K-SADS-PL

To the Editor:

We applaud the excellent review of the development of the K-SADS provided in the article titled "Historical Development and Present Status of the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS)" (Ambrosini, 2000). Please note, however, that the user information for the K-SADS-PL was incorrectly supplied in the article. For information on the K-SADS-PL, readers should contact Joan Kaufman, Ph.D., Yale University, University Towers, Suite 2H, 100 York Street, New Haven, CT 06511; fax: (203) 764-9990; e-mail: joan.kaufman@yale.edu. The interview can also be downloaded from the Internet at www.wpic.pitt.edu or www.info.med.yale.edu/psych.

The administration time of the K-SADS-PL was also incorrectly noted. When the K-SADS-PL is administered to normal controls, the parent and child interviews each take approximately 35 to 45 minutes. When the K-SADS-PL is administered to psychiatric patients, depending on the range and severity of psychopathology, parent and child interviews each take approximately 1.25 hours—or 2.5 hours total to collect the data from both informants.

We would also like to provide some additional information about the K-SADS-PL that may be helpful to readers. The K-SADS-PL includes an initial 82-item screen interview that surveys key symptoms for current and past episodes of 20 different diagnostic areas, skip-out criteria that determine whether additional interviewing is necessary, and supplemental diagnostic sections to be completed if indicated. As noted by Ambrosini, the screen interview and skip-out criteria shorten administration time. The screen interview also provides a diagnostic overview of lifetime psychopathology that facilitates differential diagnoses by permitting more targeted probing of relevant symptoms. For example, if after completing the screen interview a child appears to meet possible criteria for attention-deficit/hyperactivity disorder (ADHD) beginning at age 5, and major depression (MDD) beginning at age 9, interviewers are instructed to complete the supplement for ADHD before the supplement for MDD. If the child was found to have a history of attention difficulties associated with ADHD, when inquiring about concentration difficulties in assessing MDD, interviewers are instructed to find out whether the onset of depressed mood was associated with a worsening of the long-standing concentration difficulties. If there was no change in attention problems with the onset of depressive symptoms, the symptom concentration difficulties would not be rated positively in the MDD supplement. Likewise, information about a possible substance abuse disorder obtained in the screen interview can be quite helpful when inquiring about supplemental symptoms of depression and mania and finalizing diagnoses of the affective disorders. The screen interview and diagnostic supplement format is unique to the K-SADS-PL, and it greatly facilitates administration of the instrument with normal controls and patient populations.

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SEVERE LEUKOPENIA WITH VALPROATE

To the Editor:

Valproate (divalproex sodium, Depakote®) is increasingly being used in child and adolescent psychiatry. Although leukopenia with use of valproate has been reported, treating 2 patients with severe leukopenia in 1 year reminded me of the need for alertness to this possibility.

Patient A., a nearly 13-year-old African-American boy, had been hospitalized twice and was placed in a residential treatment center for about 6 months prior to returning to a special school placement. He was receiving no medications. He was living with his elderly great-grandmother, who was unsure of his history except that his biological mother had a history of "ups and downs." He had no reported allergies and was in good health. Prior reported problems with his temper and fighting resurfaced. He became "mad at people because they lie on me; teacher acts too smart!" The patient and his guardian agreed to a valproate trial after a risk-benefit discussion that included the court-