BPRS-C-9 (and 21)

Guidelines for Administration and Use of the Brief Psychiatric Rating Scale for Children nine and 21-item versions.

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MANUAL USES AND CONTENTS

This manual was created to provide guidelines for the use of the anchored Brief Psychiatric Rating Scale for Children (BPRS-C-9 and BPRS-C-21). The manual includes a description of the instrument, general guidelines for administration, and an expanded description of each item on the instrument.

The Brief Psychiatric Rating Scale for Children should be completed by a mental health professional with training in the assessment of children and adolescents and training in basic measurement principles. This individual should complete some training on the administration of the instrument, which may include formal didactic training or a complete reading of this manual.

This manual utilizes a similar format as the manual for the Expanded Brief Psychiatric Rating Scale, utilized in the assessment of adults (Ventura, Lukoff, Nuechterlein, Liberman, Gree, Shaner, 1993).

DESCRIPTION OF THE BPRS-C-9 (21)

The Brief Psychiatric Rating Scale for Children was created to provide a concise profile of childhood behavioral and emotional symptomatology (Hughes et al, 2001; Overall & Pfefferbaum, 1982). The BPRS-C-21 was devised through the factor analysis of a large sample of items addressing important psychiatric symptoms in children. Three items were selected to best represent each of the seven scales derived through the factor analysis. This resulted in a 21-item measure with each subsequent 3 items summed to determine scale scores. The seven scales represented by the BPRS-C-21 are:

- Behavior Problems (Items 1-3)  
- Depression (Items 4-6)  
- Thinking Disturbance (Items 7-9)  
- Psychomotor Excitation (Items 10-12)  
- Withdrawal (Items 13-15)  
- Anxiety (Items 16-18)  
- Organicity (Items 19-21)

To improve BPRS-C inter-rater reliability when completed by clinicians with various levels of training, the instrument was revised to include descriptive verbal anchors for ratings of each item, thereby giving clinicians guidance in determining severity ratings. This new instrument was used in the one-year pilot study and demonstrated equivalent or superior reliability and validity to the previous version (Hughes et al, 2001).
ADMINISTRATION OF THE BPRS-C-9 (21)

The BPRS-C is intended to provide a clinician’s rating of recent psychiatric symptomatology. The clinician will need to collect information from a variety of sources to provide accurate ratings. The clinician when completing the assessment should utilize the following sources of information:

- Clinical Interviews
  - Caregiver(s)
  - Child/Adolescent
  - Family members
- Direct Observation
  - In waiting area
  - During interview
  - On ward, school, or play situations
- Review of Medical Records
  - Current treatment records
  - Historical records
- School Reports
  - Teacher/counselor report
  - School records

The clinician should base ratings on all available information and should not rely exclusively on parent or client report. Other sources of information are particularly important when the clinician believes that caregiver or child may be minimizing or exaggerating symptoms.

Choosing the Appropriate Time Period for Rating Symptoms

Outpatient settings. Ratings can be based on symptoms/behavior with different time intervals depending on a site's particular need. This can vary from a week to the last two months. While symptomatology occurring prior to this period may be vital clinical information (e.g., historical suicide attempts), it should not be reflected in BPRS-C ratings if no problems have occurred within the two-month time period for example. While some BPRS-C items are rated primarily on the basis of the current interview, information gathered during earlier interviews (during the past 2 months) can also be utilized.

Because children’s behavior/symptomatology does not remain constant over even a brief period, clinicians must aggregate data to form one “blended” rating. In general, ratings should reflect the average score over the time period. This score will represent the average level of symptomatology experienced over two months. Although an average score will be reflected, clinicians may decide to place some emphasis in their ratings on the most recent behavior, thereby shifting the average score slightly to reflect either the improvement or exacerbation of symptoms that has occurred recently. This will allow for the distinction between a child with mild symptomatology for the first month of the rating
period with an exacerbation to moderate symptoms in the second month from a child with moderate symptoms in the first month whose symptomatology has reduced to a mild level in the past month.

