Children's Depression Rating Scale—Revised¹ (September 1984)

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Description of the Scale

The Childhood Depression Rating Scale—Revised (CDRS-R) is a clinician-rated instrument designed to measure the presence and severity of depression in children aged 6 to 12 years. The CDRS-R consists of 17 items. Fourteen of these items are rated on the basis of the subjects' responses to a series of standardized questions. This semi-standard interview can be administered to children ages 6 to 12, their parents, teachers, case workers, or other sources of information in approximately 30 minutes. The first 14 items are rated on the basis of this interview. The remaining 3 items of the CDRS-R are rated by the clinician on the basis of the child's nonverbal behavior. These 3 items are not rated when interviewing a subject other than the child.

The 17 items of the CDRS-R are scales from 1 to 5 for sleep, appetite, and tempo of speech items and from 1 to 7 for the remaining 14 items. A rating of 1 indicates no abnormality while a rating of 3 indicates mild symptomatology. A rating of 5 or more on all items indicates definite psychopathological symptomatology.

Reliability and validity studies on this instrument have been carried out in a hospitalized pediatric population, in a child psychiatric inpatient population, in three outpatient child psychiatric clinics, and in an elementary school sample.

¹The CDRS-R was developed by E.O. Poznanski, M.D., with assistance of the staff of the Youth Affective Disorders Clinic. Investigators wishing to use or quote the CDRS-R should contact Dr. Poznanski at the address below.
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Administering the CDRS-R

Prior to administration of the scale, the clinician should familiarize himself or herself with the interview so that a freely flowing interview style is developed. Although the interview is designed so that the examination proceeds from less threatening areas of questioning to more emotionally evocative areas, some children spontaneously provide information for items out of the interview sequence. This should be accommodated in a manner that allows for the building of rapport between clinician and subject. The clinician should anticipate that some subjects are slow to become involved in the interview and may initially give bland and guarded responses. After more rapport has been developed, it may be necessary to re-question such a person about earlier items.

The developmental level of the subject being examined must always be considered in interpreting responses to questions on the CDRS-R. Some children cannot understand words such as guilt, irritability, or suicide. Suggestions are included in the interview for ways to rephrase these concepts in more concrete language that the child may better understand. The child's ability to understand time concepts must also be considered. Again, concrete time markers such as usual daily activities or meals may be helpful in assessing the duration of an unhappy, sad mood state. The clinician must make an effort to use language and time markers consistent with the child's developmental capacities throughout the interview and rating process.

The effect of various settings in which the CDRS-R may be administered must also be considered by the clinician rating the instrument. Children in psychiatric settings are more likely to give guarded responses or withhold information than those in nonpsychiatric settings such as schools. Within the pediatric liaison setting, where children have debilitating physical illness or fever, the physical state of subjects may promote apathetic withdrawn behavior, fatigue, or sleep disturbance. Children
may also suffer severe separation anxiety, appearing withdrawn, tearful, and socially isolative outside of their mother's presence, yet happily interact with peers when their mother is present. Gathering information from multiple sources is recommended to make the most valid CDRS-R rating. However, it is important to consider the source of information when determining the final, combined CDRS-R score. For example, the child's description of sleep disturbance is often more valid than the parental description since parents are often not aware of the child's sleep behavior after they have retired to bed. On the other hand, children may be reluctant to report behaviors that would promote reprimands from adults. Therefore, behaviors such as irritability and eating disturbances are more accurately reported by parents.

Determining Diagnosis

Prior experience with clinical populations indicate that a summary score of 40 or above on the CDRS-R is a strong indicator of the presence or potential for a Major Depressive Disorder. Although the score of 40 is a reliable indicator of depression, it should serve as a heuristic, not as a criterion by which a child is diagnosed Major Depressive Disorder or not. Other usual methods of psychiatric evaluation such as unstructured interviews, family history, pediatric examination, laboratory examinations, etc. may be used to determine the diagnosis using diagnostic criteria such as DSM-III (Diagnostic and Statistical Manual—3rd ed., 1980) or Research Diagnostic Criteria. When a diagnosis of depression is certain, the CDRS-R may be used as a measure of severity of the depression and to provide a basis for comparison over time.

