Teens, Screens, and In-Betweens...

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Rock Hill Pediatrics
Presentation Format

• For each Screening Tool:
  – Overview & Administration
  – Tool
  – Scoring
  – Psychometric Properties

• PSC-Y - Pediatric Symptom Checklist – Youth Report
• PHQ-9 - Patient Health Questionnaire
• CRAFFFT - Car, Relax, Alone, Forget, Friends, Trouble
• SCARED - Screen for Childhood Anxiety Related Emotional Disorders
Screening is...

“Assessment of a population to determine if they (individually or collectively) are “at risk” for a particular problem”

~ UMASS – Certificate Program in Primary Care Behavioral Health
Screening ≠ Evaluation

- does not provide a diagnosis,
- identifies those in need of further assessment,
- designed for those thought to be developing normally (asymptomatic),
- a brief process,
- helps to formulate referral questions

Overview

• 35 item self-completion screening questionnaire
• Broad range of behavioral and psychosocial problems in youth
• Internalizing, externalizing, and attention problems
• 2 additional questions
  – Suicidal thinking
  – Suicidal attempts

Administration

• Less than 5 minutes to complete and score
• Can be scored by nurse, medical tech, other staff
• Inform parents that MH checkup will be administered
• Patients should be left alone in private place to complete
• Inform regarding confidentiality
**A Survey From Your Healthcare Provider — PSC-Y**

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>ID</th>
</tr>
</thead>
</table>

Please mark under the heading that best fits you or circle Yes or No

- 1. Complain of ache or pain
- 2. Spend more time alone
- 3. Tire easily, little energy
- 4. Fidgety, unable to sit still
- 5. Have trouble with teacher
- 6. Less interested in school
- 7. Act as if driven by motor
- 8. Daydream too much
- 9. Distact easily
- 10. Are afraid of new situations
- 11. Feel sad, unhappy
- 12. Are irritable, angry
- 13. Feel hopeless
- 14. Have trouble concentrating
- 15. Less interested in friends
- 16. Fight with other children
- 17. Absent from school
- 18. School grades dropping
- 19. Down on yourself
- 20. Visit doctor with doctor finding nothing wrong
- 21. Have trouble sleeping
- 22. Worry a lot
- 23. Want to be with parent more than before
- 24. Feel that you are bad
- 25. Take unnecessary risks
- 26. Get hurt frequently
- 27. Seem to be having less fun
- 28. Act younger than children your age
- 29. Do not listen to rules
- 30. Do not show feelings
- 31. Do not understand other people’s feelings
- 32. Tease others
- 33. Blame others for your troubles
- 34. Take things that do not belong to you
- 35. Refuse to share
- 36. During the past three months, have you thought of killing yourself? Yes No
- 37. Have you ever tried to kill yourself? Yes No

\[\text{TS} = \frac{A \geq 7}{A \geq 5} \text{ or } \frac{E \geq 7}{E \geq 7}\]

Note — the sub-scores do not impact the overall score; they are for interpretation purposes only.

**FOR OFFICE USE ONLY**

- Plan for Follow-up  
- Annual screening  
- Return visit w/ PCP  
- Referred to counselor  
- Parent declined  
- Already in treatment  
- Referred to other professional

Source: Ped Sysmop Axis Disorders — Youth Report (PSC-Y)
Scoring and Interpreting the Results

Below are the scoring instructions for the PSC-Y:

**Scoring**

- Each item on the PSC-Y is scored as follows:
  - Never = 0
  - Sometimes = 1
  - Often = 2

- To calculate the score, add all of the item scores together:
  - Total Score = _____ (range 0–70)
  - If items are left blank, they are scored as 0.
  - If four or more items are left blank, the questionnaire is considered invalid.
  - Note if either suicide question has been endorsed (Questions 36 and 37).

- Score is positive if:
  - Total Score ≥ 30
  - OR
  - Recent suicidal ideation is reported (Q36)
  - OR
  - Past suicide attempt is reported (Q37)

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**Interpreting the Screening Results**

- Patients that score positive on their PSC-Y should be evaluated by the primary care provider (PCP) to determine if the symptoms endorsed on the questionnaire are significant, causing impairment, and warrant a referral to a mental health specialist or follow-up or treatment by the PCP.

