided, place a check mark in the diamond. **CRITERION**

	Fear		Fear Rating (0–8)	Avoidance/ Distress	
	Yes	No		Yes	No
Classrooms	☐	☐	☐	☐	☐
School bus	☐	☐	☐	☐	☐
Cafeteria	☐	☐	☐	☐	☐
Other school situations (specify):	☐	☐	☐	☐	☐
Riding in a car	☐	☐	☐	☐	☐
Public transportation (e.g., bus, train)	☐	☐	☐	☐	☐
Crowds	☐	☐	☐	☐	☐

	Fear		Fear Rating	Avoidance/ Distress	
	Yes	No	(0–8)	Yes	No
Waiting in line	☐	☐	☐	☐	☐
Doctor or dentist visit	☐	☐	☐	☐	☐
Restaurants	☐	☐	☐	☐	☐
Movie theaters or auditoriums	☐	☐	☐	☐	☐
Being at home alone	☐	☐	☐	☐	☐
Enclosed places: Elevators Tunnels or small rooms	☐	☐	☐	☐	☐
Open spaces (e.g., ballfields, parks, playground)	☐	☐	☐	☐	☐
Church or temple	☐	☐	☐	☐	☐
Being away from home	☐	☐	☐	☐	☐
Taking walks	☐	☐	☐	☐	☐
Stores or malls	☐	☐	☐	☐	☐
Camp (specify type):	☐	☐	☐	☐	☐
Other (specify):	☐	☐	☐	☐	☐

Agoraphobia Without History of Panic Disorder

Fear (Yes or No)

5a. **Okay, I'm now going to list some other places** (see the list following Question 5c), **and I would like you to tell me if you think your child is scared to go to there because** (he or she) **thinks** (he or she) **might get these feelings in** (his or her) **body and it would be hard to get away or to get help. First, just tell me "Yes" or "No."**

Fear Ratings (0–8)

5b. For those situations to which the parent responded "Yes," obtain fear ratings using the Feelings Thermometer.

Now, using the Feelings Thermometer, tell me how scared (specific situation) **makes** (him or her)?

Avoidance (Yes or No)

5c. For those situations that the parent endorsed with a fear rating of 4 *(Some)* or greater, inquire for avoidance.

Does (child's name) **try to stay away from or avoid** (specific situation)?

If one or more situations have a rating of 4 or greater and are avoided, place a check mark in the diamond.

	Fear Yes	Fear No	Fear Rating (0–8)	Avoidance Yes	Avoidance No
Classrooms	☐	☐	☐	☐	☐
School bus	☐	☐	☐	☐	☐
Cafeteria	☐	☐	☐	☐	☐
Other school situations	☐	☐	☐	☐	☐
Riding in a car	☐	☐	☐	☐	☐
Public transportation (e.g., bus, train)	☐	☐	☐	☐	☐
Crowds	☐	☐	☐	☐	☐
Waiting in line	☐	☐	☐	☐	☐
Doctor or dentist visit	☐	☐	☐	☐	☐
Restaurants	☐	☐	☐	☐	☐
Movie theaters or auditoriums	☐	☐	☐	☐	☐
Being at home alone	☐	☐	☐	☐	☐
Enclosed places: Elevators Tunnels or small rooms	☐	☐	☐	☐	☐
Open spaces (e.g., ballfields, parks, playground)	☐	☐	☐	☐	☐
Church or temple	☐	☐	☐	☐	☐
Being away from home	☐	☐	☐	☐	☐
Taking walks	☐	☐	☐	☐	☐
Stores or malls	☐	☐	☐	☐	☐
Camp (specify type):	☐	☐	☐	☐	☐
Other (specify):	☐	☐	☐	☐	☐

5d. If the parent answered "Yes" to Question 1a and gave a rating of 4 *(Some)* orgreater to at least one situation in Question 4b, then consider a diagnosis of Panic Disorder With Agoraphobia. Mark the appropriate diamond. **CRITERION**

5e. If the parent answered "Yes" to Question 1b and gave a rating of 4 *(Some)* or greater to at least one situation in Question 5b, then consider a diagnosis of Agoraphobia Without Panic Disorder. Mark the appropriate diamond. **CRITERION**

In considering the two previous questions, if only one situation was endorsed, rule out the possibility of Specific Phobia.

Range of Activity

In discussing the places to which you said your child is afraid to go, such as (list places the parent has mentioned), **tell me,**

6a. **How long can your child spend in one of those places before** (he or she) **gets too frightened?** _____

6b. **Are there times when those situations do not cause** (him or her) **fear?** ☐ Yes ☐ No ☐ Other

If "Yes," ask, **What makes it better?** _____

_____

6c. **Does** (child's name) **get frightened only if the place is far away from home, or will** (he or she) **still get scared even if it is close to home?** ☐ Yes ☐ No ☐ Other

If "Yes," **Tell me about that.** _____

_____

6d. **Does** (child's name) **need to have someone go with** (him or her)? **Does it make it easier if someone goes with** (him or her)? ☐ Yes ☐ No ☐ Other

If "Yes," **Who?** _____

6e. **Does your child carry anything with** (him or her) **or take any special precautions to feel "safe" in these situations?** (Inquire for safety signals such as water, gum, or paper bags, or having the parent available by phone.) ☐ Yes ☐ No ☐ Other

If "Yes," **Tell me about that. What does** (he or she) **do?** _____

_____

6f. **Tell me exactly what happens when your child goes to one of these places.** _____

_____

_____

Interference

Parent's Rating ☐

Now, I want to find out how much this problem interferes with your child's life. That is, how much has it interfered with your child's friendships, caused problems at school or at home, and stopped your child from doing the things (he or she) **would like to do? If you could rate the degree of interference from 0 to 8, where 0 is *Not at all*, 4 is *Some*, and 8 is *Very, very much*, what would you say** (record the number corresponding to the parent's anchor response, 0–8)?

If clinical interference is indicated (a rating of 4 or greater), place a check mark in the diamond.

CRITERION

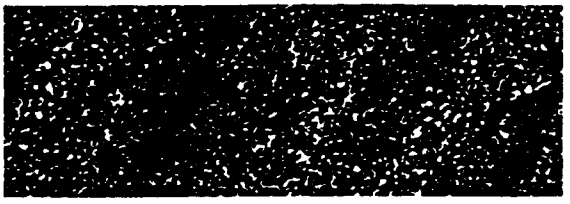
If the interference criteria is marked and the criteria is met for Panic Disorder With Agoraphobia (5d), mark the appropriate star.

If the interference criteria is marked and the criteria for Agoraphobia Without History of Panic Disorder is met (5e), mark the appropriate star.

Age of onset: _____

Panic Disorder With Agoraphobia **DIAGNOSIS**

Agoraphobia Without History of Panic Disorder **DIAGNOSIS**



Generalized Anxiety Disorder

Initial Inquiry

1a. **Some children (teenagers) always seem to be worrying. They might worry about school and how well they are doing; they worry about things that can happen in the future; they worry about their friends, or family, or other things. Do you think that your child has been worrying a lot about such things?**

☐ Yes ☐ No ☐ Other

1b. If "Yes," **What kinds of things does** (he or she) **worry about?** Ask the parent to elaborate. _____

_____

_____

Okay, now I want to ask you some questions about worrying.

Worry (Yes or No)

2a. Use the space below each general worry area in the list (following Question 2c) to record the specific content of the child's worry (including information obtained from Question 1b). Record the parent's responses (Yes or No) in the "Worry" column.

First, I'd like to read you a list of some general topics and I would like you to tell me if your child worries about them more often than other children (teenagers) do. Just tell me "Yes" or "No." Do you think (child's name) **worries about** (specific area) **more than other kids** (his or her) **age do?**

If the parent responds "No" to all of the worry inquiries, skip to Obsessive-Compulsive Disorder (p. 43). Otherwise, continue.

Severity Ratings (0–8)

2b. For those items to which the parent responded "Yes," inquire about excessiveness (severity rating).

Now, using the Feelings Thermometer, tell me how much you feel your child worries about (specific area).

If the parent reports excessive worry (a severity rating of 4 or greater) to one or more of the areas in the list, place a check mark in the diamond. **CRITERION**

Hard to Stop (Yes or No)

2c. For each worry area that the parent endorsed with a severity rating of 4 *(Some)* or greater, inquire about perceived control over these worries.

Do you think it is hard for your child to stop worrying about (specific example)**? For example, do you think your child worries about** (specific example) **when** (he or she) **is trying to do other things?**

Record the parent's Yes or No response in the "Hard To Stop" column.

If the parent reports the worry is hard to stop for one or more areas, place a check mark in the diamond. **CRITERION**

	Worry Yes	Worry No	Severity Rating (0–8)	Hard To Stop Yes	Hard To Stop No
School (e.g., starting school, classwork, grades, homework)	☐	☐	☐	☐	☐
Performance (e.g., being good enough in things such as sports, dance, art)	☐	☐	☐	☐	☐
Social or Interpersonal (e.g., making friends, impressions, appearance)	☐	☐	☐	☐	☐
Little things (e.g., things that happened in the past, saying the wrong thing)	☐	☐	☐	☐	☐
Perfectionism (e.g., being on time, keeping schedules)	☐	☐	☐	☐	☐

	Worry Yes	Worry No	Severity Rating (0–8)	Hard To Stop Yes	Hard To Stop No
Health (child)	☐	☐	☐	☐	☐
Health (significant others)	☐	☐	☐	☐	☐
Family (divorce, finances)	☐	☐	☐	☐	☐
Things going on in the world (e.g., war; crime; community; local, and world affairs; floods, hurricanes, tornadoes)	☐	☐	☐	☐	☐
Other (specify):	☐	☐	☐	☐	☐

If no evidence of excessive or uncontrollable worry, skip to Obsessive-Compulsive Disorder (p. 43). Otherwise, continue.

