Schedule for Affective Disorders and Schizophrenia for School Aged Children (6-18 Years)

Kiddie-SADS - Lifetime Version (K-SADS-PL DSM-5 November 2016)

The K-SADS-PL DSM-5 November 2016 combines dimensional and categorical assessment approaches to diagnose current and past episodes of psychopathology in children and adolescents according to DSM-5 criteria. Prior to administering the interview portion of the K-SADS-PL, parents and children are to complete the DSM-5 cross-cutting 25-item symptom rating scales. Responses on these dimensional rating scales are then taken into account in completing the interview portion of the assessment. The primary diagnoses assessed with the K-SADS-PL DSM-5 November 2016 include: Major Depression, Persistent Depression, Mania, Hypomania, Cyclothymia, Bipolar Disorders, Disruptive Mood Dysregulation Disorder, Schizoaffective Disorders, Schizophrenia, Schizophreniform Disorder, Brief Psychotic Disorder, Panic Disorder, Agoraphobia, Separation Anxiety Disorder, Simple Phobia, Social Anxiety Disorder, Selective Mutism, Generalized Anxiety Disorder, Obsessive-Compulsive Disorder, Attention Deficit Hyperactivity Disorder, Conduct Disorder, Oppositional Defiant Disorder, Enuresis, Encopresis, Anorexia Nervosa, Bulimia, Binge Eating Disorder,Transient Tic Disorder, Tourette's Disorder, Chronic Motor or Vocal Tic Disorder, Alcohol Use Disorder, Substance Use Disorder, Post-Traumatic Stress Disorder, Adjustment Disorders, and Autism Spectrum Disorder.

The K-SADS-PL DSM-5 November 2016 is a semi-structured interview. The probes that are included in the interview do not have to be, and should not be, recited verbatim. Rather, they are provided to illustrate ways to elicit the information necessary to score each item. The interviewer should feel free to adjust the probes to the developmental level of the child, and use language supplied by the parent and child when querying about specific symptoms.

After reviewing parent and child responses on the DSM-5 cross-cutting rating scales, the K-SADS-PL DSM-5 November 2016 is administered by interviewing the parent(s), the child, and finally achieving summary ratings which include all sources of information (parent, child, school, chart, and other). In general, when administering the instrument to pre-adolescents, conduct the parent interview first. In general, when working with adolescents, begin with them. There may be clinical reasons to alter the order of administration.

When there are discrepancies between different sources of information, the rater will have to use his/ her best clinical judgment. In the case of discrepancies between parents' and child's reports, the most frequent disagreements occur in the items dealing with subjective phenomena where the parent does not know, but the child is very definite about the presence or absence of certain symptoms. This is particularly true for items like guilt, hopelessness, interrupted sleep, hallucinations, and suicidal ideation. If the disagreements relate to observable behavior (e.g., truancy, fire setting, or a compulsive ritual), as appropriate, the examiner should query the parent(s) and child about the discrepant information. Ultimately the interviewer will have to use his/her best clinical judgment in assigning the summary ratings.

The following guidelines should be used in coding symptoms:

1) *Current Diagnoses*: In coding current episodes (CE) of disorders, symptoms should be rated for the time period when they were the most severe during the episode. *Note in the margins if and when particular symptoms (e.g., insomnia) improved or resolved*. Patients typically present when symptoms are at the worst. In follow-up research assessments, symptoms may be in partial remission.
2) *Disorders Targeted with Medication*: In coding disorders treated with medication (e.g., ADHD) use the ratings to describe the most intense severity of symptoms experienced prior to initiation of medication, when medications wear off, or during 'drug holidays'. *Note in margins symptoms targeted effectively with medication*.
3) *Past Diagnoses*: In order for an episode to be considered 'resolved' or 'past', the child should have had a minimum of *two months* free from the symptoms associated with the disorder. Episodes rated in the past disorders section should represent the most severe past (MSP) episode experienced of that given disorder.
4) *Time Line*: For children with a history of recurrent or episodic disorders, it is recommended that a time line be generated to chart lifetime course of disorder and facilitate scoring of symptoms associated with each episode of illness.

In the process of completing the full interview, diagnoses initially believed to be 'past' may turn out to be current diagnoses in partial remission. Corrections in the coding of current and past severity ratings can be made after completion of the interview.

