

## ECHO Idaho: Behavioral Health in Primary Care

### Behavioral Health Screenings in Outpatient Pediatrics

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The speaker has no financial relationship(s) to disclose.

# Objectives

- Present validated screening tools for the most common childhood mental health disorders for use in primary/outpatient care settings
- Provide resource links
- What this is not:
  - A presentation about diagnosis or treatment

# Common childhood behavioral health disorders encountered in primary care

- General Screenings
- Anxiety
- ADHD
- Depression
- Bipolar Disorder
- Disruptive Disorders
  - DMDD, ODD, Conduct
- Autism
- Eating Disorders
- Substance Use Disorders (*not included*)
- Trauma

# General Screenings

- Pediatric Symptoms Checklist (PSC-17)<sup>1</sup>
  - General mental health screening questionnaire in ages 4-17
    - Parent completes age 4-12
    - Child may complete age 13-17
  - Assesses likelihood of child mental health disorder
    - Attention (ADHD)
    - Internalizing (anxiety or other mood disorder)
    - Externalizing (conduct disorder, oppositional defiant disorder, adjustment disorder)

# Pediatric Symptom Checklist-17 (PSC-17)

Caregiver Completing this Form: ..... Date:.....

Name of Child:.....

	Please mark under the heading that best fits your child			For Office Use		
	NEVER	SOMETIMES	OFTEN	I	A	E
1. Fidgety, unable to sit still						
2. Feels sad, unhappy						
3. Daydreams too much						
4. Refuses to share						
5. Does not understand other people's feelings						
6. Feels hopeless						
7. Has trouble concentrating						
8. Fights with other children						
9. Is down on him or herself						
10. Blames others for his or her troubles						
11. Seems to be having less fun						
12. Does not listen to rules						
13. Acts as if driven by a motor						
14. Teases others						
15. Worries a lot						
16. Takes things that do not belong to him or her						
17. Distracted easily						
(scoring totals)						

**Scoring:**

- Fill in unshaded box on right with: "Never" = 0, "Sometimes" = 1, "Often" = 2
- Sum the columns.  
 PSC17 Internalizing score is sum of column I  
 PSC17 Attention score is sum of column A  
 PSC17 Externalizing score is sum of column E  
 PSC-17 Total Score is sum of I, A, and E columns

**Suggested Screen Cutoff:**

PSC-17 - I  $\geq$  5  
 PSC-17 - A  $\geq$  7  
 PSC-17 - E  $\geq$  7  
 Total Score  $\geq$  15

*Higher Scores can indicate an increased likelihood of a behavioral health disorder being present.*

# General Screenings

- DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure
  - Self-rated age 11-17; Parent/guardian age 6-17
  - Purpose: to assist clinician recognition of problems in 12 psychiatric domains
- Available at:  
<https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures>

## DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female Date: \_\_\_\_\_

Relationship with the child: \_\_\_\_\_

**Instructions (to the parent or guardian of child):** The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the past **TWO (2) WEEKS**.

		None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
	During the past <b>TWO (2) WEEKS</b> , how much (or how often) has your child...						
I.	1.	0	1	2	3	4	
	2.	0	1	2	3	4	
II.	3.	0	1	2	3	4	
III.	4.	0	1	2	3	4	
IV.	5.	0	1	2	3	4	
	6.	0	1	2	3	4	
V. &	7.	0	1	2	3	4	
VI.	8.	0	1	2	3	4	
VII.	9.	0	1	2	3	4	
	10.	0	1	2	3	4	
VIII.	11.	0	1	2	3	4	
	12.	0	1	2	3	4	
	13.	0	1	2	3	4	
IX.	14.	0	1	2	3	4	
	15.	0	1	2	3	4	
X.	16.	0	1	2	3	4	
	17.	0	1	2	3	4	
	18.	0	1	2	3	4	
	19.	0	1	2	3	4	

		In the past <b>TWO (2) WEEKS</b> , has your child ...			
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
XII.	24.	In the past <b>TWO (2) WEEKS</b> , has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
	25.	Has he/she <b>EVER</b> tried to kill himself/herself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know

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# Scoring

Domain	Domain Name	Threshold to guide further inquiry
I.	Somatic Symptoms	Mild or greater
II.	Sleep Problems	Mild or greater
III.	Inattention	Slight or greater
IV.	Depression	Mild or greater
V.	Anger	Mild or greater
VI.	Irritability	Mild or greater
VII.	Mania	Mild or greater
VIII.	Anxiety	Mild or greater
IX.	Psychosis	Slight or greater
X.	Repetitive Thoughts and Behaviors	Mild or greater
XI.	Substance Use	Yes/ Don't Know
XII.	Suicidal Ideation/ Suicide Attempts	Yes/ Don't Know

- Threshold for each “domain” that should prompt further investigation/inquiry

# General Screenings

- Strengths and Difficulties Questionnaire (SDQ)
  - 25 items on psychological attributes, some positive and some negative
  - Divided between 5 scales
    - Emotional, conduct, hyperactivity/inattention, peer relationship, prosocial behavior
  - Various modified formats for self and parent reporting at:
    - <https://www.sdqinfo.org/a0.html>

# General Screenings - Purpose

- Prompt further investigation with disorder-specific screenings
- For use at general well child/adolescent exams and/or problem-focused visits.
- Give packet, make follow up appointment to review

# General Screenings – fee/purchase

- Child Behavior Checklist (CBCL)
- Behavior Assessment Scale for Children (BASC-3)

# Anxiety

- Screen for Child Anxiety Related Disorders (SCARED)<sup>1</sup>
  - Child (40 items) and Parent (41 items) Version
    - Takes 10-15 to complete, same to score
  - Screens for multiple types of anxiety disorder
    - General, social, separation, panic/somatic, school avoidance
  - Validated studies age 8-17<sup>2</sup>

# Screen for Child Anxiety Related Disorders (SCARED)

Name ..... Today's Date .....

