TEACHER TELEPHONE INTERVIEW FOR ATTENTION-DEFICIT/HYPERACTIVITY DISORDER AND RELATED DISORDERS: DSM-IV VERSION (TTI-IV)

BASIC TRAINING MANUAL

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GUIDELINES

1.1 PREAMBLE

Current practice parameters for the psychiatric assessment of children and adolescents recommend obtaining information from parents and teachers. Information from both parents and teachers are crucial if an accurate picture of the child’s functioning, together with the nature and extent of his/her difficulties, is to be obtained. The child does not develop within a single context and his/her psychological well being is highly dependent upon the interaction of the family, school, and community settings. Moreover, the DSM-IV requires evidence of functional impairment in two or more settings in order for diagnoses to be made. These settings typically involve the home and the school for children.

In the Clinical Practice Guideline: Diagnosis and Evaluation of the Child with Attention-Deficit/Hyperactivity Disorder of the American Academy of Pediatrics’ (2000), it is recommended that

the assessment of ADHD requires evidence directly obtained from the classroom teacher (or other school professional) regarding the core symptoms of ADHD, duration of symptoms, degree of functional impairment, and associated conditions.

Similarly, the American Academy of Child and Adolescent Psychiatry’s (1997) practice parameters for Attention Deficit Hyperactivity Disorder (ADHD) state

It is essential to obtain reports of behavior, learning, and attendance at school, as well as grades and test scores.

Although the importance of collecting school data during the assessment process is widely acknowledged, no specific guidelines for obtaining information from teachers have been provided in the practice parameters. This lack in the field may be exacerbated by the fact that while numerous parent interviews exist, teacher interviews are rare. Of the teacher interviews that are available, one is outdated and the second is a computerized telephone administration using software that is not widely available.

There are several standardized rating scales and symptom checklists with established reliability and validity that are designed for teachers and are widely used. These instruments play an important role in identifying symptoms and establishing the need for further evaluation, but they do not provide diagnoses. Also, there remains an expressed concern within the practice parameters of these instruments regarding halo and confounding effects between ADHD and aggression in teacher ratings (Abikoff et al., 1993; Schachar et al., 1986). As well, it has been noted that regular classroom teachers tend to rate the same behavior as more hyperactive than do special education teachers (Abikoff et al.,
Lastly, rating scales do not take into consideration the impact of the situational context on symptom expression. Clinical interviews using probing questions are better able to address these problems and acquire a more accurate picture of the behaviors being assessed.

Consequently, it is clear that an effective, systematic tool designed specifically for collecting data from teachers is needed. A clinically meaningful, reliable, and efficient tool to obtain information about the child’s functioning at school will have the potential to fill an important void in the field of psychiatry.

1.2 TYPES OF INTERVIEWS

Clinical interviews are integral to the assessment process. The clinical interview is the cornerstone for gathering information to determine the presence or absence of psychiatric disorders. It is a useful method for obtaining a verbal report from the teacher regarding the child’s learning, academic productivity, and behavior since it is often not feasible to perform observations at the school.

There are two types of diagnostic interviews, respondent-based and interviewer-based, designed specifically to identify different disorders. Respondent-based interviews, commonly referred to as “structured interviews”, provide a standardized, rule-based organization for the manner in which information is to be gathered. Respondent-based interviews contain a fixed set of questions that organize the responses of the informant and typically allow little room for the interviewer to ask additional, clarifying questions. The advantages of this approach include the elimination of variation in “clinical judgment” and reduction of clinical bias in terms of the tendency to selectively collect information that conforms to the initial diagnostic impression (Angold, 1997). On the other hand, the clinician has to assume that the respondent understands the intention of the question, is able to use a symptom severity scale that may be mainly familiar to clinicians, and has to accept the respondent’s judgment of whether a symptom is present or not. These three assumptions are questionable. Furthermore, most structured interviews are designed as symptom inventories and do not aim to provide an assessment of the impact of the situational context, coping mechanisms, or adaptive strengths on symptom expression.

In contrast, interviewer-based interviews (also referred to as “semi-structured” interviews) attempt to organize the mind of the interviewer by including a flexible list of diagnostic questions or probes, the use of which is dependent upon the judgment of the interviewer (Angold et al., 1995). This type of interview is typically preferred in clinical settings. This is because in clinical practice, judgments are based on detailed questioning leading to clearer descriptions of the phenomena and their levels of intensity, duration, and frequency in various contexts. Discrepant or ambiguous information may be explored more fully and the final coding may be viewed more confidently as reflecting a clinically meaningful diagnosis. The disadvantage is that unless the interviewers are
trained rigorously to make their judgments in the same way, variability in clinical judgments may lead to unreliability of clinical diagnosis. The essential requirement of interviewer-based, or semi-structured interviews, is a clear operationalization of the criteria for making symptom judgments.

1.3 PURPOSE OF THE CAPABLE- TTI

The Teacher Telephone Interview for Attention-Deficit/Hyperactivity Disorder and Related Disorders: DSM-IV Version (TTI-IV) is a diagnostic interview for use with teachers. It is unique in its use of a semi-structured approach. It was developed primarily to systematically assess children’s disruptive behavior problems and functioning as observed in the school environment. Specifically, the interview is designed to obtain a more accurate understanding of the nature and impact of a child’s behavioral difficulties while allowing rapport to be established between the interviewer and the teacher. It was also developed to improve precision in clinical diagnosis in child psychiatry for ADHD and related disorders. The TTI-IV is a useful tool for children and adolescents. However, special accommodations are necessary in conducting the TTI-IV once children and adolescents have entered a rotary system at school (see Section 2.84 Interviewing High School or Rotary Teachers). Typically, it takes 30 minutes to administer and score the telephone interview.

The TTI-IV is designed to be used in conjunction with a comparable semi-structured interview for parents (Parent Interview for Child Symptoms - 4; Schachar, Ickowicz, & Wachsmuth, 1995) to diagnose ADHD and to distinguish ADHD from Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD). The TTI-IV also allows for screening of aggression and other major disorders in the differential diagnosis of ADHD (e.g., General Anxiety Disorder, Phobia, Obsessive-Compulsive, Separation Anxiety, Psychotic symptoms and Tic disorders). The TTI-IV includes all of the DSM-IV criteria for ADHD, ODD, and CD.

1.31 Unique Characteristics

The TTI-IV is distinct from other diagnostic interviews in several ways:

1. It aims to elicit evidence of behavior that is describable (phenomenological) as opposed to inferential. That is, the interviewer asks the teacher to provide detailed descriptions of child behavior in a variety of school situations during the past few months, but does not require the teacher to provide a rating of that particular behavior or symptom. Instead, using predefined criteria, it is the interviewer who makes the judgment about the presence and severity of each symptom. This approach also contrasts to questionnaires in which the teacher’s subjective responses are the main source of information for diagnosis.
2. **Operational definitions** are provided for all the symptoms. The DSM-IV provides descriptions of symptoms but they are not operationalized nor do they explain what behaviors are covered by each symptom. In the TTI-IV, operational definitions made specifically for the school setting are provided to assess the behavioral descriptions elicited by the teacher. This is an important asset since one symptom may be interpreted as representing different behaviors. Operational definitions are particularly useful for interviewing teachers who often use one word (e.g., fidgety) to mean many symptoms (e.g., out of seat, fiddling, distracted).

3. The TTI-IV allows for a **systematic check** of all symptoms to facilitate diagnosis. This check can be done while the interview is in progress as the ADHD, ODD, and CD items can be quickly scanned to ensure the teacher has discussed all symptoms. If there is insufficient information to rate a symptom, or if the teacher has yet to discuss certain symptoms, probes may be used.

4. Using **probes** is the fourth distinct feature of the TTI-IV compared to other diagnostic interviews. The direct repetition of DSM-IV symptoms is not used in the TTI-IV. Instead, probes consistent with the operational definitions are used to elicit behavioral descriptions of the behaviors to determine if a specific symptom is present or absent.

### 1.4 ORGANIZATION OF THE TTI-IV

The TTI-IV consists of three primary components: 1) academic placement review; 2) symptom review; and 3) impact review.

#### 1.41 Academic Placement Review

The academic placement review has three goals. The first is to ascertain the degree of structure in the current placement, since symptoms may be attenuated in the presence of high external structure (Dulcan, 1997). The second goal is to determine the need to interview other teachers if the first teacher is unable to provide sufficient information on the child. The third goal is to ascertain what academic intervention or supports are currently in place.

#### 1.42 Symptom Review

In the second part, the teacher is asked to describe the child’s behavior in four domains (academic performance, classroom behavior, peer relations, relationships with adults in the school) to obtain a picture of the child’s functioning in a variety of situational contexts. During the symptom review, the interviewer attempts to elicit specific descriptions of the child’s behavior to rate the severity and frequency of symptoms on a four-point scale, using predefined
The specific contexts to probe are school arrival, didactic group lessons, independent seatwork, and transitions (i.e., going to and coming back from recess, lunch, and other classes) at school. Other contexts such as art, music, and gym may also be explored if doing so facilitates the evaluation of a child’s behavioral difficulties. Finally, social contexts are probed to examine the child’s interpersonal dynamics and assess his/her relationships with peers and adults in the school.