3a. **Do you think** (he or she) **worries about these things more days than not?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the diamond. **CRITERION**

3b. **Would you say** (he or she) **has been worrying this way for at least six months?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the diamond. **CRITERION**

If no evidence of excessive or uncontrollable worry, skip to Obsessive-Compulsive Disorder (p. 43). Otherwise, inquire about physical symptoms.

4. **Does your child complain of any of the following when worried:**
   a. **Is** (he or she) **unable to sit still or relax?** ☐ Yes ☐ No ☐ Other
   b. **Does** (he or she) **tire easily?** ☐ Yes ☐ No ☐ Other
   c. **Does** (he or she) **have difficulty paying attention to things or concentrating?** ☐ Yes ☐ No ☐ Other
   d. **Does** (he or she) **get upset easily or become irritable?** ☐ Yes ☐ No ☐ Other
   e. **Does** (he or she) **get muscle aches, such as in** (his or her) **legs, arms, or neck?** ☐ Yes ☐ No ☐ Other
   f. **Does** (he or she) **have trouble sleeping** (falling or staying asleep or experiencing restless sleep)? ☐ Yes ☐ No ☐ Other

If "Yes" to one or more physical symptoms listed in Question 4, place a check mark in the diamond. **CRITERION**

To meet diagnostic criteria for Generalized Anxiety Disorder, the parent must endorse excessive worry more days than not for at least 6 months, report that the child has difficulty controlling the worry, endorse one physical symptom, and report distress or impairment in functioning (interference), as indicated in the following section.

Interference

Now, I want to find out how much this problem interferes with your child's life. That is, how much has it interfered with your child's friendships, caused problems at school or at home, and stopped your child from doing the things (he or she) **would like to do? If you could rate the degree of interference from 0 to 8, where 0 is *Not at all*, 4 is *Some*, and 8 is *Very, very much*, what would you say** (record the number corresponding to the parent's anchor response, 0–8)?

Parent's Rating

☐

If clinical interference is indicated (a rating of 4 or greater), place a check mark in the diamond.

CRITERION

If all six diamonds are checked, consider Generalized Anxiety Disorder diagnosis and place a check mark in the star.

Age of onset: _____

OVERANXIOUS DISORDER

Questions in this section should be used to establish the presence of excessive and fearful behavior with no specific focus on a specific situation or object (e.g. separation from a parent). It is not sufficient to count as "Yes" to any of the questions in this section a parent's response that is merely an example of another anxiety disorder (e.g., if child has a phobia of doctors, the child must worry about things other than doctors to merit a "Yes" to Question 1).

1. **Does your child seem to worry a lot about things before they happen, such as starting school in the fall, a test, or going to see a doctor?**

   ____ Yes ____ No ____ Other

   If "YES", Could you give me an example?

2. **Does it seem like your child is always worrying about little things that s/he did in the past, such as something s/he said that might have been taken the wrong way?**

   ____ Yes ____ No ____ Other

   If "YES", Could you give me an example?

3. **Does your child seem to worry a lot about his/her performance in certain things like sports or school or making friends?**

   ____ Yes ____ No ____ Other

4. **Does your child sometimes worry so much that s/he gets headaches, or his/her stomach gets upset, or some other physical problem?**

   ____ Yes ____ No ____ Other

   If "YES", What happens?

5. **Does it seem like your child worries a lot about what other people might think of him/her?**

   ____ Yes ____ No ____ Other

6. **Does your child almost always need other people to tell him/her "don't worry" or that s/he is doing well?**

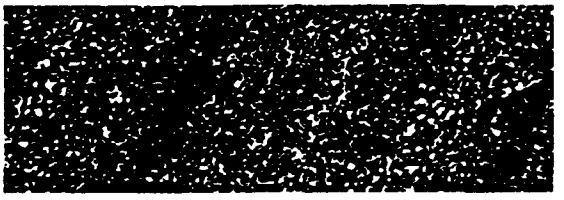
   ____ Yes ____ No ____ Other

7. **Does your child often seem very nervous, shakey, and jumpy, and can't relax?**

   ____ Yes ____ No ____ Other

If parent does not respond "YES" to at least 4 items above (1 to 7), then skip to GENERALIZED ANXIETY DISORDER (GAD). If met, continue.

Interference Rating _____



Obsessive–Compulsive Disorder

Initial Inquiry

Now, I want to ask you more about worry, but this kind of worry is very different from what we were just talking about.

Obsessions

1a. **Does your child experience repetitive thoughts or images that don't seem to make sense, and does** (he or she) **complain of being unable to control or stop these thoughts?** ☐ Yes ☐ No ☐ Other

If "No," skip to Question 1b.

If "Yes," place a check mark in the circle. **SYMPTOM**

If "Yes," **What kinds of thoughts does** (he or she) **have?**

_____ _____

_____

Additional Probe

1b. If the parent did not appear to understand the question, or if you are unsure, ask,

Does (he or she) **complain of hearing songs or sentences in** (his or her) **head over and over? OR does** (he or she) **ever have thoughts over and over of hurting** (himself or herself) **or hurting someone else or that bad things might happen to someone? Or that** (he or she) **might get contaminated by germs or dirt?** ☐ Yes ☐ No ☐ Other

If "No," skip to Compulsions (p. 47).

If "Yes" to Question 1b, place a check mark in the circle and continue. **SYMPTOM**

Can (he or she) **stop the thought(s) if** (he or she) **tries?** ☐ Yes ☐ No ☐ Other

Does it bother your child to have these thought(s)? ☐ Yes ☐ No ☐ Other

If "Yes" to Question 1a or 1b, place a check mark in the circle. **SYMPTOM**

Ratings of Obsessions

In assessing for obsessions, persistence is first assessed, then distress and resistance. Use the following list of obsessions for Questions 2a, 2b, and 2c.

	Persistence Yes	Persistence No	Distress Rating (0–8)	Resistance—Trying To Stop Yes	Resistance—Trying To Stop No
Aggressive Obsessions					
Does (child's name) **get thoughts over and over about hurting** (himself or herself), **hurting someone else, or wanting to break or throw things?**	☐	☐	☐	☐	☐
Contamination					
Does (child's name) **get thoughts over and over about spreading germs or contracting diseases from doorknobs, toilets, or sticky substances?**	☐	☐	☐	☐	☐
Doubting					
Does (child's name) **tell** (himself or herself) **that** (he or she) **didn't do a good job or that** (he or she) **wasn't sure about something that** (he or she) **did or said?** **Regarding older children, ask, Does** (child's name) **doubt how accurately or well** (he or she) **does things?**	☐	☐	☐	☐	☐
Nonsensical Thoughts					
Does (child's name) **hear songs or sentences in** (his or her) **head over and over that** (he or she) **can't seem to stop?**	☐	☐	☐	☐	☐
Does (child's name) **have to repeat numbers, words, or letters over and over, even when** (he or she) **doesn't want to?**	☐	☐	☐	☐	☐
Does (child's name) **use special numbers or say things so** (he or she) **won't feel nervous or scared?**	☐	☐	☐	☐	☐

	Persistence Yes	Persistence No	Distress Rating (0–8)	Resistance—Trying To Stop Yes	Resistance—Trying To Stop No
Hoarding or Saving					
(*Note.* Distinguish from hobbies such as stamp or coin collecting.) **Does** (child's name) **save all sorts of things that** (he or she) **doesn't need, such as old papers or bits of string, because** (he or she) **feels something bad might happen if** (he or she) **throws these things away?**	☐	☐	☐	☐	☐
Religious or Satanic					
Does (child's name) **worry over and over about things like God or the devil? For example, does** (he or she) **worry terribly about being good or saying** (his or her) **prayers perfectly so that** (he or she) **won't upset God?**	☐	☐	☐	☐	☐
Symmetry or Exactness					
Do things have to be in the right order or else (child's name) **fears something terrible will happen? For example, if** (he or she) **has a special way of fixing things in** (his or her) **room, does** (he or she) **get scared or nervous if they are displaced?**	☐	☐	☐	☐	☐
Do things have to be "even"? For instance, if (child's name) **touches** (his or her) **left leg, does** (he or she) **then have to touch** (his or her) **right leg?**	☐	☐	☐	☐	☐
Miscellaneous					
Is (child's name) **bothered by gross thoughts or pictures of accidents or cut up bodies?**	☐	☐	☐	☐	☐
thoughts about hurting other people?	☐	☐	☐	☐	☐
thoughts that something is wrong with (his or her) **body, such as being ugly, being deformed, or being very afraid of gaining weight?**	☐	☐	☐	☐	☐
Thoughts About Sex					
Does (child's name) **have any obscene thoughts or images that make** (him or her) **feel ashamed or uncomfortable?**	☐	☐	☐	☐	☐

	Persistence Yes	Persistence No	Distress Rating (0–8)	Resistance—Trying To Stop Yes	Resistance—Trying To Stop No
Other					
Are there any other thoughts that (child's name) **gets over and over again and can't seem to stop?**					
_____ _____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

Persistence Rating (Yes or No)

2a. **Does your child often complain about** (obsession)**?**

If "Yes" to any obsession, place a check mark in the circle and continue. **SYMPTOM**

Distress Ratings (0–8)

2b. For those items to which the parent responded "Yes," ask the parent for his or her best estimate of the child's feelings of distress, using the Feelings Thermometer.

How upset does (he or she) **get when** (obsession) **preoccupies** (his or her) **mind?**

For any distress rating of 4 (*Some*) or greater for obsessions, place a check mark in the circle. **SYMPTOM**

Resistance—Trying To Stop (Yes or No)

2c. For those obsessions endorsed with a distress rating of 4 (*Some*) or greater, inquire about resistance to the obsession using the following query:

Do you think (child's name) **tries to get rid of** (obsession) **by ignoring it, doing something else, or trying to stop it with some thought or action?**

About how much time each day does (child's name) **spend thinking about the obsessions?** (If necessary, ask, **more or less than one hour?**) _____

Presence of one or more obsessions for more than 1 hour a day or distress rated at 4 (*Some*) or greater, place a check mark in the diamond. **CRITERION**

Compulsions

3a. **Does your child complain of feeling anxious or uncomfortable if** (he or she) **cannot do the same thing over and over in a special order or manner? Like washing** (his or her) **hands over and over again?** ☐ Yes ☐ No ☐ Other

If "No," skip to Question 3b.