**Directions:**

Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then for each sentence, fill in one circle that corresponds to the response that seems to describe you **for the last 3 months**.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1. When I feel frightened, it is hard for me to breathe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I get headaches when I am at school	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. I don't like to be with people I don't know well	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I get scared if I sleep away from home	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I worry about other people liking me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. When I get frightened, I feel like passing out	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. I am nervous	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. I follow my mother or father wherever they go	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. People tell me that I look nervous	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. I feel nervous with people I don't know well	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. I get stomachaches at school	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. When I get frightened, I feel like I am going crazy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. I worry about sleeping alone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. I worry about being as good as other kids	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. When I get frightened, I feel like things are not real	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. I have nightmares about something bad happening to my parents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. I worry about going to school	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. When I get frightened, my heart beats fast	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. I get shaky	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. I have nightmares about something bad happening to me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

# SCARED Rating Scale Scoring Aid

Question	Panic Somatic	Generalized Anxiety	Separation	Social	School Attendance
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					

0 = not true or hardly true

1 = somewhat true or sometimes true

2 = very true or often true

## SCORING

A total score of  $\geq 25$  may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific.

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**.

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**.

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety Disorder**.

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**.

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**.

The SCARED target population is 9-18 years old.

# Anxiety

- Generalized Anxiety Disorder 7-item Scale (GAD-7)
  - Small studies validated in adolescents and teens<sup>3</sup>

## Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
<i>Add the score for each column</i>	+	+	+	
<b>Total Score (add your column scores) =</b>				

### Scoring:

- 5 = mild
- 10 = moderate
- 15 = severe
- Further evaluation when score  $\geq 10$

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all \_\_\_\_\_

Somewhat difficult \_\_\_\_\_

Very difficult \_\_\_\_\_

Extremely difficult \_\_\_\_\_

# ADHD

- Vanderbilt<sup>1</sup>
  - Initial parent scale
    - Sensitivity 80%, specificity 75%
  - Initial teacher scale
    - Sensitivity 69%, specificity 84%
  - Follow up parent AND teacher version
  - Validated age 6-12

# Vanderbilt ADHD Teacher Rating Scale

Child's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ Today's Date \_\_\_\_\_

Completed by \_\_\_\_\_ Subject Taught (if applicable) \_\_\_\_\_

Each rating should be considered in the context of what is appropriate for the age of the child. If you have completed a previous assessment, your rating should reflect the child's behavior since you last completed a form.

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes, such as in homework	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instruction and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining in seated is expected	0	1	2	3
12. Runs about or climbs excessively when remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others (butts into conversations or games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adults' requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations ("cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3

# Vanderbilt ADHD Teacher Rating Scale

Child's Name .....

Today's Date .....

Symptoms	Never	Occasionally	Often	Very Often
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems, feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him/her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance	Problematic		Average		Above Average	
<b>Academic Performance</b>						
Reading	1	2	3	4	5	
Mathematics	1	2	3	4	5	
Written Expression	1	2	3	4	5	
<b>Classroom Behavior</b>						
Relationship with Peers	1	2	3	4	5	
Following Directions/Rules	1	2	3	4	5	
Disrupting Class	1	2	3	4	5	
Assignment Completion	1	2	3	4	5	
Organizational Skills	1	2	3	4	5	

Comments:

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**For Office Use Only**

**SYMPTOMS:**

Number of questions scored as 2 or 3 in questions 1-9: .....

Number of questions scored as 2 or 3 in questions 10-18: .....

Total symptom score for questions 1-18: .....

Number of questions scored as 2 or 3 in questions 19-28: .....

Number of questions scored as 2 or 3 in questions 29-35: .....

# Vanderbilt Scoring

## Parent Version

### Predominantly Inattentive Subtype

Requires 6 or more counted behaviors on items 1 through 9 and a performance problem (score of 1 or 2) in any of the items on the *performance* section.

### Predominantly Hyperactive/Impulsive Subtype

Requires 6 or more counted behaviors on items 10 through 18 and a performance problem (score of 1 or 2) in any of the items on the *performance* section.

### Combined Subtype

Requires 6 or more counted behaviors each on both the inattention and hyperactivity/impulsivity dimensions.

### Oppositional-defiant disorder

Requires 4 or more counted behaviors on items 19 through 26.

### Conduct disorder

Requires 3 or more counted behaviors on items 27 through 40.

### Anxiety or depression

Requires 3 or more counted behaviors on items 41 through 47.

## Teacher Version

### Predominantly Inattentive Subtype

Requires 6 or more counted behaviors on items 1 through 9 and a performance problem (score of 1 or 2) in any of the items on the *performance* section.

### Predominantly Hyperactive/Impulsive Subtype

Requires 6 or more counted behaviors on items 10 through 18 and a performance problem (score of 1 or 2) in any of the items on the *performance* section.

### Combined subtype

Requires 6 or more counted behaviors each on both the inattention and hyperactivity/impulsivity dimensions.

### Oppositional defiant and conduct disorders

Requires 3 or more counted behaviors from questions 19 through 28.

### Anxiety or depression

Requires 3 or more counted behaviors from questions 29 through 35.

The *performance* section is scored as indicating some impairment if a child scores 1 or 2 on at least 1 item.