1.43 Impact Review

The interview is concluded by asking the teacher if s/he has any main concerns about the child. During this section, the teacher is asked to comment on the extent to which the child’s difficulties are impeding his/her progress and function at school. S/he is also asked the extent to which the child’s difficulties place a burden on the teacher and/or other students in the class.

1.5 USER QUALIFICATIONS

TTI-IV results provide valuable information to a variety of professionals in mental health settings and others who classify students, diagnose disorders, and/or plan intervention programs: School Psychologists, Clinical Psychologists, Psychoeducational Consultants, Developmental Pediatricians, and Child Psychiatrists. Interviewers using the TTI-IV should have training and experience in the administration and interpretation of clinical interviews.

Interviewers must have in-depth knowledge of the diagnostic categories and criteria of the DSM-IV. Interviewers should also have experience working with children and adolescents with psychiatric disorders and also be familiar with the educational system, curriculum requirements, classroom routines, and demands of the classroom. Sensitivity to diverse cultural backgrounds is also required in order to differentiate culturally normed behaviors from ones that are truly deviant.
GENERAL INSTRUCTIONS FOR IMPLEMENTATION

2.1 OBTAIN PARENTAL CONSENT

Parental written informed consent must be obtained prior to conducting the interview. It is suggested a letter be sent to the teacher (and the School Principal) ahead of time requesting their assistance and informing them of the total requirements. As part of the total requirements, it may be helpful to ask the teacher to complete standardized behavioral rating scales before the interview occurs in order to focus the teacher on the child. If behavioral rating scales are being used, the requirement should be made clear for the teacher in the letter so s/he will be able to arrange his/her time accordingly. Enclosed with the letter should be a consent form signed by the parents giving permission for the teacher to provide the interviewer with information about their son/daughter.

2.2 CHECK MEDICATION STATUS

It is important to determine whether the child is currently receiving any medication. Ideally, the TTI-IV should be completed when the child is in a medication-free state. If the teacher has observed the child both on and off medication, then the teacher can be asked to describe the child’s behavior when s/he was not medicated (and perhaps contrast it with behavior when medicated). In some circumstances, it may be necessary to arrange for a medication-free period prior to obtaining behavioral descriptions from the teacher. This must be arranged in consultation with the child’s parents and treating physician.

2.3 BOOK A TELEPHONE APPOINTMENT

Schedule an appointment with the teacher prior to the interview. Flexibility in scheduling during and after school/work hours is the key to gaining access to teachers. Typically, the interview can be completed in 30 minutes. In order to minimize “telephone tag” with the teacher, it is helpful to leave a message with the school secretary asking the teacher to leave a message for the interviewer with three separate dates and times that would be convenient for him/her. The interviewer can then call back to confirm a date and time that would be mutually agreeable to both parties. Confirm whether the interviewer or teacher will make the phone call. On the day of the interview, it is imperative that the interviewer is ready to start at the agreed time, since being five minutes late may mean the teacher is unavailable. At the start of the interview, clarify the amount of time the teacher has available for the interview. Keep to that time. If necessary, reschedule an additional time to complete the interview.
2.4 TIME FRAME FOR DESCRIPTIONS/RATINGS

Ideally, ratings should be based on the child’s behavior over the last six months. Often this is not feasible, but the minimum time frame should be about one month. Note on the Interview Protocol: Report & Scoring Form how long the teacher has known the child.

2.5 WRITING BEHAVIORAL DESCRIPTIONS

During the interview, it is imperative that the interviewer listens to the behavioral descriptions given by the teacher. Active listening is required to ensure the teacher has discussed all the symptoms so that each one may be rated by the interviewer. As the interviewer listens to the descriptions, s/he is required to write notes in the Interview Protocol: Report & Scoring Form. It is important that detailed notes of actual examples of problem symptoms are written down. For example, if the teacher says the child is “always fidgeting”, ask what behaviors would be seen and how frequently (e.g., hourly, daily, weekly). Reported behaviors are then written as evidence for fidgeting. Large spaces in each section have been provided on the protocol for the purpose of writing these examples. It is important that the interviewer write objective behavioral descriptions, not interpretations or impressions from the teacher or the interviewer. Furthermore, it is essential to ensure that there is enough information to score each symptom, since writing and systematic scoring is performed on-line. Examples of the child’s symptoms should be written clearly and with adequate information so that other clinicians reading them will acquire a good picture of the child. Other clinicians should also be able to read the detailed examples to see the reasoning and the justification for the ratings given to a child.

2.51 TTI-IV as Part of the Clinical Record

Remember that the written documentation in this interview becomes part of the clinical record and could be used for legal purposes. If the teacher uses strong, interpretative language to describe a behavior, the child, and/or the family it should not be written verbatim. Instead, the information should be written in a non-offending and non-libelous manner.

If the teacher mentions family issues, stop him/her by thanking him/her for the valuable information and state that the issues will be discussed with the family. The family issues reported by the teacher should be made as a note at the end of the interview as a flag to the clinical team to explore the issues specifically with the family.
2.6 ON-LINE RATING OF SYMPTOMS

The TTI-IV requires the systematic checking of symptoms to ensure each has been discussed adequately to allow rating. As the teacher’s behavioral descriptions are being summarized in the spaces provided on the *Interview Protocol: Report & Scoring Form*, the interviewer rates the symptoms concurrently. The written examples are used as evidence and provide the rationale for the rating of a symptom. During the interview, look for examples of inattention, impulsiveness, over-activity, oppositional behavior, and conduct problems. As well, note any spontaneous comments about misery, anxiety, or self-esteem, then probe more specifically for these areas. Throughout the interview, quickly skim scoring of ADHD, ODD, and CD items. Probes should be directed at specific symptoms that have not been covered adequately to permit a rating. If the total count for a given diagnosis or subtype (e.g., inattention vs. impulsive/hyperactivity) is borderline (i.e., one or two more problems are needed to make a diagnosis), or if there was an area that was not clear, re-check the items in that area and probe further if necessary.

It is important to highlight that “provisional” rating occurs on-line throughout the interview. Ratings should always be double-checked at the end of the interview using the written examples and the general information provided by the teacher as evaluation for accuracy. Scoring is based on a four-point rating scale ranging from 0 (no problem) to 3 (severe problems).

2.7 CLINICAL RESEARCH GUIDELINES

The TTI-IV may be used for clinical research purposes. It is still implemented in the same manner with the following additions to consider:

1) Standardized behavioral rating scales *must* be completed prior to the interview by the teacher to focus the teacher’s attention and observations of the child. It would be useful to send the behavioral rating scales as part of a “Teacher Package” to the parents along with instructions for them to sign an enclosed consent form for the school’s records. The parents are asked to call the contact person on the research team once the “Teacher Package” has been delivered to the teacher to ensure it has been received by the teacher. The interview is conducted only when the package has been received and the teacher has filled out the behavioral rating scales.

2) The parents and the teacher should be interviewed by different clinicians.

3) Training of interviewers and assessment of interviewer reliability should be executed prior to the start of the project.
2.8 SPECIAL CONSIDERATIONS

2.81 Teacher Interviews During the Academic Year

Although it is ideal for the ratings to be based on the child’s behavior over the last six months, this is not always feasible. However, it is essential that the teacher know the child well to be an effective reporter. It is only when the teacher knows the child well that the interviewer is able to obtain good behavioral descriptions to allow rating of symptoms. Earlier, it was stated that a minimum time frame of one month be used. Therefore, if the interview must be done shortly after the school year begins, then one of two options may be used:

1) The ideal situation would be to ascertain whether the previous teacher (e.g., the Grade 4 teacher if the child is entering Grade 5 in the new school year) would be able to do the interview since that teacher already taught the child for one academic year.

2) If a school year starts in September and the new teacher does not know the child well, the earliest time the interview should take place is late October. Often September is an adjustment month for both the child and the teacher. Thus, the behaviors exhibited by the child in the first few weeks may not be indicative of what the child is truly like. Interviewing in late October allows the teacher to have a more accurate picture of the child since children usually have settled in to their new classrooms by then.

2.82 Interviewing Teachers in Segregated/Special Education Classes

Important differences may exist that have implications for scoring the presence/absence and severity of symptoms. For example, typically there are fewer students in the class (i.e., 8 or less) and a higher degree of structure may exist in the learning situation (behavior modification techniques/programs such as token economies, point systems, daily school-behavior report cards, etc.). The goal is to determine to what extent the child's behavior is being modified by the current placement/program (i.e., would specific problems arise if the current behavior techniques were not in place).

2.83 Assessing Symptom Presence and Severity in Children with Learning Disabilities

Clarify with the teacher about the presence and nature of specific learning disabilities that the student is known to have. Also, ascertain strengths or specific interests in other areas (e.g., art, drama, gym, and social studies) that can subsequently be probed for presence of symptomatology. Clarify whether problems in some areas (e.g., in following through with instructions, paying attention to detail/carelessness, difficulty organizing tasks/activities) might be attributable to the learning disability (e.g., cannot read the instructions - skills deficit) or actually reflect symptoms of ADHD. Confidence in the possibility of
ADHD is increased if symptoms are present in school activities in which the student shows strengths.