If "Yes," place a check mark in the circle. **SYMPTOM**

If "Yes," **What kinds of things does** (he or she) **do?** _____

_____

_____

Additional Probe

3b. If the parent does not appear to understand the question, or if you are unsure, ask,

Does (he or she) **have to use special numbers or have to do things a certain number of times? Does** (he or she) **count things over and over? Does your child touch things in a special way or have to touch things a certain number of times? Does your child have any special habits that** (he or she) **has to do before going to bed or leaving the house?** ☐ Yes ☐ No ☐ Other

If "Yes" to Question 2b, place a check mark in the circle. **SYMPTOM**

If no evidence of compulsions is obtained, skip to Posttraumatic Stress Disorder (p. 51). Otherwise, continue.

Is it difficult for (him or her) **to stop doing these things?** ☐ Yes ☐ No ☐ Other

Would it bother (him or her) **if** (he or she) **was prevented from doing these things?** ☐ Yes ☐ No ☐ Other

If "Yes" to Question 3a or 3b, place a check mark in the diamond and continue. **CRITERION**

Ratings of Compulsions

In assessing for compulsions, persistence is first assessed, then distress and resistance. Use the following list of compulsions for Questions 4a, 4b, and 4c.

	Persistence Yes	Persistence No	Distress Rating (0–8)	Resistance—Trying To Stop Yes	Resistance—Trying To Stop No
Cleaning or Washing Does your child have to clean things over and over again? For example, does (he or she) have to wash (his or her) hands or shower a lot during the day?	☐	☐	☐	☐	☐
Checking Does your child have to check things over and over again? For example, does he check to make sure the door is locked, check (his or her) toys or school books, check that (he or she) didn't make a mistake or do something bad, check that nothing terrible will happen to (him or her) or to the family or that (his or her) body is okay?	☐	☐	☐	☐	☐
Counting Does your child count things over and over again or have to repeat things a certain (special) number of times?	☐	☐	☐	☐	☐
Hoarding or Collecting Does your child have to save things, such as old papers and string, because (he or she) thinks (he or she) might need them again?	☐	☐	☐	☐	☐
Repeating Does your child have to do things over and over again such as homework papers, walking in and out of doorways, or getting up and down out of chairs? Does (he or she) have to read things or erase and rewrite things over and over?	☐	☐	☐	☐	☐
Ordering or Arranging Does your child have to arrange things, such as (his or her) books and toys, in a certain way or else (he or she) gets very upset? Do things have to be "even" all the time? For instance, if (he or she) touches (his or her) left leg, does (he or she) then have to touch (his or her) right leg?	☐	☐	☐	☐	☐

Miscellaneous Rituals

	Persistence Yes	Persistence No	Distress Rating (0–8)	Resistance—Trying To Stop Yes	Resistance—Trying To Stop No
Does your child have to touch, tap, or rub things in a special way?	☐	☐	☐	☐	☐
always ask if (he or she) **did the right thing or did something correctly?**	☐	☐	☐	☐	☐
have to ask the same question over and over?	☐	☐	☐	☐	☐
feel like (he or she) **has to "tell on** (himself or herself)"?	☐	☐	☐	☐	☐
***keep pulling** (his or her) **hair out (trichotillomania)?**	☐	☐	☐	☐	☐
keep saying or thinking the same words, prayers, or sentences over and over?	☐	☐	☐	☐	☐
***eat or drink things in a special order? only eat certain foods?**	☐	☐	☐	☐	☐
Other (specify):	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

**Note.* If such symptoms are endorsed, further evaluation is necessary for accurate differential diagnosis from other Axis I disorders.

Persistence (Yes or No)

4a. **Does your child often have to do things such as** (compulsion)?

If "Yes" to any compulsion, place a check mark in the circle and continue. **SYMPTOM**

Distress Ratings (0–8)

4b. For those items to which the parent responded "Yes," ask the parent for his or her best estimate of the child's feeling of distress, using the Feelings Thermometer.

How upset does (he or she) **get when** (he or she) **has to** (compulsion)? **Or, how upset is** (he or she) **if interrupted or prevented from** (compulsion)?

For any distress rating of 4 (*Some*) or greater, place a check mark in the circle. **SYMPTOM**

Resistance—Trying To Stop (Yes or No)

4c. For those items endorsed with a distress rating of 4 or greater, inquire about the child's resistance to the compulsive behavior.

Do you think your child tries to resist doing (compulsion)**? For example, does** (he or she) **try to do something else?**

How much time each day does (child's name) **spend doing the** (compulsion indicated)**?** _____

Note. For rituals involving activities of daily living (e.g., showering, dental hygiene, grooming), ask, **In comparison to other kids, how much longer does it take** (child's name) **to** (e.g., brush his or her teeth) **because of these habits?** _____

CRITERION

If the parent reports compulsions totalling more than 1 hour a day or distress rated at 4 (*Some*) or greater, place a check mark in the diamond.

Diagnosis of Obsessive–Compulsive Disorder requires the presence of persistent obsessions, compulsions, or both (more than 1 hour each day) that are repetitive and difficult to control. In addition, the symptoms must cause marked distress or cause significant interference in functioning, as indicated in the following section.

If no evidence of obsessions or compulsions is obtained, skip to Posttraumatic Stress Disorder (p. 51). Otherwise, continue.

Interference

Parent's Rating

☐

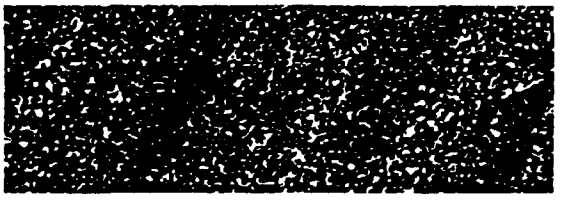
Now, I want to find out how much this problem interferes with your child's life. That is, how much has it interfered with your child's friendships, caused problems at school or at home, and stopped your child from doing the things (he or she) **would like to do? If you could rate the degree of interference from 0 to 8, where 0 is *Not at all*, 4 is *Some*, and 8 is *Very, very much*, what would you say** (record the number corresponding to the parent's anchor response, 0–8)**?**

CRITERION

If clinical interference is indicated (a rating of 4 or greater), place a check mark in the diamond.

If two or more diamonds are checked, consider Obsessive–Compulsive Disorder diagnosis and place a check mark in the star.

Age of onset: _____



Posttraumatic Stress Disorder (PTSD)/Acute Stress Disorder

Initial Inquiry

Okay, (parent's name), **now I want to ask you some questions that are a little different. Some of them might be difficult for you to talk about, but it's important that I ask you these questions. These things I am going to ask you would have caused your child to become extremely frightened and would have made** (him or her) **feel incapable of stopping the situation. Do you understand?**

Traumatic Event

By *DSM–IV* definition, the person must have experienced, witnessed, or been confronted with (an) event(s) that involved actual or threatened death, injury, or threat to the physical integrity of self or others; the person's response must involve intense fear, helplessness, horror or, in children, disorganized or agitated behavior.

1. **Has anything really terrible or upsetting happened to your child? Has** (he or she) **been very sick or badly hurt?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. **SYMPTOM**

   If "Yes," **What happened? What were your child's reactions?**

   _____

   _____

2. **Has** (he or she) **ever witnessed anyone die or get badly injured?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. **SYMPTOM**

   If "Yes," **What happened? What were your child's reactions?**

   _____

   _____

3. **Has** (he or she) **ever been in a really bad accident or fire where** (he or she) **could have died?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

If "Yes," **What happened? What were your child's reactions?**

_____

_____

4. **Has your child ever been in anything such as a hurricane, flood, or earthquake, or has a tornado ever come close to where you live?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

If "Yes," **What happened? What were your child's reactions?**

_____

_____

5. **Has anyone ever robbed or attacked your child?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

If "Yes," **What happened? What were your child's reactions?**

_____

_____

6. **Has anyone ever touched your child inappropriately or molested your child?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

If "Yes," **What happened? What were your child's reactions?**

_____

_____

7. **Has anyone ever physically abused your child or hurt** (him or her) **very badly?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

If "Yes," **What happened? What were your child's reactions?**

_____

_____

8. **Has any other very upsetting event happened to your child?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

If "Yes," **What happened? What were your child's reactions?**

_____

_____

If one or more circles for Questions 1–8 have been checked and the event is truly a PTSD type, place a check mark in the diamond and continue. **CRITERION**

PTSD event specified by the parent: _____

9. **How long ago did** (PTSD event) **happen?** _____

If response to Question 9 is more than 1 month, place a check mark in the diamond and continue. Otherwise, skip to Affective Disorders (p. 57). **CRITERION**

Note. If interview occurs within 4 weeks of the traumatic event, consider a diagnosis of Acute Stress Disorder.

PTSD Symptoms

Reexperiencing Symptoms

10. **Does your child complain of thoughts about** (PTSD event) **that** (he or she) **doesn't want to have?** For younger children, ask, **Does** (he or she) **ever play or draw pictures about** (PTSD event)? ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

11. **Does** (he or she) **complain of bad dreams or nightmares?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

12. **Do you think that** (he or she) **sometimes feels that** (PTSD event) **is about to happen again?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

13. **When reminded of** (PTSD event), **does** (he or she) **get very upset?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

14. **When** (child's name) **is reminded of** (PTSD event), **does** (he or she) **report uncomfortable physical sensations? For example, does** (he or she) **report a fast-beating heart, sweating, or shaking?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

If one or more circles for Questions 10–14 have been checked, place a check mark in the diamond and continue. **CRITERION**

If "No" to all of Questions 10–14, skip to Affective Disorders (p. 57).

