Introduction to the PICS

The PICS is a semi-structured diagnostic instrument developed particularly for the purpose of diagnosis of disruptive behaviour disorders (ADHD, ODD and CD). For diagnoses of other disorders, the interview follows the format of the K-SADS. The Disruptive Disorders Module of the PICS is adapted from the PACS (Taylor et al, 1986) interviews, but differs in several important ways from the PACS, KSADS and other diagnostic interviews.

- The PICS is not a structured interview. It does not ask the informant to provide a rating of a particular symptom or ask how severe it is. Rather, it asks the informant to provide a description of child behaviour in a variety of different situations.

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

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

The PICS interview encourages and facilitates the development of rapport with the informant and a precise understanding of the nature of each child's psychiatric disorder to the informant. Therefore, the PICS is appropriate for clinical as well as research setting.
The task of the interviewer is to encourage the informant to describe their child’s behaviour in sufficient detail for the interviewer to determine whether the criteria for a symptom have been met.

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

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

In general terms, the description of syndromes and symptoms follows that of DSM. The interviewer should refer to this as a resource for definition of symptoms. PICS-6 has been revised for DSM-V.

Overview of the General Interview Procedures

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

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

- The contrast between medicated and unmedicated behaviour can allow the interviewer to assess positive and negative drug effects and get a clearer picture of the severity of the child’s unmedicated behaviour.

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

- It is essential that the interviewers should question the informant to the point that they have obtained clear descriptions of the behaviour to be rated.

- Interviewers should remember that they are making their own judgments about severity and presence of symptoms not accepting the informant’s subjective opinion. Interviewers must avoid deciding on the presence of a behaviour or symptom based on answers to previous questions. Just because a child is very inattentive, it does not follow that the child is also very impulsive even if that is the impression given by the informant.

- It is particularly important to pursue an issue that the informant continues to raise, thereby indicating an eagerness to discuss a topic, or the impact that it may have on diagnosis. For example, if the informant continually answers with “It depends on his mood,” then one might pursue the Mood Disorders Section in the General Pathology Module. “It seems that Johnny’s behavior is quite dependent on his mood. Let’s talk about his mood for a bit so that I can get an impression of it.”

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

- Different sections of the PICS require that behaviours be rated over a specific time period.

  The ADHD and ODD sections of the Disruptive Disorders Module are concerned with the child’s behaviour over the preceding 6 months. Clarifying this time frame can be done by establishing a point in time as a reference, for example, “since last Christmas” or “since starting school in September.”

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

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

NOTE: The General Pathology Module contains two different types of disorders: those for which multiple symptoms are scored, and those which receive only a single code.
The General Pathology Module contains some disorders, particularly ones that are found in children and adolescents, for which every symptom/item is listed. These should be rated like items within the Disruptive Disorders Module, as follows:

<table>
<thead>
<tr>
<th>For symptom ratings:</th>
<th>0 = not at all</th>
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<tbody>
<tr>
<td></td>
<td>1 = dubious or trivial</td>
</tr>
<tr>
<td></td>
<td>2 = definite and clinically significant</td>
</tr>
<tr>
<td></td>
<td>3 = severe</td>
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*Ratings of 2 or 3 contribute to a diagnosis* (see page 7-8 for more information).

However, some disorders in the KSADS are based on a “screen + probe” methodology. We do not expect that the interviewer will rate every symptom of every DSM diagnosis in detail in the presence of a positive screen. However, it is important for the interviewer to cover all pertinent symptoms and criteria for a disorder if appropriate. These sections of the PICS rest on the experience of the interviewer and their knowledge of all symptoms and criteria for disorders, even if not explicitly stated or listed in the interview. The ratings that you give for these disorders will be based as follows:

<table>
<thead>
<tr>
<th>For single-code disorders:</th>
<th>0 = no symptoms</th>
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<tbody>
<tr>
<td></td>
<td>1 = some symptoms</td>
</tr>
<tr>
<td></td>
<td>2 = disorder is present but does not meet full criteria</td>
</tr>
<tr>
<td></td>
<td>3 = disorder is clearly present and meets full criteria</td>
</tr>
</tbody>
</table>

*A rating of 2 is subclinical for these disorders.*

*Do not be superficial* - always probe for examples of reported behaviours. Remember, responses that are offered enthusiastically [“Is he ever aggressive!”] still need to be probed.

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

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

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

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

It is essential to probe the severity of a symptom. It is insufficient to base a severity rating on the informant’s single comment such as, “Oh yes, is he ever restless!” or “I do have trouble with her breaking rules” or “He is unable to wait his turn.” Ask “How often does the behaviour occur, what are the consequences, has it been possible to get the child to alter the behaviour?” etc. in order to assess the severity. (See Definition of Severity page for more details). Some parents feel that a single temper tantrum in an eight year old during a one month period is highly excessive. The informant might not agree once a full picture of the tantrums is obtained.