The Individual Items

A. Schoolwork

A child's schoolwork is usually impaired while he or she is depressed. The cognitive impairment stems from a general lack of interest or enthusiasm, difficulty in concentrating, and negative cognitions (views of the world). The difficulty concentrating on external tasks is the result of a turning inward and a preoccupation with thoughts and worries rather than the result of distractibility by external stimuli. The child may be negative about the school environment and/or his or her school performance. He or she may perceive his or her schoolwork to be poorer than it objectively appears.

The depressed child's diminished academic performance represents a change as opposed to chronic and consistently poor schoolwork. There may also be variability in performance of schoolwork associated with mood shifts. Children with chronic learning problems also decline in performance relative to their usual capacity to achieve academically. Likewise, bright children may maintain high grades, but teachers or parents report a decrease in their usual enthusiasm for learning. It is necessary to assess the child's usual capability and motivation to perform academically, prior to the depressive episode, to accurately rate this item.

The rater should take care, further, to distinguish between general diminished school performance and disturbance with a specific subject or teacher.

If school is not in session, the clinician can assess difficulty attending to other activities, e.g., games, at-home reading, television.

Examples:

Rating of 1. “I like school, except for math. I got all B’s except a C in Math—It’s hard.”

Rating of 3. “My teacher says I don’t do enough work . . . my mind wanders . . . I think of things people said, or about music.”

Rating of 5. “I’m trying the best I can but my schoolwork is not good, I might have to go back to 5th grade . . . I don’t finish homework . . . it’s hard to keep what I remember in my head” (11-year-old who tested on the WISC-R in bright normal range).

Rating of 7. “I am failing all subjects . . . I don’t like it . . . they ain’t teaching me nothing . . . I hate my teachers and the kids.”

B. Capacity to Have Fun

Loss of interest or pleasure in activities can be striking in a depressed child. Although adults
can remain very serious and get to enjoy a

game of cards or chess, normal children rarely
hide their pleasure and enthusiasm at their
games. The presence and severity of this
symptom can be assessed by the types and
numbers of activities the child can enjoy, by
the child's interest or enthusiasm expressed
while describing the activity, and by the amount
of boredom the child feels. While every child
occasionally feels boredom, the depressed an-
hedonic child may say he or she feels bored
50 to 100% of the time. This loss of interest
may be expressed more subtly. For example,
a child may describe pleasurable activities
which only occur on rare occasions, or are only available
in a different season of the year, e.g., ice
skating in the summer. Some children cannot
name any activity that they enjoy. Severely
depressed children may become primarily pas-
sive watching others play without participating
themselves or watch television with little
awareness of the program playing. They may
participate in games but only "go through the
motions," not enjoying themselves.

Examples:

Rating of 1. "I like to go sledding and skating
(in winter) or just play outside. Yeah, I get bored sometimes—on
Sunday when I have to sit at
church."

Rating of 3. "I go bike riding . . . about twice
a week . . . oh, and Boy Scout outings can be fun . . . no, I don't
think I'm bored too much."

Rating of 5. "Going fishing is fun, my Dad and
I went fishing twice last year . . .
I color and play with the dog. Oh
yes, I got really bored . . . I got
bored every day . . . a lot."

Rating of 7. "I don't like nothing, I want to be
by myself." (Mother confirms child
does not play and refused activities suggested by her.)

C. Social Withdrawal

Depressed children commonly have diffi-
culty socializing with peers. They withdraw from
peer activities, turn down opportunities to play
with peers, or provoke peers to reject them.
Unlike schizoid or avoidant children, de-
pressed children usually have developed the
capacity for interpersonal relationships and
have been able to socialize with peers prior to

the onset of the depressive episode. There-
fore, it is necessary to distinguish between a
chronically isolative personality style and a
change in social behavior to rate this item. When
the difficulty in social relating has been long-
standing and unchanged, "5" is the appro-
piate rating for this item.

Examples:

Rating of 2. "He had a few friends in the
neighborhood but they change
every few weeks. He's never had
any close friends."

