CY-BOCS Severity Ratings

Children's Yale-Brown Obsessive Compulsive Scale

Administering the CY-BOCS Symptom Checklist and CY-BOCS Severity Ratings

1. Establish the diagnosis of obsessive compulsive disorder.
2. Using the CY-BOCS Symptom Checklist (other form), ascertain current and past symptoms.
3. Next, administer the 10-item severity ratings (below) to assess the severity of the OCD during the last week.
4. Readminister the CY-BOCS Severity Rating Scale to monitor progress.

Patient _____

Date 1st Report _____ Date This Report _____

Obsession Rating Scale (circle appropriate score)

Note: Scores should reflect the composite effect of all the patient's obsessive compulsive symptoms.
Rate the average occurrence of each item during the prior week up to and including the time of interview.

QUESTIONS ON OBSESSIONS (ITEMS 1-5) *"I AM NOW GOING TO ASK YOU QUESTIONS ABOUT THE THOUGHTS YOU CANNOT STOP THINKING ABOUT."*
(Review for the informant(s) the Target Symptoms and refer to them while asking questions 1-5).

1. Time Occupied by Obsessive Thoughts
[Be sure to exclude ruminations and preoccupations which, unlike obsessions, are ego-syntonic and rational (but exaggerated)]

	None	Mild	Moderate	Severe	Extreme
		less than 1 hr/day or occasional intrusion	1 to 3 hrs/day or frequent intrusion	greater than 3 and up to 8 hrs/day or very frequent intrusion	greater than 8 hrs/day or near constant intrusion
Score	0	1	2	3	4

2. Interference Due to Obsessive Thoughts
- How much do these thoughts get in the way of school or doing things with friends?
- Is there anything that you don't do because of them? (If currently not in school, determine how much performance would be affected if patient were in school)

	None	Mild	Moderate	Severe	Extreme
		slight interference with social or school activities, but overall performance not impaired	definite interference with social or school performance, but still manageable	causes substantial impairment in social or school performance	incapacitating
Score	0	1	2	3	4

3. Distress Associated with Obsessive Thoughts

	None	Mild	Moderate	Severe	Extreme
		infrequent, and not too disturbing	frequent, and disturbing, but still manageable	very frequent, and very disturbing	near constant, and disabling distress/frustration
Score	0	1	2	3	4

4. Resistance Against Obsessions
- How hard do you try to stop the thoughts or ignore them? (Only rate effort made to resist, not success or failure in actually controlling the obsessions. If the obsessions are minimal, the patient may not feel the need to resist them. In such cases, a rating of "0" should be given.)

	None	Mild	Moderate	Severe	Extreme
	makes an effort to always resist, or symptoms so minimal doesn't need to actively resist	tries to resist most of the time	makes some effort to resist	yields to all obsessions without attempting to control them, but does so with some reluctance	completely and willingly yields to all obsessions
Score	0	1	2	3	4

5. Degree of Control Over Obsessive Thoughts

	Complete Control	Much Control	Moderate Control	Little Control	No Control
		usually able to stop or divert obsessions with some effort and concentration	sometimes able to stop or divert obsessions	rarely successful in stopping obsessions, can only divert attention with difficulty	experienced as completely involuntary, rarely able to even momentarily divert thinking
Score	0	1	2	3	4

Obsession subtotal (add items 1-5) _____

QUESTIONS ON COMPULSIONS (ITEMS 6-10) *"I AM NOW GOING TO ASK YOU QUESTIONS ABOUT THE HABITS YOU CAN'T STOP"*
(Review for the informant(s) the Target Symptoms and refer to them while asking questions 6-10)

6. Time Spent Performing Compulsive Behaviors

	None	Mild less than 1 hr/day	Moderate 1 to 3 hrs/day	Severe greater than 3 & up to 8 hrs/day	Extreme greater than 8 hrs/day
Score	0	1	2	3	4

7. Interference Due to Compulsive Behaviors

- How much do these habits get in the way of school or doing things with friends?
- Is there anything you don't do because of them? (If currently not in school, determine how much performance would be affected if patient were in school.)