2.84 Interviewing High School or Rotary Teachers

The TTI-IV may be used for adolescents. However, because adolescents are on a rotary system at school, it may not be possible to conduct the interview precisely in the same manner as for younger children. Thus, certain safeguards should be applied in order to achieve the most successful interview possible. First, prior to the interview, ascertain which teacher at school knows the adolescent best. It is with this teacher that the interview should be conducted. Second, it should be kept in mind that regardless of which teacher knows the adolescent best, it is likely that this teacher only sees the adolescent for one period (i.e., 40-70 minutes) per day (this should be explicitly noted at the front of the Interview Protocol: Report & Scoring Form to inform other clinicians of this constraint). Subsequently, the following is recommended based on the contextual format of the Interview Protocol: Report & Scoring Form:

1) Unless the teacher has the adolescent for homeroom, “School Arrival” cannot be queried. To assess similar symptoms tapped in the “School Arrival” context, the interviewer may wish to ask the teacher about the adolescent’s arrival to his/her class and how s/he gets ready for the period or for the lesson of the day.

2) When querying for ADHD symptom 1D – Finishes Work, it may be possible that the students in the teacher’s class are not required to finish their work in one period. Typically, these may be Science or Geography classes where work is expected to be taken home on a regular basis. The teacher should be asked if the adolescent completes homework and the symptom be rated accordingly. This question, however, may pose a problem for adolescents who finish their homework, but regularly forget to bring it back to school. Alternatively, the adolescent’s ability to finish homework may be an uncertainty for the teacher if the adolescent possesses other symptoms that may affect finishing of work. Thus, the teacher should be asked whether the adolescent is typically able to finish a set amount of work in class as indicated by the teacher (e.g., three questions, Exercise 1).

3) If an adolescent is not doing his/her work nor finishing it, it is crucial to tease apart learning problems. The adolescent may be having specific problems with that class (e.g., mathematics) and the teacher may not have other means of comparison (i.e., other subjects) to report capabilities.

4) The teacher may not see the adolescent in the hallways during transition periods. Transitions can be queried by asking the teacher if the adolescent typically has his/her materials needed for the class and how s/he prepares him/herself to leave for the next class.
5) The teacher may not have any awareness of the adolescent’s peer relationships. It may be necessary to restrict queries to the adolescent’s interaction style in class with his/her peers. Further queries can be directed at group work (if applicable), or any other situation where peer interaction is required in class, to assess how the adolescent interacts with his/her team members.

It is important to highlight that if there is insufficient information to permit rating of certain symptoms, it may be necessary to contact a second teacher for an interview.

2.85 Addressing Reports of Abuse or Neglect

Although rare, a teacher may present knowledge of or concerns about child abuse or neglect at some point during the interview. If this occurs, it is important that the interviewer follow the procedures and guidelines set by his/her profession, institution, or country.

The procedure used thus far by the TTI-IV team at the Hospital for Sick Children is suggested if no guidelines are in place for the new interviewer: If the teacher mentions abuse or neglect, it is imperative that the interviewer ask the teacher if a report has been made to the appropriate agencies. If a report has not been made, then the interviewer must discuss with the teacher the need to report. If the teacher agrees to report, it is recommended that the interviewer follow up with the teacher at a later date to ensure a report has been made. If the teacher declines to report, it becomes the interviewer’s responsibility to do so. If there are any doubts about the reporting process or the steps that need to be taken, it is recommended that the appropriate agencies be contacted for direction.
The DSM-IV provides behavioral symptoms for the disruptive behavior disorders, but it does not operationally define them nor does it give information on how to differentiate one symptom from another. For the TTI-IV, operational definitions for ADHD, ODD, and CD were created specific to the school setting to facilitate the evaluation of symptom presence. Evidence for each symptom is also provided to highlight examples of behaviors that the interviewer is seeking to endorse symptom presence. Finally, examples of probes are listed to assist the interviewer in querying for information that has not yet been provided by the teacher.

3.1 ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

3.11 Inattention

1A. Often fails to give close attention to details or makes careless mistakes in school work, work, or other activities.

The key to this symptom is the quality of and approach to the work is below the child’s demonstrated abilities.

EVIDENCE: a) Omitting required details (e.g., no name, date; b) Rushes through work, activities or may be slow and last to finish, but makes silly mistakes; c) Sloppy work (e.g., poor printing/writing and typically illegible, but has ability to print/write neatly); d) Not proofreading or checking work.

CONSIDER: Fine motor skills problems or skills deficits.

PROBES : 1) What is the quality of work like?
2) How much care does this child put into his work?
3) Is this child losing marks for careless errors?
4) Does this child find it difficult to pay close attention to what needs to be done?

1B. Often has difficulty sustaining attention in tasks or play activities.

The key to this symptom is the child “drifting away” or unable to concentrate on task/activity at hand for a reasonable length of time (i.e., developmentally appropriate) in the absence of salient stimuli (e.g., noise in hallway). Child may eventually finish activity, but take longer to do so or may need more breaks than peers.
The critical issue is not the ability to start activities, but an inability to “stick with” activities. Child may show good initiation.

The critical distinction is whether the “distracter” is external to the child (e.g., noise in hallway, other people) that draws attention; versus the child’s inability to maintain/sustain attention so that attention “drifts away” in the absence of some external stimulus. See ADHD-1H “easily distracted”.

*If the child is distracted by external stimuli, consider coding under ADHD-1H “easily distracted”.*

For the child with learning disabilities, look for evidence of this symptom in their academic areas of strength, areas s/he enjoys, and/or non-pencil to paper tasks (e.g., class discussions, story time).

EVIDENCE: a) Staring into space or looking around, but not focused on anything; b) Daydreaming; c) Lost in thought; d) Described as “not with you”; e) Described as “spacey”; f) Child starts and engages in a task, but does not continue with it for a reasonable period of time relative to peers.

CONSIDER: Will need to query Absence Seizures (Petit mal seizures) if the child is frequently staring into space. Absence Seizures should be ruled out when there is a combination of high frequency of staring into space and disorientation when the child emerges from these states.

PROBES: 1) When the class is relatively quiet, is this child able to focus on her work? 2) Is this child able to focus for the duration of the task? 3) During group discussion or individual seatwork, where is this child looking? 4) For the things this child is able to do, is s/he able to sit there and really work at it for a reasonable period?

**1C. Often does not seem to listen when spoken to directly.**

The key to this symptom is that the child does not give any verbal or non-verbal acknowledgment that s/he heard the speaker when addressed one-to-one. The child does not appear “to be with you”. This symptom is not synonymous with “does not obey”.
EVIDENCE:  a) Unable to keep his/her mind on the conversation, etc.; b) Provides no other feedback such as nodding, saying “Mm, O.K.”, or making eye contact; c) Does not look as if the child is listening (e.g., body stance - body turned away, head down); d) Teacher has to make big effort to secure child’s attention and repeat what s/he just said; e) Child cannot repeat or paraphrase what was said.

CONSIDER:  Noncompliance or lack of comprehension.

PROBES:  1) When you are talking to him/her one-to-one, is this child able to follow what you are saying?  2) Does this child tune out when you are having a conversation with him/her?  (Follow up with “How often”)  3) Do you have to use any strategies to help this child follow what you are saying?

1D. Often does not follow through on instructions and fails to finish schoolwork {chores, or duties in the workplace} (not due to oppositional behavior or failure to understand instructions).

The key to this symptom is that the child starts multi-component instructions, but not follow through and complete work, school chores, etc.

If it is difficult to probe this symptom in academic work, areas of strengths, or recreationally-oriented activities for the child with severe learning disabilities, ask the teacher for examples of the instructions given to the child to assess for developmental appropriateness. In addition, query if the child is able to follow through on classroom chores that involve multi-component instructions.

EVIDENCE:  a) Rarely finishes; b) Low productivity; c) Leaving things half done; d) Shifting from one uncompleted activity to another; e) Only completes work with close supervision; f) Rushes through work and is sent back by teacher because child has not followed all instructions or completed all components; g) Need for frequent reminders to continue and complete work, chores; h) Does not finish in-class assignments.

CONSIDER:  Noncompliance (e.g., ask “Is the child refusing to do the work?”), skills deficits (e.g., ask “How does the child handle assignments and seatwork when s/he knows how to do it?”), and constant need for feedback/reassurance (indicative of anxiety).

PROBES:  1) How often do you have to remind this child to finish work
or duties?
2) Can you give me an idea as to how much this child can do within his/her ability level?
3) What is this child’s ability to complete hands-on activities (e.g., science and geography activities, art)?

1E. **Often has difficulty organizing tasks and activities.**

The key to this symptom is a lack of systematic and planned approach to a task, not due to forgetfulness or losing things (i.e., child knows where things are).

**EVIDENCE:**
- a) Messiness in at least 2 areas (desk, locker, cubby hole, knapsack, notebooks, or work area) causing impairment;
- b) In transitions, does not “get it all together”.

**CONSIDER:** Noncompliance or skills deficits.

**PROBES:**
1) How well is this child able to get ready and prepare for the next activity or class?
2) How well does this child put his/her papers in the place they belong, such as writing folders, binders, or boxes?
3) Can this child use the existing organizational routine set up in the classroom? (Seek examples)

Follow up to Probe 3): Do you have to set up additional strategies for this child?