- For patients who score negative on the PSC-Y, it is recommended that the PCP briefly review the symptoms marked as “sometimes” and “often” with the patient.

- For help assessing mental illness and suicide risk, refer to the TeenScreen Post-Screening Interview Guide.

- The questionnaire indicates only the likelihood that a youth is at risk for a significant mental health problem or suicide; its results are not a diagnosis or a substitute for a clinical evaluation.

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**Individual Problem Areas (For Interpretation Only)**

<table>
<thead>
<tr>
<th>Internalizing Problems (i.e., Depression or Anxiety)</th>
<th>Attention Problems (i.e., ADHD)</th>
<th>Externalizing Problems (i.e., Conduct Disorder, Oppositional Defiant Disorder)</th>
<th>Suicidality (If either question is endorsed, further assess for suicidal thinking and behavior and depression)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Feel sad, unhappy</td>
<td>• Fidgety, unable to sit still</td>
<td>• Fight with other children</td>
<td>• Recent suicide ideation</td>
</tr>
<tr>
<td>• Worry a lot</td>
<td>• Distress easily</td>
<td>• Tease others</td>
<td>• Prior suicide attempt</td>
</tr>
<tr>
<td>• Feel hopeless</td>
<td>• Act as if driven by anger</td>
<td>• Do not listen to rules</td>
<td></td>
</tr>
<tr>
<td>• Seem to be having less fun</td>
<td>• Daydream too much</td>
<td>• Refuse to share</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Have trouble concentrating</td>
<td>• Do not understand</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>other people’s feelings</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Blame others for your troubles</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Take things that do not belong to you</td>
<td></td>
</tr>
</tbody>
</table>

**Non-Categorized Items**

- Complain of aches or pains
- Spend more time alone
- Feel tired, little energy
- Do not show feelings
- Have trouble with teacher
- Less interested in school
- Absent from school
- School grades dropping
- Visit doctor with doctor finding nothing wrong
- Have trouble sleeping
- Feel that you are bad
- Want to be with parents more than before
- Take unnecessary risks
- Get hurt frequently
- Act younger than your age
PSC-Y Psychometric Properties

PSC-Y Psychometric Characteristics

PSC-Y Prevalence:

- 14% of 13-18 year olds in a school-based health center located in a small city scored positive on the PSC-Y.
- 20% of 9-14 year olds in an inner-city public school scored positive on the PSC-Y.

Suicide Prevalence:

- 3% of 11-18 year olds endorsed the suicide ideation question added to the PSC-Y in a primary care sample.
- 2% of 11-18 year olds endorsed the suicide attempt question added to the PSC-Y in a primary care sample.

PSC-Y Psychometrics:

- 94% Sensitivity
- 88% Specificity
- 12% False Positive
- 6% False Negative

Factor Analysis:
The authors of the PSC did a factor analysis to determine what items on the questionnaire were most predictive of internalizing, externalizing and attention problems. These are indicated on the questionnaire through symbols and can be helpful for health care providers to assist with interpreting the screening results.
PHQ-9

Overview

• 13 item self-completion screening questionnaire designed to detect symptoms of depression and suicide risk in adolescents
• 9 core items ask about symptoms of depression
• 2 items ask about severity of symptoms/impairment
• 2 items ask about suicide risk

Administration

• Takes less than 5 minutes to complete and score
• PHQ-9 Modified is derived from PHQ-9 for adults
• Both AAP and US Preventative Services Task Force recommends depression screening annually
• Can be scored by nurse, medical tech, other staff
• Inform parents that MH checkup will be administered
• Patients should be left alone in private place to complete
• Inform regarding confidentiality
A Survey From Your Healthcare Provider — PHQ-9 Modified for Teens

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an “X” in the box beneath the answer that best describes how you have been feeling.