**Inpatient settings.** Ratings are typically made at admission and can then be done daily, or every few days to monitor progress. The baseline ratings would include observations of symptoms during the interview, as well as historical information gathered from clinical interviews and medical records reflecting symptoms prior to admission.

Because children’s behavior/symptomatology does not remain constant over even a brief period, clinicians must aggregate data to form one “blended” rating. In general, ratings should reflect the average score over the time period. This score will represent the average level of symptomatology experienced over the past three days. Although an average score will be reflected, clinicians may decide to place some emphasis in their ratings on the most recent behavior, thereby shifting the average score slightly to reflect either the improvement or exacerbation of symptoms that has occurred recently. This will allow for the distinction between a child with mild symptomatology for the first day of the rating period with an exacerbation to moderate symptoms on the third day from a child with moderate symptoms on the first day whose symptomatology has reduced to mild on the third day.

**Integrating Frequency and Severity in Symptom Rating**

Completion of the BPRS-C requires the clinician to integrate information about both the frequency of the occurrence of symptoms and the severity of the symptom. Many times, this task can be accomplished by examining the anchors for each rating, which frequently indicate information about both aspects. For example, a “mild” rating on Uncooperativeness is made when the child “occasionally refuses to comply with rules and expectations, in only one situation/setting.”

At times, the descriptive anchors may not provide the information necessary to integrate frequency and severity. At these times, when frequency and severity ratings are not consistent, the clinician should provide an “average” rating, reflecting both aspects of the symptom presentation.

**Example:**

A client is being assessed on the Distractibility item. The child is found to be persistently distractible and the provider judges the frequency of the symptom to be Severe (5). However, the child is placed in an ideal educational environment, with extraneous stimuli minimized, low student-teacher ratios, and frequent prompts to remain on task. The child is performing moderately well in this environment and impairment in functioning is judged to be Moderate (3). In this instance, the clinician may judge the child to have an overall, blended rating of Moderate-severe (4) on Distractibility.
Selecting the Appropriate Reference Group

When making ratings on the BPRS-C, the clinician should rely on a standardized reference group for comparison purposes. The appropriate reference group is normal children/adolescents, at a similar developmental level to the child being evaluated, who have no psychiatric symptoms and are living and functioning in the community and school free of symptoms. Clinicians should not evaluate symptomatology in comparison to other children receiving mental health services, as this will systematically bias the ratings.

When assessing children and adolescents, it is imperative to maintain a sense of developmentally appropriate behavior. Some symptoms assessed on the BPRS-C can be non-pathological at certain developmental levels and ratings should reflect the symptom in this context. In addition, behaviors may be rated as more severe when they occur outside of a developmentally appropriate time period. For example, a school-age child who demonstrates difficulty maintaining attention would be rated as more severe than a preschooler who demonstrates a similar level of distractibility.

Rating Symptoms When a Child or Parent Misrepresents Them

Children and adolescents all too often deny or minimize psychiatric symptoms. They may not recognize the behavior/cognition as unusual or problematic or they may be hesitant to reveal private information to the clinician. Caregivers may also have reasons to minimize the child’s problems. In addition, both informants may have motivations to exaggerate symptoms as well. If a clinician suspects the client or caregiver may be misrepresenting symptoms, it becomes imperative to gather and use other sources of information. Ratings should not be based solely on parent or child report in these situations, as the BPRS-C information will be invalid and uninterpretable. Ultimately the accuracy of ratings relies on the clinician’s ability to explore motives for the misrepresentation of symptoms and to integrate information from other sources. Utilizing the most sensitive and empathic interview techniques, the clinician should explore reasons for minimizing or exaggerating symptoms with the informant. When a clinician is unable to resolve conflicts between various informants, he or she must make a clinical judgment about the accuracy of the information they have accumulated and the reliability of the informant.