Rating of 3. "Usually Sue calls me . . . some-
times I play with her but mostly
I'd just rather stay home . . ."

Rating of 5. "He had friends in school last year
and two boys he grew up with in
the neighborhood—now they call
him names and fight a lot . . . it's
because he won't play with them
anymore or he only plays with
Alex."

Rating of 7. "I'd rather be alone . . . I like being
by myself . . . It's better that way—
all those kids smoke and drink now
. . . I don't have friends any more."

D. Sleep

Although the total sleep time of depressed
children is not different from that of normal
children, depressed children often report ini-
tial, terminal, or middle-of-the-night insom-
nia. Many children have intermittent awak-
eness because of anxiety, nightmares, etc. from
which they return to sleep quickly. Depressed
children have more consistent patterns of sleep
disturbance and often stay awake more than
30 minutes after awakening.

Example:

Rating of 3. "About twice a week I wake up.
It's dark and my parents are asleep
. . . I stay awake for an hour!"

Rating of 5. "I can't sleep ever. They put me
to bed at 9 p.m. but I don't go to
sleep until 10 p.m. I get up at 2
a.m. and watch TV."

E. Appetite or Eating Patterns

Depressed children may have changes in their
eating patterns during a depressive episode.
These may be loss of appetite and weight loss
or excessive appetite and weight gain. Chi-

dren can describe changes in appetite. Usually
parents give more objective information regarding the child's food intake.

Examples:
Rating of 3. "I eat lunch and dinner, but I'm not really hungry... I lost 3 pounds on the scale."
Rating of 5. "I starve myself even though I'm hungry... I think the food is poisoned—and my clothes fit too big now."

F. Excessive Fatigue

While all children may feel tired during the day, depressed children feel unusually tired and heavy. They may complain frequently of fatigue or even nap frequently. Typically, even after a nap, a depressed child continues to feel tired or drowsy. The fatigue is not specifically related to boring schoolwork or a situation the child may wish to avoid, but instead is more pervasive and persists across environments or situations. When a child is persistently and frequently so tired that he or she prefers to sleep or rest instead of to play, a severe rating of 7 is indicated.

Examples:
Rating of 1. "I feel tired sometimes like when my mother asks me to clean up my room... math homework makes me feel tired, too."
Rating of 3. "I usually take a nap after school... yeah, then I feel o.k. to do my homework (10-year-old boy)."
Rating of 5. "I always go to sleep 3 times in the day" (child looks fatigued in the interview).
Rating of 7. "After school I'm too tired to play... I lay on the couch from 3 to 5 p.m. but I still feel tired after dinner."

G. Physical Complaints

Somatic complaints are common in depressed children and may represent either the gastrointestinal disturbances which occur in depression as well as physiological concomitants of anxiety. Pains may be subjectively experienced as more intense during a depressive episode. Since every child has occasional complaints, a pathological rating should not be considered unless the child's complaints seem excessive.

Examples:
Rating of 3. "He has little tiffs with his brother several times a week. It's because he's so grouchy... the brother doesn't do anything and he's mad for a half hour."
Rating of 5. "Whenever my sister talks to me I get so mad... I just go in my room and sit for an hour until I..."
feel better... Oh yeah, it happens 3 or 4 times a week."
Rating of 7. "Every day she gets angry and slams her door when she goes to her room... she says she hates Dr. H. and wants to kill him."

I. Guilt

Children can feel overwhelmingly guilty; but guilt is a difficult area to obtain consistent and reliable information from children. Developmentally, the concept of guilt is not cognitively accessible to a very young child. It is rarely grasped by a child under the age of 8 years. Lack of evidence of guilt does not necessarily mean the child does not feel guilt. A child may make a conscientious effort to make a good impression on the examiner, and not reveal misdeeds.

Pathological guilt is an important item to assess when the child is able to describe these feelings. Often, it is necessary to define guilt for the child and to be sure he or she understands the concept before proceeding with the interview. In assessing for pathological guilt— as opposed to guilty feelings appropriate for a misdeed—the clinician must evaluate the duration and intensity of the child’s feelings in relation to the severity of the event reported.

It should be determined when a guilt-inducing event occurred and the length of time that the child continues to blame himself or herself for the outcome.