<table>
<thead>
<tr>
<th>No.</th>
<th>(0) Not At All</th>
<th>(1) Several Days</th>
<th>(2) More Than Half the Days</th>
<th>(3) Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Feeling down, depressed, irritable, or hopeless?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Little interest or pleasure in doing things?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Trouble falling asleep, staying asleep, or sleeping too much?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Poor appetite, weight loss, or overeating?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Feeling tired, or having little energy?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Trouble concentrating on things like school work, reading, or watching TV?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Thoughts that you would be better off dead, or of hurting yourself in some way?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. In the past year have you felt depressed or sad most days, even if you felt okay sometimes?  
    - [ ] Yes  
    - [ ] No

11. If you are experiencing any of the problems on this form, 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

12. Has there been a time in the past month when you have had serious thoughts about ending your life?  
    - [ ] Yes  
    - [ ] No

13. Have you ever, in your whole life, tried to kill yourself or made a suicide attempt?  
    - [ ] Yes  
    - [ ] No

FOR OFFICE USE ONLY  
Score: ________________________  

Q. 12 and Q. 13: Y or TS = 11

Source: Patient Health Questionnaire-9 (PHQ-9)  
Author: Dr. Robert L. Spitzer, M.D.  
Special thanks to Dr. Kat versions, Kurt Knott, and colleagues.

P091095mo/01/01/003
PHQ-9 Scoring

Scoring and Interpreting the Results
Below are the scoring instructions for the PHQ-9 Modified:

**Scoring**
- For every X:
  - Not at all = 0
  - Several days = 1
  - More than half the days = 2
  - Nearly every day = 3
- Add up all “X’ed boxes on the screen.

**Defining a Positive Screen on the PHQ-9 Modified:**
- Total scores ≥ 10 are positive

**Suicidality:**
Regardless of the PHQ-9 Modified total score, endorsement of serious suicidal ideation OR past suicide attempt (questions 12 and 13 on the screen) should be considered a positive screen.

**Interpreting the Screening Results**
- Patients that score positive on the questionnaire should be evaluated by their primary care provider (PCP) to determine if the depression symptoms they endorsed on the screen are significant, causing impairment and/or warrant a referral to a mental health specialist or follow-up treatment by the PCP.
- It is recommended that the PCP inquire about suicidal thoughts and previous suicide attempts with all patients that score positive, regardless of how they answered these items on the PHQ-9 Modified.
- For patients who score negative on the PHQ-9 Modified, it is recommended that the PCP briefly review the symptoms marked as “more than half days” and “nearly every day” with the patient.
- The questionnaire indicates only the likelihood that a youth is at risk for depression or suicide; its results are not a diagnosis or a substitute for a clinical evaluation.

**Depression Severity**
- The overall score on the PHQ-9 Modified provides information about the severity of depression, from minimal depression to severe depression.
- The interview with the patient should focus on their answers to the screen and the specific symptoms with which they are having difficulties.
- Additional questions on the PHQ-9 Modified also explore dysthymia, impairment of depressive symptoms, recent suicide ideation and previous suicide attempts.

**Total Score: Depression Severity**
- 1–4: Minimal depression
- 5–9: Mild depression
- 10–14: Moderate depression (≥ 11 = Positive Score)
- 15–19: Moderately severe depression
- 20–27: Severe depression
PHQ-9 Psychometric Characteristics

The PHQ-9 Modified offered through TeenScreen Primary Care is a version of the adult PHQ-9 that has been slightly adapted (see below under Important Information). The adult version of the PHQ-9 has been studied and demonstrated good criterion and construct validity among adolescents, with high levels of sensitivity and specificity in this age group. A PHQ-9 score of $\geq 11$ has the following sensitivity and specificity for detecting youth meeting DSM-IV criteria for major depression in the prior month:

- 89.5% Sensitivity
- 78.8% Specificity
- 21.2% False Positive
- 10.5% False Negative
CRAFFT

Overview
• Brief substance use and alcohol screen
• Can be used with other MH screens
• Recommended by AAP Committee on Substance Abuse for 11-21 year olds

Administration
• Less than 5 minutes to complete
• Can be scored by nurse, tech, doctor, or other appropriate office staff
• Inform parents that MH checkup will be administered
• Patients should be left alone in private place to complete
• Inform regarding confidentiality
CRAFFT

Please answer all questions honestly; your answers will be kept confidential.