Scale Items and Anchor Points

1. **(BPRS-C-9 item 1) Uncooperativeness** - negative, uncooperative, resistant, difficult to manage

   This symptom is described in the DSM-IV as oppositional or defiant behaviors. This behavior may occur in only one setting (e.g., home) or may be found in multiple settings and with multiple relationships (e.g. school, work, community). Some sample behaviors that may be described are often arguing with adults or refusing to comply with rules or requests.
0 Not Present - Cooperative, pleasant.
1 Very Mild
2 Mild – Occasionally refuses to comply with rules and expectations, in only one situation or setting.
3 Moderate
4 Moderate/Severe – Persistent failure to comply with rules/expectations in more than one setting.
5 Severe
6 Extremely Severe – Constantly refuses to comply with rules and expectations, delinquent behaviors, running away. Causes severe impairment in functioning in most situations/settings.

2. **(BPRS-C-9 item 2)** Hostility- angry or suspicious affect, belligerence, accusations & verbal condemnation of others

This symptom is described in DSM-IV as negativistic and hostile behaviors. Some characteristics that may be reported or observed include verbal aggression towards others, often angry and resentful, and blames others for own behaviors.

0 Not Present - Cooperative, pleasant.
1 Very Mild
2 Mild – Occasionally sarcastic, loud, guarded, quarrelsome. Causes mild dysfunction in one situation or setting.
3 Moderate
4 Moderate/Severe – Causes frequent impairment in several situations/settings.
5 Severe
6 Extremely Severe – Assaultive, destructive. Causes severe impairment in functioning in most situations/settings.

3. **(BPRS-C-9 item 3)** Manipulativeness- lying, cheating, exploitive of others

This symptom is described in DSM-IV as violating the basic rights of others as well as societal norms or rules. A child with this symptom may lie frequently, bully others, or force someone into unwanted activities (e.g. sexual activity).

0. Not Present – Not at all.
1. Very Mild
2. Mild – Occasionally gets in trouble for lying, may cheat on occasions.
3. Moderate
5. Severe
6. Extremely Severe – Constantly relates to others in an exploitive/manipulative manner, cons strangers out of money/situations. Causes severe impairment in functioning in most situations/settings.

4. (BPRS-C-9 item 4) Depressed Mood - sad, tearful, depressive demeanor

Depressed mood involves feelings of sadness, hopelessness, discouragement, or feeling “down in the dumps”. This symptom may need to be inferred from facial expression and demeanor if the child/adolescent is unable to describe the feeling states themselves. However, depressed mood should not be inferred because of a theoretical belief that children with certain presentations also demonstrate a “masked” or “hidden” depression. Although irritability is a common symptom in childhood depression, it should not be rated on this item.

0. Not Present – Occasionally/quickly disappears.
1. Very Mild
3. Moderate
4. Moderate/Severe – Unhappy most of the time/no precipitant.
5. Severe

5. (BPRS-C-9 item 5) Feelings of Inferiority- lacking self-confidence, self-depreciatory

This symptom may be described as low self-esteem or feelings of worthlessness. A child with this presentation may engage in behaviors such as making negative statements about him or herself or behaving in ways that are not respectful to self.

0. Not Present – Feels good/positive about self.
1. Very Mild
2. Mild – Occasionally feels not as good as others/deficits in one area.
3. Moderate
4. Moderate/Severe – Feels others are better than they are. Gives negative, bland answers, can’t think of anything good about themselves.
5. Severe
6. Extremely Severe – Constantly feels others are better. Feels worthless/unlovable.

6. Suicidal Ideation- thoughts, threats, or attempts of suicide

This item addresses the consumer’s thoughts or behaviors related to suicide. Information used to score this item will be based on the consumer’s self-report, information provided by the caregiver or other source, as well as medical records. When completing a rating on this item, the clinician should consider how frequent/bothersome are suicidal thoughts, what situations may lead to suicidal thoughts or threats, how well-
developed are plans if present, the consumer’s level of hopelessness, the assessed level of intent, any previous history of attempts that would indicate increased concern about current symptoms, etc. An “Extremely Severe” rating would be made if the child/adolescent has made a suicide attempt within the last month or there is judged to be “imminent danger” of suicide.

0. Not Present – Not at all.
1. Very Mild
3. Moderate
5. Severe
6. Extremely Severe – Attempted within last month/actively.