	None	Mild slight interference with social or school activities, but overall performance not impaired	Moderate definite interference with social or school performance, but still manageable	Severe causes substantial impairment in social or school performance	Extreme incapacitating
Score	0	1	2	3	4

8. Distress Associated with Compulsive Behavior

- How would you feel if prevented from carrying out your habits? How upset would you become?

	None	Mild only slightly anxious if compulsions prevented	Moderate anxiety would mount but remain manageable if compulsions prevented	Severe prominent and very disturbing increase in anxiety if compulsions interrupted	Extreme incapacitating anxiety from any intervention aimed at modifying activity
Score	0	1	2	3	4

9. Resistance Against Compulsions

- How much do you try to fight the habits? (Only rate effort made to resist, not success or failure in actually controlling the compulsions.)

	None makes an effort to always resist, or symptoms so minimal doesn't need to actively resist	Mild tries to resist most of the time	Moderate makes some effort to resist	Severe yields to all obsessions without attempting to control them, but does so with some reluctance	Extreme completely and willingly yields to all obsessions
Score	0	1	2	3	4

10. Degree of Control Over Compulsive Thoughts

- How strong is the feeling that you have to carry out the habit(s)?
- When you try to fight them, what happens?

	Complete Control	Much Control experiences pressure to perform the behavior, but usually able to exercise voluntary control over it	Moderate Control moderate control, strong pressure to perform behavior, can control it only with difficulty	Little Control little control, very strong drive to perform behavior, must be carried to completion, can only delay with difficulty	No Control no control, drive to perform behavior experienced as completely involuntary and overpowering, rarely able to delay activity [even momentarily]
Score	0	1	2	3	4

Compulsion subtotal (add items 6-10) _____

CY-BOCS total (add items 1-10) ☐

Total CY-BOCS score: range of severity for patients who have both obsessions and compulsions

0-7	Subclinical	24-31	Severe
8-15	Mild	32-40	Extreme
16-23	Moderate		

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ADHD RATING SCALE-IV: HOME VERSION

Child's Name _____ Sex: M F Age _____ Grade _____

Completed by: Mother _____ Father_____ Guardian _____ Grandparent _____

Circle the number that *best describes* your child's home behavior over the past 6 months.

	Never or rarely	Sometimes	Often	Very often
1. Fails to give close attention to details or makes careless mistakes in schoolwork.	0	1	2	3
2. Fidgets with hands or feet or squirms in seat.	0	1	2	3
3. Has difficulty sustaining attention in tasks or play activities.	0	1	2	3
4. Leaves seat in classroom or in other situations in which remaining seated is expected.	0	1	2	3
5. Does not seem to listen when spoken to directly.	0	1	2	3
6. Runs about or climbs excessively in situations in which it is inappropriate.	0	1	2	3
7. Does not follow through on instructions and fails to finish work.	0	1	2	3
8. Has difficulty playing or engaging in leisure activities quietly.	0	1	2	3
9. Has difficulty organizing tasks and activities.	0	1	2	3
10. Is "on the go" or acts as if "driven by a motor."	0	1	2	3
11. Avoids tasks (e.g., schoolwork, homework) that require sustained mental effort.	0	1	2	3
12. Talks excessively.	0	1	2	3
13. Loses things necessary for tasks or activities.	0	1	2	3
14. Blurts out answers before questions have been completed.	0	1	2	3
15. Is easily distracted.	0	1	2	3
16. Has difficulty awaiting turn.	0	1	2	3
17. Is forgetful in daily activities.	0	1	2	3
18. Interrupts or intrudes on others.	0	1	2	3

SOME NOTES ON DI INGUISHING ATTENTION . FICIT DISORDER (ADD) FROM BIPOLAR MOOD DISORDERS (BMD)

All or the features of ADD can be seen In Bipolar Mood Disorders; namely, impulsively, inattention, hyperactivit pressured speech, unusual physical energy and excitability, rapid thoughts, behavioral and emotional lability, and sle disturbances (especially difficulty with sleep onset).