Avoidance Symptoms

15. **Does** (child's name) **try very hard not to think about** (PTSD event)? ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

16. **Does** (child's name) **try to avoid things that remind** (him or her) **of** (PTSD event)? ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

17. **Are there some things about** (PTSD event) **that** (he or she) **can't remember?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

18. **Since** (PTSD event), **has** (he or she) **stopped doing things that** (he or she) **used to enjoy** (e.g., playing games, outings, hobbies)? ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

19. **Has** (he or she) **become less interested in seeing friends since** (PTSD event)? ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

20. **Since** (PTSD event), **has it become difficult for** (him or her) **to show other people how** (he or she) **feels?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

21. **Do you think your child has a sense that the future won't work out for** (him or her)? ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. SYMPTOM

If three or more circles for Questions 15–21 have been checked, place a check mark in the diamond and continue. Otherwise, skip to Affective Disorders (p. 57). CRITERION

Hyperarousal Symptoms

Has your child had any of these problems since (PTSD event):

22. **Not being able to sleep well.** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. SYMPTOM

23. **Being irritable or losing** (his or her) **temper.** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. SYMPTOM

24. **Having a hard time paying attention.** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. SYMPTOM

25. **Being on the "look out" a lot so** (he or she) **will be ready if something happens.** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. SYMPTOM

26. **Being startled or surprised easily.** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. SYMPTOM

If two or more circles for Questions 22–26 have been checked, place a check mark in the diamond and continue. CRITERION

For the child to meet diagnostic criteria for PTSD, the parent must answer "Yes" to at least one of Questions 1–8, "Yes" to one of Questions 10–14, "Yes" to at least three of Questions 15–21, and "Yes" to at least two of Questions 22–26. In addition, symptoms must be present for more than 1 month, and interference in functioning must be evident (if less than 1 month since the traumatic event, consider Acute Stress Disorder).

How long has (child's name) **been experiencing these problems?**

If longer than 1 month, place a check mark in the diamond and continue. **CRITERION**

Interference

Now, I want to find out how much this problem interferes with your child's life. That is, how much has it interfered with your child's friendships, caused problems at school or at home, and stopped your child from doing the things (he or she) **would like to do? If you could rate the degree of interference from 0 to 8, where 0 is *Not at all*, 4 is *Some*, and 8 is *Very, very much*, what would you say** (record the number corresponding to the parent's anchor response, 0–8)?

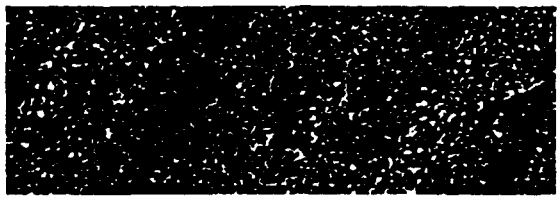
Parent's Rating

☐

If clinical interference is indicated (a rating of 4 or greater), place a check mark in the diamond. **CRITERION**

If all seven diamonds are checked, consider Posttraumatic Stress Disorder (Acute Stress Disorder) diagnosis and place a check mark in the star.

Age of onset: _____



Affective Disorders: Dysthymia

Initial Inquiry

1a. **Has your child ever experienced an entire year of feeling sad and blue, or** (he or she) **was irritable more days than** (he or she) **felt good?** ☐ Yes ☐ No ☐ Other

1b. **Has your child been feeling sad more days than** (he or she) **has been feeling good this past year?** ☐ Yes ☐ No ☐ Other

If "Yes" to Question 1a or 1b, place a check mark in the diamond and continue. **CRITERION**

If "No" to both Questions 1a and 1b, skip to Major Depressive Disorder (p. 61). Otherwise, continue.

1c. **During that year, was there ever a two-month period of time when your child actually felt good *more* days than** (he or she) **felt bad? For example, did** (he or she) **feel good during the summer?** ☐ Yes ☐ No ☐ Other

If the parent responds "Yes" to Question 1c, then Dysthymia is ruled out, and the interviewer should skip to Major Depressive Disorder (p. 61). If the parent responds "No," continue.

Now, I am going to ask you about things that happen to some people when they feel blue or sad. I want to find out if these things happen to your child when (he or she) **feels sad. Or, rather than looking sad, some children might be more irritable than usual when feeling down. These things could be either something that you yourself noticed or perhaps someone else, like your spouse or your child's teacher, noticed.**

2a. **Eating more than** (he or she) **usually does.** ☐ Yes ☐ No ☐ Other

2b. **Eating less than** (he or she) **usually does.** ☐ Yes ☐ No ☐ Other

Count any "Yes" response to Questions 2a and 2b as one symptom only and place a check mark in the circle. **SYMPTOM**

3a. **Trouble sleeping.** ☐ Yes ☐ No ☐ Other

3b. **Sleeping a lot more than usual.** ☐ Yes ☐ No ☐ Other

Count any "Yes" response to Questions 3a and 3b as one symptom only and place a check mark in the circle. **SYMPTOM**

4. **Felt really tired or had no energy.** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

5. **Felt worthless or guilty.** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

6. **Had trouble making decisions or had difficulty concentrating.** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

7. **Felt like things were hopeless.** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

If two or more circles for Questions 2–7 are checked, place a check mark in the diamond and continue. Otherwise skip to Major Depressive Disorder (p. 61). **CRITERION**

8. **Do you think that your child is currently feeling this way? When was the last time that** (he or she) **felt like that? How long has** (he or she) **been feeling this way?** (Assess for current dysthymia.)

_____

_____

If the parent reports the presence of at least two of the symptoms in Questions 2–7, and interference in functioning is evident, then consider a diagnosis of Dysthymia. Whether or not the child meets criteria for Dysthymia, continue and assess for Major Depressive Disorder (p. 61).

Interference

Now, I want to find out how much this problem interferes with your child's life. That is, how much has it interfered with your child's friendships, caused problems at school or at home, and stopped your child from doing the things (he or she) **would like to do? If you could rate the degree of interference from 0 to 8, where 0 is *Not at all*, 4 is *Some*, and 8 is *Very, very much*, what would you say** (record the number corresponding to the parent's anchor response, 0–8)?

Parent's Rating

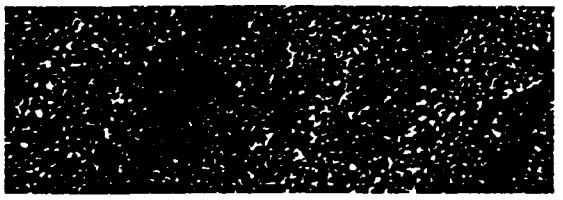
☐

If clinical interference is indicated (a rating of 4 or greater), place a check mark in the diamond.

CRITERION

If all three diamonds are checked, consider Dysthymia diagnosis and place a check mark in the star.

Age of onset: _____



Affective Disorders: Major Depressive Disorder

Initial Inquiry

Now, I want to ask you again about sad feelings, but this time I want to know if your child has ever felt depressed. Clarify the meaning of *depressed* by saying, ***Depressed* is a feeling that some people have when they are extremely sad. It is not like the temporary sadness children experience when they lose a pet or move away from good friends. This is much worse because the child feels unable to have fun or to lift** (himself or herself) **out of the down mood. Also, many times they feel that things are not going to work out for them, and they don't have the energy to even try. When some children are depressed, besides feeling very sad, they might also be more irritable than usual.**

Do you understand what I mean by "feeling depressed"? Be certain that the parent understands the meaning.

1a. **Okay, has your child ever felt depressed?** ☐ Yes ☐ No ☐ Other

If "No," skip to Externalizing Disorders (p. XX). Otherwise, place a check mark in the diamond and continue. **CRITERION**

1b. If "Yes," **Tell me about that.**

If the parent responds "Yes" to Question 1a and reports an episode that is clinical in nature in Question 1b, then continue. If the parent responds "Yes" to Question 1a but reports an episode that is nonclinical in nature in Question 1b, then probe further to determine whether the child ever experienced clinically significant depressive episodes. If inquiry reveals no such episodes, then skip to Externalizing Disorders (p. 65). Otherwise, continue.

2. **Has** (child's name) **ever felt that way for more than one day?** ☐ Yes ☐ No ☐ Other

If "No," skip to Externalizing Disorders (p. 65). Otherwise, continue.

3a. **Has** (he or she) **ever felt that way every day for at least two weeks?** ☐ Yes ☐ No ☐ Other

3b. **Has** (he or she) **been feeling this way nearly every day for these past two weeks?** ☐ Yes ☐ No ☐ Other

If "Yes" to Question 3a or 3b, inquire whether there was a legitimate reason for sadness (death in family, etc.). If inquiry shows that depression was limited to those instances in which there was a legitimate reason and was not longer or more severe than would be expected, code as "Other" and skip to Externalizing Disorders (p. 65). Otherwise, place a check mark in the diamond and continue. **CRITERION**

If "No" to Questions 3a and 3b, skip to Externalizing Disorders (p. 65).