# ADHD – advanced testing

- Conners Testing (Conners Rating Scale-Revised, or CRS-R)
  - Fee, computer software to score
- CBCL-AP (Child Behavior Checklist – Attention Problem Scale)

# Conduct Disorder, Oppositional Defiant Disorder?

- Emerging evidence of racial biases in these diagnoses
- When compared to non-Hispanic white youth, some ethnic and racial minority youth are *more likely* to receive a diagnosis of a disruptive behavior disorder and are *less likely* to receive a diagnosis of ADHD<sup>4</sup>

# Depression

- PHQ-2
  - Score of 3 or greater, give PHQ-9

# Patient Health Questionnaire-2 (PHQ-2)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Not at all      Several days      More than half the days      Nearly every day

1. Little interest or pleasure in doing things

0      1      2      3

2. Feeling down, depressed, or hopeless

0      1      2      3

For office coding:

\_\_\_\_\_0\_\_\_\_\_+\_\_\_\_\_+\_\_\_\_\_+

= Total Score \_\_\_\_\_

# Patient Health Questionnaire (PHQ-9)

NAME \_\_\_\_\_ DATE \_\_\_\_\_

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "✓" to indicate your answer).

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
add columns <input type="text"/> + <input type="text"/> + <input type="text"/>				
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). <b>TOTAL:</b> <input type="text"/>				

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people.

Not difficult at all \_\_\_\_\_

Somewhat difficult \_\_\_\_\_

Very difficult \_\_\_\_\_

Extremely difficult \_\_\_\_\_

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# Depression

- PHQ-9<sup>1</sup>
  - For use in adolescent/teens
  - Not validated in pre-pubertal children

A depression diagnosis requires a functional impairment to be present.

**Add up the total number from items 1-9**

Estimated depression severity:

0-4 None

5-9 Minimal symptoms

10-14 Possible dysthymia, or mild Major Depression

15-19 Consistent with Major Depression

≥ 20 Consistent with severe Major Depression

# Depression

- Short Mood and Feelings Questionnaire (SMFQ)<sup>1</sup>
  - Validated in children age 6-17
  - Sensitivity 60% and specificity 85%
  - Parent and child version

# Short Mood and Feelings Questionnaire

This form is about how you might have been feeling or acting recently.

For each question, please check how much you have felt or acted this way *in the past two weeks*.

If a sentence was true about you most of the time, check TRUE.

If it was only sometimes true, check SOMETIMES.

If a sentence was not true about you, check NOT TRUE.

	NOT TRUE	SOMETIMES	TRUE
1. I felt miserable or unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I didn't enjoy anything at all	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I felt so tired I just sat around and did nothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I was very restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I felt I was no good any more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I cried a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I found it hard to think properly or concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I hated myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I was a bad person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I felt lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I thought nobody really loved me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I thought I could never be as good as other kids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I did everything wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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# Short Mood and Feelings Questionnaire

This form is about how your child may have been feeling or acting recently.

For each question, please check how much she or he has felt or acted this way *in the past two weeks*.

If a sentence was true about your child most of the time, check TRUE.

If it was only sometimes true, check SOMETIMES.

If a sentence was not true about your child, check NOT TRUE.

	NOT TRUE	SOMETIMES	TRUE
1. S/he felt miserable or unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. S/he didn't enjoy anything at all	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. S/he felt so tired that s/he just sat around and did nothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. S/he was very restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. S/he felt s/he was no good any more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. S/he cried a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. S/he found it hard to think properly or concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. S/he hated him/herself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. S/he felt s/he was a bad person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. S/he felt lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. S/he thought nobody really loved him/her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. S/he thought s/he could never be as good as other kids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. S/he felt s/he did everything wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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# Scoring the SMFQ

Note: the SMFQ has been validated for use in children age 6 years and up.

The SMFQ should not be used to make a definitive diagnosis of depression. It has usefulness as a screening tool for situations where depression is suspected, and as an aid toward following a child's symptom severity and treatment response over time.

## Scoring:

Assign a numerical value to each answer as follows:

Not true = 0

Sometimes = 1

True = 2

Add up the assigned values for all 13 questions. Record the total score.

*A total score on the child version of the SMFQ of 8 or more is considered significant.*

