Enclosed you will find the current draft of the KID-SCID. We will probably add an eating disorders and Tourette's modules in the near future. It is meant to be a double sided copy, hence the occasional "this page intentionally blank" notice. Let me know if you will be using this instrument, or if you need any more information.

The Structured Clinical Interview for DSM-IV, Childhood version (KID-SCID), is a new semistructured instrument designed to generate childhood DSM-IV diagnoses for clinical research studies. The authors are: Denise Hien, Ph.D., Fredrick Matzner, M.D., Michael First, M.D., Robert Spitzer, M.D., Janet Williams, D.S.W., and Miriam Gibbon, M.S.W. It is based on the adult version of the SCID. The first draft has modules for the Disruptive Behavior Disorders, Mood and Psychotic Episodes, Mood and Psychotic Disorders, Anxiety Disorders, Alcohol and Substance Disorders, and Adjustment Disorders.

The KID-SCID is designed to be administered by trained mental health clinicians and generates Diagnostic and Statistical Manual 4th Edition (DSM-IV) child and general psychiatric disorders. It is divided into modules, each module assessing one class of disorder. After the scoring section, there is an overview interview, followed by the diagnostic modules themselves. If you turn to page A-1, you will see how the instrument is designed. There are three columns. The center column lists word for word DSM-IV criteria for each disorder. The left hand column consists of suggested (not required) probe questions which are designed to help the rater determine whether the center column criteria are present or not. It should be explained that clinical judgment is used to determine if criteria are present. That is, a child demonstrating an obviously sad affect would receive a true for a sad criteria, even if he or she denied feeling sad. Finally, the rightmost column contains coding boxes where the rater codes his or her answers.

Since we do not yet have a manual, here are some guidelines:
Impress on the raters that the instrument is a container for them to do a normal clinical evaluation. They will almost certainly fall into the trap of treating the KID-SCID as a questionnaire, and simply code the patient's responses. This is incorrect. The probe questions are simply guidelines to determining whether the criteria are satisfied. You really are not asking questions, you are determining whether the criteria is present. So the rater should always stop and read the center column first to understand what they are supposed to figure out. Then look at the probe questions from that viewpoint. Some of the probe questions lead up to the meat of the matter. For example, in the Conduct Disorder, a criteria states "lies to ... obtain goods or favors (i.e., cons....)". But the first probe question merely asks if the patient lies. If you get a yes, then further probe questions zero in on the central aspect of the criteria, conning others.

Raters will invariably say, “the patient satisfies the criteria, so I had to mark it a 3 (true), but I could tell he wasn’t really (whatever the diagnosis is)”. This cannot happen if the instrument is administered correctly. The rater has to include their own judgment in determining whether a 3 is warranted. One of the real strengths of semi-structured instruments over fully structured is that the clinician can hear a yes response and reject it if clinically appropriate. In other words, fully structured interviews must accept a yes. This means they will be over inclusive, make too many diagnoses, have too many false positives. Clinical judgment in a semi-structured interview allows the clinician to reject diagnoses that may technically satisfy the criteria but do not, for example, cause significant impairment. So many children will be afraid of clowns, but the clinician can decide they do not have a disorder.

Probe questions are suggestions only. Make sure the child or parent understands the questions. Frequently the response will be “sometimes”, so you will have to probe further to determine for example severity or frequency. “How often do you fight? How bad are the fights?”

Clinical judgment also includes the mental status exam. So a patient denying problems but looking, say, markedly sad, would merit a yes in a criteria for sad mood. Same with hyperactivity, obvious fidgetiness would merit a 3 even if the patient denies it.

The coding box looks like this:

	?	1	2	3
CHI				
PAR				
OTH				
BEST				

? means insufficient information, 1 means untrue, 2 means subthreshold (pay attention to this box. Most incidences of unreliability happen when a patient is barely under or barely over threshold), and 3 means definitely true.

The “CHI” row is for coding based on the interview of the child, and includes all sources of information during the interview with the child, including as stated above, your observations of the child. Over nine years old, a child can usually answer probe questions. The younger the child, the more you will rely only on observation to determine whether the criteria is true.

The “PAR” row is for the interview with the parent. Again, use clinical judgment, not just a yes or no from the parent. With small children especially it makes sense to interview the parent and child together. Ask the parent questions and code in the PAR row, while observing the child and coding that information in the CHI row.