Example:
Rating of 1. “I broke a lamp... it was my fault... but I feel better about it now.”
Rating of 3. “I hit my brother... I felt bad about it... yes, I do still think about it...”
Rating of 5. “I feel bad when I don’t do something my mother tells me to do and then I lie and say I did it and I feel badly the whole day.”
Rating of 7. “I said I hate my uncle... he died... it’s all my fault that he died... why... because I said it!”

J. Self-Esteem

Feelings of self-reproach are common in depression. Loss of self-esteem may be difficult to determine, especially in 6- to 9-year-olds whose self-concept is less developed. Structured questions about the child’s degree of satisfaction with his or her looks, personality, intelligence, and acceptance or rejection by peers yield more information than abstract questions such as “do you like yourself?” Observers often may report on the child’s propensity to be teased, called names, or be picked on by other children; propensities which diminish a child’s self-esteem.

Low self-esteem, however, is not specific to depression. It is seen in a variety of psychiatric diagnoses as well as in children who do not qualify for any psychiatric diagnosis.

Many children will spontaneously volunteer information about their self-concepts, but others may be modest and require encouragement before responding. If a child hesitates on every question about him or herself, or gives only half-hearted responses, we recommend a higher rating.

It is important to evaluate the overall affective tone of the child’s responses. Some children will describe themselves negatively, calling themselves “stupid” or admit their peers call them nicknames such as “fatso” or “fag.” Derogatory nicknames tend to lower a child’s self-esteem. When children admit to being called such names, a higher rating is also recommended.

For this item, and the morbid ideation item, a pathological rating is 4 or more. A child must report two or more major areas of self-image in which he or she feels deficient to be scored a rating of 4.

Example:
Rating of 1. “Basically, I like my looks and wouldn’t want to change anything... except maybe (offhandedly), I could be skinnier.”
Rating of 3. “I’d like to change my nose. I’m smart more than dumb. Most kids like me” (mentions changing looks twice more to subsequent questions).
Rating of 4. “I wish I had my teeth straightened... I think I should be smarter...”
Rating of 5. “I hate my face... kids call me retardo.”
Rating of 7. “I'd like to change my face, my hair, and my personality. They say I'm smart but I think I'm dumb... nobody likes me.”

K. Depressed Feelings
This item rates verbally expressed depressed feelings. Since every child feels unhappy from time to time, the clinician must determine the intensity, duration, and degree of association of the sad feelings to an event. Higher ratings are indicated when either the intensity or duration of unhappiness are excessive. Lack of association with an event as well as lack of reactivity of the mood also elevates the rating score.

Examples:
Rating of 1. “I felt so sad when my dog ran away... I cried... I felt sad a lot until my mom gave me a new dog.”
Rating of 2. “I cry when my mother goes away... I'm afraid she won't come back... no, I'm not sad if she's at home.”
Rating of 3. “I tell my mom I feel moody... it's hard to shake that feeling when I feel moody... oh, a few times a week.”
Rating of 5. “I feel sad a lot... I go in my room and lay down... nothing happened... I don't know why.”
Rating of 7. “I feel sad a lot... it hurts my heart... I went to the doctor because my chest hurts... I feel so sad it hurts but they can't find anything wrong with me.”

L. Morbid Ideation
Depressed children often have thoughts of death, passive wishes to die, and other morbid concerns. Concerns about one's own death are considered morbid rather than suicidal ideation, unless the child only considers his or her own death in the context of suicide. Most non-depressed latency children develop temporary fears of separation and death of the quality described in the child's prayer “If I should die before I wake, I pray the Lord my soul to take...” These types of concerns should not be assessed as pathological and should receive ratings of only 1 or 2. Concerns or fears about death shortly after a traumatic environmental event, such as separation from death of a pet or family member, should not be rated pathologically (i.e., 4 or above).

Depressed children, on the other hand, may have exaggerated responses to reality events and remain excessively preoccupied with deaths which occurred in the distant past, or of people little known by the child. The thoughts may seem excessive because of the frequency or intensity with which the child recalls the precipitating event. If these thoughts are excessive but not bizarre and are related to the reality event, we recommend a rating score of 3. When the morbid thoughts preoccupy the child's thoughts and extend beyond external reality or become extensive or bizarre, we recommend a rating of 4 or higher.