**Additional probes for children or adolescents on rotary systems:**

4) What is this child’s organizational skills like?
   (Ask for examples of organization or disorganization to ensure teacher is giving you evidence for this symptom)

1F. **Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework).**

The key to this symptom is unwillingness to **engage in challenging** and/or **lengthy** tasks (even though the child may be okay with simple or rote activities).

**EVIDENCE:**
- a) Active avoidance (makes comments such as “Yeah, in a minute”; engages in another activity; leaves the room;
dawdling; disappears into bathroom); b) Change in behavior or mood at the onset of more challenging and/or lengthy tasks (e.g., whining, complaining); c) Child does not start on the activity without many prompts or active teacher supervision; d) Child starts, but does not engage in or put effort to the task.

CONSIDER: Skills deficits, oppositional defiant behavior, and/or anxiety (e.g., constant need for reassurance).

PROBES: 1) How does this child handle challenging or lengthy activities or work within his/her ability level? 2) Does this child get going on an independent project?

1G. Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools).

The key to this symptom is the child not knowing where the needed item is.

EVIDENCE: a) Constantly looking for things (e.g., pencils, textbooks, personal belongings); b) Child constantly asking teacher and other children "Where’s my…”.

PROBES: 1) How well does this child keep track of his/her belongings?

(If teacher responds child is okay, confirm with “This is a child who is not constantly looking for his/her things because s/he has no idea where they are?” to ensure the losing symptom is not endorsed).

(If teacher responds this is a problem, also ask “How well does s/he keep track of his/her personal belongings?” if s/he does not spontaneously include this in her descriptions, for scoring purposes).

2) To what extent does this child constantly look for his/her things because s/he has no idea where they are? 3) To what extent is the case where the student has forgotten the materials or doesn’t have any clue where they are?
1H. *Is often easily distracted by extraneous stimuli.*

The key to this symptom is that the child’s attention is being drawn away from the current focus by something external to the child. The child is not momentarily distracted - s/he is unable to leave or disengage himself/herself and get back to the task without teacher intervention.

The critical distinction is whether the “distracter” is external to the child (e.g., noise in hallway, other children working) that draws attention. The distracter may not necessarily be salient to others (i.e., typical everyday activities).

Easily distracted refers to the child’s inability to ignore other events or noises outside the classroom (in hallways, outside window) or inside the classroom. Whereas most children would look up momentarily given an unexpected noise or event, they would quickly and spontaneously get back to work. By contrast, a child who is easily distracted appears at the mercy of the environment and is unable to resist the pull of external noises or events. Typical descriptions are: “If there’s something happening outside in the hallway or in the school yard, he just has to look and go and see”. Note that here the essential behavior is the frequency and consistency with which the child’s attention is drawn away. The child may be described as getting up from his/her seat to go and look out of the window, door, etc., but the eliciting stimulus should be some external noise or activity.

Simply staring into space, daydreaming, or “drifting away” should be coded as ADHD-2B “difficulty sustaining attention”.

EVIDENCE: a) In the presence of other activities going on in the classroom, child stops work to look and is unable to restart without prompts from teacher; b) Turning in his/her seat or moving towards the distracter; c) Child complains about noise and may ask to work elsewhere; d) On the way to doing something child gets sidetracked (e.g., child stops to watch others, play with something) and does not get back to the original activity without prompts.

CONSIDER: Other symptoms are not the problem to prevent double scoring.

PROBES: 1) How does this child handle noises or other activities occurring inside/outside the classroom when s/he should be focused on a task? 2) Does this child constantly need redirection to get back to the task at hand?
3) Are other children bothered by this distracter to the same extent?

1I. *Is often forgetful in daily activities.*

The key to this symptom is absentmindedness (i.e., the child *inadvertently* forgets to bring something back or to do something that is a typical daily activity).

EVIDENCE: a) Rarely remembers to bring home or hand in homework, notes, books; b) Forgets to take things home; c) Teacher constantly has to remind child of the daily activities or chores (e.g., get school bag ready, take or bring back lunch box); d) Forgets that there is to be a test or a quiz; e) Child keeps going back and forth from locker/cubby hole/knapsack to get needed materials.

CONSIDER: Lack of understanding.

PROBES: 1) Would you describe this child as absentminded? (Seek examples) 2) Does this child forget things s/he needs for school (e.g., homework, notes)? 3) Do you have to keep reminding this child to take things home such as his/her lunch box?

3.12 Impulsivity

2G. *Often blurts out answers before questions have been completed.*

The key to this symptom is the child interrupts the teacher by speaking or starting to do something *before a question or instruction has been completed.* Typical contexts are 1) a didactic lesson in which the teacher is in control of the session; 2) less structured situations; or 3) one-to-one situations, where the teacher asks the questions and gives the instructions. Thus, the child is acting without sufficient information. The child anticipates the question without adequate information and thus, responds too soon. The child is already engaged in the relationship with the teacher. The interrupting is premature, but not from the sidelines. Interrupting a non-engaged relationship such as a teacher speaking to another person would be coded under Interrupting (ADHD – 2I).

EVIDENCE: a) Child responds or talks *before* the teacher stops talking (e.g., “I know, I know”; “Oh, Oh”); b) Child starts to do something before it is possible for the child to know what to
do; c) Child does not wait until the teacher finishes giving the instructions or asks the question.

PROBE: 1) When you are asking this child or the entire class questions or giving instructions, how does s/he handle the situation?
2) Can this child wait until you finish asking the question or giving the instructions?
3) Does this child cut you off when you are asking questions or giving instructions?

2H. **Often has difficulty awaiting turn.**

The key to this symptom is that the child is violating social norms or expectations for turn taking in situations in which there is a specified or expected order for speaking, responding, or acting (e.g., conversations, games, lining up). The teacher would have completed the question in contrast to ADHD-2G “blurts out”.

EVIDENCE: a) Child shouts out the answer or talks out of turn (does not wait to be called upon); b) The child insists upon immediate attention or action (e.g., pushes in front of another child to get into line first or to talk first); c) Child gets very frustrated when s/he has to wait his/her turn.

PROBE: 1) What happens when this child has to wait his/her turn?

2I. **Often interrupts or intrudes on others (e.g., butts into conversations or games).**

*The key to this symptom is that the child stops or disrupts (interferes with) the flow of ongoing discussions or activities to the extent that the teacher, peer has to respond or react.* The child is not already engaged in the relationship. Instead s/he is interrupting a non-engaged relationship such as a teacher speaking to another child: 1) **Interrupts** refers to stopping another person in the midst of doing or saying something, especially by an interjected remark; 2) **Intrudes** refers to thrusting oneself in without invitation, permission or welcome, meddling in other's affairs, or hampering action.

EVIDENCE: a) Typically cuts off or talks over the person who is talking; b) Persists in calling out or pulling at the arm/clothing of the teacher when s/he is talking with someone else, or busy doing something else; c) Teacher or peers complains about the child interrupting activities or conversations; d) Pushing
into or joining a game or group activity without asking or being invited (i.e., against the wishes of the group);
e) Grabbing toys or objects from others; f) Interrupting a peer who is working quietly by talking to him/her.

PROBE: 1) To what extent does this child disrupt or interfere with ongoing discussions or activities?
2) Do other children complain that this child is interrupting them?

3.13 Hyperactivity

2A. Often fidgets with hands or feet or squirms in seat.

The key to fidgetiness is frequent activity of fingers, hands, arms, feet, and/or legs while remaining seated or standing in one place. Whereas, squirming is frequent body movement and change of position while seated or standing.

If the predominant description is of squirming, probe further to consider “On the go” (ADHD-2E).

EVIDENCE: Fidgetiness includes frequent, continuous bouts of activity such as a) Drumming fingers on desk; b) Tapping pencil on desk; c) Spinning pencil between fingers; d) Flicking holder or the retractor switch on mechanical pencil or pen; e) Twirling hair around finger; and f) Playing with toys or other objects in/on desk. Squirming includes g) Shifting body position in chair; h) Sitting on one leg then the other; i) Leaning over desk or table then sitting down again; j) Kneeling up on chair then sitting down; l) Swaying to, or swinging arms, or tilting head back and forth, while standing.

PROBES: 1) When sitting on his/her seat or carpet, what is this child doing?
2) Is this child able to sit still for a reasonable period of time?
3) What is s/he doing with his/her hands?

2B. Often leaves seat in classroom or in other situations in which remaining seated is expected.

The key to this symptom is frequent leaving and moving away from the chair or place on carpet. By contrast a child who moves up and down,
shifts or squirms, or falls off the chair will be coded as ADHD-2A or ADHD-2E.

EVIDENCE: a) Frequently leaves seat to wander around room; b) Frequently shifts from place to place on carpet; c) Frequent trips to sharpen pencil; d) Frequent trips to the washroom; e) Frequently goes over to talk to peers; f) Has difficulty staying seated during presentations or special events.

PROBES: 1) What does this child do when s/he is supposed to be in his/her seat? 2) Do you often have to re-direct this child back to his/her seat?

2C. Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness).

The key to this symptom is speed and/or style (leaping, jumping, climbing) of movement from one location to another, which is inappropriate for the context.