“OTH” is for ALL other sources of information. Old chart, teacher reports, friends, relatives, etc.

“BEST” is where the clinician synthesizes all the information gathered. If there are any contradictions, it is up to the clinician to decide whether the child truly meets the criteria. Just like a normal clinical interview, right? Since no one has a good algorithm for combining data from parents, teachers, and child, it’s up to you. Remember that parents and teachers both identify about 10% of all children as disturbed, but it’s two different 10%! No overlap! It is the BEST row that one uses to determine whether the child has the disorder.

Try to make the interview as naturalistic as possible. Reading the probe questions stiffly as if it is a poll will get old fast. Use the overview section to get to know the child, so you too can sort of chat your way through it. DON'T ask a question you already know the answer to. Frequently the child or parent will give you information in other areas while answering a question. e.g., answering questions about nightmares with the info that they sleep poorly. Or with the Oppositional Defiant question about blaming others, the child may volunteer that they never lie. You do not have to ask the lying question in the Conduct Disorder section.

Pay close attention to the instructions below the coding box. If you get a 1 in a key spot, you can skip the rest of the module. At the top of some of the modules, you can check off no and skip the module entirely. Also look closely at the substance/alcohol modules (G). The coding is different and is listed at the bottom. This section is complicated and you have to be sure you know what you are doing.

Although the full KID-SCID is lengthy, it is unusual for an interview to last beyond sixty minutes. The KID-SCID is designed to be easy to tolerate on the part of children. Questions are naturalistic, and skip-outs are used extensively to shorten the length of the interview. For example, if a child denies any use of substances or alcohol, those sections are completely skipped.

As part of the development of the KID-SCID, pilot data was generated in order to determine whether interrater reliability was adequate. ICC 2,1 was used as the reliability statistic. The data indicated excellent interrater reliability in the Disruptive Behavior module, .842 for ODD and CD, and 1.0 for ADHD[1] .

[1] Matzner, F., 1994. "Videotapes as Training Tools for the Development of the KID-SCID", Scientific Proceedings, American Academy of Child and Adolescent Psychiatry 42nd Annual Meeting.

The next step in determining the utility of this instrument in clinical studies is to assess test-retest reliability in order to determine whether the instrument reliably generates the same diagnoses in the same subject. Following is the abstract for a poster presentation on preliminary test-retest reliability. It was presented at the 1997 meeting of the American Psychiatric Association.

PRELIMINARY TEST-RETEST RELIABILITY OF THE KID-SCID
Fredrick J. Matzner, Principal Investigator. Raul Silva, M.D, Matthew Silvan, Ph.D., Mizanur Chowdhury, Lisa Nastasi.

Objective: The Structured Clinical Interview for DSM-IV, Childhood Diagnoses (KID-SCID) is a new semistructured instrument designed for clinical research studies. It is based on the adult SCID which has good reliability and utility. The KID-SCID is easy to use, has utility as a training tool, and has demonstrated excellent interrater reliability. This study examines preliminary test-retest reliability of disruptive behavior and anxiety diagnoses in a clinic population.

Method: Subjects consisted of all patients (n=15; 11 male, 4 females; mean age 12 years, range 7-17) who received the Disruptive Behavior and Anxiety Modules of the KID-SCID during the course of two separate clinical evaluations at a Child Psychiatry clinic. These modules are part of this clinic's standard psychiatric evaluation. A chart review extracted KID-SCID diagnoses, and the kappa statistic was used to determine the chance-corrected agreement between the first and second interviews.

Results: Kappa scores consisted of:
Disruptive Behavior Disorders: Attention Deficit/Hyperactivity Disorder .84, Conduct Disorder .84, Oppositional Defiant Disorder .63.
Anxiety Disorders: Social Phobia 1.0, Separation Anxiety Disorder .66, and Posttraumatic Stress Disorder .44.
Conclusion: Preliminary reliability is shown to be good, with three diagnoses showing excellent reliability. A larger reliability study is now under way, examining more females and children from each age group. This instrument shows promise for its intended purpose.

Hope this helps. Please give me a call with any questions, and I would greatly appreciate feedback about rough edges.

Sincerely,

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