It is important to note that all children, on occasion, behave in a way that could be construed as symptomatic. Adults differ markedly in their tolerance for behavioural excesses and therefore in what they consider to be normal or abnormal. Try to ensure that parents understand that you are interested in marked behaviour problems, not trivial ones. Conversely, parents may trivialize a behaviour that the interviewer rates as more severe.

Guard against a parent minimizing or maximizing symptom severity based on the comparison with a sibling. For example, you cannot rate a child’s behaviour if it is only described as more or less than someone else.

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

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

It is essential that the interviewer question the informant to the point that clear descriptions of the behaviour to rated have been obtained. Remember, it is the interviewer’s job to make the judgments about the severity and presence of symptoms—do not accept the informant’s subjective opinion alone.

An essential aspect of the PICS is the distinction between oppositional, non-compliant, inattentive and impulsive behaviour. This is a constant theme throughout the interview and it is critical to separate these, as far as is possible, in order to make a diagnosis of ADHD. For example, some children do not listen when told what tasks to do or the rules of a game. The clinician needs to distinguish whether the failure to listen is because the child simply does not want to listen versus the child who does not take in the information. When determining if the child has difficulty following through on instructions, clarify whether the child takes in and processes the request but refuses to comply, versus the child who hears the instruction then loses it quickly (i.e. in one ear and out the other). Clarifying probes include “Do you have to repeat instructions to be sure the child has paid attention and knows what to do?” or “Do you only give one or two short instructions rather than more complex ones so that the child does not lose track of what to do?” or “Does the child not follow through because s/he just doesn’t want to do what has been asked or is in a mood?”

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

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

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

The goals of the interviewer are to “formulate each case as well as render a formal, research diagnosis.” Therefore, note things such as the parents’ degree of expressed warmth, criticism, understanding of reasonable (normative) child behaviour, range and descriptions of parenting practices and the way the informant responds to your line of questioning. Note the parents’ manner, mood and thought processes.

Definition of severity

After the interviewer determines that a particular behaviour is present, the interviewer must determine whether the child’s behaviour meets criteria for a symptom. Many children are argumentative or restless at various times, for example, when they are overtired, hungry or unwell. The presence of a behaviour by itself does not necessarily mean that the child’s behaviour is symptomatic of a disorder. This determination depends on the severity of a particular behaviour as defined below except in some situations (e.g. fire setting does not need to be severe). The clinician should inquire about the following factors which determine the severity of a child's symptoms:

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

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

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

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

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

6. Frequency with which the symptom occurs (for some symptoms such as restlessness, frequency may determine severity to a great extent, while for others such as criminal behaviour, severity may be determined more by the abnormality of the behaviour);
7. Persistence of symptoms despite efforts to alleviate the distress (some children may be very restless or may become depressed but they can recover very quickly with minimal intervention, whereas other children cannot recover no matter what is done to distract them or to alleviate the behaviour);

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

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

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>absent</td>
</tr>
<tr>
<td>1</td>
<td>dubious or trivial abnormality</td>
</tr>
<tr>
<td>2</td>
<td>definite abnormality</td>
</tr>
<tr>
<td>3</td>
<td>marked abnormality</td>
</tr>
<tr>
<td>9</td>
<td>not known or unable to rate</td>
</tr>
</tbody>
</table>

A rating of “3” is typically reserved for a symptom that is very frequent, severe, disabling etc. A rating of “2” contributes to a diagnosis.

Note: There are many instances in which a child may not be totally “responsible” for his or her behaviour. Should the lack of intent mean that the behaviour is given a lower rating? The answer lies in the particular circumstances. The only DSM behaviours which explicitly require intent are found in the CD section with items such as “Initiates physical fights,” “Deliberately set fires with the intention of causing damage,” “Deliberately destroyed others’ property,” and “Has forced someone into sexual activity.” Otherwise, there is no requirement that the child acted out of free will. Free will or intention is difficult to establish in children and this is especially true when interviewing a parent about behaviors that may not have been observed directly. Therefore, the interviewer should note but not necessarily base their ratings on comments made about intent. For example, many children will be described as irritable or provocative only under circumstances of marked duress. The interviewer will usually have a difficult time determining whether the duress was marked or whether the child has a lower threshold. It is best to rate the behaviour that is observed or described and note the mitigating circumstances. These circumstances may be important in the clinical formulation and clinical consensus diagnosis, but might not influence a research diagnosis. Another example is a child who has been involved in breaking into homes and cars in his neighbourhood. This behaviour may have been directed, and to some extent, coerced by an older sibling. On the other hand, the older sibling did not threaten to hurt the child. To what extent was this behaviour coerced or voluntary? It is difficult to tell. Certainly, the role of the older sibling should be taken into account in the formulation and treatment plan. However, the child should be rated as having been involved in stealing or breaking in.
REMEMBER, YOUR TASK IS TO GET THE INFORMANT TO PROVIDE ENOUGH CLEAR DESCRIPTIONS OR RELATED EVIDENCE TO PERMIT A RATING OF THE EXTENT OF PSYCHOPATHOLOGY. IT IS YOUR IMPRESSION OF THE CHILD’S DISTURBANCE THAT YOU ARE RATING, NOT THAT OF THE INFORMANT.