(Circle Those that Apply)

What distinguishes ADD from Bipolar Mood Disorders:

1. In Bipolar Mood Disorders, the symptoms seem to first appear in the preschool years, include temperament and oppositional behaviors, and become decidedly, worse as the child enters into puberty; ADD has a chron and continuous course starting at toddlerhood and generally (in at least in 2/3 of cases) moves towar improvement with increasing age;

2. In Bipolar Mood Disorders, the children have strong, unregulated and intense feelings. When angry, these childr get fiercely angry; when happy they are dramatically ecstatic;

3. In Bipolar Mood Disorders the children have temper outbursts that can be lengthy and dramatic may last half a hour to two hours and even in some cases four hours; the ADD child usually calms down in a few minutes and w settle down usually by 30 minutes at the very most;

4. In the Bipolar Mood Disorders, the energy put out in a temper rage by a child is enormous and exhausting ar more than one could imitate if you tried to copy the outburst;

5. In Bipolar Mood Disorders, the children disorganize and regress during their tantrums;

6. In Bipolar Mood Disorders, the trigger is usually disciplinary limit setting and not sensory and emotiona over simulation like one usually sees in the ADD child;

7. There is a sub-group of Bipolar Mood Disorders that is particularly seen during adolescence in which the teenag is floaty, drifty, dreamy, and unrealistic in their relationships with reality (grandiosity); one might refer to this a "nonpsychotic euphoria" In addition, these adolescents are very pleasant and feel that everything is fine;

8. In Bipolar Mood Disorders, the children frequently have gory and violent nightmares with the explicit appearanc of blood and body dismemberment;

9. In Bipolar Mood Disorders, the destructiveness of children occurs in anger and is more purposeful and is not result of carelessness as one might see in the ADD child;

10. In Bipolar Mood Disorders, there is a sleep disturbance with difficulty falling asleep with a frequent one t four hour delayed sleep cycle; they are slow, too, to arouse in the morning with several hours of irritability ar cantankerousness with often, associated early morning stomach aches and headaches;

11. In Bipolar Mood Disorders, the children are daredevils and seem to seek out danger, have energized gigglin demonstrate sexual hyper awareness, and show a strong denial of blame with a projection of this blame on t the world around them, They seem to personify an attitude of "I'm OK, the world around me is not," and whe particularly strongly demonstrated, might be viewed as a form of paranoia;

(OVER)

12. In Bipolar Mood Disorders, the children in social settings tend to behave negatively and to reject with hostility, whereas the ADD child is typically much more pleasant;

13. In Bipolar Mood Disorders, the children look for fights and relish power struggles;

14. In Bipolar Mood Disorders, the learning problems are more likely compromised by motivational problems and by boredom instead of as in the ADD child by inattention and distractibility;

15. In Bipolar Mood Disorders, the children are often interview intolerant and they try to disrupt or get out of the nterview and ask repeatedly, "When will the interview come to an end?"

16. In Bipolar Mood Disorders, the children more clearly have poor self-esteem problems and will be heard saying things like, 'Nobody cares about me, nobody loves me."