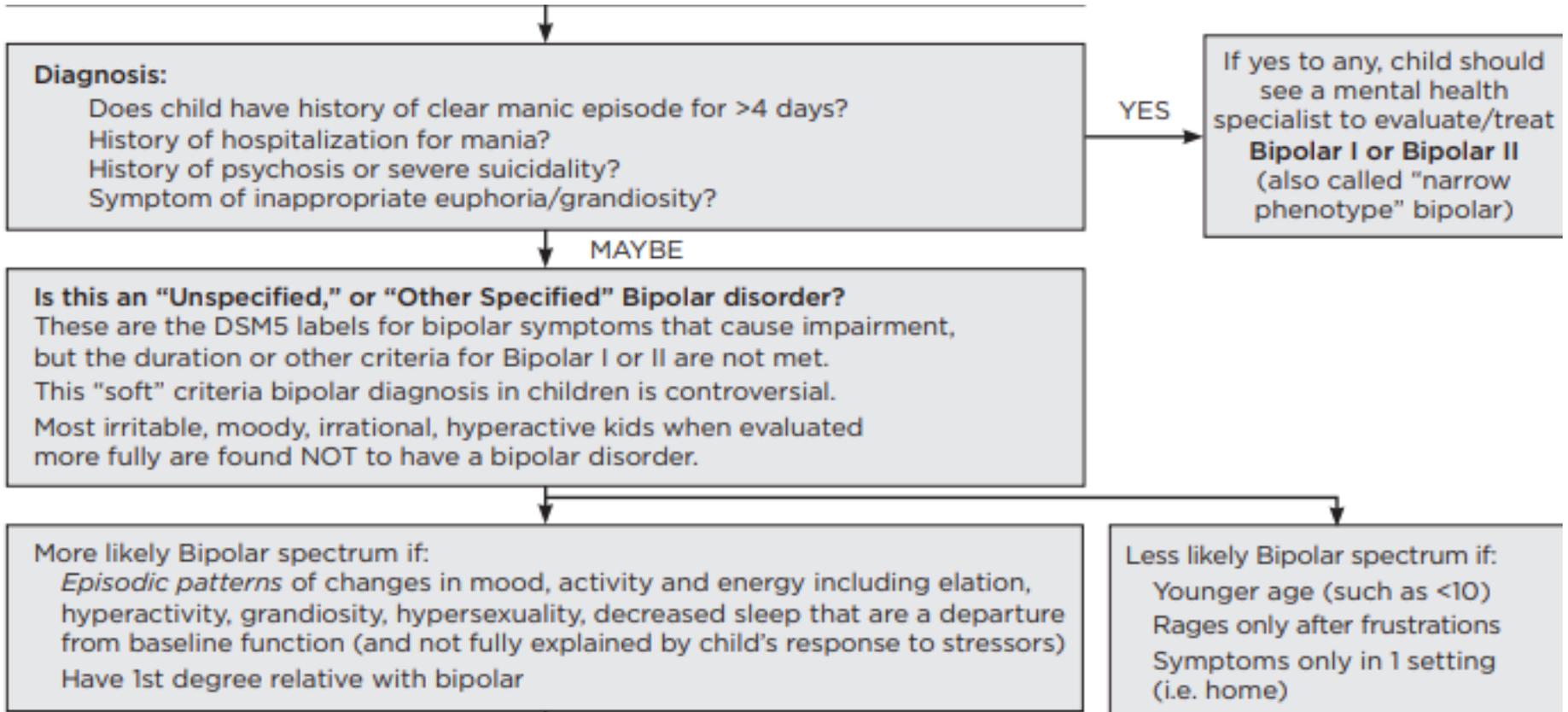
Sensitivity of 60% and specificity of 85% for major depression at a cut off score of 8 or higher. Source is Angold A, Costello EJ, Messer SC. "Development of a short questionnaire for use in epidemiological studies of depression in children and adolescents." *International Journal of Methods in Psychiatric Research* (1995), 5:237-249.

Sensitivity/specificity statistics of the parent version is not reported in the literature. If your patient does not complete the child version of SMFQ, repeated administration of the parent version over time should still be useful for symptom tracking.

# Bipolar Disorder

- Suspect: Episodic mood changes with manic features
- Diagnosis controversial within pediatric psychiatry, especially before age 10
- Strongly consider alternative diagnoses

# Bipolar Disorder



# Bipolar Disorder

- Mood Disorder Questionnaire (MDQ)
  - Some validation studies in adolescents and teens
- Found at:
  - <http://www.sadag.org/images/pdf/mdq.pdf>

**Instructions:** Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	<input type="radio"/>	<input type="radio"/>
...you were so irritable that you shouted at people or started fights or arguments?	<input type="radio"/>	<input type="radio"/>
...you felt much more self-confident than usual?	<input type="radio"/>	<input type="radio"/>
...you got much less sleep than usual and found you didn't really miss it?	<input type="radio"/>	<input type="radio"/>
...you were much more talkative or spoke much faster than usual?	<input type="radio"/>	<input type="radio"/>
...thoughts raced through your head or you couldn't slow your mind down?	<input type="radio"/>	<input type="radio"/>
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	<input type="radio"/>	<input type="radio"/>
...you had much more energy than usual?	<input type="radio"/>	<input type="radio"/>
...you were much more active or did many more things than usual?	<input type="radio"/>	<input type="radio"/>
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	<input type="radio"/>	<input type="radio"/>
...you were much more interested in sex than usual?	<input type="radio"/>	<input type="radio"/>
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	<input type="radio"/>	<input type="radio"/>
...spending money got you or your family into trouble?	<input type="radio"/>	<input type="radio"/>
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	<input type="radio"/>	<input type="radio"/>
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? <i>Please circle one response only.</i>		
No Problem    Minor Problem    Moderate Problem    Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	<input type="radio"/>	<input type="radio"/>
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	<input type="radio"/>	<input type="radio"/>

**If the patient answers:**

1. **“Yes”** to seven or more of the 13 items in question number 1;

AND

2. **“Yes”** to question number 2;

AND

3. **“Moderate”** or **“Serious”** to question number 3;

# Disruptive Mood Dysregulation Disorder (DMDD)

- Emerging Diagnosis since 2010<sup>5</sup> due to high rates of pediatric bipolar disorder 1994-2004
- Persistent and pervasive irritability, underlying and punctuated by frequent temper outbursts
  - >3 times per week, in at least 2 settings, >12 months
- High rates of comorbidity, consider when screen positive for:
  - ODD, conduct disorder, ADHD, anxiety, depression and bipolar disorder

# Autism

- Modified Checklist for Autism in Toddlers (MCHAT-R)
  - takes parents 5 minutes
  - Valid for children age 16-30 months
  - Sensitivity 91%, specificity 95%
- Found at:
  - <https://mchatscreen.com/>