7. **Peculiar Fantasies** - recurrent, odd, unusual, or autistic fantasies

   This symptom is indicated by an elaborate, age-inappropriate fantasy life. These peculiar fantasies may lead to impairments in reality testing. In general, this symptom will be inferred from child’s verbal statements and difficulty distinguishing reality and fantasy, although caregiver reports, school reports, and medical records can also be useful. Careful attention should be given to the child’s developmental level, as varying amounts of fantasy can be normative at particular developmental levels.

   0. Not Present – Not at all.
   1. Very Mild
   2. Mild – Occasionally has elaborate fantasies, imaginary companions.
   3. Moderate
   4. Moderate/Severe – Frequently has elaborate fantasies (exclude imaginary friends). Interferes occasionally with perception of reality.
   5. Severe
   6. Extremely Severe – Often absorbed in elaborate fantasies, has a difficult time distinguishing reality from fantasy.

8. **Delusions** - ideas of reference, persecutory or grandiose delusions

   DSM-IV defines delusions as a false belief about reality that is firmly held despite what others believe or obvious proof. This may include a wide range of delusional thought content. Again, normative concern or worry about what others are thinking or doing should not be rated unless these concerns are causing impairment.

   0. Not Present – No delusions or ideas of reference.
   1. Very Mild
   2. Mild – Occasionally feels strangers may be looking/talking/laughing about them.
   3. Moderate
4. Moderate/Severe – Frequent distortion of thinking, mistrust, suspicion of others.
5. Severe

9. *Hallucinations* - visual, auditory, or other hallucinatory perceptions

DSM-IV defines hallucinations as a sensory perception that has the sense of reality but occurs without external stimulation of the sensory organ. Information for rating this item will generally come from the self-report of the consumer, but other sources of information may also be helpful. Reports of hallucinatory experiences must be distinguished from experiences related to dreaming, cultural beliefs, or substance-related behaviors.

0. Not Present – No visual, auditory, sensory experiences.
1. Very Mild
2. Mild – Hears name called, experiences after an event, active/vivid imagination.
3. Moderate
4. Moderate/Severe – Definite experienced auditory (voices either command or not command?), visual (daytime, or several incidences), sensory (specific orders).
5. Severe
6. Extremely Severe – Constantly experiences auditory (commanding voices), visual (images are present during interview), or other experiences or perceptions.

10. *(BPRS-C-9 item 6)* *Hyperactivity* - excessive energy expenditure, frequent changes in posture, perpetual motion

This behavior pattern involves excessive motor activity, restlessness, and fidgetiness. Caregivers may describe a child as being “wound up” or “constantly on the go.” This behavior may be observed during the assessment interview; however, many children can maintain normal levels of activity in novel, well-structured situations and the clinician will need to rely on reports from parents, teachers, or other caregivers.

0. Not Present – Slight restlessness, fidgeting. No impact on functioning.
1. Very Mild
3. Moderate
5. Severe
6. Extremely Severe – Continuous motor excitement, cannot be stilled. Causes major interference in functioning on most occasions/situations.

11. (BPRS-C-9 item 7) Distractibility- poor concentration, shortened attention span, reactivity to peripheral stimuli

This behavior is described in the DSM-IV as difficulty maintaining attention and having one’s attention drawn away too easily to irrelevant stimuli. Caregivers may describe children with this symptom as not giving close attention to tasks, failing to listen, very forgetful, unable to complete tasks, quickly shifting from one activity to another.

0. Not Present – Performance consistent with ability.
1. Very Mild
2. Mild – Occasionally daydreams, easily distracted. Is able to focus with prompting.
3. Moderate
5. Severe
6. Extremely Severe – Constant; needs 1 to 1 assistance to stay focused.

12. Speech or Voice Pressure- loud, excessive, or pressured speech

The DSM-IV defines this symptom as speech that is increased in amount, accelerated, and difficult to interrupt. This symptom is most likely to be observed during interactions with the child, but may also be informed by other sources of information.