(thanks to Charles W. Popper, M.D. of Harvard University ...dical School for much of this information)

Differentiating ADD/ADHD from Pediatric Bipolar

Common Symptoms	ADD/ADHD	Pediatric Bipolar
Destructiveness	Careless or impulsive actions, unaware of consequences	Neuro-chemical temper tantrums & rages. Loss of rationality, often with cruel, destructive, sadistic impulses.
Duration of Anger Episodes or Rages	Usually calm down in 20-30 minutes.	45 minutes up to hours. Manic release of physical & emotional energy. Can have OCD quality or be trance like. Anterograde amnesia.
Trigger for Anger	Frustration due to sensory or emotional over stimulation.	Inability to cope with novel stimulus or perception of threat. Subsequent to simple limit setting.
Regression	Rare to see severe regression.	Clinging. Bedwetting. Social phobia. Disorganized thinking, language, and body positions.
Emotional Lability	Dysphoria or irritability generally not dominant feature. Morning alertness achieved quickly.	Morning dysphoria, irritability, ODD, fuzzy thinking, somatic complaints (head and stomach aches). Slow morning arousal common.
Sleep disturbances: Nightmares, Night terrors	Not a prominent feature. Rare.	Themes of harm & death. Morbid daytime brooding. Pre-occupation with death, suicide.
Developmental and Learning Characteristics	Normal or slow development. Learning disabilities common.	Precocious, esp. cognitive & language skills. Learning problems only if disabling mood swings, or if comorbid with ADD/ADHD.
Misbahavior/ Poor Social Relations	Much of it accidental, oblivious of rules. Inattentive to friendship obligations → ostracism	Misattribution of intentions of others → aggressive or bullying behaviors → ostracism.
Risk Taking	Satisfy need for high stimulation, often oblivious to dangerous, illegal consequences.	Satisfy need for being in control. Can be intentionally dangerous behaviors with self-harming consequences.
Sexual interest	Slow or within normal pre-adolescent developmental limits.	Often strong, early sexual interest & precocious sexual behavior.
Loss of contact with reality, Psychotic Symptoms	Sometimes clueless about the context due to inattention, but not delusional.	Delusional grandiosity. Distorted perceptions of reality, and misinterpretations of emotional events.
Medication Response	Responsive to stimulants, Strattera, or low doses of Desipramine, Welbutrin. Not responsive to lithium.	Responsive to lithium, anti-convulsives, anti-psychotics, calcium blockers, anxiolytics. Caution and supervision required.

The Pediatric Symptom Checklist (PSC) is a brief assessment instrument designed to screen for the presence of psychosocial dysfunction in children.

Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

	NEVER	SOMETIMES	OFTEN
1. Complains of aches and pains			
2. Spends more time alone			
3. Tires easily, has little energy			
4. Fidgety, unable to sit still			
5. Has trouble with teacher			
6. Less interested in school			
7. Acts as if driven by a motor			
8. Daydreams too much			
9. Distracted easily			
10. Is afraid of new situations			
11. Feels sad, unhappy			
12. Is irritable, angry			
13. Feels hopeless			
14. Has trouble concentrating			
15. Less interested in friends			
16. Fights with other children			
17. Absent from school			
18. School grades dropping			
19. Is down on him or herself			
20. Visits the doctor with doctor finding nothing wrong			
21. Has trouble sleeping			
22. Worries a lot			
23. Wants to be with you more than before			
24. Feels he or she is bad			
25. Takes unnecessary risks			
26. Gets hurt frequently			
27. Seems to be having less fun			
28. Acts younger than children his or her age			
29. Does not listen to rules			
30. Does not show feelings			
31. Does not understand other people's feelings			
32. Teases others			
33. Blames others for his or her troubles			
34. Takes things that do not belong to him or her			
35. Refuses to share			

Total score _____

In a recent PSC study,[1] parents of over 21,000 children, ages 4 to 15, completed the PSC.[2] In this sample, the rate of psychosocial dysfunction was found to be 10% among preschool-aged children, and 13% among school-aged children. The authors note that previous research has estimated that, of children with psychosocial dysfunction, only half are correctly identified by their primary care physicians. In addition, the authors note that, once identified, only a portion of these children receive appropriate mental health treatment. The PSC is useful in the recognition and management of cases of psychosocial dysfunction. It is also useful in identifying patients who may need referral to a mental health practitioner.