Name: ____________________________ Date: _________________________

Medical Record or ID Number: __________________________

Part A
During the PAST 12 MONTHS, did you:

1. Drink any alcohol (more than a few sips)?
   [ ] Yes [ ] No

2. Smoke any marijuana or hashish?
   [ ] Yes [ ] No

3. Use anything else to get high?
   “anything else” includes illegal drugs, over the counter and prescription drugs, and things that you sniff or “huff”
   [ ] Yes [ ] No

   If you answered YES to ANY (A1 to A3), answer only B1 below, then STOP.

Part B
1. Have you ever ridden in a CAR driven by someone (including yourself) who was “high” or had been using alcohol or drugs?
   [ ] Yes [ ] No

2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
   [ ] Yes [ ] No

3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?
   [ ] Yes [ ] No

4. Do you ever FORGET things you did while using alcohol or drugs?
   [ ] Yes [ ] No

5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?
   [ ] Yes [ ] No

6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?
   [ ] Yes [ ] No

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CRAFFT Scoring

Scoring and Interpreting the Results

Below are the scoring instructions for the CRAFFT:

**Scoring**

Each "Yes" response to the CRAFFT questions

Scored as 1 point

Score = 0

Adolescents who report no use of alcohol or drugs and have a CRAFFT score of 0 should receive praise and encouragement.

Score = 0 or 1

Those who report any use of alcohol or drugs and have a CRAFFT score of 1 should be encouraged to stop and receive brief advice regarding the adverse health effects of substance use.

Score = ≥ 2

A score of 2 or greater is a "positive" screen and indicates that the adolescent is at high-risk for having an alcohol or drug-related disorder and requires further assessment.

**Interpreting the Screening Results**

If the adolescent answers "No" to all 3 opening questions, they only need to answer the first question—the CAR question. If the adolescent answers "Yes" to any 1 or more of the 3 opening questions, they have to answer all 5 CRAFFT questions.

- **NO to all 3 opening questions and NO to CAR question.**
  - Give praise, encouragement, and advise to avoid riding with an intoxicated driver. At next regular visit, ask how this is going. (1-2 minutes)

- **NO to all 3 opening questions and YES to CAR question.**
  - Ask patient to agree to avoid riding with a driver who has used drugs or alcohol. (1-2 minutes)

- **YES to any opening question.**
  - Look at the patient's overall CRAFFT score. (each "Yes" = 1)

- **CRAFFT Score = 0 or 1**
  - If Yes to CAR question: Ask patient to agree to "avoid riding with a driver who has used drugs or alcohol. (1-2 minutes)
  - If Yes to any other question except the CAR question: Counsel patient to stop using substances. Provide brief advice linking substance use to undesirable health, academic, and social consequences.
  - Follow up at next visit. (2-5 minutes)

- **CRAFFT Score = ≥ 2**
  - Conduct brief assessment of substance use to understand whether disorder exists. (<15 minutes)

Assessment questions:

1. Tell me about your alcohol/substance use.
2. Has it caused you any problems?
3. Have you tried to quit? Why?

See box at left.

Information adapted from the CRAFFT Toolkit — Massachusetts Department of Public Health Bureau of Substance Abuse Services, Provider Guide: Adolescent Screening, Brief Intervention, and Referral to Treatment using the CRAFFT Screening Tool, Boston, MA.
CRAFFT Psychometric Characteristics

The CRAFFT screening questionnaire is a valid means of screening adolescents for substance-related problems and disorders, which may be common in some general clinic populations. The following was taken from the CRAFFT's validation study conclusions:

A CRAFFT score of 2 or higher was optimal for identifying any problem (sensitivity, 0.76; specificity, 0.94; positive predictive value, 0.83; and negative predictive value, 0.91), any disorder (sensitivity, 0.80; specificity, 0.86; positive predictive value, 0.53; and negative predictive value, 0.96) and dependence (sensitivity, 0.92; specificity, 0.80; positive predictive value, 0.25; and negative predictive value 0.99). Approximately one fourth of participants had a CRAFFT score of 2 or higher. Validity was not significantly affected by age, sex, or race.²
Overview