3c. **Is your child currently depressed? When was the last time** (he or she) **was depressed? How long has** (he or she) **been feeling this way?**

_____

_____

Now, I am going to list some symptoms (see the following list) **that people experience when they feel depressed. I want to find out if these things happen to your child when** (he or she) **feels depressed. Again, it could be either something that you yourself noticed or that someone brought to your attention. Now, I only want you to answer "Yes" if the things I ask you happen almost every day for at least two weeks. For example, if just one day** (child's name) **had trouble eating, you would answer "No" because it was not every day. But if it happened almost every day, then you would answer "Yes."**

4a. **Increased eating or appetite** ☐ Yes ☐ No ☐ Other

4b. **Loss of appetite** ☐ Yes ☐ No ☐ Other

4c. **Gained weight** ☐ Yes ☐ No ☐ Other

4d. **Lost weight** ☐ Yes ☐ No ☐ Other

Count any "Yes" response to Questions 4a, 4b, 4c, or 4d as one symptom only and place a check mark in the circle. **SYMPTOM**

5a. **Had trouble sleeping** ☐ Yes ☐ No ☐ Other

5b. **Slept a lot more than usual** ☐ Yes ☐ No ☐ Other

Count any "Yes" response to Question 5a or 5b as one symptom only and place a check mark in the circle. **SYMPTOM**

6a. **Had trouble sitting still** ☐ Yes ☐ No ☐ Other

6b. **Moved very, very slowly** ☐ Yes ☐ No ☐ Other

Count any "Yes" response response to Question 6a or 6b as one symptom only and place a check mark in the circle. **SYMPTOM**

7. **Couldn't seem to have fun or did not seem interested in almost all** (his or her) **usual activities** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

8. **Felt really tired or had no energy** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

9. **Felt worthless or guilty** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

10. **Had trouble concentrating** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

11. **Seemed excessively irritable** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

12a. **Thought a lot about death or dying** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

12b. **Thought about killing** (himself or herself) ☐ Yes ☐ No ☐ Other

Okay, you just answered whether some things happened almost every day for two weeks when your child felt depressed. Now, I just want to know if the following things ever happened at all, even just once:

12c. **Has** (child's name) **actually thought of a way to try to kill** (himself or herself)? ☐ Yes ☐ No ☐ Other

12d. **Has** (child's name) **ever tried to kill** (himself or herself)? ☐ Yes ☐ No ☐ Other

SYMPTOM

Count any "Yes" response to Question 12a, 12b, 12c, or 12d as one symptom only and place a check mark in the circle.

If the parent responds "Yes" to Question 12a, 12b, 12c, or 12d, obtain further details and assess the child's current risk of harm to self or others. Inquire about specifics of plan, time of occurrence, frequency of such thoughts, details of the attempt, current absence or presence of ideation, and so forth, and take appropriate preventative action.

CRITERION

Diagnosis of Major Depressive Disorder requires five "Yes" responses to Questions 3–12. (*Note.* At least one symptom must be depressed or irritable mood or loss of interest in usual activities.) Also, the symptoms must occur together nearly every day for at least 2 weeks, and interference in functioning must be evident. If five or more circles are checked, place a check mark in the diamond.

Interference

Parent's Rating ☐

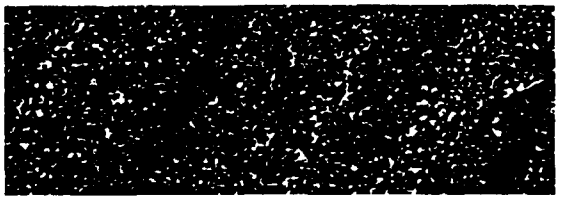
Now, I want to find out how much this problem interferes with your child's life. That is, how much has it interfered with your child's friendships, caused problems at school or at home, and stopped your child from doing the things (he or she) **would like to do? If you could rate the degree of interference from 0 to 8, where 0 is *Not at all*, 4 is *Some*, and 8 is *Very, very much*, what would you say** (record the number corresponding to the parent's anchor response, 0–8)?

CRITERION

If clinical interference is indicated (a rating of 4 or greater), place a check mark in the diamond.

If all four diamonds are checked, consider Major Depressive Disorder diagnosis and place a check mark in the star.

Age of onset: _____



Externalizing Disorders

Up until now, all of the questions I've asked you regarding (child's name) **have had to do with feeling anxious or depressed. But now, I will be asking you about things that** (he or she) **might do or ways that** (he or she) **might act that might make it hard for** (him or her) **at school, with friends, or at home.**

Attention-Deficit/Hyperactivity Disorder (ADHD)

For the next series of questions, answer "Yes" only if your child shows this behavior *much* more than do most kids (his or her) **age.**

Attention Deficit

1. **Does** (child's name) **often make little mistakes, such as on school work, chores, or other things that** (he or she) **does?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

2. **Is** (he or she) **easily distracted?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

3. **Does your child have trouble listening to other people?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

4. **Is it difficult for your child to finish things that others ask** (him or her) **to do, such as chores, homework, and so on?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

If "Yes" to any of Questions 1–4, continue. Otherwise, skip to Hyperactivity–Impulsivity (p. 67).

5. **Does** (he or she) **have difficulty organizing** (his or her) **schoolwork or notebooks, or does** (he or she) **have a hard time getting things together for outings or activities?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

6. **Does** (he or she) **dislike or refuse to do schoolwork or homework because it's hard for** (him or her) **to concentrate on assignments?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

If three or more circles for Questions 1–6 have been checked, place a check mark in the diamond and continue. Otherwise, skip to Hyperactivity–Impulsivity (p. 67). CRITERION

7. **Does** (he or she) **often lose things that** (he or she) **needs, such as school books, pencils, toys, and so forth?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

8. **Is** (he or she) **easily distracted by noise or other things going on around** (him or her)? ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

9. **Does** (he or she) **often lose** (his or her) **place or forget what** (he or she) **is doing?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

If six or more circles for Questions 1–9 have been checked, place a check mark in the diamond and continue. Otherwise, skip to Hyperactivity–Impulsivity (p. 67). CRITERION

10. **How old was your child when** (he or she) **started** (list items to which the parent responded "Yes" in Questions 1–9)? _____

    If response is below age 7, place a check mark in the diamond and continue. CRITERION

If all three diamonds are checked, consider a diagnosis of Attention Deficit and continue to determine a diagnosis of Hyperactivity–Impulsivity.

Hyperactivity-Impulsivity

1. **Does** (he or she) **usually have difficulty staying in** (his or her) **seat?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

2. **Do you often have to reprimand your child for acts such as climbing on the furniture, running through the house, or constantly being on the go?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

3. **Does your child have trouble playing quietly?** ☐ Yes ☐ No ☐ Other

   For adolescents, ask, **Does your child have trouble sitting and doing things by** (himself or herself) **quietly?**

   If "Yes," place a check mark in the circle. SYMPTOM

4. **Does your child often seem restless?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

5. **Does your child often start one thing and then go on to something else before it is finished?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

6. **Is your child overly talkative?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

7. **Does your child usually answer a question before the person has finished asking it?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

8. **Is it hard for your child to wait for** (his or her) **turn when playing games or in groups?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

9. **Does your child "butt into" things too much?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

If six or more circles for Questions 1–9 have been checked, place a check mark in the diamond and continue. CRITERION

10. **How old was your child when** (he or she) **started** (list some items to which the parent responded "Yes" in Questions 1–9)? _____

    If response is below age 7, place a check mark in the diamond and continue. CRITERION

11a. **Does your child** (list some items to which parent responded "Yes") **in school?** ☐ Yes ☐ No ☐ Other

    If "Yes," place a check mark in the circle. SYMPTOM

11b. **Does your child** (list some items to which parent responded "Yes") **at home?** ☐ Yes ☐ No ☐ Other

    If "Yes," place a check mark in the circle. SYMPTOM

11c. **Does your child** (list some items to which parent responded "Yes") **with friends?** ☐ Yes ☐ No ☐ Other

    If "Yes," place a check mark in the circle. SYMPTOM

    If two or more circles for Questions 11a–11c, place a check mark in the diamond and continue. CRITERION

Interference

Now, I want to find out how much this problem interferes with your child's life. That is, how much has it interfered with your child's friendships, caused problems at school or at home, and stopped your child from doing the things (he or she) **would like to do? If you could rate the degree of interference from 0 to 8, where 0 is *Not at all*, 4 is *Some*, and 8 is *Very, very much*, what would you say** (record the number corresponding to the parent's anchor response, 0–8)?

Parent's Rating ☐

If clinical interference is indicated (a rating of 4 or greater), place a check mark in the diamond. CRITERION

Age of onset: _____

For the child to meet the criteria for a diagnosis of ADHD, the parent must respond "Yes" to at least six of Questions 1–9 in the Attention Deficit section or "Yes" to at least six of Questions 1–9 in the Hyperactivity–Impulsivity section. Also, the parent must have indicated that the problem has been going on for at least 6 months, began before age 7, and occurs in more than one setting.

Specific ADHD subtypes might apply if criteria are met for only Attention Deficit or only Hyperactivity–Impulsivity.

If all diamonds in Attention Deficit but none in Hyperactivity–Impulsivity are checked, consider ADHD Predominantly Inattentive Type (Attention Deficit) diagnosis and place a check mark in that star.

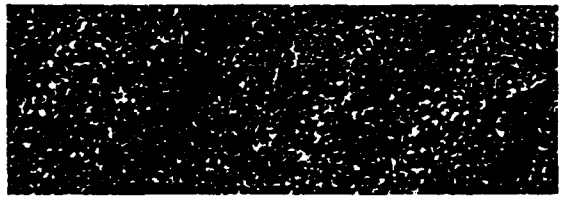
If no diamonds in Attention Deficit and all diamonds in Hyperactivity–Impulsivity are checked, consider ADHD Predominantly Hyperactive–Impulsive Type (Hyperactivity–Impulsivity) diagnosis and place a check mark in that star.

If all diamonds in Attention Deficit and in Hyperactivity–Impulsivity are checked, consider ADHD Combined Type (Attention Deficit and Hyperactivity–Impulsivity) diagnosis and place a check mark in that star.

ADHD Predominantly Inattentive Type

ADHD Predominantly Hyperactive–Impulsive Type

ADHD Combined Type



Conduct Disorder

Initial Inquiry

Does (child's name) **do things such as break rules, steal, lie, act aggressively toward other people or animals, or destroy things that belong to others?** ☐ Yes ☐ No ☐ Other

If "No," skip to Oppositional Defiant Disorder (p. 75). Otherwise continue.