Administration of the K-SADS-PL DSM-5 November 2016 requires the completion of: 1) the parent and child DSM-5 cross-cutting symptoms measures (DSM-5 CC-SM); 2) an Unstructured Introductory Interview; 3) a Diagnostic Screening Interview; 4) the Supplement Completion Checklist; 5) the appropriate Diagnostic Supplements; and 6) the Summary Lifetime Diagnostic Checklist. The K-SADS-PL is initially completed with each informant separately. If there is no suggestion of current or past psychopathology, no assessments beyond the Screen Interview will be necessary. The Summary Lifetime Diagnostic Checklist is completed after synthesizing all the data and resolving discrepancies in informants' reports. Each of the phases of the K-SADS-PL Interview is discussed briefly below.

1) *The DSM-5 Cross-Cutting Symptoms Measures (DSM-5 CC-SM).* The DSM-5 CC-SM are designed to be self-report measures completed independently by the parent and child before beginning the KSADS Interview. Scores on these self-report scales should be reviewed and recorded in the space provided before beginning the interview portion of the KSADS. The DSM-5 CC-SM include 25-items that assess symptom severity over the past two weeks. The parent and child DSM-5 CC-SM are included at the end of the KSADS. The American Psychiatric Association recommends specific follow-up measures that can be completed if threshold scores are obtained on the 25-item DSM-5 CC-SM and several disorder-specific severity scales. These additional scales can be accessed at: http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Level1, but do not need to be completed as part of the KSADS diagnostic assessment.

2) *The Unstructured Introductory Interview.* This section of the K-SADS-PL DSM-5 November 2016 takes approximately 10 to 15 minutes to complete. In this section, the parent provides information about health, presenting complaint and prior psychiatric treatment data, and both the parent and the child are surveyed about the child's school functioning, hobbies, and peer and family relations. Discussion of these latter topics is extremely important, as it provides a context for eliciting mood symptoms (depression and irritability), and obtaining information to evaluate functional impairment. This section of the K-SADS-PL should be used to establish rapport with the parent(s) and the child, and should never be omitted.
3) *The Screen Interview.* The Screen Interview surveys the primary symptoms of the different diagnoses assessed in the K-SADS-PL DSM-5 November 2016. Specific probes and scoring criteria are provided to assess each symptom. *The rater is not obliged to recite the probes verbatim, or use all the probes provided, just as many as is necessary to score each item.* Probing should be as neutral as possible, and leading questions should be avoided (e.g., "You don't feel sad, do you?"). Symptoms rated in the screen interview are surveyed for *current* (CE) and *most severe past* (MSP) episodes simultaneously. Begin by asking if the child has *ever* experienced the symptom. If the answer is no, rate the symptom negative for current and past episodes and proceed to the next question. If the answer is yes, find out when the symptom was present. If the symptom is endorsed for one time frame (e.g., currently), inquire if it was ever present at another time (e.g., past).

The diagnoses assessed with the screen interview do not have to be surveyed in order. The interviewer may begin inquiring about relevant diagnoses suggested by the presenting complaint information obtained during the unstructured interview. All sections of the Screen Interview must be completed, however, and most people find it easiest to proceed from start to finish.

Skip Out Criteria. After the primary symptoms associated with each diagnosis are surveyed in the Screen Interview, skip out criteria are delineated for current and past episodes of the disorder. A space is provided to indicate if the child met the skip out criteria, or if the child has clinical manifestations of the primary symptoms associated with the specific diagnosis. If the child failed to meet the skip out criteria for some diagnoses, the appropriate supplements should be administered after the Screen Interview is completed in its entirety.

Scoring. While interviewers are free to utilize latitude in the manner in which symptoms are queried, the scoring criteria are to be applied rigidly. The majority of the items in the K-SADS-PL DSM-5 November 2016 are scored using a 0–3 point rating scale. Scores of 0 indicate no information is available, scores of 1 suggest the symptom is not present, scores of 2 indicate subthreshold levels of symptomatology, and scores of 3 represent threshold criteria. The remaining items are rated on a 0-2 point rating scale on which 0 implies no information, 1 implies the symptom is not present, and 2 implies the symptom is present. When determining whether a symptom meets threshold vs subthreshold level criteria, it is important to assess the severity, frequency, and duration of the symptom, as well as impairment from the symptom. It is often helpful to ask for examples of specific behaviors or symptoms. To attain a threshold score of 3, the child must meet or exceed the threshold scoring criteria. If his symptom severity falls between the threshold and subthreshold criteria, the symptom would be rated subthreshold; a score of 2.