NOTE: For this interview, it was decided not to interpret “in adolescents or adults, may be limited to subjective feelings of restlessness” as indicative of this symptom (i.e., ADHD-2C). Instead, for the purposes of this interview, it was decided that this portion would be a better fit in ADHD-2E “on the go” and should be coded accordingly. See ADHD-2E.

EVIDENCE: a) Climbing over desks; b) Climbing over other children on the carpet; c) Sliding or running in hallways; d) Racing from one activity to another or during transitions.

PROBES: 1) Describe how this child moves around the classroom and hallways. 2) How often would I see this child running in hallways, racing into class, or climbing over desks?

2D. Often has difficulty playing or engaging in leisure activities quietly.

The key to this symptom is the child’s noise level (voice or activity) above what is expected for that context. In the school context, leisure activities can occur when the child has completed his/her work and the child can choose the activity (i.e., leisure is the child’s chosen activity). In many
classrooms, silent reading is the only permitted “leisure activity” and can be used to probe this behavior.

EVIDENCE:  a) Singing; b) Humming; c) Yelling across the classroom; d) Banging objects; e) Having loud conversations with others; and e) Kicking desk legs.

PROBES:  1) What is this child’s noise level like during play time (younger students) or down time (i.e., non-academic times for older students)?
2) Compared to other boys/girls, would this child stand out in terms of noise level?

2E. **Is often “on the go” or often acts as if “driven by a motor”**.

The key to this symptom is **constant, sustained** and **high level** of motor activity. In adolescents, this can include **verbal** self-reported feelings of restlessness to the teacher and/or leg jiggling.

EVIDENCE:  a) Rocking chair to and fro; b) Falling off chair frequently as a result of excessive movement in seat; c) Constant getting up and down in seat; and d) Rocking to and fro or twirling around on floor/carpet time; e) Has trouble slowing down or relaxing.

PROBES:  1) How much does this child move in the classroom?
2) Is this whole body movement or just fiddling?

2F. **Often talks excessively**.

The key to this symptom is the **frequency** of talking at **inappropriate** times.

EVIDENCE:  a) Turning in seat to speak to others; b) Rambling on and on about something; c) Talking when s/he is supposed to get materials ready for next activity

PROBES:  1) How chatty is this child compared to others?
2) How often does this child chat when s/he is not supposed to?
3) Does this interfere with his/her work or others’ work?
3.2 OPPOSITIONAL DEFIANT DISORDER (ODD)

In general, evidence of a **recurrent and persistent pattern** of negativistic
defiant, disobedient, and hostile behavior towards authority figures. Hostility can
be directed towards teacher or peers (e.g., as in deliberately annoying others or
verbal aggression). If the negativistic behavior is restricted to one peer or one
adult only, consider carefully if there is sufficient evidence for **pattern of
negativistic behavior**.

A1. **Often loses temper.**

The key to this symptom is **sudden loss** of self-control with overt signs
(i.e., visible to others) of anger.

May include slamming books down, stamping foot, rage attacks, yelling
and screaming at others.

EVIDENCE: a) Slamming books down; b) Stamping foot; c) Rage attacks;
d) Yelling and screaming at others; e) Red faced; f) Throwing self on floor and screaming; g) Clenching teeth
and fists.

PROBES: 1) Compared to other children of the same age, how often
does this child lose his/her self-control and get angry?
2) What does this child do when s/he gets angry?
3) Does this behavior occur with a specific child or teacher,
or specific situation, or is it generalized?

A2. **Often argues with adults.**

The key to this symptom is the child **engages in verbal battles** with the
teacher or other adults in the school setting.

EVIDENCE: a) Talking back; b) Child refusing to back down; c) “In your
face” behavior.

CONSIDER: Complaining and whining.

PROBES: 1) How does this child interact with adults in the school?
2) Is this a polite child or one who tends to be “lippy” or talks back?
3) Compared to other children of the same age, how often
would this behavior occur?
A3. **Often actively defies or refuses to comply with adults’ requests or rules.**

The key to this symptom is *negativistic* and *defiant* behavior towards adults in the school setting.

**EVIDENCE:** a) Child saying “No, I don’t have to do that”; b) “You can’t tell me what to do”; c) Child turns his/her back on adult, or looks at adult, and ignores request.

**CONSIDER:** Lack of comprehension. Failure to hear request. Lack of attention.

**PROBES:**
1) How does this child handle adult requests or school rules?
2) Does this child typically do as you ask?
3) Can you typically get this child to comply?

A4. **Often deliberately annoys people.**

The keys to this symptom are 1) *clear, deliberate intent* to annoy others (other children and/or adults in school setting) and 2) the behavior is perceived by the recipient(s) to be annoying.

**EVIDENCE:** a) Poking; b) Deliberate invasion of others’ private space; c) Persistent teasing; d) Pulling hair; e) Grabbing others’ clothes and possessions.

**CONSIDER:** Inadvertently annoying behavior (i.e., not *purposely* directed towards others) as a result of other ADHD symptoms or poor social skills.

**PROBES:**
1) To what extent does this child push other people’s buttons?
2) Does this child go out of his/her way to bother others?
3) Does this child persist in bugging others even when told to stop?
4) Is this child’s behavior directed towards a specific child or adult in the school setting or is it generalized?

A5. **Often blames others for his or her mistakes or misbehavior.**

The key to this symptom is the child *implicates others* and not accept responsibility for his/her own behavior.
EVIDENCE: a) Child says “someone else did it”; b) “He started it”; c) Child does not show remorse.

PROBES: 1) How does this child handle reprimands? 2) Does this child typically accept responsibility for his/her own actions?

A6. **Is often touchy or easily annoyed by others.**

The key to this symptom is the child readily takes offense on slight or no provocation and is over reactive.

EVIDENCE: a) Becomes irritated by others; b) Frequent complaints about others’ behavior towards self; c) Cries easily; d) Whining.

CONSIDER: Depression.

PROBES: 1) Does this child tend to misinterpret others’ behavior as negative and targeted towards him/her? 2) Do little things that other people do rub him/her the wrong way and bother him/her?

A7. **Is often angry and resentful.**

The keys to this symptom are a) retained bitterness and b) sustained pattern of angry and sullen behavior.

EVIDENCE: a) Child says “You’re always on my back”; b) “You never give me a chance”; c) “It’s not fair”; e) Child cannot let go of perceived wrongdoing and keeps on about it, will not let it go.

CONSIDER: Depression.

PROBES: 1) Can this child typically let go of perceived wrongdoing? 2) Is this the type of child to have a chip on his/her shoulder?

A8. **Is often spiteful or vindictive.**

The keys to this symptom are a) a desire to inflict a wrong or injury on someone (usually in return for one received or perceived to have been received) or b) a malicious desire (usually petty) to harm, annoy, frustrate,
or humiliate another person. Whereas spiteful implies a desire for revenge, vindictive does not imply action necessarily, but stresses the unforgiving nature of the avenger.

Differential Diagnosis: If this behavior is prolonged or exaggerated, consider coding under Conduct Disorder: A1) Often bullies, threatens, or intimidates others; or A4) Has been physically cruel to people.

EVIDENCE: a) Getting back at someone; b) Taking pleasure in and laughing at other’s misfortunes; c) Laughing at others’ distress; d) Using cruel insults or “verbal put downs” spoken aloud in public so that others can hear such as “You’re just stupid”, “Your breath really stinks”, and “You’re so fat and ugly”.

PROBES: 1) Is this the type of child to hold grudges? 2) Does this child typically try to get back at people? 3) Does this child pick on anyone specific at school?

3.3 CONDUCT DISORDER (CD)

In general, you are looking for evidence of repetitive and persistent pattern of behavior in which the basic rights of others, or major age-appropriate societal norms or rules, are violated.

Note that only the operational definitions have been provided, with examples where necessary, for the CD symptoms. Due to the clear nature of the symptoms, “Evidence” has not been included as a separate section. As well, the CD symptoms do not need probes and may be queried in the format stated in the DSM-IV.

Aggression to People and Animals

A1. Often bullies, threatens, or intimidates others.

The key to this symptom is intentional physical or verbal behavior directed at someone to scare, force, or intimidate. This behavior is chronic and causes distress to the victim.

A2. Often initiates physical fights.

The key to this symptom is the child engages in fights (e.g., pushing, punching) even when there is no clear provocation.
A3. *Has used a weapon that can cause physical harm to others (e.g., a bat, brick, broken bottle, knife, gun).*

The key to this symptom is that the child uses an object as a weapon other than his/her own hands. The act of picking up or holding a weapon, even if it is not used, would be coded.

*Verbal threats should be coded as “Threatens” CD-A1.*

A4. *Has been physically cruel to people.*

The key to this symptom is the child causes pain to another person (e.g., twisting arm, smashing head on ground, kicking hard, pushing over) and shows indifference to or pleasure in another’s suffering.

A5. *Has been physically cruel to animals.*

The key to this symptom is the child causes pain to animals and shows indifference to or pleasure in the animals' suffering.

A6. *Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery).*

The key to this symptom is using violent means or intimidation to forcibly extract another person’s **valuable** belongings.