0. Not Present – Not at all.
1. Very Mild
2. Mild – Noticeably more verbose than normal, conversation is not strained.
3. Moderate
4. Moderate/Severe – Very verbose or rapid, making conversation strained or difficult to maintain.
5. Severe
6. Extremely Severe – Talks rapidly, continuously, and cannot be interrupted. Conversation is extremely difficult or impossible.

13. Underproductive Speech- minimal, sparse, inhibited verbal response pattern, or weak low voice

This symptom describes a child whose communication is hampered by an inability or unwillingness to speak with enough words or loudly enough for others to comprehend. This symptom may occur in specific situations/contexts only or be a more
general trait. Although this symptom may be evident during observation of the child, the clinician should gather sufficient information to determine whether the behavior occurs outside of the unique situation of a clinical interview. The variety of contexts in which the symptom occurs as well as the impairment in communication and social functioning caused by the symptom should be reflected in ratings.

0. Not Present – Not at all.
1. Very Mild
2. Mild – Occasionally conveys little information because of minimal speech, vague, sparse, low or weak voice.
3. Moderate
4. Moderate/Severe – Persistently the client is vague, low or weak voice, in which at least ¼-½ of the conversation comprehension is impaired.
5. Severe
6. Extremely Severe – On numerous occasions/situations conversation is severely impaired.

14. Emotional Withdrawal- unspontaneous relations to examiner, lack of peer interaction, hypoactivity

This symptom can be described as a lack of relatedness to others. It may be evidenced by a failure to initiate or maintain appropriate eye contact, react to social cues, engage in reciprocal interactions, or show appropriate reactions to others’ behaviors. The child may seem disinterested or fearful of engaging with others. Information should be gathered to determine the contexts in which this symptom occurs and the extent of impairment in social functioning that results.

0. Not Present – Not at all.
1. Very Mild
2. Mild – Occasionally is unresponsive, sometimes refuses peer interaction.
3. Moderate
4. Moderate/Severe – Frequently unresponsive, lacks peer interaction, hypoactive. Interferes with relationships.
5. Severe
6. Extremely Severe – Constantly oblivious to those around. Preoccupied facial expressions, does not respond to questions or look at interviewer.

15. Blunted Affect- deficient emotional expression, blankness, flatness of affect

The DSM-IV defines this symptom as a significant reduction in the intensity of affect. The child may demonstrate less affect than would be expected for the situation. For example, the child may fail to show pleasure or happiness when engaging in favorite activities or demonstrate no signs of sadness or distress when discussing a sad event. As severity increases, the voice may become more monotonic and the child may show no facial expressions.
0. Not Present – Not at all.
1. Very Mild
3. Moderate
4. Moderate/Severe – Considerable flattening. Frequently the client does not show emotional response (does not smile, laugh, look, cry).
5. Severe
6. Extremely Severe – Constantly flat. The client does not show emotional response (does not smile, laugh, look, cry).

16. **(BPRS-C-9 item 8)** *Tension*- nervousness, fidgetiness, nervous movement of hands or feet

This symptom includes a variety of nervous movements, such as biting fingernails, twisting hair, shifting in seat. This symptom is generally assessed from behaviors observed in a variety of situations. Information about somatic symptoms that suggest changes in muscle tension may also indicate problems (e.g., backaches, headaches, stomachaches caused by tension).

0. Not Present – Not at all.
1. Very Mild
2. Mild – Occasionally feels nervous or fidgets. Can be relaxed or reassured.
3. Moderate
4. Moderate/Severe – Most days/time feels nervous/fidgety. Causes mental or physical distress.
5. Severe
6. Extremely Severe – Pervasive and extreme nervousness, fidgeting, nervous movements of hands or feet.

17. **(BPRS-C-9 item 9)** *Anxiety*- clinging behavior, separation anxiety, preoccupation with anxiety topics, fears or phobias

This symptom involves apprehension or worry about future danger or misfortune. The information needed to assess this symptom may be gathered through observation of the child or adolescent. For example, the child may become overly distressed when separated from caregivers, even for a brief time, or the child or adolescent may be observed to become agitated and avoidant of a fearful object or situation. Information may also be gathered from the self-report of the child and report by caregivers of cognitive symptoms of anxiety. The child may describe excessive worry about possible negative occurrences, such as a parent dying; disruptions in functioning, such as not being able to spend time apart from parent; or specific fearful stimuli, such as fear of dogs. The child’s caregiver may describe the child needing constant reassurance or avoiding normal activities that are fear arousing for the child. Phobias or fears may be specific to certain contexts (e.g. school) or generalized.