The following scoring and interpretation guides are excerpted and adapted from PSC materials.[2]

Instructions for Scoring: The PSC consists of 35 items that are rated as *never*, *sometimes*, or *often* present and scored 0, 1, and 2, respectively. Item scores are summed. For children aged six through sixteen, the cut-off score is 28 or higher. For four- and five-year-old children, the cut-off is 24 or higher. Items that are left blank by parents are simply ignored (score = 0). If 4 or more items are left blank, the questionnaire is considered invalid.

How to Interpret the PSC: A positive score on the PSC suggests the need for further evaluation by a qualified health or mental health professional. Both false positives and false negatives occur, and only an experienced clinician should interpret a positive PSC score as anything other than a suggestion that further evaluation may be helpful. Data from past studies using the PSC indicate that 2 out of 3 children who screen positive on the PSC will be correctly identified as having moderate to serious impairment in psychosocial functioning. The one child "incorrectly" identified usually has at least mild impairment, although a small percentage of children turn out to have very little actually wrong with them (eg, an adequately functioning child of an overly anxious parent). Data on PSC-negative screens indicate 95% accuracy, which, although statistically adequate, still means that 1 out of 20 children rated as functioning adequately may actually be impaired. The inevitability of both false-positive and false-negative screens underscores the importance of experienced clinical judgment in interpreting PSC scores.

[1] Jellinek MS, Murphy M, Little M, Pagano ME, Comer DM, & Kelleher KJ. Use of the Pediatric Symptom Checklist to screen for psychosocial problems in pediatric primary care: A national feasibility study. *Archives of Pediatric and Adolescent Medicine*, 153:254-260, 1999.

[2] The PSC (along with additional information) is available at the PSC Web site (http://healthcare.partners.org/psc), or by contacting the authors (Michael Jellinek MD & Michael Murphy EdD, Child Psychiatry, Bulfinch 351, Massachusetts Gen Hosp, Boston, MA 02114; tel: 617-724 3163; fax: 617-726-9219; e-mail: PSC@partners.org). Versions include English (parent-form), English (youth self-report form), Spanish (parent-form), and Spanish (youth self-report form). The PSC may be used free of charge. The authors request to receive a copy of any study using the PSC.

SYMPTOMS OF BIPOLAR CHILDREN

VERY COMMON:

___ Separation Anxiety
___ Rages & Explosive Temper Tantrums (lasting up to several hours)
___ Marked Irritability
___ Oppositional Behavior
___ Frequent Mood Swings
___ Distractibility
___ Hyperactivity
___ Restlessness/Fidgetiness
___ Silliness, Goofiness, Giddiness
___ Racing Thoughts
___ Aggressive Behavior
___ Grandiosity
___ Carbohydrate Cravings
___ Risk-Taking Behaviors
___ Depressed Mood
___ Lethargy
___ Low Self-Esteem
___ Difficulty Getting Up in the Morning
___ Social Anxiety
___ Oversensitivity to Emotional or Enviornmental Triggers

COMMON:

___ Bed-Wetting (especially in boys)
___ Night Terrors
___ Rapid or Pressured Speech
___ Obsessional Behavior
___ Excessive Daydreaming
___ Compulsive Behavior
___ Motor and Vocal Tics
___ Learning Disabilities
___ Poor Short-Term Memory
___ Lack of Organization
___ Fascination with Gore or Morbid Topics
___ Hypersexuality
___ Manipulative Behavior
___ Bossiness
___ Lying
___ Suicidal Thoughts
___ Destruction of Property
___ Paranoia
___ Hallucinations & Delusions

LESS COMMON:

___ Migraine Headaches
___ Bingeing
___ Self-Mutilating Behaviors
___ Cruelty to Animals

From: The Bipolar Child: The Definitive & Reassuring Guide to Childhood's Most Misunderstood Disorder. Authors: Dimitri Papolos, MD and Janice Papolos