A7. *Has forced someone into sexual activity.*

The key to this symptom is the child uses violence or intimidation to force another person to do something sexual. This includes a) intentionally cornering another to fondle or grab; b) taking off another’s clothes; c) the child showing his/her private parts; d) the child making another touch his/her private parts.
Destruction of Property

A8. **Has deliberately engaged in fire setting with the intention of causing serious damage.**

   The key to this symptom is a malicious setting of fire (i.e., arson). Other fire setting behaviors (e.g., carrying matches, setting paper on fire) should be flagged although they may be insufficient for symptom endorsement.

A9. **Has deliberately destroyed others’ property (other than by fire setting).**

   The key to this symptom is breaking or destroying on purpose 1) property (e.g., school windows, walls, doors, desks) or 2) others’ personal belongings (e.g., teachers’ cars, other students’ school or personal belongings).

Deceitfulness or Theft

A10. **Has broken into someone else’s house, building, or car.**

   The key to this symptom is forcibly entering when access is denied for the purpose of stealing, destroying, or other illegal activities (e.g., changing school marks on the computer). This would typically involve a locked door.

A11. **Often lies to obtain goods or favors or to avoid obligations (i.e., “cons” others).**

   The key to this symptom is lying with an intent to deceive for self-gain. It is not a reactive response (e.g., “I didn’t do it”).

A12. **Has stolen items of nontrivial value without confronting a victim and without breaking and entering (e.g., shoplifting, forgery).**

   The key to this symptom is stealing valuable items in the school setting (i.e., from adults and/or children, or stealing school property). Occasional stealing of small items (e.g., pencils, candy) should be noted, but is not sufficient to warrant symptom endorsement.
Serious Violations of Rules

A13. *Often stays out at night despite parental prohibitions, beginning before age 13.*

This symptom is not applicable to the school setting, but should be queried if the teacher has knowledge of this in order to explore further with the parents.

A14. *Has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period).*

This symptom is not applicable to the school setting, but should be queried if the teacher has knowledge of this in order to explore further with the parents.

A15. *Is often truant from school, beginning before age 13 years.*

The key to this symptom is being absent intentionally from school without permission. This includes leaving the school property without permission.

*It excludes absences because of Separation Anxiety or School Phobia.*
APPENDICES

4.1 NOTE TO USERS OF THE TTI-IV: DISCLAIMER

We do not claim that the operational definitions of the DSM-IV symptoms provided in this Manual are “correct” or valid. The underlying premise is that each of the 18 symptoms of ADHD (and likewise, the 8 ODD symptoms and 15 CD symptoms) are separable and contribute unique information to the diagnostic profile. Thus the goal was to provide operational definitions that permitted the interviewer to distinguish between each of the symptoms.

These definitions and the types of evidence sought were developed exclusively for application to the school setting and for interviewing teachers. These definitions and evidence may not be applicable in the home setting.

The development of this instrument occurred in a Canadian setting in which English and French are the national languages. The selection and organization of the contexts (e.g., School Arrival, Classroom Behavior - Group, Classroom Behavior - Individual, Transition Points, Relationship with Peers, etc.), the suggested terminology and language used in the interview, were developed in consultation with teachers in the Greater Metropolitan Toronto area. The specific contexts, terminology, and language may not be optimal for school systems in other geographic regions.

We would appreciate any feedback regarding the contexts for inquiring about symptomatology, operational definitions, and probes. If there are any useful tips or strategies in using the TTI-IV, please let us know as we are always looking for ways to improve the tool. As well, if there are any problems with administering or scoring the TTI-IV, please contact us and we will do our best to assist you. We can be reached at:

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Tel: (416) 813-7048
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4.2 INTERVIEW PROTOCOL: REPORT & SCORING FORM

TEACHER TELEPHONE INTERVIEW FOR ATTENTION-DEFICIT/HYPERACTIVITY DISORDER AND RELATED DISORDERS: DSM-IV VERSION (TTI-IV)


Interviewer’s Initials:____________________ Child’s ID #:____________________________

Date of Interview:_______________________ Teacher’s Name:________________________

Child’s Name:__________________________ School Name:___________________________

Grade:_________ Class Size:___________ Telephone #:____________________________

Structure:____________________________________________________________________

Assistant in Class:_____________________________________________________________

Special Help: Yes_________ No________ Frequency:_______________________________

Type of Help:_________________________________________________________________

On Medication:  Yes________   No________ Type of Medication:_______________________

Has Seen Child Off Medication:_________________________________________________
## ATTENTION DEFICIT HYPERACTIVITY DISORDER

**INATTENTION**  
0-3 or 9

1A. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.

1B. Often has difficulty sustaining attention in tasks or play activities. (R-7)

1C. Often does not seem to listen when spoken to directly. (R-12)

1D. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions). (R-6)

1E. Often has difficulty organizing tasks and activities.

1F. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental efforts (such as schoolwork or homework).

1G. Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools). (R-13)

1H. Is often easily distracted by extraneous stimuli. (R-3)

1I. Is often forgetful in daily activities.

**TOTAL INATTENTION**

### IMPULSIVITY

2G. Often blurts out answers before questions have been completed. (R-5)

2H. Often has difficulty awaiting turn.

2I. Often interrupts or intrudes on others (e.g., butts into conversations or games).

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<tr>
<th>Often shifts from one uncompleted activity to another. (R-8)</th>
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<th>Often engages in physically dangerous activities without considering consequences. (R-14)</th>
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**TOTAL IMPULSIVITY/HYPERACTIVITY**

### HYPERACTIVITY

2A. Often fidgets with hands or feet or squirms in seat. (R-1)

2B. Often leaves seat in classroom or in other situations in which remaining seated is expected. (R-2)

2C. Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents, may be limited to subjective feelings of restlessness).

2D. Often has difficulty playing or engaging in leisure activities quietly. (R-9)

2E. Is often "on the go" or often acts as if "driven by a motor".

2F. Often talks excessively. (R-10)

**TOTAL IMPULSIVITY/HYPERACTIVITY**
## OPPOSITIONAL DEFIANT DISORDER

| A1. Often loses temper. (R-1) |
| A2. Often argues with adults. (R-2) |
| A3. Often actively defies or refuses to comply with adults’ requests or rules. (R-3) |
| A4. Often deliberately annoys people. (R-4) |
| A5. Often blames others for his/her mistakes or misbehavior. (R-5) |
| A6. Is often touchy or easily annoyed by others. (R-6) |
| A7. Is often angry and resentful. (R-7) |
| A8. Is often spiteful or vindictive. (R-8) |
| Often swears or uses obscene language. (R-9) |

---

**TOTAL ODD**

## CONDUCT DISORDER

### AGGRESSION TO PEOPLE & ANIMALS

| A1. Often bullies, threatens, or intimidates others. |
| A2. Often initiates physical fights. (R-11) |
| A3. Has used a weapon that can cause physical harm to others. (R-10) |
| A4. Has been physically cruel to people. (R-13) |
| A5. Has been physically cruel to animals. (R-8) |
| A6. Has stolen while confronting a victim. (R-12) |
| A7. Has forced someone into sexual activity. (R-9) |

### DESTRUCTION OF PROPERTY

| A8. Has deliberately engaged in fire setting with the intention of causing serious damage. (R-4) |
| A9. Has deliberately destroyed others’ property (other than by fire setting). (R-7) |

### DECEITFULNESS OR THEFT

| A10. Has broken into someone else’s house, building, or car. (R-6) |
| A11. Often lies to obtain goods of favors or to avoid obligations (i.e., “cons” others). (R-3) |
| A12. Has stolen items of nontrivial value without confronting a victim and without breaking and entering. (R-1) |

### SERIOUS VIOLATIONS OF RULES

| A13. Often stays out at night despite parental prohibitions, beginning before age 13. |
| A14. Has run away from home overnight at least twice while living in parental or parental surrogate home. (R-2) |
| A15. Is often truant from school, beginning before age 13 years. (R-5) |

