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Adaptation Of The Kiddie Schedule For Affective Disorders And Schizophrenia (K-SADS-PL-5) For Diagnosing Oppositional Defiant Disorder In The Algerian Educational Setting (6-18 Years)

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Abstract:

The current study aims to describe the psychometric properties of the Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS-PL-5) for children of school age. This version, extended to life span, was specifically adapted to assess Oppositional Defiant Disorder (ODD) after being translated into Arabic and culturally tailored for the Algerian context. Information was collected from a sample of 221 children and adolescents aged 6 to 17 years, along with parent-reported data. Data analysis was performed using statistical software, relying on frequencies and percentages for categorical variables, and means and standard deviations for continuous variables. To assess reliability and validity, unweighted Kappa coefficients, criterion validity, and construct validity were computed using ROC analysis and non-parametric AUC estimation. The study's findings reveal high reliability and validity for the tool used to diagnose Oppositional Defiant Disorder, with a Cronbach's alpha of 0.893 and a composite reliability coefficient of 0.73, indicating strong reliability. Furthermore, the validity results from expert raters (0.81) and confirmatory factor analysis supported the tool's applicability in diagnostic settings. These findings highlight the diagnostic strength and strong psychometric properties of the tool, confirming its high reliability and validity in diagnosing mental disorders in children, particularly in school settings, thus supporting its clinical use.

Keywords: Adaptation; K-SADS-PL-5; Oppositional Defiant Disorder; Algerian Educational Setting.

Introduction:

The Kiddie Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS-PL-5) is a widely used semi-structured tool for assessing mental disorders in children and adolescents. It was developed to provide reliable and accurate diagnoses of mood disorders, anxiety disorders, schizophrenia spectrum disorders, and other neuropsychological conditions.

The latest edition reflects updated criteria from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

Numerous psychometric studies have confirmed the reliability and validity of the K-SADS-PL-5 across different cultural and linguistic contexts, demonstrating its clinical efficacy and robustness as a diagnostic tool. For instance, the study by Kaufman et al. (2006) reported a high level of inter-rater agreement ($\kappa = 0.93$) and good internal consistency for several of its subscales ($\alpha = 0.79–0.94$), reinforcing its effectiveness in diagnosing a range of mental disorders in childhood. Similar studies conducted in non-English-speaking environments also indicated acceptable sensitivity and reliability for the tool, supporting its applicability across different cultural contexts (Ortuño-Cierra et al., 2019; Chang et al., 2020).

The updated version, in line with DSM-5, shows inter-rater agreement between $\kappa = 0.68$ to 1.00 and test-retest reliability between $\kappa = 0.73$ to 0.82, suggesting strong diagnostic stability. Recently, research into online computerized versions of the K-SADS-PL-5 (K-SADS-COMP) has further supported the efficiency and reliability of digital modifications. A study conducted by the Childmind Institute's Healthy Brain Network tested various K-SADS-COMP versions administered by clinicians, parents, or children themselves on a sample of 511 children and adolescents aged 6 to 18 years. Results showed that clinician-administered versions took significantly less time (91.9 ± 50.1 minutes) compared to traditional paper versions. The child-administered version took 50.9 ± 28.0 minutes, while the parent-administered version took 63.2 ± 38.3 minutes.

Moreover, users reported a positive experience with the online version, and all three K-SADS-COMP versions demonstrated good convergent validity with established clinical measures and post-assessment diagnostic evaluations for each disorder. Furthermore, combining data from both parents and children showed good to excellent agreement (AUC = 0.89–1.00) for clinician-administered versions (Townsend et al., 2020). These results support the effectiveness of K-SADS-COMP in both clinical practice and large-scale epidemiological studies, including applications in schools, emergency departments, and telemedicine mental health services.

However, despite the widespread use of this tool internationally, there is a lack of studies assessing its application within the Algerian educational setting, emphasizing the need to verify its validity and reliability in this environment.

Among the many disorders assessed by the K-SADS-PL-5, Oppositional Defiant Disorder (ODD) is of particular significance. This disorder is characterized by persistent patterns of negative, oppositional, and defiant behavior towards authority figures, significantly impacting a child's social, academic, and familial functioning. Accurate diagnosis of this disorder is crucial for developing appropriate intervention strategies that improve the child's adjustment and minimize the negative impact.