A GENERAL INFORMATION MODULE

The interview starts with a brief unstructured section. The interviewer introduces himself or herself to the parent or parents and explains the purpose of the interview. Clarify permission to videotape the interview and excuse yourself for a moment to start the tape.

The initial objective of the interview is to:

- make the informants comfortable,
- clarify the purpose of the interview,
- develop a working rapport with the informant(s), and
- establish the tone of the interview, which should be empathic and attentive to detail.

Tell the informant that you know very little about the child (i.e. you come to the interview with no preconceived ideas) and that you may ask a number of questions that the parents may have already answered for other team members, through previous questionnaires or during interview with other professionals.

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

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

- behaviour
- favourite subjects
- grades
- hobbies

- siblings
- family relationships
- social functioning
- friends
03 Presenting Concerns

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

04 History of the Presenting Concerns

04.1 Code age of onset in years.

04.2 This probe provides a clue to parental threshold for concern about child behaviour. For example, the parent might say that the child’s behaviour did not change when he or she first went to school, but that the teacher quickly noticed that the child’s behaviour was problematic. This probe also provides a clue to the onset and potential precipitants of the child’s behaviour.

04.3 The objective of this item is to permit coding of the first problem which was observed. If several problems appeared simultaneously, e.g. overactivity and aggressiveness, please code all problems. However, attempt to determine which specific behaviour was observed initially.

04.4 Precipitating Factors (page 6). Note the nature of these factors but rate only those factors which you believe were instrumental in the development of the child’s symptoms.

04.5 Use the back of the protocol to trace and document the course and development of the child’s problems if you like. Ask whether “things” have been getting better or worse. As you will see below, behaviours which are getting worse receive higher severity ratings than those which are improving. You can ask why the informant thinks that “things” are improving. By asking what factors have been responsible for alteration in behaviour, you may obtain information that is useful for treatment planning.

04.6 & 04.7 Note the nature of any previous treatment. If child has been involved in treatment, note the name of the responsible therapist. If medication has been used, note the name of medication, dose, and side-effects if possible (see 04.7 for medication tables). Get an impression of the effectiveness of these interventions, and whether they were implemented with sufficient rigour or
intensity to be adequately assessed. Also, elicit and note parental attitude toward the use of medication at this point. It may be helpful to reassure the informant that

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

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

Since PICS ratings should be based on child behaviour when the child is unmedicated, it is important to establish whether the child has been continuously medicated to ensure that there is a sufficient unmedicated window of time on which to base your ratings. Some children have been continuously medicated without interruption. For these children, it might be necessary to assess unmedicated behaviour based on after school or other times when the medication has worn off.

05 Medical and Developmental History

Review SDI and Family and Household Form and inquire about any developmental or medical problems that are reported there. Inquire about any questions which were left blank. Prompts are provided for an overview of the child’s developmental history. Ask if there were any “other” medical or developmental concerns.

06 Family History

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

Draw a family tree on the facing page. Obtain a complete family history for first degree relatives e.g., mother, father, brothers, sisters. Review more briefly, family history of other family members.

Ask whether any family members have had a problem with the areas listed. There are two tables for family medical history: one for mental health and learning problems (pages 10-11) and one for physical or genetic conditions (page 12).

Discussing family issues often leads informants to go off on tangents providing details of the personalities and problems of extended family members. It is important that the interviewer stay on track and not lose time delving into extraneous issues. Note these issues and move on.
**B DISRUPTIVE DISORDERS MODULE**

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

See page 8 for coding key.

The coding sheet indicates:

- the diagnosis to which the item is associated,
- whether the item pertains to DSM-V, DSM-IV or DSM-III-R schemata.