---

**TOTAL CD**
### OTHER SYMPTOMS OF PSYCHIATRIC DISORDERS

<table>
<thead>
<tr>
<th>DSM-IV Internalizing Disorders &amp; Other Problems</th>
<th>Rating (0-3)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Depression:</strong> (e.g., depressed mood or diminished interest or pleasure in most activities, irritable mood, feelings of inadequacy, worthlessness, suicidal)</td>
<td></td>
</tr>
<tr>
<td>1) What is this child’s mood like? Generally, would you describe him/her as a happy or sad child?</td>
<td></td>
</tr>
<tr>
<td>2) Does his/her mood change during the day? (IF HAVE MOOD SWINGS, QUERY BIPOLAR)</td>
<td></td>
</tr>
<tr>
<td>3) Can you or his/her peers get him/her to laugh and have fun?</td>
<td></td>
</tr>
<tr>
<td>4) Has this child ever made self-deprecating comments (e.g., “I’m no good”)?</td>
<td></td>
</tr>
<tr>
<td><strong>Separation Anxiety:</strong> (e.g., excessive distress if separated from parents or other major attachment figures; worries that attachment figures will be hurt or not return; persistent refusal or reluctance to go to school or elsewhere because of fear of separation; excessive fear of being alone or without teacher or other adults; repeated complaints of physical symptoms - stomach ache, head aches, etc. - when separation is anticipated)</td>
<td></td>
</tr>
<tr>
<td><strong>Generalized Anxiety:</strong> (e.g., excessive anxiety and worry most days about a number of events or activities, such as school performance, competence; difficult to control the worry; perfectionist, tends to redo tasks because of excessive dissatisfaction about less-than-perfect performance; anxiety and worry accompanied by symptoms such as restlessness, difficulty concentrating, tense, easily fatigued)</td>
<td></td>
</tr>
<tr>
<td>1) Would you describe this child as a worrier?</td>
<td></td>
</tr>
<tr>
<td>2) How often does this child need reassurance from you (generally / to do their work)?</td>
<td></td>
</tr>
<tr>
<td>3) Is this child a perfectionist?</td>
<td></td>
</tr>
<tr>
<td><strong>Phobia:</strong> (e.g., scared of animals, darkness, heights, etc.; avoids the object or situation; interferes with normal routines)</td>
<td></td>
</tr>
<tr>
<td><strong>Obsessive-Compulsive:</strong> (e.g., recurrent &amp; persistent ideas, thoughts, impulses, images; repetitive behaviors such as hand washing, ordering, checking, counting)</td>
<td></td>
</tr>
<tr>
<td><strong>Motor Tics:</strong> (e.g., eye blinking, tongue protrusion, neck jerks, sniffing, uttering sounds)</td>
<td></td>
</tr>
<tr>
<td><strong>Psychotic:</strong> (e.g., hears voices, smells scents, sees things others do not)</td>
<td></td>
</tr>
</tbody>
</table>
AGGRESSION RATING

Rate the child’s aggressive behavior on the following dimensions:

<table>
<thead>
<tr>
<th>Physical Aggression</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>No aggression.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Typically aggressive behavior characterized by hitting, use of weapons, or objects.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Verbal Aggression</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>No aggression.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Typically aggression involves verbal attacks.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reactive</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggression typically in response to provocation, rarely planned, impulsive.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proactive</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggression rarely a response to provocation, typically planned, rarely impulsive.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hostile</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rarely an attempt to achieve a specific goal or obtain an object, typically an act designed exclusively to hurt another.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Instrumental</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Typically an attempt to achieve a specific goal or obtain an object, rarely an act designed exclusively to hurt another.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
INTRODUCTORY COMMENTS

Script: During this interview I am interested in getting a picture of what (Child's Name) is like at school [when s/he is not on medication]. My goals for this interview are to get an understanding of his/her academic performance (i.e., strengths and weaknesses), classroom behavior, friendships and peer relations, and his/her relationship with the adults in the school. I would like to get this picture of (Child's Name) by having you discuss the different activities that s/he typically would be involved in on a daily basis. Please note that I will be making written notes on the interview form based on your comments.

SCHOOL ARRIVAL

Script: I would like to start with (Child's Name) arrival at school in the morning. I am interested in his/her mood, activity level, and appearance when s/he comes into the classroom; how s/he follows the arrival routine; and whether s/he has all the things s/he needs for school. I would also like to know what his/her behavior is like during National Anthem / Prayers / Morning Announcements.

Behavioral Description:
CLASSROOM BEHAVIOR - GROUP

Script: I would now like to discuss teacher directed instruction to the class. Where do group lessons take place (i.e., carpet time or at their desks)? I would like to know how (Child’s Name) handles these situations and whether s/he participates in the group discussions.

Behavioral Description:

CLASSROOM BEHAVIOR - INDIVIDUAL

Script: After the group lesson is completed and the students are required to go back to their seats to do individual seatwork, is (Child’s Name) able to carry out the instructions given by you?

Behavioral Description:
**TRANSITION POINTS**

Script: I would like to get a picture of how (Child's Name) handles transition points such as going in and out for recess, lunch, or other classes. I would like to know whether s/he is able to follow routines such as putting materials away, getting the next set of materials ready, and putting on/taking off his/her coat.

**Behavioral Description:**

---

**RELATIONSHIP WITH PEERS**

Script: You have given me a great picture of what (Child's Name) is like during academic situations. I would now like to get a picture of (Child's Name)'s relationships in the school. What is his/her relationship like with the children in the school and what are his/her play behaviors like?

**Behavioral Description:**
RELATIONSHIP WITH ADULTS

Script: What is (Child’s Name)’s relationship like with you and the other adults in the school?

Behavioral Description:

---

Script: I would now like to ask you some general questions about (Child’s Name) regarding his/her abilities and skills.

ACADEMIC FUNCTIONING

---

GENERAL ABILITY

---

SELF-HELP SKILLS

---

MOTOR SKILLS
Script: We are now near the end of our session. You have given me a lot of helpful information to understand (Child’s Name) at school. I would like to finish the interview by asking you to comment on the extent to which his/her difficulties impede progress and functioning at school.

TEACHER’S PRIMARY CONCERNS

Script: You have described a variety of concerns/problems for (Child’s Name). Do you have any major concerns about (Child’s Name)? What are they?

CHRONICITY OF PROBLEM

Script: 1) From your knowledge of the Ontario School Record, did the problem(s) start this year or in previous years?
   2) To what extent do these difficulties upset/distress him/her?
   3) To what extent do these difficulties put a burden on you and/or students in the class?
COMPARISON ON / OFF MEDICATION

Script: Is there anything you would like to highlight about the differences in (Child’s Name) when s/he was on medication compared to off medication?

OTHER INFORMATION

Script: 1) Is there any other information you would like to share with me?
    2) Do you have any questions for me?

Script: That completes the interview. The information you provided really helps us to understand (Child’s Name) behavior and will provide us with a clearer picture of (Child’s Name) than would be available from the questionnaires. Thank you very much for your time and help.
# 4.3 PROBE REFERENCE SHEET

## ATTENTION DEFICIT HYPERACTIVITY DISORDER

<table>
<thead>
<tr>
<th>SYMPTOM</th>
<th>PROBE</th>
<th>EVIDENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INATTENTION</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 1A. Careless mistakes. | 1) What is the quality of work like?  
2) How much care does this student put into his work?  
3) Is this student losing marks for careless errors?  
4) Does he find it difficult to pay close attention to what needs to be done? | Omitting required details; Rushes through work, activities, or slow and last to finish, but makes silly mistakes; Sloppy work, but has ability to print/write neatly; Not proofreading/checking work. |
| 1B. Sustain attention. | 1) When the class is relatively quiet, is this student able to focus on her work?  
2) Is this student able to focus for the duration of the task?  
3) During group discussion or individual seatwork, where is he looking?  
4) For the things this student is able to do, is he able to sit there and really work at it for a reasonable period? | Staring into space; Looking around, but not focused on anything; Daydreaming; Lost in thought; “Not with you”; “Spacey”; Starts and engages in a task, but does not continue with it for reasonable period of time relative to peers. |
| 1C. Not listen. | 1) When you are talking to this student one-to-one, is he able to follow what you are saying?  
2) Does he tune out when you are having a conversation with him?  (Follow up with “How often”)  
3) Do you have to use any strategies to help him follow what you are saying? | Unable to keep mind on conversation; Provides no feedback such as nodding, saying “Mm, O.K.”, or make eye contact; Does not look as if he is listening (body stance); Teacher has to make big effort to secure student’s attention and repeat what was said; Student cannot repeat or paraphrase what was said. |
| 1D. Fails to finish. | 1) How often do you have to remind this student to finish his work or duties?  
2) Can you give me an idea as to how much he can do within his ability level?  
3) What is this student’s ability to complete hands on activities (e.g., science, geography, art)? | Rarely finishes; Low productivity: Leaving things half done; Shifting from one uncompleted activity to another; Only completes work with close supervision; Need for frequent reminders to continue and complete work, chores; Rushes through work and is sent back by teacher to redo. |
| 1E. Difficulty organizing. | 1) How well does this student put his papers in the place they belong, such as writing folders, binders, or boxes?  
2) How well does he get his materials together for the next lesson or task?  
3) Do you have to set up additional strategies for this student? | Messiness in at least 2 areas (desk, locker, cubby hole, knapsack, notebooks, work area); Keeps messiness in at least 2 areas (desk, locker, cubby hole, knapsack, notebooks, work area); Keeps messiness in at least 2 areas (desk, locker, cubby hole, knapsack, notebooks, work area); Keeps messy in at least 2 areas (desk, locker, cubby hole, knapsack, notebooks, work area). |
| 1F. Avoids tasks. | 1) How does this student handle challenging or lengthy activities or work within his ability level?  
2) Does this student get going on an independent project? | Avoidance; Change in behavior/mood at onset of more challenging and/or lengthy tasks; Not start on activity without many prompts or active supervision; Student starts, but does not engage in or put effort to the task. |
| 1G. Loses things. | 1) How well does this student keep track of his belongings?  
2) To what extent does this student hunt everywhere for his belongings because he has no idea where they are? | Constantly looking for things; Constantly asking teacher and peers “Where’s my…?”; “Where’s my…?” |
| 1H. Easily distracted. | 1) How does this student handle noises or other activities occurring inside/outside the classroom when he should be focused on a task?  
2) Does this student constantly need redirection to get back to the task at hand?  
3) Are other students bothered by this distracter to the same extent? | “Head on a swivel”; Turning in seat or moving towards distracter; Watching others; On the way to doing something gets sidetracked and does not get back to original activity without prompts. |
| 1I. Forgetful. | 1) During the course of the day, does this student typically remember the materials he needs or the routine activities he has to do?  
2) Do you have to keep reminding this student to take things home, such as his agenda or putting items in his knapsack? | Rarely remembers to bring home or hand in homework, notes, books; Teacher constantly has to remind of daily activities or chores; Forgets there is a test/quiz. |