Subthreshold Symptoms While subthreshold manifestations of symptoms are not sufficient to count toward the diagnosis of a disorder, further inquiry may be warranted in certain cases. Subthreshold scores of psychotic symptoms or clusters of other symptoms associated with a given diagnosis should be brought to the attention of the attending physician or research supervisor. If subthreshold scores are attained on multiple items within a given diagnostic section of the Screen Interview, the supplement for that section can be completed to further assess relevant clinical symptomatology.

4) Supplement Completion Checklist. The Supplement Completion Checklist is on the last page of this Screen Interview. It should be torn off before starting the interview. Supplements requiring completion should be noted in the spaces provided, together with the dates of possible current and past episodes of disorder.

5) Diagnostic Supplements. There are five Diagnostic Supplements included with the K-SADS-PL: Supplement #1: Depressive and Bipolar Related Disorders; Supplement #2: Schizophrenia Spectrum and Other Psychotic Disorders; Supplement #3: Anxiety, Obsessive Compulsive, and Trauma-Related Disorders; Supplement #4: Neurodevelopmental, Disruptive, and Conduct Disorders; Supplement #5: Eating Disorders and Substance-Related Disorders. The format of the KSADS with its Screen Interview and five Diagnostic Supplements is designed to facilitate differential diagnoses, with the Screen Interview providing a good overview of potentially relevant diagnostic categories before surveying symptoms associated with the different disorders in detail.

The diagnoses surveyed in each of these supplements are outlined in the Supplement Completion Checklist, and in the Table of Contents at the beginning of each supplement. The skip out criteria in the Screening Interview specify which supplements, if any, should be completed. Like in the Screen Interview, each supplement has a list of symptoms, probes, and criteria to assess current (CE) and most severe past (MSP) episodes of disorder.

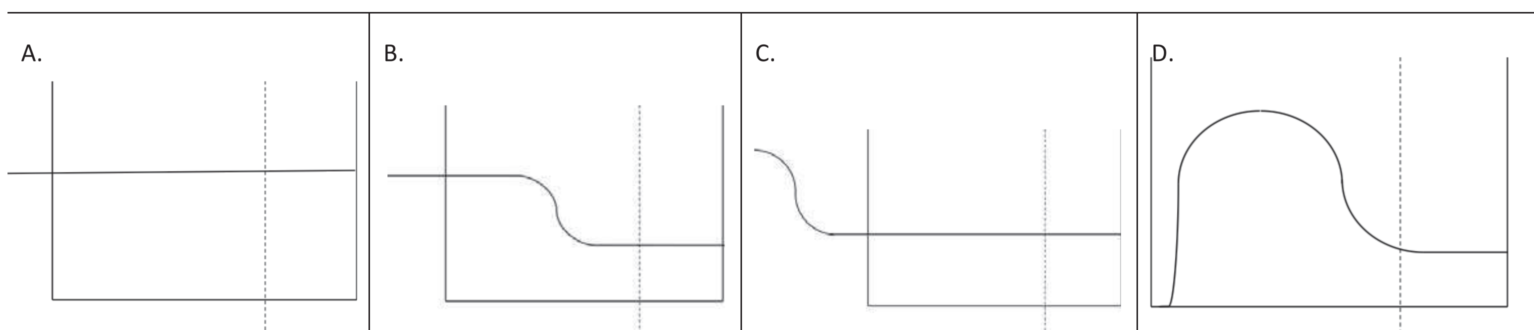
Supplements should be administered in the order that symptoms for the different diagnoses appeared. For example, if the child had evidence of Attention Deficit Hyperactivity Disorder (ADHD) beginning at age 5, and possible Major Depression (MDD) beginning at age 9, the Supplement for ADHD should be completed before the supplement for MDD. If the child had a history of attention difficulties associated with ADHD, when inquiring about concentration difficulties in assessing MDD, it is important to find out if the onset of depressive symptoms was associated with a worsening of the long standing concentration difficulties. If there was no change in attention problems with the onset of the depressive symptoms, the symptom 'Difficulty Concentrating' should not be rated positively in the MDD supplement.

When the time course of disorders overlap, supplements for disorders that may influence the course of other disorders should be completed first. For example, if there is evidence of substance use and possible Mania or Psychosis, the substance abuse supplement should be completed first, and care should be taken to assess the relationship between substance use and possible manic and/or psychotic symptoms.

6) *The Summary Lifetime Diagnostic Checklist* is a template that was designed to record basic lifetime and current diagnostic information. Clinicians / Investigators may wish to record additional, more specific information (e.g., dates of onset/offset or duration of additional episodes). The Follow-up Summary Diagnostic Checklist is a template designed to record longitudinal course of illness. These template checklists are included at the end of the supplements of the KSADS.