The flow of the interview may be as follows:

Interviewer: "Now I would like to ask you about your child's behaviour in a variety of different situations. I do that because it is very common for children to behave very differently in different situations. I will be asking you about a lot of different situations and problems. Not all of these situations may be problematic for your son (daughter). I ask everyone the same questions in the same way. It doesn't mean that I think that your child has or should have the difficulties that I will ask about."

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

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

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

**Restless, fidgetiness, running and climbing & driven by a motor**

These behaviours are difficult to discriminate although most people have an intuitive sense of how they differ.

- **Fidgetiness** refers to activity of small parts of the body; fingers, hands, arms, feet, legs.
• **Restlessness** refers to movement of the entire torso.

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

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

**Outdoors**

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

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

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

**Leisure Time Indoors**

This section is usually started by asking what a child generally likes to do when alone indoors, with their leisure time. Remember that the interviewer wants to obtain a picture of the child in general, not a limited picture of when the child is at his/her best or worst. Avoid rating a child solely on playing with the computer, sega, nintendo, etc. Probe to find other activities in which the child engages or played in last 6 months.
There are children who do nothing else other than computer games and they typically avoid other more demanding tasks. For these children, ask whether the child ever takes on a new challenge in these games.

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

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

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

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

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

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

Playing Indoors with parent

This item refers to the child’s attention to instructions and his ability to take them in when spoken to directly, not whether the child likes the rules or wishes to abide by them. If the informant says the child “always likes to make up his/her own rules” you should probe to determine whether this is because the child did not pay attention and listen to the instructions or because s/he doesn’t like the rules, or for instance cheats to win. The issue is whether the child is taking in the information (e.g. making eye contact).
Following through on instructions refers to actually acting in accord with stated rules. If the child does not do this, clarify whether this is done on purpose to win or to spoil the game, versus the child having difficulty in following through with stated instructions.

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

**Playing with other children (indoors)**
These situations include play with other children at home, at clubs, or in daycare.

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

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

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

Although this item (“blames others”) is situated in this section, it refers to a symptom of ODD. The rating should be based on whether or not the child takes responsibility for his/her mistakes in general and not just when playing with others.

**TV**

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

**Homework**

This rating should not reflect a “like” of homework, rather it is an effort to code the child’s reluctance or avoidance to participate in these kind of tasks.

Does the child have the required materials arranged in an appropriate way? Does s/he follow reasonable steps in starting and completing a homework task?
When probing as to whether the child pays attention to detail, a parent may say that the child’s writing or printing is very messy. This is a comment on neatness and is not sufficient for this rating. In order to rate this item ask the parent questions like “If the child is doing a math sheet, does s/he notice when signs change from addition to subtraction?” or “Does s/he do homework without reading through the instructions carefully?”

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

**Dinner Table**

261-263 Self-explanatory.

**Oppositional Defiant Disorder**

271-278

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

- The first three items (265-267) are rated as symptoms of ADHD, but can also provide insight into symptoms if ODD. Do not ask about attention and compliance in situations in which the assigned or required task is one that is desirable, but suggest alternative scenarios such as “If you ask him/her to run an extra errand, tidy up make the bed, etc., how would s/he respond?”

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

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

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

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

- It is important to understand the context of behaviours like temper tantrums, not just their frequency. When do they happen? Are they in response to a request? Is the child touchy in the sense that you feel that you are walking on eggshells or having to measure your words carefully so as to not create an outburst or temper tantrum? (274)

- It is important to appraise whether the annoyance or provocation is deliberate on the part of the child, or a perception and response to a normal parenting situation from a vulnerable parent. **“What is it about this behaviour that is annoying for you?”** (276)

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

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

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

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

- By contrast, intent or the extent to which behaviour is proactive or planned does not impact ratings except for CD 2 (item 282) “initiates physical fights”. There is always some degree of provocation and DSM makes no specific reference to provocation. Initiation of fights whether provoked or not counts as CD 2. However, initiation of a fight under extreme provocation would decrease the severity rating of this item. Initiation is difficult to define. Some children have a very low threshold for being provoked. Consequently, initiation of fights should not be limited to instances in which the child started something out of the blue. On the other hand, if someone started to fight with the child and the child responded in kind, that would seem not to be initiation.

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

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

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

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

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

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

295 “Often” here refers to more than twice in a six month period on the grounds that truancy is highly infrequent in elementary school-age children.
**Type of Conduct Disorder Page 11**

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

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

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

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

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

**GENERAL PSYCHOPATHOLOGY MODULE**

This module follows a somewhat different format. Each section of this module (e.g. anxiety, mood, etc.) begins with a general probe related to that area of psycho-pathology. Note that this module covers behaviour observed by parents or reported to them by significant others in the child’s life (e.g. Scout Masters), but does not deal with behaviours reported by the child’s teacher. School behaviours are covered by the Teacher Telephone Interview.