# M-CHAT-R™

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

1. If you point at something across the room, does your child look at it? (FOR EXAMPLE, if you point at a toy or an animal, does your child look at the toy or animal?)	Yes	No
2. Have you ever wondered if your child might be deaf?	Yes	No
3. Does your child play pretend or make-believe? (FOR EXAMPLE, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	Yes	No
4. Does your child like climbing on things? (FOR EXAMPLE, furniture, playground equipment, or stairs)	Yes	No
5. Does your child make <u>unusual</u> finger movements near his or her eyes? (FOR EXAMPLE, does your child wiggle his or her fingers close to his or her eyes?)	Yes	No
6. Does your child point with one finger to ask for something or to get help? (FOR EXAMPLE, pointing to a snack or toy that is out of reach)	Yes	No
7. Does your child point with one finger to show you something interesting? (FOR EXAMPLE, pointing to an airplane in the sky or a big truck in the road)	Yes	No
8. Is your child interested in other children? (FOR EXAMPLE, does your child watch other children, smile at them, or go to them?)	Yes	No
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (FOR EXAMPLE, showing you a flower, a stuffed animal, or a toy truck)	Yes	No
10. Does your child respond when you call his or her name? (FOR EXAMPLE, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	Yes	No
11. When you smile at your child, does he or she smile back at you?	Yes	No
12. Does your child get upset by everyday noises? (FOR EXAMPLE, does your child scream or cry to noise such as a vacuum cleaner or loud music?)	Yes	No
13. Does your child walk?	Yes	No
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	Yes	No
15. Does your child try to copy what you do? (FOR EXAMPLE, wave bye-bye, clap, or make a funny noise when you do)	Yes	No
16. If you turn your head to look at something, does your child look around to see what you are looking at?	Yes	No
17. Does your child try to get you to watch him or her? (FOR EXAMPLE, does your child look at you for praise, or say "look" or "watch me"?)	Yes	No
18. Does your child understand when you tell him or her to do something? (FOR EXAMPLE, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)	Yes	No
19. If something new happens, does your child look at your face to see how you feel about it? (FOR EXAMPLE, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	Yes	No
20. Does your child like movement activities? (FOR EXAMPLE, being swung or bounced on your knee)	Yes	No

## Scoring Algorithm

For all items except 2, 5, and 12, the response "NO" indicates ASD risk; for items 2, 5, and 12, "YES" indicates ASD risk. The following algorithm maximizes psychometric properties of the M-CHAT-R:

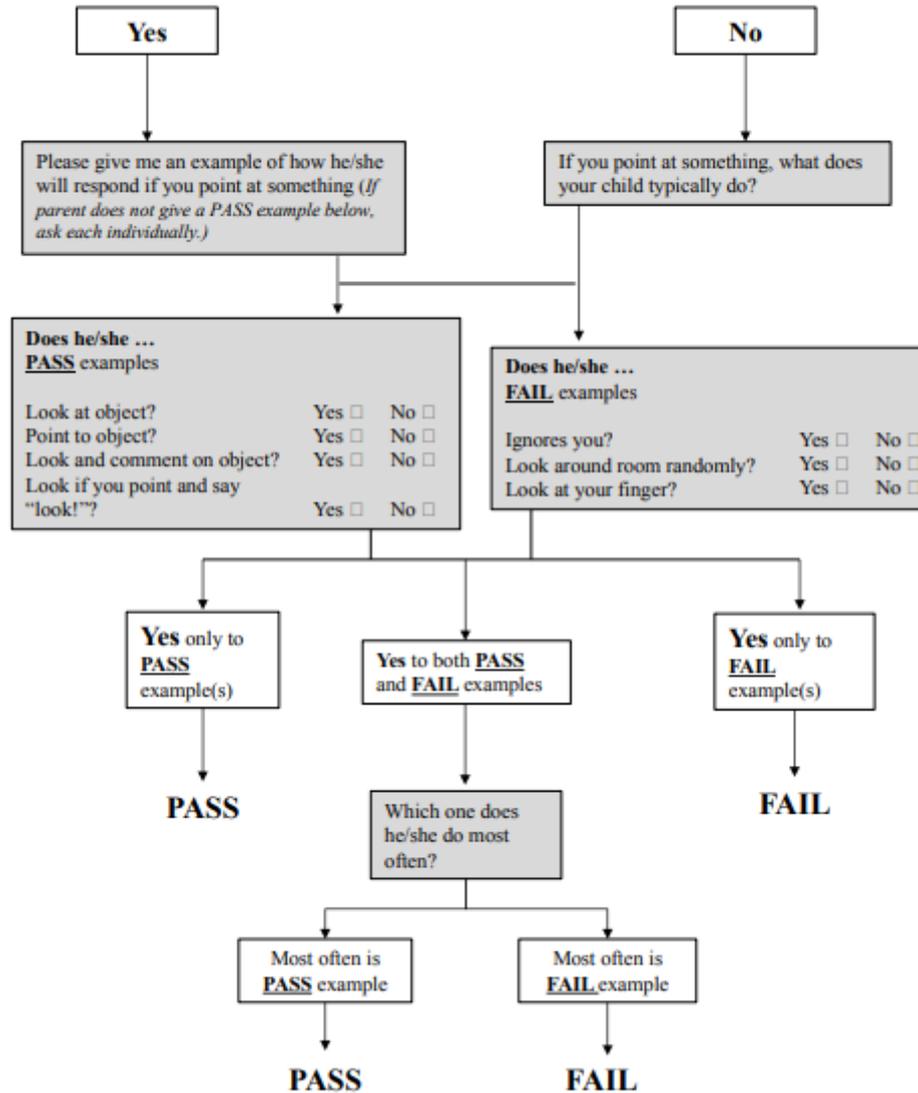
**LOW-RISK:** Total Score is 0-2; if child is younger than 24 months, screen again after second birthday. No further action required unless surveillance indicates risk for ASD.

**MEDIUM-RISK:** Total Score is 3-7; Administer the Follow-Up (second stage of M-CHAT-R/F) to get additional information about at-risk responses. If M-CHAT-R/F score remains at 2 or higher, the child has screened positive. Action required: refer child for diagnostic evaluation and eligibility evaluation for early intervention. If score on Follow-Up is 0-1, child has screened negative. No further action required unless surveillance indicates risk for ASD. Child should be rescreened at future well-child visits.