Using the K-SADS in Longitudinal Studies. When the KSADS is used to monitor subjects longitudinally, it is important to be sure that the symptoms and diagnoses are being scored since the last interview. The timeframe for the Current ratings needs to be defined, based on the aims of the study. For example, the Current period could be the month prior to the interview (or 2 weeks, or 2 months, etc.). Then symptoms and diagnoses are rated for the most symptomatic time during the current period. Past symptoms and diagnoses are rated based on the most severe symptomatology between the last interview and whatever time is defined as the Current rating period. These rules are more relevant for episodic disorders such as depression and mania/hypomania. It is recommended that each study define *a priori* the timeframes to be used in administering the KSADS for longitudinal assessments. Results from the follow-up interviews can then be recorded on the Longitudinal Summary Diagnostic Checklist. The longitudinal summary diagnostic checklist may require some modifications by Investigators to accommodate the aims, methodology, and outcome definitions (e.g., remission, recovery, remission, recurrence) utilized in each study.

As depicted below, the KSADS can be used to characterize the subject's longitudinal course of illness. The space between the first two lines on the left side of each diagram below depicts the course of illness since the last assessment up to the "current episode" timeframe, and the space on the right side of each diagram depicts the characterization of the current (e.g., last two months) symptomatology.



Legend. A) Figure A depicts a child with a chronic course of illness from the last interview; B) Figure B depicts a child who met full criteria during the last interview and continued to meet criteria during his most severe past episode during the follow-up interval, then met partial remission criteria during the "current" time frame assessed at follow-up; C) Figure C depicts a child who was in partial remission but never went into full remission during the "past" or "current" follow-up intervals, and is currently in partial remission: D) Figure D depicts a child who had no diagnosis at the initial interview, and then had an onset of a full diagnosis during the follow-up, but met for partial remission during the "current" follow-up interval.

Guidelines for the Administration of the Introductory Unstructured Interview

The unstructured interview should take at least 15 minutes to administer. The aim of the unstructured interview is to establish rapport and obtain information about presenting complaints, prior psychiatric problems, and the child's global functioning. It is helpful to spend a few minutes in general conversation in order to make the child and parent feel at ease.

The interview opens with questions about basic demographics. This is a very easy thing for most people to talk about, and the information helps to orient the interviewer to the child's life circumstances. Health and developmental history data should also be obtained from the parent, as this information may be helpful in making differential diagnoses. The child does not need to be queried about these things.

In discussing onset and course of symptoms, many children will be unable to provide reliable time data. This is developmentally normal. If the child does not provide such data in the first questioning, s/he will probably not provide it at all.

In interviewing the parent, modify the questions to refer to the child.

In the introductory interview and throughout the K-SADS, interviewers are encouraged to use language generated by the child and/or parent when asking about symptoms (e.g., "For how long did you feel bummed?").

After surveying the reason for referral, obtain information about treatment history. Then ask about the child's school adaptation and social relations.

In interviewing children, it is not necessary --- and usually not productive to try to complete all of the introductory interview. Review basic demographics (e.g., age, grade, family constitution, siblings' names and ages), presenting complaints (likely in less detail than with the parent), and family, school adaptation, and peer relations information. The discussion of these latter topics are extremely *important*, as it provides a context for eliciting mood symptoms (depression and irritability) from children, generate hypotheses about possible relevant diagonstic areas, and obtain preliminary information to evaluate functional impairment.

SUBJECT INFORMATION

First Name: 　　**Last Name:**

Date of Birth: __ __ / __ __ / __ __ __ __

Gender: ○ Male ○ Female

Ethnicity: ○ Hispanic or Latino ○ Not Hispanic or Latino

Race *(Mark all that apply)*:
- ○ Black or African American
- ○ Asian
- ○ White or Caucasian
- ○ Other Specify:
- ○ Native Hawaiian or Pacific Islander
- ○ Native American or Alaskan Native

With whom is subject currently living (choose one)?
- ○ Both biological parents
- ○ Both biological parents, but joint custody
- ○ Biological mother and stepfather
- ○ Biological father and stepmother
- ○ Biological mother and boyfriend/girlfriend
- ○ Biological father and boyfriend/girlfriend
- ○ Biological mother only
- ○ Biological father only
- ○ Stepmother only
- ○ Stepfather only
- ○ Grandparent
- ○ Adoptive parent
- ○ Other relative/friend
- ○ Foster home
- ○ Group home
- ○ Residential institution
- ○ Boarding home
- ○ Runaway
- ○ College student
- ○ Lives independently
- ○ Other