Aggression Toward People and Animals

1. **Is** (child's name) **known as a bully in your school or neighborhood, and does** (he or she) **often threaten or intimidate others?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

2. **Is** (child's name) **known in your school or in the neighborhood for being a "fighter" because** (he or she) **starts fights with other kids?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

3. **To your knowledge, has** (child's name) **ever used a weapon such as a baseball bat, knife, brick, gun, or other object that could seriously harm someone?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

4. **Is** (he or she) **physically cruel to other people? For example, does** (he or she) **purposely hurt others by pinching, hitting, or doing other harmful things?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

5. **Has** (child's name) **ever hurt or been mean to animals, such as a cat or dog, just for fun?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

6. **Has** (child's name) **ever been involved in a mugging, purse snatching, robbery, or other crime against another person?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

7. If the parent of an older child, **Has** (child's name) **ever forced someone to have sex with** (him or her) **against that person's will?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

Destruction of Property

8. **Has** (he or she) **ever set any fires which could have hurt others or caused damage?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

9. **Has** (he or she) **ever been in trouble for destroying property?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

Deceitfulness or Theft

10. **Has** (he or she) **ever been caught breaking into a house, a building, or a car?** ☐ Yes ☐ No ☐ Other

    If "Yes," place a check mark in the circle. SYMPTOM

11. **Does** (child's name) **very frequently lie in order to avoid meeting** (his or her) **obligations? For example, does** (he or she) **lie to get out of school, work, or other responsibilities?** ☐ Yes ☐ No ☐ Other

    If "Yes," place a check mark in the circle. SYMPTOM

12. **Has** (child's name) **ever shoplifted or forged checks? Has** (he or she) **stolen from someone without the person knowing it?** ☐ Yes ☐ No ☐ Other

    If "Yes," place a check mark in the circle. SYMPTOM

Serious Violations of Rules

13a. **Does** (child's name) **disobey curfews and stay out at night later than you wish?** ☐ Yes ☐ No ☐ Other

If the parent answered "Yes," and child is older than 13, ask,

13b. **Did** (he or she) **begin staying out late before age 13?** ☐ Yes ☐ No ☐ Other

Count any "Yes" response to Questions 13a and 13b as one symptom and place a check mark in the circle. SYMPTOM

14. **Has** (child's name) **ever run away from home overnight?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. SYMPTOM

14a. If "Yes," **How often has that happened?** _____

14b. **What is the longest period of time that** (he or she) **was gone?**

_____

Count response to Question 14 as a "Yes" if the child has run away at least two times, or one time without returning for a lengthy period.

If "Yes," place a check mark in the circle. SYMPTOM

15a. **Does** (child's name) **often "play hookey" from school?** ☐ Yes ☐ No ☐ Other

If the parent answered "Yes," and the child is older than 13, ask,

15b. **Did** (he or she) **begin "playing hookey" before age 13?** ☐ Yes ☐ No ☐ Other

If "Yes" to both Questions 15a and 15b, place a check mark in the circle. SYMPTOM

16a. **You told me about** (refer to those items to which the parent responded "Yes" or "Other"). **Has** (he or she) **done any of these things in the past six months?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. SYMPTOM

If "No," skip to Oppositional Defiant Disorder (p. 75). Otherwise, continue.

16b. **Has** (he or she) **done any of these things in the past year?** ☐ Yes ☐ No ☐ Other

SYMPTOM

If "Yes," place a check mark in the circle.

CRITERION

If three or more circles for Questions 1–16 have been checked, place a check mark in the diamond and continue.

Diagnosis of Conduct Disorder requires three or more of the criteria in Questions 1–16 in the past 12 months, with any one criterion present in the past 6 months. If criteria are met, evidence of interference in academic, social, or occupational functioning must also be assessed.

Interference

Parent's Rating ☐

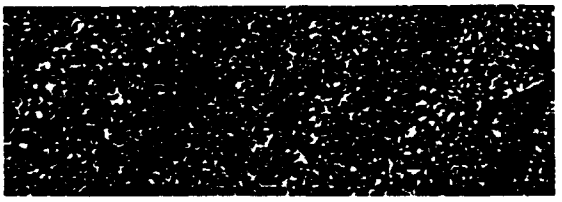
Now, I want to find out how much this problem interferes with your child's life. That is, how much has it interfered with your child's friendships, caused problems at school or at home, and stopped your child from doing the things (he or she) **would like to do? If you could rate the degree of interference from 0 to 8, where 0 is *Not at all*, 4 is *Some*, and 8 is *Very, very much*, what would you say** (record the number corresponding to the parent's anchor response, 0–8)?

CRITERION

If clinical interference is indicated (a rating of 4 or greater), place a check mark in the diamond.

If both diamonds are checked, consider Conduct Disorder diagnosis and place a check mark in the star.

Age of onset: _____



Oppositional Defiant Disorder

Note. According to *DSM-IV*, if the child meets criteria for Conduct Disorder, Oppositional Defiant Disorder cannot be assigned. If criteria for Conduct Disorder are met, skip to Selective Mutism (p. 79).

Initial Inquiry

For the next series of questions, only respond "Yes" if you mean "a lot more than would be appropriate for (his or her) **age."** (Do not count normal sibling rivalry and arguing as a "Yes" response.)

Does (child's name) **always seem angry, often lose** (his or her) **temper, always argue, frequently try to annoy other people, and often refuse outright to do what** (he or she) **is told or asked to do?** ☐ Yes ☐ No ☐ Other

If "No," skip to Selective Mutism (p. 79). If "Yes," continue.

1. **Does your child usually get upset and lose** (his or her) **temper if, for example, things do not go** (his or her) **way?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. **SYMPTOM**

2. **Does** (he or she) **often argue with adults?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. **SYMPTOM**

3. **Does** (child's name) **often refuse to do what** (he or she) **is told or often purposely break rules?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. **SYMPTOM**

4. **Does** (he or she) **often do things to annoy other people, such as grab something of theirs?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. **SYMPTOM**

5. **Does** (child's name) **usually blame others for** (his or her) **mistakes?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

6. **Is** (he or she) **usually "touchy" or easily annoyed by others?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

If "No" to *all* of Questions 1–6, skip to Selective Mutism (p. 79). Otherwise, continue.

7. **Does** (child's name) **often seem as though** (he or she) **is angry at and resentful of other people?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

8. **If someone does something to** (child's name) **that** (he or she) **does not like, does** (he or she) **often take revenge, and, if so, is it with a spiteful or mean attitude?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

9. **Have these behaviors led to problems for your child at home, in school, or in** (his or her) **friendships?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the circle. SYMPTOM

If four or more circles for Questions 1–8 are checked and if "Yes" to Question 9, place a check mark in the diamond and continue. CRITERION

10. **You told me that** (child's name) (list items the parent reported as "Yes" to Questions 1–9). **Has** (he or she) **been behaving this way for as long as six months?** ☐ Yes ☐ No ☐ Other

    If "Yes," place a check mark in the diamond. CRITERION

If "Yes" to Question 10 and child does *not* meet criteria for Conduct Disorder, consider Oppositional Defiant Disorder.

Interference

Now, I want to find out how much this problem interferes with your child's life. That is, how much has it interfered with your child's friendships, caused problems at school or at home, and stopped your child from doing the things (he or she) **would like to do? If you could rate the degree of interference from 0 to 8, where 0 is *Not at all*, 4 is *Some*, and 8 is *Very, very much*, what would you say** (record the number corresponding to the parent's anchor response, 0–8)?

Parent's Rating

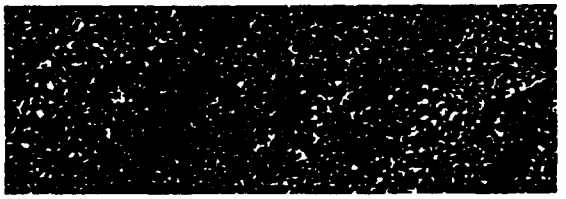
☐

If clinical interference is indicated (a rating of 4 or greater), place a check mark in the diamond.

CRITERION

If all three diamonds are checked, consider Oppositional Defiant Disorder diagnosis and place a check mark in the star.

Age of onset: _____



Selective Mutism

Initial Inquiry

Some children have no difficulty talking, laughing, and even singing in front of family members, but in public situations, such as school, they are unable to speak aloud in front of other people.

1. **Does** (child's name) **refuse to speak at school or in other social situations? For example, does** (he or she) **refuse to answer questions in school or refuse to respond when persons other than family members speak to** (him or her)? ☐ Yes ☐ No ☐ Other

2. **Does** (he or she) **refuse to answer friends and other people who ask** (him or her) **questions?** ☐ Yes ☐ No ☐ Other

If "Yes" to Questions 1 and 2, place a check mark in the diamond and continue. **CRITERION**

If "No" to both Questions 1 and 2, skip to Enuresis (p. 81).

3. **Does** (he or she) **talk when** (he or she) **is at home with the rest of the family?** ☐ Yes ☐ No ☐ Other

4. **Does** (he or she) **have any friends who speak for** (him or her) **when** (he or she) **needs something at school? Or, do family members speak for** (him or her) **in situations such as ordering food, talking on the phone, and so forth?** ☐ Yes ☐ No ☐ Other

5. **Has school become difficult because of** (his or her) **not talking?** ☐ Yes ☐ No ☐ Other

6. **Do you get upset because** (child's name) **won't speak to other people?** ☐ Yes ☐ No ☐ Other

7. **Has** (he or she) **ever spoken in school?** ☐ Yes ☐ No ☐ Other

   If "Yes," **When did** (he or she) **stop? Did anything happen to upset** (him or her)? _____

   _____

8. **Has this been going on for longer than the first month of school?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the diamond.

CRITERION

Diagnosis of Selective Mutism requires a failure to speak in selected situations such as school, despite speaking in other situations; interference in functioning; and duration of at least 1 month (excluding the first month of school). If criteria are met, consider Selective Mutism diagnosis and place a check mark in the diamond.

CRITERION

Interference

Parent's Rating

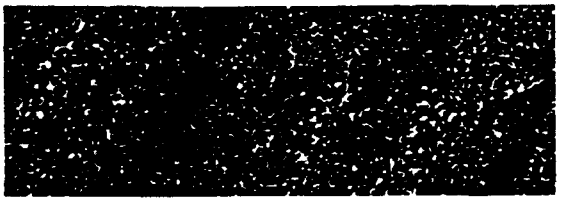
☐

Now I want to find out how much this problem interferes with your child's life. That is, how much has it interfered with your child's friendships, caused problems at school or at home, and stopped your child from doing the things (he or she) **would like to do? If you could rate the degree of interference from 0 to 8, where 0 is *Not at all*, 4 is *Some*, and 8 is *Very, very much*, what would you say** (record the number corresponding to the parent's anchor response, 0–8)?