**HIGH-RISK:** Total Score is 8-20; It is acceptable to bypass the Follow-Up and refer immediately for diagnostic evaluation and eligibility evaluation for early intervention.

MCHAT-R-F

1. If you point at something across the room, does \_\_\_\_\_ look at it?



# Autism

- Childhood Autism Spectrum Test (CAST)
  - takes parents 5 minutes
  - Valid for children age 4-11 years
  - Sensitivity 98%, specificity 97%
- Found at:
  - <https://psychology-tools.com/test/cast>

# Autism - CAST

Please read the following questions carefully, and circle the appropriate answer. All responses are confidential.

- |  |     |    |
|--|-----|----|
| 1. Does s/he join in playing games with other children easily?   | Yes | No |
| 2. Does s/he come up to you spontaneously for a chat?  | Yes | No |
| 3. Was s/he speaking by 2 years old?   | Yes | No |
| 4. Does s/he enjoy sports?   | Yes | No |
| 5. Is it important to him/her to fit in with the peer group?   | Yes | No |
| 6. Does s/he appear to notice unusual details that others miss?  | Yes | No |
| 7. Does s/he tend to take things literally?  | Yes | No |
| 8. When s/he was 3 years old, did s/he spend a lot of time pretending (e.g., play-acting being a superhero, or holding teddy's tea parties)? | Yes | No |
| 9. Does s/he like to do things over and over again, in the same way all the time?  | Yes | No |
| 10. Does s/he find it easy to interact with other children?  | Yes | No |
| 11. Can s/he keep a two-way conversation going?  | Yes | No |

## How to Score:

- 3, 4, 12, 22, 16 are controls. Answer does not count.
- Total score is out of 31, and score  $\geq 15$  is concerning for ASD.

# Autism - POSI

- Parent Observations of Social Interactions (POSI)
  - Age 16 months to 36 months
  - 7 item scoring tool
  - Increased sensitivity from MCHAT, but MCHAT more specific
- Available at
  - <https://www.tuftschildrenshospital.org/The-Survey-of-Wellbeing-of-Young-Children/Parts-of-the-SWYC/POSI.aspx>



# POSI:

18 months, 0 days to 34 months, 31 days  
V1.07, 4/1/17

Child's Name:

Birth Date:

Today's Date:

## PARENT'S OBSERVATIONS OF SOCIAL INTERACTIONS (POSI)

Does your child bring things to you to show them to you?	Many times a day <input type="radio"/>	A few times a day <input type="radio"/>	A few times a week <input type="radio"/>	Less than once a week <input type="radio"/>	Never <input type="radio"/>
Is your child interested in playing with other children?	Always <input type="radio"/>	Usually <input type="radio"/>	Sometimes <input type="radio"/>	Rarely <input type="radio"/>	Never <input type="radio"/>
When you say a word or wave your hand, will your child try to copy you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Does your child look at you when you call his or her name?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Does your child look if you point to something across the room?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How does your child <u>usually</u> show you something he or she wants?	Says a word for what he or she wants <input type="checkbox"/>	Points to it with one finger <input type="checkbox"/>	Reaches for it <input type="checkbox"/>	Pulls me over or puts my hand on it <input type="checkbox"/>	Grunts, cries or screams <input type="checkbox"/>
<i>(please check all that apply)</i>					
What are your child's favorite play activities?	Playing with dolls or stuffed animals <input type="checkbox"/>	Reading books with you <input type="checkbox"/>	Climbing, running and being active <input type="checkbox"/>	Lining up toys or other things <input type="checkbox"/>	Watching things go round and round like fans or wheels <input type="checkbox"/>
<i>(please check all that apply)</i>					
For acknowledgments, validation, and other information concerning the POSI, please see <a href="http://www.theswyc.org/posi">www.theswyc.org/posi</a>					

Flooring Hospital  
for Children  
at Tufts Medical Center



# SWYC:

18 months, 0 days to 34 months, 31 days

3 or more responses (from different items) in these 3 columns

## PARENT'S OBSERVATIONS OF SOCIAL INTERACTIONS (POSI)

	Many times a day	A few times a day	A few times a week	Less than once a week	Never
Does your child bring things to you to show them to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Is your child interested in playing with other children?	Always	Usually	Sometimes	Rarely	Never
When you say a word or wave your hand, will your child try to copy you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Does your child look at you when you call his or her name?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Does your child look if you point to something across the room?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How does your child <u>usually</u> show you something he or she wants?	Says a word for what he or she wants	Points to it with one finger	Reaches for it	Pulls me over or puts my hand on it	Grunts, cries or screams
<i>(please check all that apply)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What are your child's favorite play activities?	Playing with dolls or stuffed animals	Reading books with you	Climbing, running and being active	Lining up toys or other things	Watching things go round and round like fans or wheels
<i>(please check all that apply)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How to Score:

- 7 total questions
- Score 1 point per row if anything checked in right 3 columns (*even if multiple checked, only 1 point per row*)
- If  $\geq 3$ , recommend referral

# Autism - Adult

- Autism Spectrum Quotient (AQ-10)
- Found at:
  - <https://www.nice.org.uk/guidance/cg142/resources/autism-spectrum-quotient-aq10-test-143968>

# AQ-10

## Autism Spectrum Quotient (AQ)

*A quick referral guide for adults with suspected autism who do not have a learning disability.*

**Please tick one option per question only:**

		Definitely Agree	Slightly Agree	Slightly Disagree	Definitely Disagree
1	I often notice small sounds when others do not				
2	I usually concentrate more on the whole picture, rather than the small details				
3	I find it easy to do more than one thing at once				
4	If there is an interruption, I can switch back to what I was doing very quickly				
5	I find it easy to 'read between the lines' when someone is talking to me				
6	I know how to tell if someone listening to me is getting bored				
7	When I'm reading a story I find it difficult to work out the characters' intentions				
8	I like to collect information about categories of things (e.g. types of car, types of bird, types of train, types of plant etc)				
9	I find it easy to work out what someone is thinking or feeling just by looking at their face				
10	I find it difficult to work out people's intentions				

**SCORING:** Only 1 point can be scored for each question. *Score 1 point for Definitely or Slightly Agree on each of items 1, 7, 8, and 10. Score 1 point for Definitely or Slightly Disagree on each of items 2, 3, 4, 5, 6, and 9.* If the individual scores **6 or above**, consider referring them for a specialist diagnostic assessment.