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0. Not Present – Not at all.
1. Very Mild
2. Mild – Occasionally worries (at least 3 times a week) about anticipated/current events, separation, fears or phobias. These worries appear excessive for situation.
3. Moderate
4. Moderate/Severe – Most days/time worries about at least 2 life circumstances, or anticipated/current events.
5. Severe
6. Extremely Severe – Pervasive and extreme worry about most everything, real or imagined.

18. Sleep Difficulties- inability to fall asleep, intermittent awakening, shortened sleep time

This symptom includes any age-inappropriate disruptions to a normal sleep pattern, resulting in less or poorer sleep or excessive sleep. It may be evidenced by difficulty falling asleep or returning to sleep after waking, difficulty maintaining sleep for a developmentally appropriate amount of time, or inability to sleep during appropriate times. It may also be evidenced by too much sleep or an unwillingness to awaken, despite adequate sleep periods. Awakenings or insomnia may be related to sleep events, such as nightmares or preoccupied thoughts.

0. Not Present – Not at all.
1. Very Mild
2. Mild – Some difficulty (at least 1 hour initial, no middle or terminal insomnia).
3. Moderate
4. Moderate/Severe – Definitely has difficulty (at least 2 hours initial insomnia, any middle, or terminal lasting up to half an hour). Feelings of unrestorative sleep, evidence of mild circadian reversal.
5. Severe
6. Extremely Severe – Claims to never sleep, feels exhausted the rest of day, or severe circadian reversal.

19. Disorientation- confusion over persons, places or things

This symptom involves a lack of awareness about time, where or who one is, that is inappropriate for the child’s developmental level. This information will primarily be obtained from a mental status exam of the child or adolescent. The child or adolescent may evidence difficulty comprehending situations or communications and appear muddled or confused.

0. Not Present – Not at all.
1. Very Mild
2. Mild – Occasionally appears confused or puzzled. Easily reacquainted with surroundings when prompted.
3. Moderate
4. Moderate/Severe – Frequently appears puzzled, confused, baffled regarding familiar surroundings, people, or things.
5. Severe

20. **Speech Deviance** - inferior level of speech development, underdeveloped vocabulary, mispronunciations

This symptom involves a developmentally inappropriate delay in speech production, either in vocabulary, grammatical quality, or articulation. It may be evidenced by a limited vocabulary, poorly constructed or very simple sentences, difficulty in word choice, or difficulty in pronouncing words or sounds.

0. Not Present – Not at all.
1. Very Mild
2. Mild – Occasional instances of distorted or idiosyncratic speech. Little impairment of understandability.
3. Moderate
4. Moderate/Severe – Frequent instances with definite impairment in understandability.
5. Severe
6. Extremely Severe – Constant speech distortion, almost incomprehensible.

21. **Stereotypy** - rhythmic, repetitive, manneristic movements or posture

This symptom involves nonfunctional, stereotyped motor behaviors or posturing. Some sample behaviors include hand shaking or waving, body rocking, head banging, mouthing of objects, self-biting, picking at skin, or hitting oneself. These behaviors should be distinguished from self-injurious behaviors intended to gain attention from caregivers or peers or serving to reduce emotional distress. Mild versions of some stereotyped behaviors may be developmentally appropriate for very young children.

0. Not Present – Not at all.
1. Very Mild
2. Mild – Occasionally displays rhythmic, repetitive, manneristic movements or posture.
3. Moderate
4. Moderate/Severe – Frequent rhythmic, repetitive, manneristic movements or posture.
5. Severe
6. Extremely Severe - Most of the time (>50%) displays rhythmic, repetitive, manneristic movement or posture.
References