Our study aims to translate and adapt the section of the K-SADS-PL-5 dedicated to diagnosing Oppositional Defiant Disorder to Arabic, while considering cultural and linguistic differences. This work includes a precise translation followed by an evaluation of the validity and reliability of the translated version, ensuring its clinical effectiveness and diagnostic importance in the Algerian educational setting.

1- The objectives of this study are:

* To adapt the section on Oppositional Defiant Disorder of the tool to Arabic, while considering cultural and linguistic differences.
* To assess the reliability and validity of the translated version through psychometric analyses.
* To compare the obtained results with data from the original version.

2- Methodology:

* 2.1 Research Approach or Methodology Adopted for the Adaptation and Translation

The nature of the research problem and study requires the researcher to adopt a specific approach in accordance with the objectives they aim to achieve. To test the hypotheses of the current study, the descriptive-analytical method was employed due to its suitability for the topic and study goals, which seek to verify the psychometric properties of the tool under investigation. The descriptive method is defined as the approach that involves studying existing, observable phenomena and practices that are available for study and measurement as they are, without researcher bias (Al-Agha, 2000, p. 43).

The study adhered to the guidelines and procedures set by the International Test Commission (ITC) for the adaptation of psychological tests.

*2.2 Study Sample:

This study included a sample of Algerian students from primary and middle schools. Participants were selected based on specific criteria to ensure accurate representation of the target group. The study focused on school-aged children between the ages of 6 and 16, who had obtained prior consent from their parents to participate. Data collection took place within educational institutions, following approval from the relevant administrative authorities and in adherence to ethical standards regarding parental consent. A total of 221 students were contacted for the study.

*2.3 Study Sample:

The Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS-PL-5) is a semi-structured diagnostic interview tool designed to assess mental and psychiatric disorders in children and adolescents, based on the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) for individuals aged between 6 and 18 years. It assesses symptoms both in their present and past forms. This tool evaluates a wide range of mental disorders, including mood and anxiety disorders, psychotic disorders, behavioral disorders, and neurodevelopmental disorders (Kaufman et al., 2016; Townsend et al., 2020).

Diagnoses are classified into three categories:

- **Confirmed**
- **Probable**, when about 75% of the diagnostic criteria for symptoms are met
- **Not present**

3- Interview Components:

- 1. **Preliminary Interview**: The first part involves establishing rapport with the examinee and gathering demographic information, medical history, and psychiatric history, including previous treatments and school performance. This step is crucial for contextualizing symptoms such as depression, irritability, and anxiety, as well as assessing the level of functional impairment (Rutter & Graham, 1968).

- 2. **Diagnostic Interview**: The diagnostic interview consists of 82 items related to symptoms, distributed across twenty diagnostic domains. This stage aims to improve the efficiency of the evaluation by allowing specialists to bypass diagnostic areas that are irrelevant when no symptoms surpass the diagnostic threshold (Nishiyama et al., 2020).

- 3. **Diagnostic Appendices**: The guide includes five diagnostic appendices:

- Mood disorders
- Psychotic disorders
- Anxiety disorders
- Substance use disorders, eating disorders

The application of each appendix is based on the results of the diagnostic interview. If the child meets the criteria for multiple disorders, priority is given to those with an early onset to facilitate differential diagnosis (Ortuño-Sierra et al., 2019)

4- Guidelines and Timeframe Coding:

For current disorders, symptoms are evaluated based on their peak intensity during the episode. The examiner documents symptom changes over time to determine if the disorder is active, partially improved, or resolved. In cases where medications are used (e.g., for ADHD), evaluations reflect the severity of symptoms before treatment began or during periods when the child is without medication (Zhang et al., 2020).

5- Rating System:

*Most items in the guide are rated from 0 to 3 as follows:

- 0 = No information available
- 1 = Symptom not present
- 2 = Symptoms below the diagnostic threshold
- 3 = Symptom meets the diagnostic threshold.

Some items follow a 0–2 scale, depending on the symptom area being assessed.

*** Duration of Administration:**

When applied to typically developing children, interviews with both parents and children take approximately 35 to 45 minutes each. In the case of a real disorder, the duration may extend to approximately 1 hour and 15 minutes per interview (Townsend et al., 2020).

1. **Procedure:**

For children, the interview is conducted first with the parents, followed by the child. For adolescents, the order is reversed, with the adolescent being interviewed first, followed by the parents.