Examples:
Rating of 2. “I worry that my grandfather might die." (Grandfather is in the hospital.)
Rating of 3. “Someone shot a bullet in our house... I'm still afraid I might die... I might get shot.”
Rating of 4. “I worry that my father will get sick and lose his job... or he might die” (Father has been hospitalized twice—not currently ill or hospitalized.)
Rating of 5. “I don't think I should exist in the world... at night I can feel death's presence.”
Rating of 7. “My dog might die... I have pain in my heart and stomach because I am dying... my food is poisoned... am I going to die?" (asks mother daily “am I going to die?”)

M. Suicidal Ideation
Suicidal ideation, gestures, and attempts occur in childhood depression. Most children 7 years or older are familiar with the word suicide and its meaning or can readily understand once the meaning of the word is explained to them. However, the child's response to questioning about suicidal ideas is not always straightforward. Sometimes a child will deny or sharply deny suicidal thoughts when they are present. The child should be further questioned after attempts to put him or her more at ease. But, if sharp denial persists, we recommend a rating of 2. When a child admits
to thoughts of suicide, usually when angry, not accompanied by suicidal gestures or attempts, we recommend a rating of 3. Recurrent thoughts of suicide merit a rating of 5. Any child admitting to active suicidal thoughts or who has made a suicide attempt within the prior month, should be given a rating of 7.

Examples:
Rating of 3. “When my mother yelled at me and made me stay in my room, I told her ‘I’m going to kill myself.’”
Rating of 5. “Yeah, I think about walking in front of a car or jumping out of a high window ... it makes me sad to think about it, so I try not to.”
Rating of 7. “I want to kill myself ... I think I’ll go in front of a car ... I tried to stab myself with a knife ... last week.”

N. Weeping
Weeping can be seen in childhood depression due to depressed or irritable moods. Most often, parents or other observers report excessive weeping. At times, depressed children themselves admit to feeling they are more depressed than other children, or that they often cry for no reason. Some children who have difficulty admitting to crying often, will admit to feeling like crying even though they do not cry. A mildly pathological rating of 3 is recommended for a child who cries slightly more often than peers. A rating of 5 is recommended if the child admits to crying for no reason and/or cries frequently. The severest rating of 7 is recommended for daily weeping.

O. Non-Verbal Items
The final 3 items of the CDRS-R are rated by the clinician using clinical judgment based on the child’s appearance and non-verbal behavior. The guidelines for each rating on the non-verbal items are explained on the CDRS-R rating scale.

Children's Depression Rating Scale—Revised

Schoolwork
Do you like school or dislike school? What parts do you like? What parts do you dislike? (Note: if teacher, peers, activities, e.g., recess, etc.)
What kind of grades do you get in school? Are they different now than they were last year? (Or most recent grading period.)
Do your parents or your teacher(s) think you ought to be doing better? What do they say?
Do you agree or disagree with them?
If grades are a problem, ask: Do you have trouble paying attention? Why? Do you take longer to finish your assignments than other kids? Do you daydream?
Do other children bother you? Does the teacher often ask you to listen to what he/she is saying?
If not in school, ask about ability to concentrate on a TV program or game.

Ratings
1. Performance consistent with ability.
2. 
3. Decrease in school performance.
4. 
5. Major interference in most subjects.
6. 
7. No motivation to perform.

Capacity to Have Fun
What do you like to do for fun? (Note interest, involvement, enthusiasm.) Discuss individual activities named.
How often do you have fun? (Note whether activities available daily, weekly, seasonally, or very infrequently.)
Are you ever bored? How often?
(If very inactive) What do you like to watch on TV? Discuss favorite TV shows. (Determine if active or passive viewer.)

Ratings
1. Interest and activities realistically appropriate for age, personality, and social environment. Shows no appreciable change with present illness. Any feelings of boredom are transient.
2. 
3. Describes some activities realistically available several times a week but not on a daily basis. Shows interest but not enthusiasm.
4. Is easily bored. Complains of "nothing to do." Participates in structured activities with a "going through the motions" attitude. May express interest primarily in activities that are (realistically) unavailable on a daily or weekly basis.

