Interview Manual

K-SADS-BP

(Modified Manual for Adolescents at High Risk for Familial Bipolar Disorder)

2006
Contents

A. General Guidelines
   1. Notes
   2. Probe examples
      a. coding guidelines
   3. Summary scores
   4. Current and Past Episodes
      a.
B. Unstructured Introductory Interview
C. KSADS-PL Screening Interview
   1. Depression
      a. Organic Precipitants
      b. Tally Sheets
   2. Mania
      a. Organic Precipitants
      b. Tally Sheets
   3. Other
D. Summary Lifetime Diagnosis Checklist
E. Supplements
   1. Supplement #2 – Psychotic Disorders
   2. Supplement #3 – Anxiety Disorders
   3. Supplement #4 – Behavioral Disorders
   4. Supplement #5 – Substance Abuse
F. Narrative
G. Appendix A and B
A. General Guidelines
   1. Notes

   a. Use the informants vocabulary.
   b. Consider all possible diagnoses that could be made.
   c. Be sure to use different colors for each respondent
   d. Elicit a clear history of episode and chronology of disorder.
   e. Threshold (meets criteria for a symptom) is marked with an arrow.
   f. Marginal notes – marginal notes – marginal notes
2. Probes
(unwritten, suggested; ask as many as needed to determine presence/absence of symptoms,
or to get the required information)

To elicit age:

How old is (child/adolescent)?
What is the child’s date of birth?
Be sure to clarify ethnic category/race

To determine home environment:

Who lives in the home with (child/adolescent)?
Does (child/adolescent) have any contact with his/her biological father/mother? How often? Does he/she have visitations? Is the contact regular?
Does (child/adolescent) know of his/her whereabouts?
Has (child/adolescent) ever had contact with the absent parent? When was the last contact?

To determine health history:

Do you have any physical/medical problems?
Do you take any medication for a physical/medical problem?
Does this problem keep you from doing things you would like to do?
Does it cause any problems at school or with friends?
How do you feel about having this problem?

To determine medication compliance:

Do you take any medication for a physical/medical problem?
Does this problem keep you from doing things you would like to do?
Does it cause any problems at school or with friends?
How do you feel about having this problem?
Does taking medication on a regular basis cause any problems for you?
Do you take the medication when you are supposed to?
Do you ever not take the medication when you are supposed to?
To determine present complaint:

Do you have any concerns about (child/adolescent) mood or behavior?

(ask to the controls)

Do you or does anyone like your parents or teachers have any concerns about the way you behave or feel?

To elicit prior psychiatric treatment:

Has (child/adolescent) ever seen a doctor, counselor or therapist because of the way he/she was feeling or acting?

Has there ever been a time when (child/adolescent) saw a doctor, counselor or therapist for a problem with his/her mood or behavior?

Has there ever been a time when you or someone else thought that (child/adolescent) should have seen someone but you didn’t take him/her?

Has (child/adolescent) ever been a patient in a psychiatric hospital or ward or drug and alcohol rehabilitation center?

Was there ever a time when you saw a doctor, counselor or therapist because of the way you were feeling or acting?

Was there ever been a time when you saw a doctor, counselor or therapist for a problem with your mood or behavior?

- **For psychiatric treatment**, be sure to get all information regarding: dates seen, frequency of visits, age at time of contact, facility, contact person’s name and title, method of treatment provided, symptoms or conditions that initiated the contact (record in the margins)

- **For hospitalizations**, be sure to get all information regarding: dates hospitalized, duration of stay, age, hospital name, method of treatment, symptoms or conditions that initiated hospitalization (record in the margins)

- day hospital = psychiatric hospitalization

To elicit family history of medical and psychiatric illness:

Is there a history of any medical problems in the family such as heart disease, thyroid problems, cancer…?

Is there a history of any psychiatric problems in the family such as depression, anxiety…?
Does anyone in your family have a medical problem or a problem with their mood, like heart problems or depression?

**To elicit family, school, peer functioning:**

- What grade is (child/adolescent) in?
- Did (child/adolescent) ever repeat a grade?
- Is (child/adolescent) receiving any special services in school?
- What is your favorite class?
- What do you like/dislike in school?
- What are your grades like?
- Do you like your teachers?
- Do you have any school friends? Neighborhood friends?
- What do you like to do with your friends?
- How is your relationship with your mother? Father? Siblings?
- What do you like to do in your spare time?

**Supplement Probes**

**Anxiety Disorders**

**Separation Anxiety Disorder** – Missing Criteria that must be asked about, make marginal notes and consider when making diagnosis:

- Does (child/adolescent) endure the situation with intense anxiety or distress, and recognizes that the fear is excessive?
- Does (child/adolescent) have marked distress about having the phobia?

**Agoraphobia and Specific Phobia** – Missing Criteria that must be asked about, make marginal notes and consider when making diagnosis:

**Specific Phobia:**

- Does (child/adolescent) endure the phobic stimuli with intense anxiety?
- Does (child/adolescent) have marked distress about having the phobia?
Agoraphobia:

Does (child/adolescent) endure the situation with distress or anxiety about having a panic attack or panic-like symptoms?