Diagnoses are assigned using a composite evaluation that integrates data from both sources. Independent raters verify adherence to DSM criteria to ensure diagnostic accuracy.

2. 3.3 Translation and Cultural Adaptation of the Guide

In this study, the translation process for the K-SADS-PL-5, specifically for the Oppositional Defiant Disorder section, was carried out using rigorous procedures to ensure conceptual and linguistic equivalence between the original version and the Arabic version within the Algerian context.

Cultural adaptation extends beyond literal translation and involves rephrasing sections to preserve their psychological significance and original meaning. To achieve this, a multi-stage approach was adopted:

1. **Initial Translation**: The first stage involved a translation by experts in psychology and linguistics.
2. **Back Translation**: A back-translation was then conducted to verify how closely the translated version matches the original text.
3. **Semantic and Contextual Analysis**: A panel of experts in psychology and psychometrics conducted a semantic and contextual analysis. This stage helped identify any cultural or linguistic differences that might affect participant understanding of the items. Based on this analysis, adjustments were made to ensure alignment with Algerian Arabic culture and social norms.
4. **Pilot Study**: An experimental study was conducted on a small sample to evaluate the clarity and ease of understanding of the items. Participant feedback facilitated further refinement in the phrasing, ensuring that the tool was culturally and socially appropriate for Algeria.

As a result, the translation and cultural adaptation of the K-SADS-PL-5 for the Oppositional Defiant Disorder section yielded a valid and reliable version that meets the methodological requirements for use in clinical and research settings in Algeria.

3. 4. Statistical Methods Used in the Study:

Data were processed using the Statistical Package for Social Sciences (SPSS) v22 and the specialized SPSS Amos v22 software for structural equation modeling to conduct confirmatory factor analysis. The following statistical methods were employed:

- **Loehlin's Equation**: To calculate apparent validity.
- **Pearson Correlation Coefficient**: To compute the correlation for internal consistency validity, criterion validity, and test-retest reliability.
- **Spearman's Rank Correlation:** To calculate the correlation for internal consistency validity and convergent validity.
- **Cronbach's Alpha**: To measure internal consistency reliability.
- **Stratified Alpha:** To assess internal structure reliability.
- **Composite Reliability:** To measure internal structure reliability.
- **Weighted Omega (ω):** To measure internal structure reliability.
- **Confirmatory Factor Analysis:** To verify the factorial structure.
- **Guttman's Coefficient and Rulon's Coefficient:** To check reliability using the split-half method.
- **Binary Logistic Regression**: To assess predictive validity.

Additionally, the following fit indices were used to assess model fit:

- **SRMR (Standardized Root Mean Square Residual)**
- **RMSEA (Root Mean Square Error of Approximation)**
- **ECVI (Expected Cross-Validation Index)**
- **AIC (Akaike Information Criterion)**
- **TLI (Tucker-Lewis Index)**

4. 3. Presentation of Results

1. 3.1 Validity

1. Internal Structure Validity of the Oppositional Defiant Disorder (ODD) Scale (TOP)

Expert Validity:

The expert validity data, assessed using Loehlin's equation, were obtained after presenting the scale to 15 professors and specialists from various national universities. They provided a range of suggestions and modifications, resulting in a strong expert validity coefficient of 0.81. This indicates that most of the experts agreed that the tool measures what it is intended to measure, confirming that the test belongs to the domain it was designed to assess.

Internal Consistency Validity of the Oppositional Defiant Disorder (ODD) Scale (TOP):

Item Number	Item Description	Correlation Value	Significance
01	Destruction of physical property	0.444	0.000
02	Examination	0.446	0.000
03	Theft with violence	0.559	0.000
04	Arson	0.507	0.000
05	Staying out at night	0.601	0.000
06	Night-time escape	0.396	0.000
07	Use of a weapon	0.548	0.000
08	Physical force with others	0.455	0.000
09	Coercive sexual practices	0.499	0.000
10	Animal abuse	0.392	0.000
11	Social feedback	0.606	0.000
12	Family	0.628	0.000
13	In school	0.437	0.000
14	Duration	0.487	0.000
15	Type: onset in childhood	0.473	0.000
16	Type: onset in adolescence	0.413	0.000
17	Arguments in favor of behavioral disorder according to DSM-5	0.478	0.000
18	Type: in-group	0.537	0.000
19	Type: solitary aggressive	0.437	0.000
20	Type: indifferent	0.451	0.000
21	Limited positive social feelings	0.450	0.000
22	Intensity	0.452	0.000

Table 2: **Spearman's Correlation Coefficient between Each Item of the Oppositional Defiant Disorder (ODD) Scale (TOP) and the Total Score of the Scale**.