This test is recommended in 'Autism: recognition, referral, diagnosis and management of adults on the autism spectrum' (NICE clinical guideline CG142). [www.nice.org.uk/CG142](http://www.nice.org.uk/CG142)

**Key reference:** Allison C, Auyeung B, and Baron-Cohen S, (2012) *Journal of the American Academy of Child and Adolescent Psychiatry* 51(2):202-12.

# Developmental Screenings

- Ages and Stages Questionnaire (ASQ-3)
  - Screening every 2-3 months from 2 to 60 months
  - Takes 10-15 minutes for parent to complete, 2-3 minutes for professional to score
  - Sensitivity 86%, specificity 86%
  - 5 main areas: Communication, Gross motor, Fine motor, Problem solving, Personal-social
- Found at:
  - <https://agesandstages.com/>



# 18 Month Questionnaire

17 months 0 days  
through 18 months 30 days

On the following pages are questions about activities children may do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

### Important Points to Remember:

- Try each activity with your child before marking a response.
- Make completing this questionnaire a game that is fun for you and your child.
- Make sure your child is rested and fed.
- Please return this questionnaire by \_\_\_\_\_.

### Notes:

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At this age, many toddlers may not be cooperative when asked to do things. You may need to try the following activities with your child more than one time. If possible, try the activities when your child is cooperative. If your child can do the activity but refuses, mark "yes" for the item.

## COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. When your child wants something, does she tell you by pointing to it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. When you ask your child to, does he go into another room to find a familiar toy or object? (You might ask, "Where is your ball?" or say, "Bring me your coat," or "Go get your blanket.")	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your child say eight or more words in addition to "Mama" and "Dada"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. Does your child imitate a two-word sentence? For example, when you say a two-word phrase, such as "Mama eat," "Daddy play," "Go home," or "What's this?" does your child say both words back to you? (Mark "yes" even if her words are difficult to understand.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Without your showing him, does your child point to the correct picture when you say, "Show me the kitty," or ask, "Where is the dog?" (He needs to identify only one picture correctly.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your child say two or three words that represent different ideas together, such as "See dog," "Mommy come home," or "Kitty gone"? (Don't count word combinations that express one idea, such as "bye-bye," "all gone," "all right," and "What's that?") Please give an example of your child's word combinations:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

1. **SCORE AND TRANSFER TOTALS TO CHART BELOW:** See *ASQ-3 User's Guide* for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	13.06		●	●	●	○	○	○	○	○	○	○	○	○	○
Gross Motor	37.38		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	34.32		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	25.74		●	●	●	●	●	○	○	○	○	○	○	○	○
Personal-Social	27.19		●	●	●	●	●	○	○	○	○	○	○	○	○

3. **ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP:** You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the child's total score is in the  area, it is above the cutoff, and the child's development appears to be on schedule.

If the child's total score is in the  area, it is close to the cutoff. Provide learning activities and monitor.

If the child's total score is in the  area, it is below the cutoff. Further assessment with a professional may be needed.

# ASQ-3: practical use

- AAP recommends at all 9 months, 18 months well child check-ups
- Any time a parent or provider has concern for development
  - Give ASQ-3 for age in just area of concern
    - Example: “I’m worried about their speech”
    - Provider: score the ASQ-3 communication section
  - If abnormal can do full ASQ-3, refer to infant toddler or appropriate services based on results

# Developmental Screenings

- Early Childhood Screening Assessment (ECSA)<sup>1</sup>
  - Screening for emotional and behavioral development as well as caregiver distress
  - 1.5 to 5 years old
  - Sensitivity 85%, specificity 83%

# Early Childhood Screening Assessment (ECSA)

Child name: \_\_\_\_\_ Date: \_\_\_\_\_

- Please circle the number that best describes your child compared to other children the same age.
- For each item, please circle the + if you are concerned and would like help with the item.

0=Rarely/Not True 1=Sometimes/Sort of 2= Almost always/Very true Completed by: \_\_\_\_\_