Does (child/adolescent) require the presence of a friend or family member, other companion?

a. Coding Guidelines

1. Get as many examples as possible; marginal notes should be as detailed as possible.
2. Should be coding for:
   a. Severity
   b. Frequency
   c. Duration
   d. Functional Impairment

0 = no information
1 = symptom is not present
2 = subthreshold
3 = threshold

0 = no information
1 = symptom is not present (“no”)
2 = symptom is present (“yes”)

0 = no information
1 = not at all, no clinical significance
2 = slight
3 = mild
4 = moderate
5 = severe
6 = extreme
7 = very extreme

P = Parent
C = Child
S = Summary

KSADS Adolescent High Risk Study
KSADS-PL
WUSM 2006
7
3. Summary Scores

Summary ratings for current and past are determined from the ratings given by the child and parent.
- for subjective symptoms (internal) give more weight to adolescent’s rating
- for behavior symptoms (external) give more weight to the parent’s rating

If there is doubt about how to rate a summary score, i.e. over/under reporting of a symptom, use the self-report data from the questionnaires to make the final determination. The interviewer should also determine who is the more reliable reporter. In the most extreme circumstances, bring the parent and child together to get the most accurate rating.

4. Episodes
(see directions in Depression and Mania)

- **Current episode** – period of time when symptoms were at their worst during the designated episode. *Current is within 60 days of the date of the interview.*
- **Past episode** – period of time when symptoms were most severe during the most severe episode; to be considered past, there must be at least a 2 month remission of symptoms between episodes. *Past is more than 60 days from the date of the interview.*

- There will not always be a current and past episode.
  a. If there is no episode, current and past episodes will be asked
    1) **current**: “In the past 60 days, have you ever…?”
    2) **past**: “Has there been a time in the past, more than 60 days ago, when…?”
  b. Make sure to code each rating in the appropriate box.
  c. Make sure to get onset date and duration for each symptom not associated with an episode.

- Remind the informant frequently about what time period is being asked about.
- Follow this guideline throughout the entire interview to determine episodes

B. Unstructured Introductory Interview

The purpose of the unstructured introductory interview is to obtain information about demographics, personal and family medical history, psychiatric treatment history, academic, peer and family functioning. Questions in this section are asked of both the parent and child. There
are no specific probes for eliciting information. The interviewer must develop his/her own
questions or use the examples provided in the previous section of the manual.

Demographics:
   - be sure to ask or clarify race and ethnicity

Health History:
   - review mainly with the parent, because children do not always know the
specifics of this information; ask general questions to the child about
physical problems and medication use
   - be sure to review medication with the adolescents to determine
medication compliance
   - be sure to obtain clear onset/offset of physical problems and
medication

Developmental History:
   - ask of parent only

Details/Presenting Complaint
   - ask of both parent and child
   - should take about 3 minutes each

C. Screening Interview

1. Depression

   - Medication – should focus on a time prior to the onset medication or during  medication
holidays; note in margins which symptoms are/were effectively treated with medication
   - QDS4.a.1. To determine if the episode is clean, use information received earlier in the
introductory interview, and be sure to ask “what was going on” when the subject was feeling that
way. This will give you the best idea as to whether or not the episode is clean.

   a. DOP

   - DOP1  Code silently if male

   - If there is no episode to direct questions, i.e. only 1 or 2 symptoms, ask,
     “The symptoms that you did have, did they occur…?”

   b. Tally Sheets

   - Fill out the tally sheets no matter how many symptoms endorsed in the section. Ask,
“Did any of these occurred for a period of at least 2 weeks?”

2. Mania

- **Medication** – should focus on a time prior to the onset medication or during medication holidays; note in margins which symptoms are/were effectively treated with medication
- QDS4.a.1. To determine if the episode is clean, use information received earlier in the introductory interview, and be sure to ask “what was going on” when the subject was feeling that way. This will give you the best idea as to whether or not the episode is clean.
- Q18: the given ratings are not structured for episodes. Use your best judgment from the probes on the left to determine where an individual rates.

a. MOP

- If there is no episode to direct questions, i.e. only 1 or 2 symptoms, ask,
  
  “The symptoms that you did have, did they occur…”
- MOP5.a thru b – if there has been no evidence of an overlap of mania and depression, no need to ask all the questions. Just code N/A box.

b. Tally Sheets

- Fill out the tally sheets no matter how many symptoms endorsed in the section. Ask,

  “Did any of these occurred for a period of at least 2 weeks?”

3. Other

D. Summary Lifetime Diagnosis Checklist

E. Supplements

If the subject meets criteria in the screening interview for a disorder, go directly to the corresponding supplement before continuing through the screener.

1. Supplement #2 – Psychotic Disorders
2. Supplement #3 – Anxiety Disorders
3. Supplement #4 – Behavioral Disorders
4. Supplement #5 – Substance Abuse
F. Narrative
(see example narratives)

The narrative is to be completed at the end of each KSADS. The narrative is a summary of the parent and child scores.

There should be a summary for each section of the interview. Be as thorough as possible.
A new narrative will be written for each follow-up interview.

The format of the KSADS narrative will be similar to the DIGS narrative. See “Guide to Narrative Summaries”