The table presents the Spearman correlation coefficients between each item of the ODD Scale (TOP) and the total score of the scale. At the significance level of **0.05**, all 22 items exhibit strong validity. These items are considered valid for inclusion in the scale due to their demonstrated internal consistency, indicating that the scale is measuring what it was designed to measure.

Model Testing: (Construct Validity)

The goodness of fit for the confirmatory factor analysis model of the Oppositional Defiant Disorder (ODD) Scale (TOP) is shown in the table below:

Fit Index	Calculated Value	Acceptance Criterion
Absolute Fit Indices		
Chi-Square/df Ratio (DF/x^2)	2.385	Between 1 and 3
Standardized Root Mean Square Residual (SRMR)	0.0688	Should be below 0.1, preferably less than 0.08
Root Mean Square Error of Approximation (RMSEA)	0.079 LO:0.070/HI:0.088	Values between 0.05 and 0.08 indicate good fit; confidence interval should range from 0 to 0.08
Parcimony Correction Indices		
Expected Cross-Validation Index (ECVI)	Current model: 2.666 Saturated model: 2.300 Independent model: 7.931	ECVI of the current model should be smaller than both saturated and independent models
Akaike Information Criterion (AIC)	Current model: 586 Saturated model: 506 Independent model: 1744	AIC of the current model should be smaller than both saturated and independent models
Comparative Fit Indices		
Comparative Fit Index (CFI)	0.80	Should be greater than 0.9
Tucker-Lewis Index (TLI)	0.78	Should be greater than 0.9

Table (03): Goodness of Fit Indices for the Confirmatory Factor Analysis Model of the Oppositional Defiant Disorder (ODD) Scale (TOP) Before Modification

The RMSEA value of the current model is 0.079, which is below the threshold of 0.08, indicating a good fit between the hypothesized model and the observed data. However, the confidence interval exceeded the recommended upper bound of 0.08. While most indices were satisfactory, the Expected Cross-Validation Index (ECVI) and Akaike Information Criterion (AIC) were below the acceptance threshold, as the current model's value was higher than the saturated model. This suggests the model lacks information economy. Some modifications to the model may improve these values (Daesh, 2017).

4.1 Parameter Estimation Before Modification

The values for the parameters of the current model were as follows:

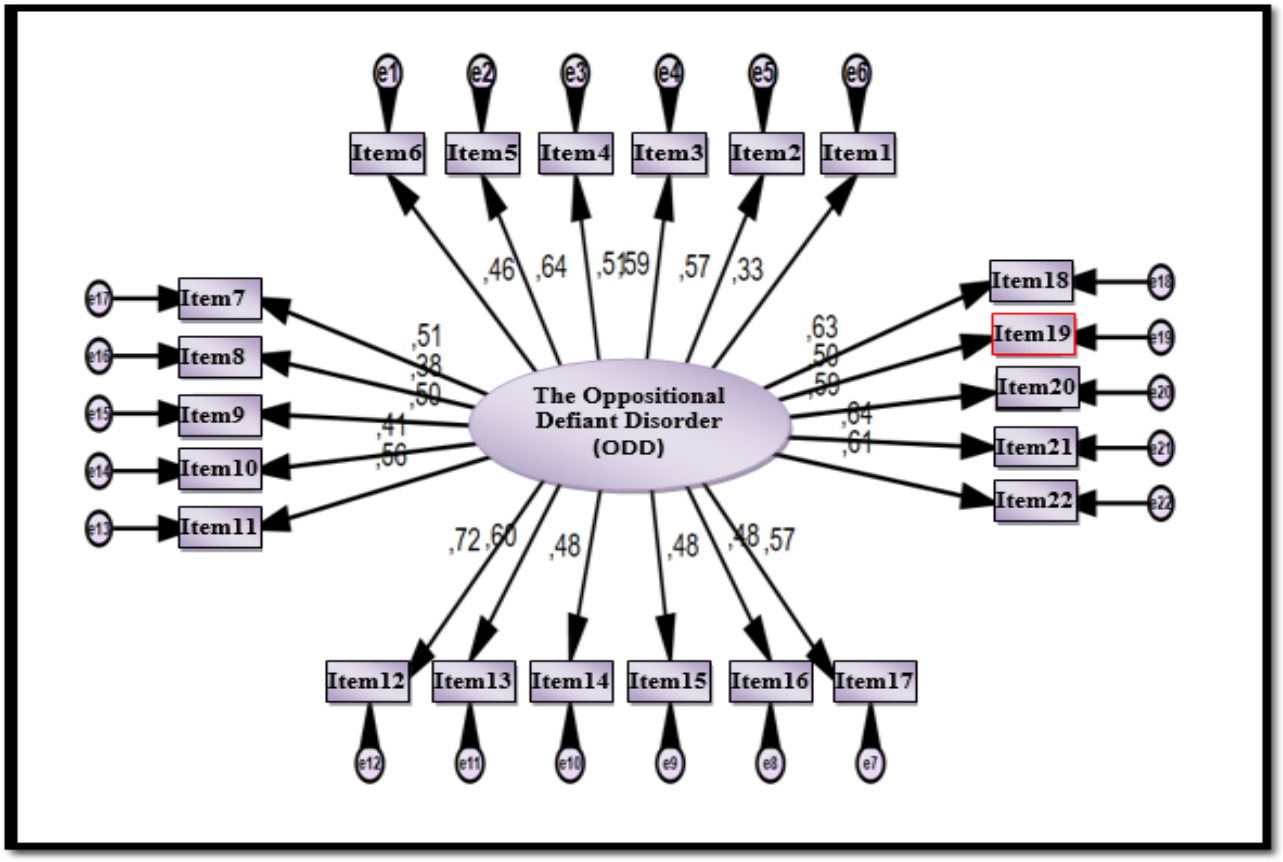

Figure (01): Standardized Parameter Values for the Confirmatory Factor Analysis Model of the Oppositional Defiant Disorder (ODD) Scale (Before Modification)

5. 4.3 Model Modification

At this stage, the researcher examines residuals and modification indices to identify areas of misfit in the hypothesized model. According to Teghza (2012, p. 286), the first diagram reflects the initial confirmatory factor analysis (CFA) model of the Oppositional Defiant Disorder (ODD) Scale (TOP), before any modifications were made. While the factor loadings appeared relatively acceptable, the fit indices—particularly the parsimony indices—were below the acceptable thresholds. This necessitated a detailed review of the modification indices, which suggested several adjustments, summarized as follows:

Path			Covariance Estimate	Standardized Estimate
e2	<--> e3		21.331	0.283
e19	<-->	e20	19.915	0.238
e3	<-->	e21	17.524	-0.192
e21	<-->	e22	15.589	0.150

Table (17): Modification Indices for the Confirmatory Factor Analysis (CFA) Model

From the table above, the most significant proposed modification was between the residuals of **Item 5 (e2)** and **Item 4 (e3)**, with a covariance value of **21.252**, the highest among all suggested modifications. The standardized estimate for this relationship was **0.283**, which was also the

highest, suggesting it would have the greatest impact on improving model fit. Consequently, three model modifications were implemented based on these indices.

6. Post-Modification Model Fit and Reliability

Statistiques de fiabilité	
Alpha de Cronbach	Nombre d'éléments
,893	22

Since the Cronbach's Alpha (α) = 0.959, it indicates that the scale items demonstrate very high internal consistency and strong reliability.

Additionally, the composite reliability was estimated using the composite reliability coefficient formula, which utilizes the outputs of confirmatory factor analysis (CFA), particularly the standardized parameters of the model and the standard errors of these values. The formula is as follows:

$$\text{composite reliability} = \frac{(\sum \text{std loading})^2}{(\sum \text{std loading})^2 + \sum \xi j}$$

Where:

- ∑Std Loading : Sum of the standardized parameters for each latent variable.
- ∑ξj : Sum of error variances for each construct (Daesh, 2017).

The results were as follows:

1. **Table (18): Composite Reliability Values**

Scale	C.R Value
Oppositional Defiant Disorder	0.73

From the table, it is evident that the composite reliability (C.R) values are high, indicating that the scale demonstrates strong reliability. According to Hair, "A value greater than 0.7 is considered good, and a value between 0.6 and 0.7 is considered acceptable and also taken into consideration."