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

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

- If there is information about a particular question from a previous comment made by the informant, the interviewer could introduce the item by saying “As you mentioned previously...” This will ensure that the informant get the feeling that you attending and listening to their earlier replies.
• Record replies that seem to you to be evidence of psychopathology or those that you would like to review with the team.

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

**Separation Anxiety Disorder**

• If a child gets upset at being separated for significant others, clarify whether it is because the child is angry or mad that s/he cannot go along, or it is because of the anxiety of separation.

• SAD A5 and A6 probe whether a child has sleep difficulties related to separation. It is possible that raising these items will lead to information about sleep in general. It may be appropriate to discuss and rate Sleep Habits (found on page 8) at this point in the interview.

**Social Phobia**

• Social Phobia does not include children who are simply slow to warm up in a social setting but rather refers to children with persistent and incapacitating anxiety when meeting new people to the extent that they will not go into a situation in which such an event might arise.

• Specific Phobia would have to be persistent and impairing to reach a rating of 2. Many children are nervous around animals or in the dark. Others will not go outside without checking for dogs or would not consider going to a dark part of the house even momentarily without someone accompanying them.

**Generalized Anxiety Disorder**

• For GAD, there is no reason to continue probing for the secondary symptoms if the screens are not positive. In other words, there is no sense in asking if symptoms were associated with worry if the child does not worry.

**Mood Disorders**

• Note especially that a diagnosis of Major Depressive Disorder may be based on persistent and severe irritability. That being the case, there may not be any evidence of a distinct episode or change in behaviour. Therefore, one should continue to probe all of the “Other Characteristics.”

• Mania can also be very difficult to diagnose. In some children, grandiosity is evident on a fairly consistent basis or may occur in episodes but evident in rather subtle form such as persistent belief that they are correct while others are not (“I don’t know who that teacher thinks she is! I am not going to do that work. I don’t need to!”).
Completion of the interview
When the interviewer has finished covering all the material in the three modules, close the session by asking whether the informant

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

Remember if taping the interview to retrieve the tape, label it as a PICS interview, with the case number, the date and your name. Return the tape to the appropriate storage place.

SPECIFIC PROBLEMS IN INTERVIEWING

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

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

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

- should feel free to interrupt the interview at any point to deal with these “process” issues;
- can comment on the extent to which informants disagree, and ask informants to speculate on the reason and nature of these disagreements - hopefully discussing the issue of interparental disagreement directly will allow the parents to achieve greater agreement; and
rates the severity of the symptom based to a greater extent on the description provided by
the parent who spends the majority of time with the child in that particular situation or
activity.

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

- should feel free to interrupt the interview to discuss this issue – the subsequent interview
  may proceed more smoothly if this is done;
- might comment, “I ask everyone the same questions in the same way and don’t expect
  that your child will have a problem with every one of these behaviours. I am mostly
  interested in the marked or more impairing behavioural problems”;
- may attempt to determine how problematic a behaviour is by asking, “How do you feel
  about these behaviours? You seem quite worried?”

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

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

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

A frequent variant of this scenario is a child who is described as being able to manage a
situation or to behave “if they want to” or “if he really likes the game.” This is a common
characteristic of all children. No matter how impaired a child may be, motivation plays a major
role in shaping child behaviour. Using the following probes, ask for a description of the child’s
behaviour in each situation.
- “Can you describe a situation in which your child is motivated and does succeed or manage well?”
- “When did that happen last?”
- “How often does that situation arise?”
- “Describe a situation in which the child is not motivated? How often does this occur?”
- “What are the consequences of each of these types of behaviour?”

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

- Many parents will report that their children are less symptomatic if they are given some assistance. For example, a child might be able to finish their homework “if I give her the help that s/he needs” or might be able to sit still at the dinner table “if I constantly remind him/her to stay put.” This indicates that considerable assistance is required to minimize symptoms. The ratings should be based on what the child would be like if no assistance were provided. You can determine the appropriate rating by:
  
  - asking about child behaviour in the absence of these supports;
  - judging by the amount of support that is typically provided and why; and
  - inquiring about why the informant feels it is necessary to provide that degree of support.

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

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

  - “Hum, that sounds like a difficult behaviour. How do you handle it?”
  - “What is the result?”
  - “What happens when somewhat else encounters the same behaviour? How do they fare?”
Clear evidence that the child’s symptoms are precipitated by maladaptive parenting practices (chaotic or inappropriate strategies) would result in lower severity ratings for child symptoms.

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

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

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

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

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

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

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