- child and parent self-report instrument used to screen for childhood **anxiety disorders** including:
  - general anxiety disorder,
  - separation anxiety disorder,
  - panic disorder, and
  - social phobia.
- In addition, it assesses symptoms related to school phobias.
- consists of 41 items and 5 factors that parallel the DSM-IV classification of anxiety disorders.
- Children ages 8-18 years

Administration

- Intended Users: Clinicians and psychiatrists
- Time to Administer: 10 minutes
- Completed By: Children and parents
- Modalities Available: Handwritten
- Languages Available: Arabic, Chinese, English, French, German, Italian, Portuguese, Spanish
- Training Requirements for Intended Users: Trained clinician

Screen for Child Anxiety Related Disorders (SCARED)

**CHILD Version—Page 1 of 2 (to be filled out by the CHILD)**

Developed by Boris Birnbaum, M.D., Suverna Khetsangyal, M.D., Marlene Cully, M.D., David Brent, M.D., and Sandra McKenize, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh (October, 1995). E-mail: birnbaum@upmc.edu

**Screen for Child Anxiety Related Disorders (SCARED)**

CHILD Version—Page 1 of 2 (to be filled out by the CHILD)

<table>
<thead>
<tr>
<th>Not True or Hardly Ever True</th>
<th>Somewhat True or Sometimes True</th>
<th>Very True or Often True</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

1. When I feel frightened, it is hard to breathe  | 0  | 0 | PN |
2. I get headaches when I am at school             | 0  | 0 | SH |
3. I don't like to be with people I don't know well. | 0  | 0 | SC |
4. I get scared if I sleep away from home.         | 0  | 0 | SP |
5. I worry about other people liking me.            | 0  | 0 | GD |
6. When I felt frightened, I feel like passing out. | 0  | 0 | PN |
7. I am nervous.                                   | 0  | 0 | GD |
8. I follow my mother or father wherever they go.  | 0  | 0 | SP |
9. People tell me that I look nervous.              | 0  | 0 | PN |
10. I feel nervous with people I don't know well.  | 0  | 0 | SC |
11. I get stomachaches at school.                   | 0  | 0 | SH |
12. When I get frightened, I feel like I am going crazy. | 0  | 0 | PN |
13. I worry about sleeping alone.                   | 0  | 0 | SP |
14. I worry about being as good as other kids.      | 0  | 0 | GD |
15. When I get frightened, I feel like things are not real. | 0  | 0 | PN |
16. I have nightmares about something bad happening to my parents. | 0  | 0 | PN |
17. I worry about going to school.                  | 0  | 0 | SH |
18. When I get frightened, my heart beats fast.     | 0  | 0 | PN |
19. I get shaly.                                    | 0  | 0 | PN |
20. I have nightmares about something bad happening to me. | 0  | 0 | SP |

**SCORING:**

A total score of ≥ 25 may indicate the presence of an Anxiety Disorder. Scores higher than 30 are more specific. **TOTAL =**

A score of 7 for items 1, 4, 5, 6, 7, 9, 11, 12, 13, 14, 18, 19, 22, 24, 27, 30, 34, 35 may indicate Panic Disorder or Significant Somatic Symptom. **PN =**

A score of 9 for items 5, 7, 14, 21, 23, 27, 33, 35, 37 may indicate Generalized Anxiety Disorder. **GD =**

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

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

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

For children ages 8 to 17, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.

The SCARED is available at no cost at www.epic.pitt.edu/research under tools and assessments, or at www.pediatric.bipolar.pitt.edu under instruments.

March 27, 2012
SCARED – Parent Version with Scoring

Screen for Child Anxiety Related Disorders (SCARED)

**PARENT Version—Page 1 of 2 (to be filled out by the PARENT)**

Developed by Brian Birmaher, M.D., Suzanne Ehtesham, M.D., Marilyn Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D.
Western Psychiatric Institute and Clinic, University of Pittsburgh (October, 1995). E-mail: birmaher@upmc.edu


Name: ___________________________ 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 your child. Then, for each statement, fill in one circle that corresponds to the response that seems to describe your child for the last 3 months. Please respond to all statements as well as you can, even if some do not seem to concern your child.