2. **Comparison Between Cronbach's Alpha and Composite Reliability:**

Scale	C.R Value	α Value (Cronbach's Alpha)
Oppositional Defiant Disorder	0.73	.....

The table shows that both Cronbach's Alpha and Composite Reliability (C.R) values for the Oppositional Defiant Disorder scale are good, further reinforcing that the scale possesses strong reliability. This provides additional evidence of the scale's stability.

Discussion

The researcher used sevral methods to measure the psychometric properties of the tool to ensure its validity and robustness, as well as its ability to be reused in future studies with specialized goals beyond the scope of the current study. To assess the reliability of the Oppositional Defiant Disorder (ODD) Scale, the researcher employed multiple methods. The first was Cronbach's Alpha,

which yielded a very high reliability estimate of 0.893, indicating excellent and highly trustworthy reliability. The researcher then utilized more advanced methods to measure reliability, such as the Composite Reliability coefficient, which examines the variability in factor loadings across the items, thus confirming the extent to which the items are correlated with the variables. In other words, it measures the contribution of each variable to explaining its latent factor, considering error values. The Composite Reliability coefficient also showed a high and very strong reliability value of 0.73.

The study's reliability results align with other similar studies, such as the study by Takeshi Nishiyama et al. (2020), where the reliability between raters was very high, with a Kappa (κ) ≥ 0.8.

Furthermore, the results of our study are consistent with those of the original version, which demonstrated a high reliability of 93% between raters, with test-retest reliability ranging from 0.77 to 1.00, as well as strong validity in diagnosing Oppositional Defiant Disorder. This makes the tool precise and reliable for both clinical and research use (Kaufman, J. 1997).

Next, the researcher calculated the validity of the tool, starting with expert validity. The initial version of the tool was distributed to 15 professors and specialists in clinical and school psychology, psychometrics, and related fields from various universities. Their feedback was considered from methodological, linguistic, and content perspectives. All scientifically-founded observations and suggestions were taken into account. Upon calculating expert validity using Loehlin's Equation, a validity coefficient of 0.81 was obtained, which indicates strong and acceptable expert validity.

The researcher then calculated the internal consistency of the tool using Spearman's correlation coefficient, obtaining strong validity for all items, with 22 items being retained for further analysis. To further ensure the tool's validity, the researcher performed confirmatory factor analysis (CFA) and obtained good fit indices, thus confirming the accuracy of the proposed model.

All of these results, which are very strong, demonstrate the validity and reliability of the tool, confirming its suitability for use in both clinical and research settings. These findings align with various similar studies, such as the study by Al-Yawa et al. (2017), where the tool was adapted using similar methods and yielded strong psychometric properties. Similarly, Ghanizadeh et al. found that the Iranian version of the tool demonstrated high validity and reliability.

In another context, Oshimaya et al. confirmed that the Japanese version of the tool also exhibited strong psychometric properties and diagnostic strength.

Conclusion

Oppositional Defiant Disorder (ODD), as addressed by the diagnostic interview guide adapted in this study, often presents diagnostic and evaluative challenges due to the similarity and overlap of symptoms—particularly the comorbidity between conduct disorder and oppositional defiant disorder. These disorders frequently share impairments in cognitive, emotional, and behavioral skills, which significantly affect adaptive functioning across school, family, and community environments. As Des Portes notes, the diagnostic tool used must not be underestimated, and the evaluation-intervention process should be initiated promptly. A dynamic clinical diagnostic approach, such as the K-SADS-PL-5, which evaluates both the current and historical state through

parental interviews and review of child records, is crucial. This diagnostic method allows for the assessment of the child's emotional, motor, cognitive, and relational development.

Therefore, the culturally adapted interview guide developed in this study represents a fundamental tool in clinical and educational evaluations. Its comprehensive symptomatology and cross-sectional and historical assessment provide meaningful clinical interpretations of symptoms in the Algerian educational context.

The study offers a standardized clinical interview guide tailored to global diagnostic criteria, providing practical value to school and clinical psychologists, especially in light of the shortage of psychological services in school-based health units. It also addresses the difficulty of accurate diagnosis faced by practitioners in clinical and school psychology due to the complex interplay of biological, cognitive, psychological, cultural, and social factors in childhood and adolescence—making child diagnosis a dynamic and adaptable process. In contrast to adults, children's psychological structures are still in development, meaning diagnosis must be flexible and context-sensitive. Misdiagnosis risks are higher during childhood, and understanding the continuity of mental disorders from childhood to adulthood remains a core developmental concern. Thus, the parent or guardian's mediation is essential for a comprehensive diagnosis, as family and social contexts often define the extent of a child's psychological distress.