## IMPULSIVITY

<table>
<thead>
<tr>
<th>SYMPTOM</th>
<th>PROBE</th>
<th>EVIDENCE</th>
</tr>
</thead>
</table>
| 2G. Blurs. | 1) When you are asking the class questions or giving instructions, how does this student handle the situation?  
2) Can this student wait until you finish speaking or does he cut you off? | Student responds or talks before the teacher stops talking; Student starts to do something before it is possible for the student to know what to do; Student does not wait until the teacher finishes giving the instructions or asks the question. |
| 2H. Difficulty waiting. | 1) Once you finish giving the question or instruction, can this student wait to be called on?  
2) How does he handle turn taking in small group or play activities? | Talks out of turn; Insists on immediate attention or action; Gets very frustrated when has to wait turn. |
| 2I. Interrupts/intrudes. | 1) How often does this student disrupt activities that you and other students are engaged in?  
2) How often do other students complain that he is interrupting them? | Cuts off or talks over others when they are talking; Persists in calling out or pulling arm/clothing of teacher when he is with someone else; Pushing into or joining a game without asking or being invited; Grabbing. |
## HYPERACTIVITY

| 2A. Fidgets/squirms. | 1) When seated, what would I see in terms of this student’s physical movement?  
2) What is he doing with his hands, legs, or feet? | Drumming fingers on desk; Playing with toys/objects in/on desk; Shifting body position in chair; Kneeling up on chair then sitting down; Swaying to/fro, or swinging arms while standing. |
|----------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| 2B. Leaves seat.     | 1) How often is this student out of his seat when he is not supposed to be?  
2) What is he doing when he is out of his seat? | Frequently leaves seat to wander around room; Frequently shifts from place to place on carpet; Frequent trips to sharpen pencil; Frequent trips to washroom; Frequently goes over to talk to peers. |
| 2C. Runs/climbs.     | 1) Would I ever see this student running in hallways, racing into class, or climbing over desks? | Climbing over desks or other students on the carpet; Sliding or running in hallways; Racing from one activity to another or during transitions. |
| 2D. Play quietly.    | 1) When students are allowed a quiet activity of their choice, what is this student’s noise level like?  
2) What is he doing that is so noisy? | Swaying to/fro, or swinging arms while standing; Drumming fingers on desk: Playing with toys/objects in/on desk; Shifting body position in chair; Kneeling up on chair then sitting down; Swaying to/fro, or swinging arms while standing. |
| 2E. “On the go”.     | 1) Does this student need to be constantly moving?  
2) Is this whole body movement or just fiddling? | Rocking chair to and fro; Falling off chair frequently as a result of excessive movement in seat; Constant getting up and down in seat; Rocking to and fro or twirling around on floor. |
| 2F. Talks excessively. | 1) How often does this student chat when he is not supposed to?  
2) Does this interfere with his or others’ work? | Turning in seat to speak to others; Rambling on and on about something; Talking when he is supposed to get materials ready for next activity. |
|                      | 2) What is he doing with his hands, legs, or feet? | Swaying to/fro, or swinging arms while standing; Drumming fingers on desk: Playing with toys/objects in/on desk; Shifting body position in chair; Kneeling up on chair then sitting down; Swaying to/fro, or swinging arms while standing. |

## OPPOSITIONAL DEFIANT DISORDER

<table>
<thead>
<tr>
<th>SYMPTOM</th>
<th>PROBE</th>
<th>EVIDENCE</th>
</tr>
</thead>
</table>
| A1. Loses temper.        | 1) Compared to other students of the same age, how often does this student lose his self-control and get angry?  
2) What does this student do when he gets angry?  
3) Does this behavior occur with a specific student, teacher, or situation, or is it generalized? | Slamming books down; Stamping foot; Rage attacks; Yelling and screaming at others; Red faced; Throwing self on floor and screaming; Clenching teeth and fists. |
| A2. Argues.              | 1) How does this student interact with adults in the school?  
2) Is this a polite student or one who tends to be “lippy” or talks back?  
3) Compared to other students of the same age, how often would this behavior occur? | Talking back; Refusing to back down; “In your face” behavior. |
| A3. Noncompliance.       | 1) How does this student handle adult requests or school rules?  
2) Does this student typically do as you ask?  
3) Can you typically get this student to comply? | “No, I don’t have to do that”; “You can’t tell me what to do”; Turns back on adult, or looks at adult, and ignores request. |
| A4. Annoys people.       | 1) To what extent does this student push other people’s buttons?  
2) Does this student go out of his way to bother others?  
3) Does this student persist in bugging others even when told to stop?  
4) Is this student’s behavior directed towards a specific student or adult in the school setting or is it generalized? | Poking; Deliberate invasion of others’ private space; Persistent teasing; Pulling hair; Grabbing others’ clothes and possessions. |
| A5. Blames others.       | 1) How does this student handle reprimands?  
2) Does this student typically accept responsibility for his own actions? | “Someone else did it”; “He started it”; Student does not show remorse. |
| A6. Easily annoyed.      | 1) Does this student tend to misinterpret others’ behavior as negative and targeted towards him?  
2) Do little things that other people do rub him the wrong way and bother him? | Becomes irritated by others; Frequent complaints about others’ behavior towards self; Cries easily; Whining. |
| A7. Angry/resentful.      | 1) Can this student typically let go of perceived wrongdoing?  
2) Is this the type of student to have a chip on his shoulder? | “You’re always on my back”; “You never give me a chance”; “It’s not fair; Cannot let go of perceived wrongdoing and keeps on about it, will not let it go. |
| A8. Spiteful/vindictive. | 1) Is this the type of student to hold grudges?  
2) Does this student typically try to get back at people?  
3) Does this student pick on anyone specific at school? | Getting back at someone; Taking pleasure in and laughing at other’s misfortunes; Laughing at others’ distress; Using cruel insults or verbal put downs such as “You’re just stupid” and “Your breath really stinks”. |
### 4.4 SCORING GUIDELINES

<table>
<thead>
<tr>
<th>FREQUENCY OF BEHAVIOR</th>
<th>0 NO PROBLEM</th>
<th>1 MILD</th>
<th>2 MODERATE</th>
<th>3 SEVERE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>✅ Not seen or rare</td>
<td>✅ Some days</td>
<td>✅ Most days</td>
<td>✅ Everyday</td>
</tr>
<tr>
<td></td>
<td>✅ Some of the day</td>
<td>✅ Most of the day</td>
<td>✅ All day</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PERVASIVENESS &amp; DEGREE OF IMPAIRMENT</th>
<th>0 NO PROBLEM</th>
<th>1 MILD</th>
<th>2 MODERATE</th>
<th>3 SEVERE</th>
</tr>
</thead>
<tbody>
<tr>
<td>✅ No impairment</td>
<td>✅ Mild impairment in 1 context</td>
<td>✅ Moderate impairment in 2 or more contexts</td>
<td>✅ Severe impairment in 2 or more contexts</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✅ Needs some teacher management</td>
<td>✅ Needs frequent teacher management</td>
<td>✅ Needs constant teacher management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✅ Minimal effect on class functioning</td>
<td>✅ Class functioning impaired</td>
<td>✅ Class functioning severely impaired</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✅ No avoidance from teacher or peers</td>
<td>✅ Some avoidance from teacher and peers</td>
<td>✅ Teacher and peers prefer to avoid</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DEVELOPMENTAL COMPARISON</th>
<th>0 NO PROBLEM</th>
<th>1 MILD</th>
<th>2 MODERATE</th>
<th>3 SEVERE</th>
</tr>
</thead>
<tbody>
<tr>
<td>✅ No difference from same-sex peers</td>
<td>✅ Some difference from same-sex peers, but not really stand out</td>
<td>✅ Different from same-sex peers that stands out</td>
<td>✅ Very different from same-sex peers and significantly stands out</td>
<td></td>
</tr>
</tbody>
</table>

9 (UNKNOWN) - No information, insufficient information, not queried
4.5 SCORING ALGORITHM

- Scoring is based on a Score (0-3) x Descriptive Category (frequency of behavior, pervasiveness and degree of impairment, and developmental comparison) grid system
- Symptoms do not require evidence from each of the Descriptive Category (DC) to be scorable (i.e., they can still be scored if only evidence for one DC is available)

Grid Algorithm:

The following rules apply when scores are evaluated using the DC:

For consistent evidence:

- If a symptom has scores of 0 and 1, it is scored a 1
- If a symptom has scores of 1 and 2, it is scored a 2
- If a symptom has scores of 2 and 3, it is scored a 3
- If a symptom requires constant teacher management, it is automatically scored a 3

For inconsistent evidence:

- If a symptom has scores of 0 and 2, it is scored a 1
- If a symptom has scores of 0 and 3, it is scored a 2
- If a symptom has scores of 1 and 3, it is scored a 2
- If a symptom has scores of 1, 2, and 3, it is scored a 2