If clinical interference is indicated (a rating of 4 or greater), place a check mark in the diamond.

CRITERION

If all four diamonds are checked or if responses to Questions 1–7 warrant further clinical inquiry necessary to confirm Selective Mutism diagnosis, place a check mark in the star.



Enuresis

1. **After reaching age 5, has your child had the problem of wetting** (his or her) **pants or bed either during the day or at night?** ☐ Yes ☐ No ☐ Other

   If "Yes," place a check mark in the diamond and continue. CRITERION

   If "No," skip to Sleep Terror Disorder (p. 83).

   When does (did) it occur? _____

2a. **Has** (child's name) **wet** (his or her) **bed at least two times a week for three consecutive months?** ☐ Yes ☐ No ☐ Other

   If "Yes" or "Other," **How often has this happened? When did it happen?** _____

   Is this going on now? _____

   If "Yes," place a check mark in the diamond. CRITERION

2b. **How does** (child's name) **react to this problem? Has it caused any difficulty in friendships, family relationships, or in** (his or her) **daily routine? Does this problem stop your child from doing things such as attending sleepovers and does** (he or she) **get teased by peers?** _____ ☐ Yes ☐ No ☐ Other

   If "No" to Questions 2a and 2b, skip to Sleep Terror Disorder (p. 83).

If the child is over 5 years of age, has no physical disorder, the parent has responded "Yes" to Question 1, and the problem has occurred at least twice weekly for three consecutive months or caused significant distress or interference in functioning, then diagnosis of Enuresis is warranted.

Interference

Now, I want to find out how much this problem interferes with your child's life. That is, how much has it interfered with your child's friendships, caused problems at school or at home, and stopped your child from doing the things (he or she) **would like to do? If you could rate the degree of interference from 0 to 8, where 0 is *Not at all*, 4 is *Some*, and 8 is *Very, very much*, what would you say** (record the number corresponding to the parent's anchor response, 0–8)?

Parent's Rating

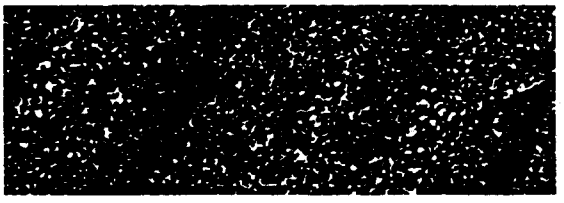
☐

If clinical interference is indicated (a rating of 4 or greater), place a check mark in the diamond.

CRITERION

If all three diamonds are checked, consider Enuresis diagnosis and place a check mark in the star.

Age of onset: _____



Sleep Terror Disorder

1a. **Has** (child's name) **ever woken up in the middle of the night with a panicky scream, feeling really scared because** (he or she) **had a terrible nightmare, but** (he or she) **doesn't clearly remember what the nightmare was all about?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the diamond and continue. **CRITERION**

If "No," skip to Substance Abuse (p. XX).

1b. **How often has this happened?** _____

2. **Does** (he or she) **seem so nervous and scared during these times that even if you or your spouse go into** (his or her) **room to try to make** (him or her) **feel better, it doesn't help?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the diamond and continue. **CRITERION**

3. **When your child wakes up in the middle of the night, do you notice that**

a. (His or Her) **heart is beating faster than usual?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

b. (He or She) **is breathing faster than usual?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

c. (He or She) **is sweating?** ☐ Yes ☐ No ☐ Other

If "Yes," place a check mark in the circle. **SYMPTOM**

If one or more circles for Questions 3a–3c are checked, place a check mark in the diamond and continue. **CRITERION**

If "Yes" to Questions 1a and 2 and "Yes" to at least one of Questions 3a, 3b, and 3c, diagnosis of Sleep Terror Disorder is warranted.

Interference

Now, I want to find out how much this problem interferes with your child's life. That is, how much has it interfered with your child's friendships, caused problems at school or at home, and stopped your child from doing the things (he or she) **would like to do? If you could rate the degree of interference from 0 to 8, where 0 is *Not at all*, 4 is *Some*, and 8 is *Very, very much*, what would you say** (record the number corresponding to the parent's anchor response, 0–8)?

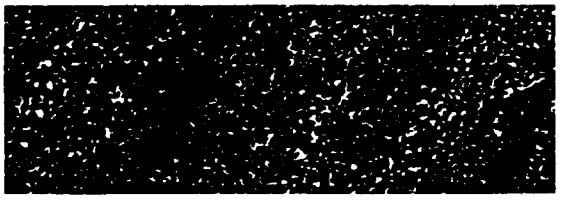
Parent's Rating ☐

If clinical interference is indicated (a rating of 4 or greater), place a check mark in the diamond.

CRITERION

If all four diamonds are checked, consider Sleep Terror Disorder diagnosis and place a check mark in the star.

Age of onset: _____



Screening Questions for Additional Childhood Disorders

This section contains screening questions for additional disorders that the interviewer may wish to pursue. The questions here are provided for the purpose of gathering basic information, *not* for establishing full diagnostic criteria. Further clinical inquiry will be necessary to confirm the presence of any of these disorders. If responses to questions in these categories indicate the need for further inquiry, the interviewer can circle the question mark at the end of each set of questions for each diagnostic category.

Substance Abuse

If the child is 11 or older or if you suspect the possibility of alcohol or other drug use in a younger child, ask Questions 1 and 2.

1. **Does your child drink alcohol, such as beer or wine?** ☐ Yes ☐ No ☐ Other

   If "Yes," ask the parent to elaborate. _____

   _____

2. **Does your child smoke pot or use any other illegal drug?** ☐ Yes ☐ No ☐ Other

   If "Yes," ask the parent to elaborate. _____

   _____

If the parent responds "Yes" to Question 1 or 2 and the elaboration suggests a problem, ask Question 3. Otherwise, skip to Schizophrenia (p. 86).

3. **Has your child ever been in trouble with family, school, or police because of** (his or her) **use of** (name substance)? ☐ Yes ☐ No ☐ Other

   If "Yes," What happened? _____

   _____

If the parent's responses suggest a possible problem with substances, obtain further details, assess current status, and take appropriate action.

If responses to Questions 1–3 warrant further clinical inquiry necessary to confirm Substance Abuse diagnosis, circle the question mark.

Substance Abuse 

Schizophrenia

If the child behaved in a bizarre manner during the child interview and you suspect possible psychosis, ask the Questions 1a and 1b.

1a. **Did your child ever tell you that** (he or she) **heard voices when no else one was around?** ☐ Yes ☐ No ☐ Other

1b. **Did your child ever tell you** (he or she) **heard voices that no one else there heard?** ☐ Yes ☐ No ☐ Other

If the parent responds "Yes" to either Question 1a or 1b, explain that the questions are referring to actually hearing through the ears, as the parent hears you, and not just to a voice in the head, as one hears a thought. If the parent confirms that this is the case, then count the response or responses as a "Yes"; otherwise, do not.

2. **Did your child ever tell you that** (he or she) **saw things that were not really there?** ☐ Yes ☐ No ☐ Other

   If "Yes," ask for elaboration to confirm clinically significant symptoms. _____

   _____

3. **Did your child ever tell you that people were doing things to pester** (him or her) **or to hurt** (him or her), **so** (he or she) **felt as if** (he or she) **had to be on the lookout?** ☐ Yes ☐ No ☐ Other

   If "Yes," ask for elaboration to confirm clinically significant symptoms. _____

   _____

4. **Is it sometimes difficult to understand your child because** (he or she) **talks in a mixed up way or because what** (he or she) **says doesn't make any sense?** ☐ Yes ☐ No ☐ Other

If "Yes," ask the parent to give an example to confirm that the symptom is clinically significant. _____

_____

If the parent's responses suggest possible Schizophrenia, obtain further details, assess current status, and take appropriate action.

If responses to Questions 1–4 warrant further clinical inquiry necessary to confirm Schizophrenia diagnosis, circle the question mark.

Schizophrenia 

Mental Retardation

1. **Is your child performing significantly below** (his or her) **grade level in school?** ☐ Yes ☐ No ☐ Other

If "No," skip to Learning Disorders. Otherwise, continue.

2. **Has your child ever been administered an intelligence test?** ☐ Yes ☐ No ☐ Other

If "Yes," **What information were you given about your child's estimated range of functioning based on this testing?** _____

_____

If the parent indicates a below-average level of functioning or an IQ less than 70, continue. Otherwise, skip to Learning Disorders.

3. **Does your child have difficulty with other areas of functioning besides academic skills?** (Inquire for deficits in communication, self-care, social or interpersonal skills, etc.) ☐ Yes ☐ No ☐ Other

If "Yes," **What other activities are difficult for your child?**

_____

_____

If responses to Questions 1–3 warrant further clinical inquiry necessary to confirm Mental Retardation diagnosis, circle the question mark.

Mental Retardation 

Learning Disorders

1. **Does your child have difficulty in school due to reading, mathematics, or writing problems?** ☐ Yes ☐ No ☐ Other

If "Yes," **Can you tell me about that? What exactly is difficult for your child?** _____

_____

2. **Has** (he or she) **ever been evaluated by a school psychologist? Has** (he or she) **been offered any assistance in school because of any of these problems?** ☐ Yes ☐ No ☐ Other

   If "Yes," **Can you tell me about that?** _____

   _____

Note. Evaluate for communication disorders that might also impair academic functioning (e.g., Expressive Language Disorder, Stuttering).