6. Has no initiative to become involved in any activities. Primarily passive. Watches others play or watches TV but shows little interest. Requires coaxing and/or pushing to get involved in activity. Shows no enthusiasm or real interest. Has difficulty naming activities.

Social Withdrawal

Do you have friends to play with? Are they at school or home? What games or things do you do? How often do you play with them?
Have you ever had a really close friend? Do you have one now?
Do your friends ever call for you and you just don't feel like going out to play? How often?
Have you ever lost friends? What happened?
Do children ever pick on you? How? What do they do? Is there anyone who will stick up for you?

Ratings
1. Enjoys friendships with peers at school and home.
2. 
3. May not actively seek out friendships but waits for others to initiate a relationship or may occasionally reject opportunities to play without a describable alternative.
4. 
5. Frequently avoids or refuses opportunities for desirable interaction with others and/or sets up situations where rejection is inevitable.
6. 
7. Does not currently relate to other children. States he or she has "no friends" or actively rejects new or former friends.

Sleep

Do you have trouble sleeping?
Do you take a long time to go to sleep? (Differentiate from resisting going to bed.) How long? How often?

Do you wake up in the middle of the night?
Do you go right back to sleep or stay awake?
How often does this happen?
Do you ever wake up before you need to in the morning? How early? Do you go back to sleep or stay awake? What do you do? How often (or when) does this happen?

Ratings
1. No (or occasional) difficulty. (Goes to sleep within 1/2 hour or less.)
2.
3. Frequently has mild difficulty with sleep.
4.
5. Moderate difficulty with sleep nearly every night.
(If applicable, indicate time of difficulty)
a. Initial
b. Middle
c. Early morning awakening

Appetite or Eating Patterns

Do you like to eat?
At meals, are you hungry for some meals, most meals, all meals? Not hungry (if not hungry, record when and how often not hungry).
Does your mother complain about your eating?
Have you gained or lost weight? (If yes) How can you tell?

Ratings
1. No problems or change in eating pattern.
2.
3. Mild change from usual eating habits within onset of current behavioral problem.
4.
5. Is not hungry most of the time or has excessive food intake since onset of current behavioral problems or marked increase in appetite.
(If applicable, circle one)
Increased appetite
Decreased appetite

Excessive Fatigue

(Consider age and activities of child)

Do you feel tired during the day? Even when you have had enough sleep? (During boring school subjects does not count.) After school?
How often do you feel tired after school?
Do you ever feel so tired you go and take a nap even if you don’t have to? How often does this happen?

**Ratings**
1. No unusual complaints of “feeling tired” during the day.
2.
3. Complaints of fatigue which seem somewhat excessive and not related to boredom.
4.
5. Daily complaints of feeling tired.
6.
7. Complains of feeling tired most of the day. May voluntarily take long naps without feeling refreshed. Interferes with play activities.

**Physical Complaints**
(Complaints of a non-organic basis)

Do you ever get stomachaches, headaches, leg pains?
Do you get other aches and pains?
What are they like?
How often do these occur?
When you get ______ aches, how long do they last? Does anything make them go away? Do they keep you from playing? How often do they do this?

**Ratings**
1. Occasional complaints.
2.
4.
5. Complains daily. Some interference with the ability of the child to function.
6.
7. Preoccupied with aches and pains; interferes with play activities several times a week.

**Irritability**

What things make you get grouchy or mad?
How mad do you get?
Do you ever feel in a mood where everything bothers you? How long do these moods last?
How often do these moods occur?

**Ratings**
1. Rare.
2. Occasional.

3. Several times a week for short periods.
4.
5. Several times a week for longer periods.
6.
7. Constant.

**Guilt**

Do you ever feel like it’s your fault or blame yourself if something bad happens?
Do you ever feel bad or sorry about certain things you have done or wished you had done? What are they? (Note act and whether guilt is proportional to deed.)
Do you know what the word guilty means? Do certain things make you feel guilty?