1. Seems sad, cries a lot	0	1	2	+
2. Is difficult to comfort when hurt or distressed	0	1	2	+
3. Loses temper too much	0	1	2	+
4. Avoids situations that remind of scary events	0	1	2	+
5. Is easily distracted	0	1	2	+
6. Hurts others on purpose (biting, hitting, kicking)	0	1	2	+
7. Doesn't seem to listen to adults talking to him/her	0	1	2	+
8. Battles over food and eating	0	1	2	+
9. Is irritable, easily annoyed	0	1	2	+
10. Argues with adults	0	1	2	+
11. Breaks things during tantrums	0	1	2	+
12. Is easily startled or scared	0	1	2	+
13. Cries to annoy people	0	1	2	+
14. Has trouble interacting with other children	0	1	2	+
15. Fidgets, can't sit quietly	0	1	2	+
16. Is clingy, doesn't want to separate from parent	0	1	2	+
17. Is very scared of certain things (needles, insects)	0	1	2	+
18. Seems nervous or worries a lot	0	1	2	+
19. Blames other people for mistakes	0	1	2	+
20. Sometimes freezes or looks very still when scared	0	1	2	+
21. Avoids foods that have specific feelings or tastes	0	1	2	+
22. Is too interested in sexual play or body parts	0	1	2	+
23. Runs around in settings when should sit still (school, worship)	0	1	2	+
24. Has a hard time paying attention to tasks or activities	0	1	2	+
25. Interrupts frequently	0	1	2	+
26. Is always "on the go"	0	1	2	+
27. Reacts too emotionally to small things	0	1	2	+
28. Is very disobedient	0	1	2	+
29. Has more picky eating than usual	0	1	2	+
30. Has unusual repetitive behaviors (rocking, flapping)	0	1	2	+
31. Might wander off if not supervised	0	1	2	+
32. Has a hard time falling asleep or staying asleep	0	1	2	+
33. Doesn't seem to have much fun	0	1	2	+
34. Is too friendly with strangers	0	1	2	+
35. Has more trouble talking or learning to talk than other children	0	1	2	+
36. Is learning or developing more slowly than other children	0	1	2	+
37. I feel down, depressed, or hopeless	0	1	2	+
38. I feel little interest or pleasure in doing things	0	1	2	+
39. I feel too stressed to enjoy my child	0	1	2	+
40. I get more frustrated than I want to with my child's behavior	0	1	2	+

Are you concerned about your child's emotional or behavioral development? Yes Somewhat No

## How to Score:

- Sum of all circled items 1-36
- Score >18 child needs further assessment
- 38, 39, 40 indicated caregiver distress

# Eating Disorder

- Eating Attitudes Test – (EAT-26)<sup>1</sup>

# Eating Attitudes Test<sup>©</sup> (EAT-26)

Instructions: This is a screening measure to help you determine whether you might have an eating disorder that needs professional attention. This screening measure is not designed to make a diagnosis of an eating disorder or take the place of a professional consultation. Please fill out the below form as accurately, honestly and completely as possible. There are no right or wrong answers. All of your responses are confidential.

## Part A: Complete the following questions:

- 1) Birth Date    Month: ..... Day: ..... Year: ..... 2) Gender:  Male  Female  
 3) Height        Feet: ..... Inches: .....  
 4) Current Weight (lbs.): ..... 5) Highest Weight (excluding pregnancy): .....  
 6) Lowest Adult Weight: ..... 7) Ideal Weight: .....

Part B: Please check a response for each of the following statements:		Always	Usually	Often	Sometimes	Rarely	Never
1.	Am terrified about being overweight.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Avoid eating when I am hungry.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Find myself preoccupied with food.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Have gone on eating binges where I feel that I may not be able to stop.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Cut my food into small pieces.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Aware of the calorie content of foods that I eat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Particularly avoid food with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Feel that others would prefer if I ate more.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Vomit after I have eaten.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Feel extremely guilty after eating.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Am preoccupied with a desire to be thinner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Think about burning up calories when I exercise.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Other people think that I am too thin.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	Am preoccupied with the thought of having fat on my body.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.	Take longer than others to eat my meals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16.	Avoid foods with sugar in them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17.	Eat diet foods.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18.	Feel that food controls my life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19.	Display self-control around food.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20.	Feel that others pressure me to eat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21.	Give too much time and thought to food.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22.	Feel uncomfortable after eating sweets.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23.	Engage in dieting behavior.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24.	Like my stomach to be empty.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25.	Have the impulse to vomit after meals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26.	Enjoy trying new rich foods.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Part C: Behavioral Questions. In the past 6 months have you:		Never	Once a month or less	2-3 times a month	Once a week	2-6 times a week	Once a day or more
A.	Gone on eating binges where you feel that you may not be able to stop?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B.	Ever made yourself sick (vomited) to control your weight or shape?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.	Ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.	Exercised more than 60 minutes a day to lose or to control your weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E.	Lost 20 pounds or more in the past 6 months	<input type="checkbox"/> Yes			<input type="checkbox"/> No		

\* Defined as eating much more than most people would under the same circumstances and feeling that eating is out of control.

# Eating Disorder

- Eating Attitudes Test – (EAT-26)
  - Score >20 indicates need for further investigation

## Scoring for Questions 1-25:

Always	=	3
Usually	=	2
Often	=	1
Sometimes	=	0
Rarely	=	0
Never	=	0

## Scoring for Question 26:

Always	=	0
Usually	=	0
Often	=	0
Sometimes	=	1
Rarely	=	2
Never	=	3

# Trauma

- DO Inquire directly about trauma
  - Child abuse, domestic violence, community violence, serious accidents
- Avoid asking specific details during a brief office visit unless necessary to ensure safety
  - Use screening questionnaires
  - Ask parent or caregiver for more information

# Screen for Child Anxiety Related Disorders (SCARED) Traumatic Stress Disorder Scale

Name ..... Today's Date .....

**Directions:**

Below is a list of sentences that describe how people feel. Read each and decide if it is "Not True or Hardly Ever True," "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then for each sentence, choose the answer that seems to describe you **for the last 3 months**.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
I have scary dreams about a very bad thing that once happened to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I try not to think about a very bad thing that once happened to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I get scared when I think back on a very bad thing that once happened to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I keep thinking about a very bad thing that once happened to me, even when I don't want to think about it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Score .....

# Trauma

- Adverse Childhood Experience (ACE Score)<sup>6</sup>
- Center for Youth and Wellness (CYW) ACES Questionnaires
  - Child (by parent/caregiver)
  - Teen (self report)
  - Teen (by parent/caregiver)
  - Found at:
    - <https://centerforyouthwellness.org/cyw-aceq/>

# References

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# Questions?