If responses to Questions 1 and 2 warrant further clinical inquiry necessary to confirm Learning Disorders diagnosis, circle the question mark. Learning Disorders 

Pervasive Developmental Disorders

1. **Does your child have difficulties dealing with social interactions? For example, does** (he or she) **seem awkward in social interactions, fail to respond to others, or seem uninterested in socializing?** ☐ Yes ☐ No ☐ Other

   If "Yes," **Can you tell me about that?** _____

   _____

2. **Does** (he or she) **have difficulty communicating with others? For example, was** (he or she) **delayed in** (his or her) **speech abilities or does** (he or she) **have difficulty initiating or following conversations?** ☐ Yes ☐ No ☐ Other

   If "Yes," **Can you tell me about that?** _____

   _____

3. **Is your child overly preoccupied with repeating things, such as certain body movements, routines, or rituals? Or does** (he or she) **get very preoccupied with certain objects or parts of objects?** ☐ Yes ☐ No ☐ Other

   If "Yes," **Can you tell me about that?** _____

   _____

If "Yes" to any of Questions 1–3, **Did your child have these delays or problems prior to age 3?** ☐ Yes ☐ No ☐ Other

Note. If necessary, evaluate for specific Pervasive Developmental Disorders (e.g., Autism, Rett's Disorder, Asperger's Disorder, Childhood Disintegrative Disorder).

If responses to Questions 1–3 warrant further clinical inquiry necessary to confirm Pervasive Developmental Disorders diagnosis, circle the question mark.

Pervasive Developmental Disorders 

Eating Disorders

1. **Does your child think that** (his or her) **weight is what it should be for** (his or her) **age?** ☐ Yes ☐ No ☐ Other
2. **Do you think your child wishes that** (he or she) **could be thinner than** (he or she) **is now?** ☐ Yes ☐ No ☐ Other
3. **Does your child worry a lot about** (his or her) **weight?** ☐ Yes ☐ No ☐ Other
4. **Does your child find it difficult to control** (his or her) **eating?** ☐ Yes ☐ No ☐ Other
5. **Does your child have times when** (he or she) **goes without eating** (fasting) **so that** (he or she) **can control** (his or her) **weight?** ☐ Yes ☐ No ☐ Other
6. **Does your child ever eat a huge amount of food at one time?** ☐ Yes ☐ No ☐ Other
7. **People try all sorts of things to control or lose weight. Some might go on diets, use medications or laxatives, exercise for hours, or even try to vomit so they don't gain any weight. Does your child do similar things to control** (his or her) **weight?** ☐ Yes ☐ No ☐ Other

   If "Yes" or "Other," **What kinds of things has** (he or she) **done in the past?** _____

If the parent's responses suggest a possible Eating Disorder, obtain further details and assess the status.

If responses to Questions 1–7 warrant further clinical inquiry necessary to confirm Eating Disorder diagnosis, circle the question mark.

Eating Disorders 

Somatoform Disorders

Hypochondriasis

1. **Is your child always worrying that** (he or she) **might have a serious disease or illness** (e.g., cancer, AIDS)? ☐ Yes ☐ No ☐ Other

If "Yes," **What types of diseases or illnesses does** (he or she) **think** (he or she) **might have?** _____

_____

2. **Does your child have any feelings** (symptoms) **or pains in** (his or her) **body that** (he or she) **thinks could be something serious?** ☐ Yes ☐ No ☐ Other

   If "Yes," **What feelings (symptoms) does** (he or she) **have?** _____

   _____

   How often do these feelings (symptoms) **happen to** (him or her)?

   _____

If "Yes" to either Question 1 or 2 or you unsure, continue. Otherwise, skip to Somatization Disorder.

3. **Has your child seen any doctors to try to find out what is wrong?** ☐ Yes ☐ No ☐ Other

   If "Yes," **What did the doctor say?** _____

   _____

4. **If you or the doctor tells your child that everything is okay and that there is nothing wrong with** (him or her), **does** (he or she) **believe it?** ☐ Yes ☐ No ☐ Other

Somatization Disorder

1. **Does your child go to the doctor often because of many different physical complaints?** ☐ Yes ☐ No ☐ Other

   If "Yes," **What kinds of physical symptoms has** (he or she) **had?**

If "No," skip to Optional Interference Inquiry (p. 92).

Note. DSM–IV requires the following criteria for Somatization Disorder:

- Four pain symptoms (e.g., head, stomach, back, joints, extremities, chest, rectal, menstruation, urination).
- Two gastrointestinal symptoms (e.g., nausea, diarrhea, bloating, vomiting, intolerance of several different foods).
- One sexual symptom (e.g., irregular menses, excessive menstrual bleeding).
- One pseudoneurological symptom (e.g., conversion symptoms, paralysis or localized weakness, difficulty swallowing or lump in throat, hearing loss, urinary retention, hallucinations, loss of

touch or pain sensations, double vision, blindness, deafness, seizures).

2. **In what ways have these physical symptoms caused problems for your child?** _____

_____

If the parent's responses suggest a possible Somatization Disorder, obtain details and assess the current status.

If responses to Questions in the Hypochondriasis and Somatization sections warrant further clinical inquiry necessary to confirm Somatoform Disorder diagnosis, circle the question mark.

Somatoform Disorder 

Optional Interference Inquiry

To identify specific areas of interference for any of the previously described disorders, the interviewer may ask the following questions:

Does this problem interfere with school? Does it stop your child from doing things at school and make it hard for (him or her) **to enjoy school?** ☐ Yes ☐ No ☐ Other

Does this problem interfere with your child's friendships? Does it keep (him or her) **from making friends or doing things with friends?** ☐ Yes ☐ No ☐ Other

Does this problem interfere with your family life? Does it cause arguments, strain your relationships, prevent the family from doing things, or cause family members to be upset? ☐ Yes ☐ No ☐ Other

Does this problem interfere with things such as your child's sleeping, eating, or concentrating on things like homework? Does it cause (him or her) **to cry or to get upset easily?** ☐ Yes ☐ No ☐ Other

Developmental Questions

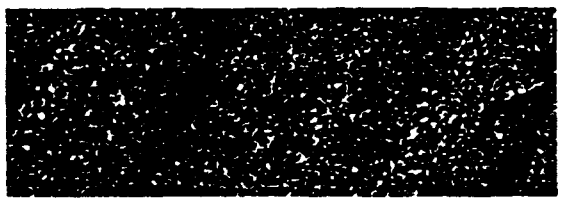
Think back to when your child was an infant. Was (he or she) **frightened by strangers or by new situations?** ☐ Yes ☐ No ☐ Other

As a toddler, did your child tend to be shy and hesitant to explore (his or her) **surroundings?** ☐ Yes ☐ No ☐ Other

When your child was an infant and toddler, what were (his or her) **reactions when you left** (him or her) **with sitters or in day care situations?**

Family History and Genogram

In the space provided, record information about emotional or mental disorders, substance or alcohol use problems, and history of physical or sexual abuse by first-degree relatives.



Treatment History

Counseling and Psychotherapy

Obtain a chronology of the child's treatment history for emotional or behavioral problems.

Dates	Problems	Agency/Therapist	Results

Medication History

Dates	Problem Focus	Medication Type/Dose	Prescribing Physician	Response

Parent-Initiated Topics (previously undiscussed)

1. **What is the main problem with which *you* would like your child to have help?** _____

   _____

2. **Is there anything else that we should talk about? Anything that we haven't covered?**

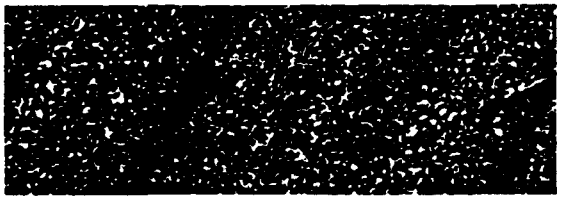
   _____

   _____

   _____

   _____

   _____



ADIS for DSM–IV:C
Parent Interview Schedule Summary

Parents' Interview Behavior

Psychosocial Stressors

The next series of questions are intended as a guide to assess the severity of psychosocial stressors. The interviewer should inquire about loss, parental divorce or separation, change in schools, and other specific stressors that might have an impact on the child's presenting complaint.

Over the past year, have there been any problems or changes

a. **In your family?** _____

_____

b. **In your child's friendships?** _____

_____

c. **With school or your child's academic performance?** _____

_____

d. **With your child's health?** _____

_____

e. **With any other family member's health?** _____

_____

Narrative Summary

This summary should include presenting complaint, history, diagnostic impression, and information obtained from the previous questions.

_____

_____

_____

Summary of Current *DSM–IV* Diagnoses and Clinician Severity Rating

The clinician's severity rating (CSR) is based on the following 9-point scale (0–8) and is guided by the parent's interference ratings, total number of symptoms endorsed, and clinician's impression for each diagnostic category.

	Principle Diagnosis	Clinician's Severity Rating	Additional Diagnoses	Clinician's Severity Rating
Axis I	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Axis II	_____	_____	_____	_____
Axis III	_____	_____	_____	_____
Axis IV	_____	_____	_____	_____
Axis V	**Present** _____		**Last Year** _____	

ABSENT	MILD		MODERATE		SEVERE		VERY SEVERE
0	1	2	3	4	5	6	7	8
None	Slightly Disturbing/ Not Really Disabling		Definitely Disturbing/ Disabling		Markedly Disturbing/ Disabling		Very Severely Disturbing/ Disabling

Past Diagnoses

Diagnosis	Clinician Severity Rating	Date of Onset	Date of Remission
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Calendar—Side 1

Month 1

Week	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Week 1							
Week 2							
Week 3							
Week 4							

Month 2

Week	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Week 1							
Week 2							
Week 3							
Week 4							

Month 3

Week	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Week 1							
Week 2							
Week 3							
Week 4							

Calendar—Side 2

January						
S	M	T	W	T	F	S

February						
S	M	T	W	T	F	S

March						
S	M	T	W	T	F	S

April						
S	M	T	W	T	F	S

May						
S	M	T	W	T	F	S

June						
S	M	T	W	T	F	S

July						
S	M	T	W	T	F	S

August						
S	M	T	W	T	F	S

September						
S	M	T	W	T	F	S

October						
S	M	T	W	T	F	S

November						
S	M	T	W	T	F	S

December						
S	M	T	W	T	F	S