Recommendations, Future Prospects, and Study Limitations

This contribution stems from the recognized importance and effectiveness of the guide, as supported by several international studies conducted in France, Spain, Portugal, South Korea, Turkey, and Brazil, all of which demonstrated good to excellent psychometric properties.

In the future, this tool could be implemented as a dynamic diagnostic instrument in school health screening and follow-up units to investigate a range of mental disorders. Additionally, further work could aim to adapt other dimensions of the guide, especially in its computerized version, which would improve accessibility and integration in modern clinical settings.

The current version of the adapted guide only became available after overcoming several obstacles and challenges. The researcher found no prior adapted or validated version of the guide in Algerian or Arab contexts, in addition to the novelty of this diagnostic tool, which requires specialized training for its clinical use. This is due to the variability and overlap of diagnostic criteria across the disorders addressed by the guide. Thus, personal training was necessary for the researcher, along with the need to train future assessors in understanding and applying this diagnostic process effectively.

Moreover, there were challenges in collecting data from students across different educational stages, which the tool is designed to assess, and in ensuring that the sample was representative of the broader population.

Despite these challenges, which may have affected the adaptation process and psychometric precision to some extent, the current study aligns with previous international research, demonstrating that the guide possesses acceptable diagnostic accuracy in the Algerian school setting, supported by its validity, reliability, and predictive capability in differentiating between past and present symptomology.

7. FUNDING

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

8. DATA AVAILABILITY

The data that support the findings of this study are available from the corresponding author upon reasonable request.

9. STATEMENTS AND DECLARATIONS

- **Conflict of Interest**: The author declares that they have no competing interests.
- **Ethics Approval**: The author declares that the work is written with due consideration of ethical standards.
- **Informed Consent**: The participants have given their written informed consent.
- **Consent for Publication**: All the participants have given their consent for the publication of the research results.

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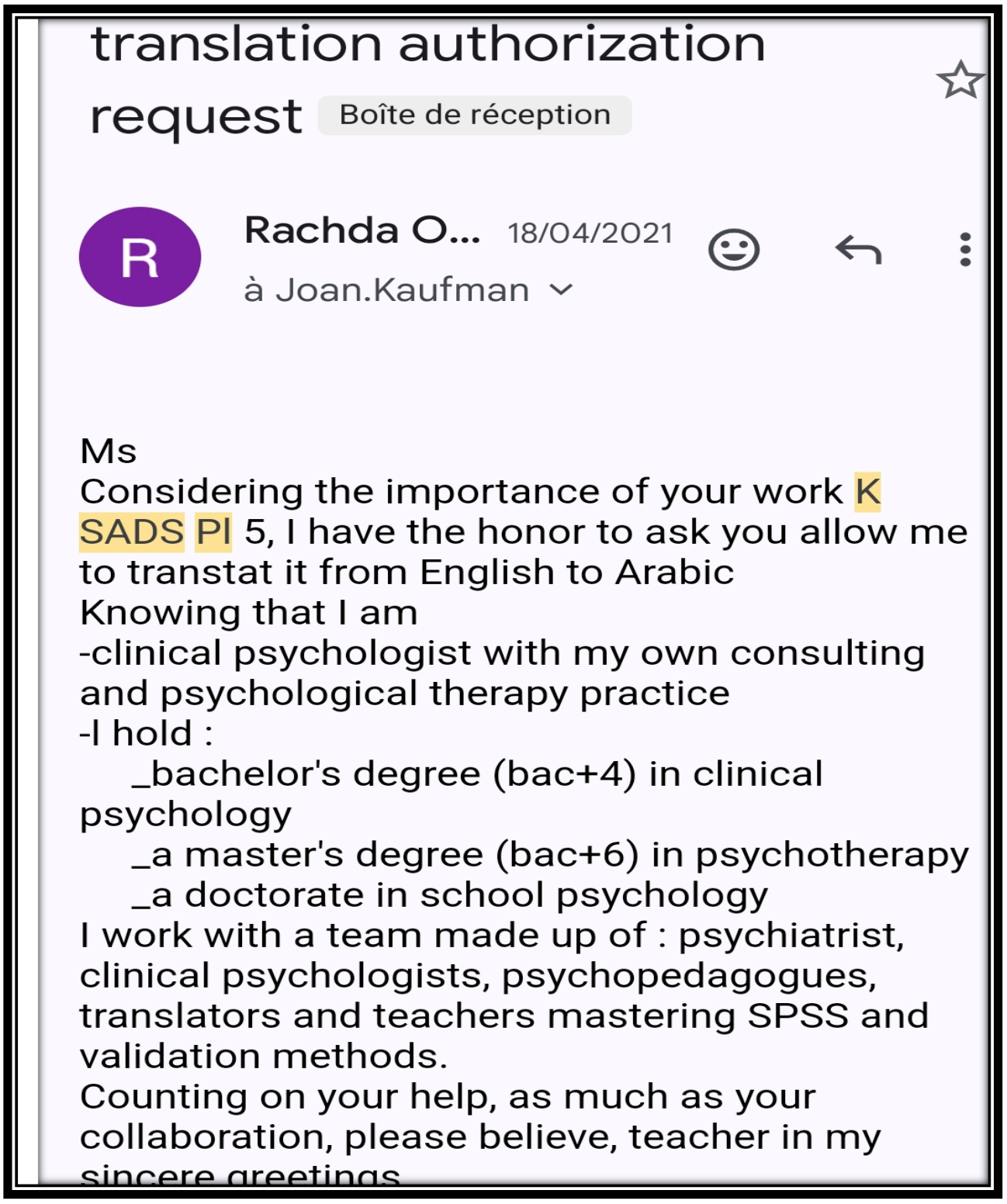
10. Appendix 1: License for Tool Adaptation