**Ratings**
1. Does not express any undue feeling of guilt.
   Appears appropriate to precipitating event.
2.
3. Exaggerates guilt and/or shame out of proportion to the event described.
4.
5. Feels guilty over things not under his or her control. Guilt is definitely pathological.
6.
7. Severe delusions of guilt.

**Self-Esteem**

Do you like the way you look? Can you describe yourself? (With a young child, ask about hair, eyes, face, clothes, etc.) Would you want to change the way you look? What way?
Do you think you are smart or stupid?
Do you think you are better or worse from other kids?
Do most kids like you? Do any not like you? Why? Do you get called names? What are they? Do other kids put you down?
What things are you good at? Not so good? What?
Do you ever feel very down on yourself? Would you like to change anything about yourself?

**Ratings**
1. Describes self in primarily positive terms.
2.
3. Describes self with one important area where the child feels deficit.
4.
5. Describes self in preponderance of negative terms or gives bland answers to questions.
Depressed Feelings
What things make you feel unhappy?
When you feel unhappy how long does it last?
An hour? A few hours? A whole day? How
often do you feel like this? Every week? Every
two weeks? (Note: for younger children, one
hour may be equivalent of 1/2 day or more
in older children.)
Do other people know when you are sad?
Do you feel sad just at certain times, like when
you mother is away?
When you feel unhappy, how miserable do
you feel? Do you ever feel so bad it hurts?
How often does it feel bad? (Reactivity is an
indicator of degree of depressed feelings.)

Ratings
1. Occasional feelings of unhappiness which
quickly disappear.
2.
3. Describes sustained periods of unhappiness
which appear excessive for events de-
scribed.
4.
5. Feels unhappy most of the time without a
major precipitating cause.
6.
7. Feels unhappy all of the time. Accompanied
by psychic pain (e.g., “I can’t stand it”).

Morbid Ideation
Have you ever had a pet die? A friend? A
relative? Do you think about it now? How
often?
Do you ever think about someone dying in
your family? Who? Describe. How often do
you think about it?
Do you ever worry about everyone else? Who?
Do you ever think that you might die? Tell me
about it.
How often do you have these kinds of thoughts?

Ratings
1. None.
2.
3. Has some morbid thoughts, all of which re-
late to a reality event but seem excessive.

Suicidal Ideation
Do you know what the word suicide means?
Have you ever thought of doing it? When? (If
yes) How have you thought of doing it?
Have you ever said you would like to kill your-
self even if you didn’t mean it? Describe.
(If appropriate) Have you ever tried to kill
yourself?

Ratings
1. Understands the word “suicide” but does
not apply term to self.
2. Sharp denial of suicidal thoughts.
3. Has thoughts about suicide, usually when
angry.
4.
5. Has recurrent thoughts of suicide.
6.
7. Has made suicide attempt within the last
month or is actively suicidal.

Weeping
Do you ever cry very much?
Do you sometimes feel like crying even if you
don’t cry? What sort of things make you feel
this way? How often do these occur?
Do you think you feel like crying more than
your friends?
Do you ever feel like crying for no reason?

Ratings
1. Normal for age.
2. Suggestive statements that child cries, or feels
like crying, more frequently than peers.
3. Child cries slightly more than peers.
4.
5. Cries or feels like crying frequently (several
times a week). Admits to crying without
knowing reason why.
6.
7. Cries nearly every day.
The following items are rated by the clinician
based on the child’s nonverbal behavior.
Depressed Affect

Ratings
1. Definitely not depressed. Facial expression and voice animated during interview.
3. Overall loss of spontaneity. Looks distinctly unhappy during parts of the interview. May still be able to smile when discussing non-threatening areas.
4.
5. Moderate restriction of affect throughout most of interview. Has longer and frequent periods of looking distinctly unhappy.
6.
7. Severe. Looks sad, withdrawn. Minimal verbal interaction throughout interview. Cries or may appear tearful.

Tempo of Speech

Ratings
1. Normal
2. Slow
4.
5. Severe. Low; marked interference with interview.

Hypoactivity

Ratings
1. None.
2.
4.
6.
7. Severe. Motionless throughout interview.