<table>
<thead>
<tr>
<th>0</th>
<th>Not True or Hardly Ever True</th>
<th>1</th>
<th>Somewhat True or Sometimes True</th>
<th>2</th>
<th>Very True or Often True</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. When my child feels frightened, it is hard for him/her to breathe</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>PN</td>
<td></td>
</tr>
<tr>
<td>2. My child gets headaches when he/she see at school.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>SH</td>
<td></td>
</tr>
<tr>
<td>3. My child doesn’t want to be with people he/she doesn’t know well.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>SP</td>
<td></td>
</tr>
<tr>
<td>4. My child gets scared if he/she sleeps away from home.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>SC</td>
<td></td>
</tr>
<tr>
<td>5. My child worries about other people hitting him/her.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>GD</td>
<td></td>
</tr>
<tr>
<td>6. When my child gets frightened, he/she feels like passing out.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>PN</td>
<td></td>
</tr>
<tr>
<td>7. My child is nervous.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>GD</td>
<td></td>
</tr>
<tr>
<td>8. My child follows me wherever I go.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>GD</td>
<td></td>
</tr>
<tr>
<td>9. People tell me that my child looks nervous.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>GD</td>
<td></td>
</tr>
<tr>
<td>10. My child feels nervous with people he/she doesn’t know well.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>SC</td>
<td></td>
</tr>
<tr>
<td>11. My child gets stomachaches at school.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>SH</td>
<td></td>
</tr>
<tr>
<td>12. When my child gets frightened, he/she feels like he/she is going crazy.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>PN</td>
<td></td>
</tr>
<tr>
<td>13. My child worries about sleeping alone.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>SP</td>
<td></td>
</tr>
<tr>
<td>14. My child worries about being as good as other kids.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>GD</td>
<td></td>
</tr>
<tr>
<td>15. When my child gets frightened, he/she feels like things are not real.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>PN</td>
<td></td>
</tr>
<tr>
<td>16. My child has nightmares about something bad happening to his/her parents.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>SP</td>
<td></td>
</tr>
<tr>
<td>17. My child worries about going to school.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>SH</td>
<td></td>
</tr>
<tr>
<td>18. When my child gets frightened, his/her heart beats fast.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>PN</td>
<td></td>
</tr>
<tr>
<td>19. He/she gets shaky.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>SP</td>
<td></td>
</tr>
<tr>
<td>20. My child has nightmares about something bad happening to him/her.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>SP</td>
<td></td>
</tr>
</tbody>
</table>

**SCORING:**
A total score of ≥ 30 may indicate the presence of an Anxiety Disorder. Scores higher than 30 are more specific. **TOTAL** =

A score of ≥ 7 for Items 1, 6, 9, 12, 15, 18, 22, 24, 37, 38 may indicate Panic Disorder or Significant Somatoform Symptoms. **PN** =

A score of ≥ 5 for Items 7, 14, 21, 23, 28, 33, 35 may indicate Generalized Anxiety Disorder. **GD** =

A score of ≥ 3 for Items 8, 13, 16, 20, 29, 31 may indicate Separation Anxiety. **SP** =

A score of ≥ 2 for Items 5, 10, 26, 32, 39, 40, 41 may indicate Social Anxiety Disorder. **SC** =

A score of ≥ 1 for Items 2, 10, 17, 25, 36, 37 may indicate Specific or School Avoidance. **SH** =

The SCARED is available as no cost at www.pyc.pitt.edu/research under tools and assessments, or at www.pediatric hippocampus.pitt.edu under instruments.

March 27, 2012
SCARED
Psychometric Properties

• The child and parent versions of the SCARED have moderate parent-child agreement and good internal consistency, test-retest reliability, and discriminant validity, and it is sensitive to treatment response.

• Scoring Information: Severity of symptoms for the past three months is rated using a 0 to 2-point rating scale with 0 meaning not true or hardly ever true, 1 meaning sometimes true, and 2 meaning true or often true.

• Availability: Free for download on website:
http://www.wpic.pitt.edu/research/AssessmentTools/default.htm
At the end of the instrument, there is information regarding scoring the instrument

Introducing new things in your office can be a challenge.
Colleagues may be influenced by cookie bribes.
If all else fails, try cold, hard cash.
And, begging while offering cash may also be effective.
References