translation authorization request Boîte de réception

Rachda O... 18/04/2021

à Joan.Kaufman

Ms
Considering the importance of your work K SADS Pl 5, I have the honor to ask you allow me to transtat it from English to Arabic
Knowing that I am
-clinical psychologist with my own consulting and psychological therapy practice
-I hold :
_bachelor's degree (bac+4) in clinical psychology
_a master's degree (bac+6) in psychotherapy
_a doctorate in school psychology
I work with a team made up of : psychiatrist, clinical psychologists, psychopedagogues, translators and teachers mastering SPSS and validation methods.
Counting on your help, as much as your collaboration, please believe, teacher in my sincere greetings

De : **Kaufman, Joan**
<Joan.Kaufman@kennedykrieger.org>
Date: dim. 18 avr. 2021, 20:33

Subject: Re: translation authorization request
To: Rachda Oumlili
<rachda.oumlili@gmail.com>

Masquer les messages précédents

Dr. oumlili racheda né Saad Hellah -
Thank you for your interest in the KSADS-PL. We have created a web-based version of the KSADS that has many advantages over the paper-and-pencil version of the instrument. I have attached a copy of our manuscript describing the development and characteristics of the web-based KSADS-COMP. You can also try a demo at www.ksads-comp.com

Programming the KSADS-COMP in foreign languages has costs -- but if you think you might have the resources, I much prefer the new web-based version of the instrument.

All the best, Joan

Joan Kaufman, Ph.D
Director of Research
Center for Child and Family Traumatic Stress
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https://www.amazon.com/Broken-Three-Times-Story-America/dp/0199399158
www.ksads-comp.com

From: Rachda Oumlili <rachda.oumlili@gmail.com>
Sent: Sunday, April 18, 2021 7:48:27 AM
To: Kaufman, Joan
Subject: translation authorization request

KKI SECURITY ALERT: This email is from an external source. Do not click on any links or open attachments unless you recognize the sender and know the content is safe.

Ms
Considering the importance of your work K SADS PI 5, I have the honor to ask you allow me to transtat it from English to Arabic
Knowing that I am
-clinical psychologist with my own consulting and psychological therapy practice
-I hold :
_bachelor's degree (bac+4) in clinical psychology
_a master's degree (bac+6) in psychotherapy
_a doctorate in school psychology
I work with a team made up of : psychiatrist, clinical psychologists, psychopedagogues, translators and teachers mastering SPSS and validation methods.
Counting on your help, as much as your collaboration, please believe, teacher in my